NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Shared Agenda for the meetings in common of:

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

Thursday 17 September 2026 10:00-13:00

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

Ref	Item	Presenter	Type	DD	L	NN	Enc	Time
	Introductory items							
1.	Welcome, introductions and apologies	Kathy McLean	-	✓	✓	✓	-	10:00
2.	Confirmation of quoracy	Kathy McLean	-	✓	✓	✓	-	-
3.	Declarations and management of interests	Kathy McLean	Information	✓	✓	✓	✓	-
4.	Minutes of the meetings in common, held on 16 July 2026	Kathy McLean	Decision	✓	✓	✓	✓	-
5.	Action log and matters arising from the meetings in common, held on 16 July 2026	Kathy McLean	Discussion	✓	✓	✓	-	-
	Leadership and operating context							
6.	Chair's Report	Kathy McLean	Information/ Decision	✓	✓	✓	✓	10:05
7.	Chief Executive's Report	Amanda Sullivan	Information	✓	✓	✓	✓	10:15
	Population health and commissioning priorities							
8.	Population Health Strategy Progress Report: Neighbourhood Health	Clair Raybould, Maria Principe, Dr Dave Briggs	Assurance	✓	✓	✓	✓	10:30
	Oversight and delivery of commissioning outcomes							
9.	Citizen experience: Maternity families	Clair Raybould	Discussion	✓	-	-	✓	10:55

Ref	Item	Presenter	Type	DD	L	NN	Enc	Time
10.	Maternity and Neonatal Services: Response to Local and National Reviews and Improvement Priorities (*to follow*)	Rosa Waddingham	Assurance	✓	✓	✓	✓	11:10
11.	Quality Oversight Report	Rosa Waddingham	Assurance	✓	✓	✓	✓	11:30
12.	Winter Plan	Maria Principe	Decision	✓	✓	✓	✓	11:45
13.	Commissioning Oversight Report	Maria Principe, Dr Dave Briggs	Assurance	✓	✓	✓	✓	12:00
14.	Finance Report	Bill Shields	Assurance	✓	✓	✓	✓	12:15
	Governance							
15.	Board Assurance Framework	Lucy Branson	Assurance	✓	✓	✓	✓	12:30
16.	Committee Highlight Reports	Committee Chairs	Assurance	✓	✓	✓	✓	12:45
	Items for information							
17.	Boards' Work Programme	-	Information	✓	✓	✓	✓	-
	Closing items							
18.	Risks identified during the course of the meeting	Kathy McLean	Discussion	✓	✓	✓	-	12:55
19.	Questions from members of the public	Kathy McLean	-	✓	✓	✓	-	-
20.	Any other business	Kathy McLean	-	✓	✓	✓	-	-
	Meeting close							**13:00**

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

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	17/09/2026
Paper title:	**Declaration and management of interests**
Paper reference:	ICB CIC 26 042
Paper author:	Committee Secretariat
Paper sponsor:	Kathy McLean, Chair
Presenter:	Kathy McLean

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

Report summary:

As custodians of tax-payers money, Integrated Care Boards (ICBs) are required to implement and demonstrate robust arrangements for the identification and management of conflicts of interest. These arrangements should support good judgement about how any interests should be approached and managed; safeguarding the organisation from any perception of inappropriateness in its decision-making and assuring the public that money is being spent free from undue influence. The ICBs' arrangements for the management of conflicts of interests are set out in the organisations' Standards of Business Conduct Policy.

Details of the declared interests for members of the Board are attached at Appendix A. An assessment of these interests has been performed against the meeting agenda and the outcome is recorded in the section below on conflicts of interest management.

Members are also reminded of their individual responsibility to highlight any interests not already declared should a conflict (or potential conflict) become apparent in discussions during the meeting. Should any interests arise during the meeting, the ICBs' agreed arrangements for managing these are provided for reference at Appendix B.

Recommendation(s):

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

Appendices

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

Board Assurance Framework

Not applicable.

Relevant statutory duties:

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

Relevant statutory duties:	
☐ Promoting education/training	☐ Climate change

Are there any conflicts of interest requiring management?
No.

Is this paper confidential?
No.

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

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

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

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Board Meetings in Common Register of Interests 2026/27

Surname	Forename	Position	Member of			Declared interest (name of organisation and nature of business)	Nature of interest	Type of Interest				Date of Interest		Action taken to mitigate risk
			NHS Derby and Derbyshire ICB	NHS Lincolnshire ICB	NHS Nottingham and Nottinghamshire ICB			Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Lalani	Mehrunnisa	Non-Executive Member	✓	✓	✓	Brother is employed by iBC Healthcare, which provides specialist support and bespoke accomodation to adults with complex care needs	Role within an NHS, local authority or provider organisation.				✓	01/01/2025	Present	To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by iBC Healthcare LTD.
Lim	Kelvin	Primary Medical Services Partner Member	–	–	✓	Registered patient at Eastwood Primary Care Centre	Use of NHS services commissioned by the ICB (registered patient).			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
Lim	Kelvin	Primary Medical Services Partner Member	–	–	✓	Clinical lead for various projects at Primary Integrated Community Service (PICS), a provider of local health services in the Nottinghamshire area	Role within an NHS, local authority or provider organisation.	✓				01/07/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by Primary Integrated Community Services.
McLean	Kathy	Chair	✓	✓	✓	Director of Kathy McLean Limited, a private limited company offering health related advice	Ownership and/or directorship of a private company	✓				01/07/2022	Present	To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Kathy McLean Limited.
McLean	Kathy	Chair	✓	✓	✓	Member of the Workforce Policy Board at NHS Employers, an organisation which supports workforce leaders and represents employers in the NHS	Role within an NHS, local authority or provider organisation.		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
McLean	Kathy	Chair	✓	✓	✓	Chair of National Negotiation Committee for staff and associate specialists on behalf of NHS Employers, an organisation which supports workforce leaders and represents employers in the NHS	Role within an NHS, local authority or provider organisation.		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
McLean	Kathy	Chair	✓	✓	✓	Occasional Advisor to the Care Quality Commission, the Independent regulator of health and social care services in England	External role or association (non-NHS), declared for transparency.	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
McLean	Kathy	Chair	✓	✓	✓	Chair of The Public Service Consultants Ltd, a public sector consultancy business	External role or association (non-NHS), declared for transparency.	✓				01/07/2022	Present	To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by The Public Service Consultants Ltd.
McLean	Kathy	Chair	✓	✓	✓	Advisor at Lio (formerly Oxehealth) Ltd, a health-tech company that develops digital monitoring and operational platforms focussed on inpatient mental health care.	External role or association (non-NHS), declared for transparency.	✓				01/11/2024	Present	To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Lio Ltd.
McLean	Kathy	Chair	✓	✓	✓	Chair of the ICS Network Board at NHS Confederation, a membership organisation for the whole healthcare system in England, Wales and Northern Ireland.	Role within an NHS, local authority or provider organisation.	✓				01/04/2024	Present	This interest will be kept under review and specific actions determined as required.
McLean	Kathy	Chair	✓	✓	✓	Trustee of the NHS Confederation, a membership organisation for the whole healthcare system in England, Wales and Northern Ireland.	Trustee or leadership role in a voluntary, charitable or community organisation		✓			01/06/2025	Present	This interest will be kept under review and specific actions determined as required.
McLean	Kathy	Chair	✓	✓	✓	Chair of an expert panel conducting an independent review of Betsi Cadwalladr Health Board (funded by NHS Wales)	Role within an NHS, local authority or provider organisation.	✓				01/08/2026	31/10/2026	This interest will be kept under review and specific actions determined as required.
McLean	Kathy	Chair	✓	✓	✓	Paid briefing to independent sector companies on strategic commissioning paid by Newmarket Strateg (health and life sciences consultancy) via Kathy McLean Ltd	Ownership and/or directorship of a private company	✓				21/07/2026	21/07/2026	This interest will be kept under review and specific actions determined as required.
Melbourne	Jon	NHS Trust/Foundation Trust Partner Member	–	–	✓	Chief Executive of Sherwood Forest Hospitals NHS Foundation Trust	Role within an NHS, local authority or provider organisation.	✓				01/10/2025	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by Sherwood Forest Hospitals NHS Foundation Trust
Melbourne	Jon	NHS Trust/Foundation Trust Partner Member	–	–	✓	Director and Shareholder of Ten Five Four Homes Limited	Ownership and/or directorship of a private company	✓				01/08/2022	Present	This interest will be kept under review and specific actions determined as required.
Mott	Andrew	Primary Medical Services Partner Member	✓	–	–	Managing GP partner at Jessop Medical Practice	Role within an NHS, local authority or provider organisation.	✓				01/07/2022	Present	To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Jessop Medical Practice.

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

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Samuels	Martin	Local Authority Partner Member	–	✓	–	Association of Directors of Adult Social Services	External role or association (non-NHS), declared for transparency.		✓			01/04/2023	Present	This interest will be kept under review and specific actions determined as required.
Shields	Bill	Director of Finance	✓	✓	✓	Chair of Financial Recovery Group at the Healthcare Financial Management Association	External role or association (non-NHS), declared for transparency.		✓			01/04/2025	Present	This interest will be kept under review and specific actions determined as required.
Shields	Bill	Director of Finance	✓	✓	✓	Vice Chair of ICB Chief Finance Officers' Forum at the Healthcare Financial Management Association	External role or association (non-NHS), declared for transparency.		✓			01/04/2025	Present	This interest will be kept under review and specific actions determined as required.
Shields	Bill	Director of Finance	✓	✓	✓	Chair of the 360 Assurance Management Board	Role within an NHS, local authority or provider organisation.		✓			01/12/2025	Present	This interest will be kept under review and specific actions determined as required.
Shields	Bill	Director of Finance	✓	✓	✓	Member of Advisory Committee on Resource Allocation	External role or association (non-NHS), declared for transparency.		✓			01/04/2026	Present	This interest will be kept under review and specific actions determined as required.
Shields	Bill	Director of Finance	✓	✓	✓	Chair of CFO AI Network	External role or association (non-NHS), declared for transparency.		✓			01/04/2026	Present	This interest will be kept under review and specific actions determined as required.
Simpson	Paul	Local Authority Partner Member	✓	–	–	Chief Executive Officer at Derby City Council	Role within an NHS, local authority or provider organisation.	✓				01/03/2026	Present	This interest will be kept under review and specific actions determined as required.
Smith	Adrian	Local Authority Partner Member	–	–	✓	Chief Executive of Nottinghamshire County Council	Role within an NHS, local authority or provider organisation.	✓				01/11/2025	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by Nottinghamshire County Council
Sullivan	Amanda	Chief Executive Officer	✓	✓	✓	Registered patient at Hillview Surgery	Use of NHS services commissioned by the ICB (registered patient).			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
Thomas	Kevin	Primary Medical Services Partner Member	–	✓	–	GP partner at Market Rasen Practice	Role within an NHS, local authority or provider organisation.	✓				01/08/2023	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
Thomas	Kevin	Primary Medical Services Partner Member	–	✓	–	Company Director of RCWT Property Ltd	Ownership and/or directorship of a private company	✓				01/11/2020	Present	This interest will be kept under review and specific actions determined as required.
Thomas	Kevin	Primary Medical Services Partner Member	–	✓	–	Clinical Director of East Lindsey Primary Care Network	Role within an NHS, local authority or provider organisation.	✓				01/03/2022	Present	This interest will be kept under review and specific actions determined as required.
Thomas	Kevin	Primary Medical Services Partner Member	–	✓	–	Workforce lead at the Lincolnshire Training Hub, which assists with workforce transformation in primary care	Role within an NHS, local authority or provider organisation.	✓				01/04/2021	Present	This interest will be kept under review and specific actions determined as required.
Thomas	Kevin	Primary Medical Services Partner Member	–	✓	–	Deputy Chair of the Lincolnshire Primary Care Network Alliance	Role within an NHS, local authority or provider organisation.		✓			01/04/2022	Present	This interest will be kept under review and specific actions determined as required.
Thomas	Kevin	Primary Medical Services Partner Member	–	✓	–	Director of East Lincolnshire Primary Care Limited	Role within an NHS, local authority or provider organisation.	✓				01/03/2022	Present	This interest will be kept under review and specific actions determined as required.
Thomas	Kevin	Primary Medical Services Partner Member	–	✓	–	Spouse is a salaried GP at Lincolnshire Practice and an employee of United Lincolnshire Hospitals NHS Trust	Role within an NHS, local authority or provider organisation.				✓	01/08/2018	Present	This interest will be kept under review and specific actions determined as required.
Towler	Jon	Non-Executive Member	✓	✓	✓	Registered patient at Sherwood Medical Practice	Use of NHS services commissioned by the ICB (registered patient).			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
Towler	Jon	Non-Executive Member	✓	✓	✓	Family members are registered patients at Major Oak Medical Practice, Edwinstowe	Use of NHS services commissioned by the ICB (registered patient).				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
Towler	Jon	Non-Executive Member	✓	✓	✓	Chair (Trustee and Director) of The Conservation Volunteers: a national charity bringing together people to create, improve and care for green spaces.	Trustee or leadership role in a voluntary, charitable or community organisation	✓				01/12/2022	31/08/2026	*N/A - This interest expired on 31/08/2026 and will be removed from the register on 01/03/2027.*
Waddingham	Rosa	Director of Quality (Nursing)	✓	✓	✓	Member of the Advisory Board at NHS Professionals, an NHS staff bank, owned by the Department of Health and Social Care.	Role within an NHS, local authority or provider organisation.		✓			01/09/2023	Present	This interest will be kept under review and specific actions determined as required.

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

Surname	Forename	Position	Member of			Declared interest (name of organisation and nature of business)	Nature of interest	Type of Interest				Date of Interest		Action taken to mitigate risk
			NHS Derby and Derbyshire ICB	NHS Lincolnshire ICB	NHS Nottingham and Nottinghamshire ICB			Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Waddingham	Rosa	Director of Quality (Nursing)	✓	✓	✓	Son is employed as a dispensing manager at Specsavers (Bingham)	Role within an NHS, local authority or provider organisation.				✓	01/02/2024	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be provided by Specsavers
Waddingham	Rosa	Director of Quality (Nursing)	✓	✓	✓	Honorary Professor at Nottingham Trent University	External role or association (non-NHS), declared for transparency.		✓			11/11/2024	Present	This interest will be kept under review and specific actions determined as required.
Waddingham	Rosa	Director of Quality (Nursing)	✓	✓	✓	Division Commissioner for Grantham and the villages / Charity Trustee of GirlGuiding Lincolnshire South	Trustee or leadership role in a voluntary, charitable or community organisation			✓		01/08/2025	Present	This interest will be kept under review and specific actions determined as required.
The following individual will be in attendance at the meeting but is not part of the Committee's membership:														
Branson	Lucy	Director of Corporate Governance and Assurance	✓	✓	✓	Registered patient at St George's Medical Practice	Use of NHS services commissioned by the ICB (registered patient).			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
King	Daniel		_	_	✓	Nottingham Trent University	Employee	✓				06/09/2023	Present	This interest will be kept under review and specific actions determined as required.

Appendix B

Managing Conflicts of Interest at Meetings

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

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

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

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

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

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

Minutes of the meetings in common of:

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

16 July 2026, 10:00-13:00

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

		NHS Derby and Derbyshire ICB	NHS Lincolnshire ICB	NHS Nottingham and Nottinghamshire ICB
Members present:				
Dr Kathy McLean	Chair	✓	✓	✓
John Dunstan	Non-Executive Director (from item ICB CIC 26 027)	✓	✓	✓
Stephen Jackson	Non-Executive Director	✓	✓	✓
Margaret Gildea	Non-Executive Director	✓	✓	✓
Mehrunnisa Lalani	Non-Executive Director	✓	✓	✓
Dr Kelvin Lim	Primary Care Partner Member	-	-	✓
Jon Melbourne	NHS Trust/ Foundation Trust Partner Member	-	-	✓
Dr Andrew Mott	Primary Care Partner Member	✓	-	-
Stephen Posey	NHS Trust/ Foundation Trust Partner Member	✓	-	-
Maria Principe	Executive Director of Commissioning	✓	✓	✓
Clair Raybould	Executive Director of Strategy and Citizen Experience	✓	✓	✓
Sharon Robson	Non-Executive Director	✓	✓	✓
Bill Shields	Executive Director of Finance	✓	✓	✓
Amanda Sullivan	Chief Executive	✓	✓	✓
Dr Kevin Thomas	Primary Care Partner Member	-	✓	-
Jon Towler	Non-Executive Director	✓	✓	✓
Rosa Waddingham	Executive Director of Quality (Nursing)	✓	✓	✓
In attendance:				
Lucy Branson	Director of Corporate Governance and Assurance	✓	✓	✓
Ellie Houlston	Director of Public Health, Lincolnshire County Council	-	✓	-
Vivienne Robbins	Director of Public Health, Nottinghamshire County Council (on behalf of Adrian Smith)	-	-	✓
Andy Smith	Director People Services, Derby City Council (Interim Local Authority Partner Member)	✓	-	-
Sue Wass	Corporate Governance Officer, NHS Nottingham and Nottinghamshire ICB (Minutes)	✓	✓	✓
Matthew Whittaker	Operational Lead, Team Up, Swadlincote Primary Care Network (for item ICB CIC 26 025)	-	-	-
Jacqui Willis	Chief Executive, Derbyshire Voluntary Action	✓	-	-

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

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

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

Introductory items

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

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

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

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

ICB CIC 26 021 **Confirmation of quoracy**

The meetings were confirmed as quorate.

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

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

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

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

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

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

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

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

No other matters were raised.

Leadership and operating context

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

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

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

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

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

The following points were made in discussion:

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

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

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

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

The Boards **noted** the Citizen Story.

At this point Matthew Whittaker left the meeting.

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

Kathy McLean introduced the item, highlighting the following points:

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

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

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

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

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

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

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

Amanda Sullivan introduced the item, highlighting the following points:

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

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

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

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

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

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

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

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

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

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

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

At this point John Dunstan joined the meeting

The following points were made in discussion:

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

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

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

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

The Boards:

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

Leadership and operating context

ICB CIC 26 028

Population Health Strategy Progress Report: Frailty and End of Life

Clair Raybould introduced the item, highlighting the following points:

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

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

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

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

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

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

The following points were made in discussion:

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

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

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

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

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

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

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

The Boards **received** the report.

Oversight and delivery of commissioning outcomes

ICB CIC 26 029

Approach to Quality

Rosa Waddingham introduced the item, highlighting the following points:

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

b) The approach built upon the ICBs' existing quality strategies, as well as the emergent National Quality Board guidance and new national quality strategy, which had been published very recently. The approach had been developed and refined following discussions at the Joint Quality and Service Improvement Committee during December 2025 and January 2026 and a Committee development session in March 2026.

c) It outlined a key set of seven quality priorities for 2026/27; and through the recently launched System Quality Group, had been tested with providers and partners for synergy and difference and aligned with the ICBs' Five-Year Population Health Strategy and Five-Year Strategic Commissioning Plan.

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

The following points were made in discussion:

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

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

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

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

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

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

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

ICB CIC 26 030 **Quality Oversight Report**

Rosa Waddingham introduced the item, highlighting the following points:

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

b) The report also reflected the establishment of the ICBs' Quality and Oversight Assurance Group as the operational coordination group for quality oversight of commissioned services, which provided an opportunity to further strengthen coordinated quality governance across the ICBs' footprints. The Group highlighted key risks, areas of focus, and the mitigating actions in place to address quality concerns and confirmed how assurance was obtained through established governance arrangements.

c) Members were asked to note that, although there were some discrepancies in data, all quality concerns were triangulated with other intelligence, including 'soft' intelligence and performance concerns.

The following points were made in discussion:

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

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

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

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

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

ICB CIC 26 031 **Commissioning Oversight Report**

Maria Principe introduced the item, highlighting the following points:

a) The report provided an overview of the national priority service delivery metrics against the operational plans submitted for 2026/27 for NHS Derby and Derbyshire, NHS Lincolnshire, and NHS Nottingham and Nottinghamshire ICBs, as well as an update on the arrangements for commissioning leadership and oversight across the ICBs' areas, and the arrangements for provider oversight and delivery.

b) Overall, detail within the report reflected a pressured system; however, there were clear areas of progress and a strengthened commissioning approach to support recovery and delivery.

c) As described in the last update to the Boards, the revised commissioning oversight approach had now been implemented across the ICBs to strengthen commissioner-led oversight of performance, finance, quality, contracting and operational delivery. This represented a significant cultural shift towards a more proactive and co-ordinated commissioning model focused on delivery, escalation and system accountability overseen by the ICBs' Commissioning Oversight Group and a series of cross-ICB Programme Boards.

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

The following points were made in discussion:

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

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

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

ICB CIC 26 032 **Finance Report**

Bill Shields introduced the item, highlighting the following points:

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

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

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

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

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

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

Governance

ICB CIC 26 033

Annual Reports on Working in Partnership with People and Communities

Clair Raybould introduced the item, highlighting the following points:

a) The paper sought to provide assurance on how the ICBs had discharged their statutory duties in relation to public involvement and consultation, setting out the ways that the ICBs had worked with people and communities from 1 April 2025 to 31 March 2026.

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

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

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

The following points were made in discussion:

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

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

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

Clair Raybould introduced the item, highlighting the following points:

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

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

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

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

The following points were made in discussion:

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

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

ICB CIC 26 035 **Risk Management Policy**

Lucy Branson introduced the item, highlighting the following points:

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

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

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

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

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

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

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

ICB CIC 26 036 **Committee Highlight Reports**

The report presented an overview of the work of the committees since the Boards' last meeting in May 2026; it aimed to provide assurance that the committees were effectively discharging their delegated duties and included assessments of the levels of assurance the committees had gained from their work during the period.

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

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

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

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

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

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

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

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

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

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

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

Meeting date	Agenda item	Action	Lead	Due date	Updates	Status
21.05.2026	ICB CIC 26 008	To progress alignment of Freedom to Speak Up arrangements between the ICBs.	Lucy Branson	17.09.2026	See agenda item 7.	**Closed – action completed**
16.07.2026	ICB CIC 026 029	To include a description of quality oversight arrangements in the strategic priority report on Strong General Practice, scheduled for presentation at the November meeting of the Board.	Rosa Waddingham	19.11.2026	Not yet due.	**Open – on track**
16.07.2626	ICB CIC 026 030	To amend future reports to bring the most critical quality concerns to the fore, along with the ICBs' commentary on how assured the ICBs were that their concerns would or could be addressed.	Rosa Waddingham	17.09.2026	See agenda item 11.	**Closed – action completed**

Key:

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

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	17/09/2026
Paper title:	**Chair's Report**
Paper reference:	ICB CIC 26 045
Paper author:	Dr Kathy McLean, Chair
Paper sponsor:	Dr Kathy McLean
Presenter:	Dr Kathy McLean

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

Report summary:

This report provides an update on my activities as Chair of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire ICB, including engagement undertaken on behalf of the ICBs and reflections on significant national, local and Board matters.

Recommendation(s):

The Boards are asked to:

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

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

Appendices

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

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Chair's Report

Introduction

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

National matters

Neighbourhood health

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

Maternity and neonatal services

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

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

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

Community mental health support

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

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

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

Industrial relations

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

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

Local and system matters

Annual Public Meetings

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

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

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

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

Organisational transition

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

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

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

Future ICB footprints and local government reorganisation

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

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

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

Winter preparedness

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

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

Visits and engagement

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

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

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

Board matters

Committee terms of reference

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

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

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

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

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

Schemes of Reservation and Delegation

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

Looking forward

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

Appendix A

Transition Committee – Terms of Reference

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

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

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

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

Finance and Performance Committee – Terms of Reference

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

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

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

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

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

Audit Committee – Terms of Reference

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

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

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

n) The Committee will:

i) Be notified of any new bank accounts or changes to existing bank accounts, and any arrangements made with the ICB's bankers for accounts to be overdrawn.

ii) Approve the use of procurement or other card services by the ICB, including the types of card services that should be allowed, the types of transactions that should be permitted, the individuals who should be issued with a card, and the overall credit and individual transaction limits to be associated with each card.

iii) Review the extent to which debt is being managed effectively.

iv) Scrutinise any retrospective approvals to commit revenue expenditure.

v) Review all losses and special payments (including special severance payments) and approve all write-offs arising from losses.

vi) Oversee compliance with the requirements of the NHS Provider Selection Regime (PSR). This will include oversight of annual reporting requirements (as set out in Regulation 25 of the PSR and associated statutory guidance) and oversight of the ICB's monitoring and publication arrangements (in line with Regulation 26 of the PSR), which will include retrospective reporting of all provider representations received in relation to procurement and contract award decisions for healthcare services.

vii) Review all instances where competitive tendering requirements have been waived for non-healthcare services.

Annual report and accounts

o) The Committee will review and approve the annual report and accounts, focusing particularly on:

i) The wording in the annual governance statement and other disclosures.

ii) Changes in, and compliance with, accounting policies, practices and estimation techniques.

iii) Unadjusted misstatements in the financial statements.

iv) Significant judgements in preparation of the financial statements.

v) Significant adjustments resulting from the audit.

vi) Letters of representation.

vii) Explanations for significant variances.

Information governance

p) The Committee will scrutinise compliance with legislative and regulatory requirements relating to information governance (including data protection and cyber security) and the extent to which associated systems and processes are effective and embedded within the ICB. This will include oversight of the

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

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

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

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

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

Appendix B: Scheme of Reservation and Delegation – proposed changes

5. Matters delegated to individuals

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

7. Delegations where financial limits apply

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

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

Derby and Derbyshire Integrated Care Board

Lincolnshire Integrated Care Board

Nottingham and Nottinghamshire Integrated Care Board

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	17/09/2026
Paper title:	**Chief Executive's Report**
Paper reference:	ICB CIC 26 046
Paper author:	Amanda Sullivan, Chief Executive
Paper sponsor:	Amanda Sullivan
Presenter:	Amanda Sullivan

Paper type:

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

Report summary:

This report provides the Boards with an update on significant national and local developments relevant to the ICBs, including statutory assurance, organisational transition, workforce, governance, neighbourhood health, quality and service developments.

Recommendation(s):

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

Board Assurance Framework

Not applicable.

Relevant statutory duties:

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

Appendices

Appendix A: Workforce Report

Appendix B: Professor Claire Fuller letter: Neighbourhood Health

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Chief Executive's Report

ICB Annual Assessments 2025/26

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

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

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

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

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

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

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

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

ICB Workforce Report, Organisational Development and NHS Job Evaluation

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

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

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

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

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

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

Alignment of ICBs' Freedom to Speak Up Arrangements

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

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

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

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

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

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

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

Independent assessment of local neighbourhood health readiness and next steps

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

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

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

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

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

b) Finalise the neighbourhood boundaries for each county.

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

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

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

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

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

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

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

Quality Strategy for NHS-funded care in England

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

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

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

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

Service developments and provider updates

Opening of National Rehabilitation Centre

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

Redeveloped Blossomwood Older People's Mental Health Unit

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

New Endoscopy Unit at Lincoln County Hospital

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

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

Lincolnshire Partnership NHS Foundation Trust

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

Lincolnshire Community and Hospitals NHS Group

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

Recent leadership appointments

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

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

Health and Wellbeing Board updates

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

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

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

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

Appendix A

NHS
Derby and Derbyshire
Integrated Care Board

NHS
Lincolnshire
Integrated Care Board

NHS
Nottingham and
Nottinghamshire
Integrated Care Board

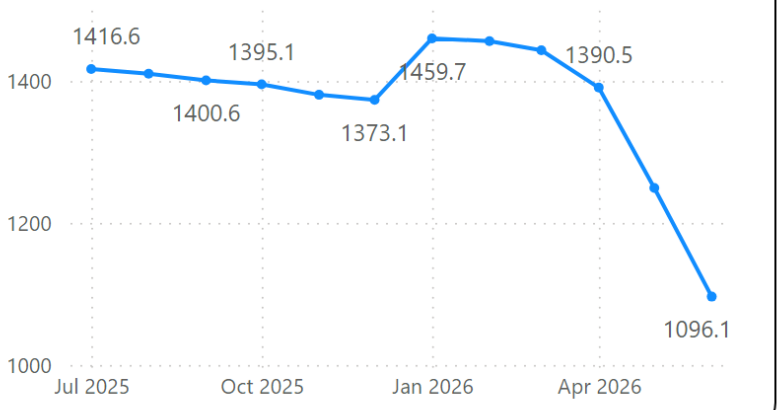
DLN Cluster People Report

Reporting Month: June 2026

SAIU
STRATEGIC
ANALYTICS
INTELLIGENCE
UNIT

DLN Cluster Workforce Metrics

Total Substantive WTE



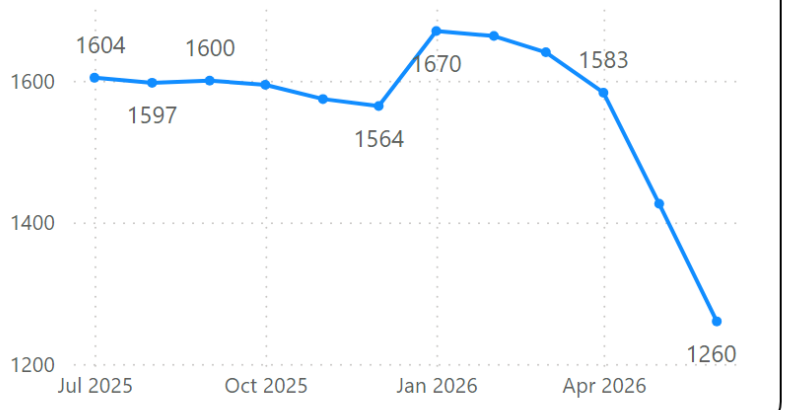
Total Substantive WTE

1,096.1

Monthly Decrease

-153.1

Total Substantive Headcount



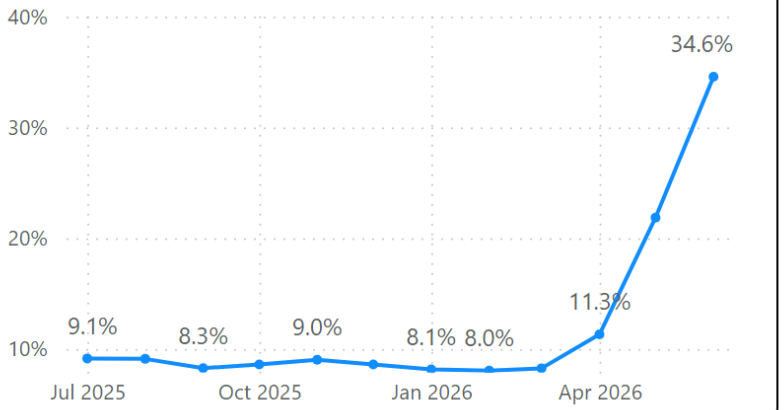
Total Substantive Headcount

1,260

Monthly Decrease

-166

Turnover Rate WTE (12m)



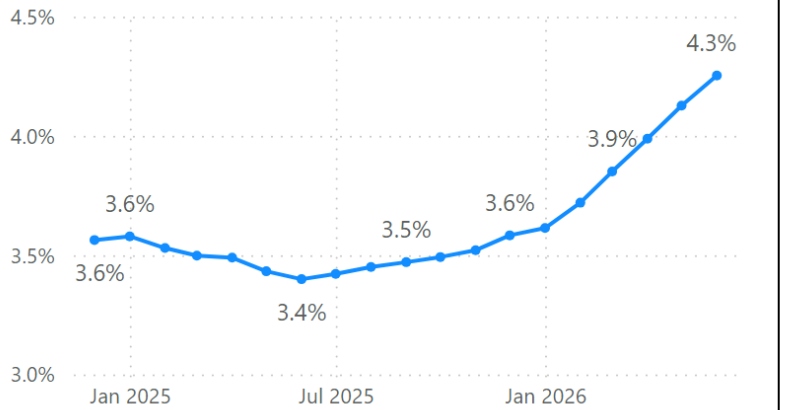
Turnover Rate WTE (12m)

34.6%

Monthly Increase

12.7%

Sickness/Absence (12m)



Rolling Absence WTE (12m)

4.3%

Monthly Increase

0.1%

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

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

Individual ICB KPI's

ICB Latest WTE

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

ICB Latest Headcount

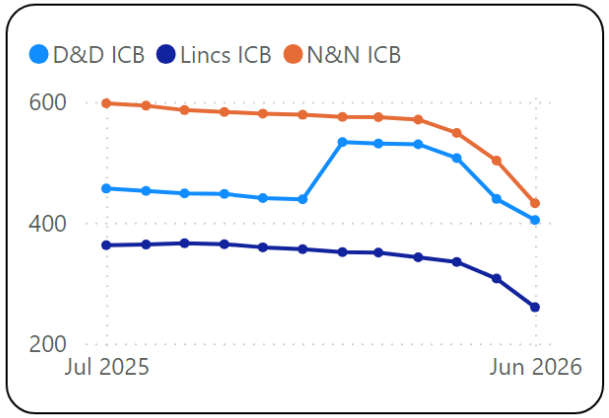
ICB	Headcount	Monthly Trend
D&D ICB	491	-40
Lincs ICB	279	-50
N&N ICB	490	-76

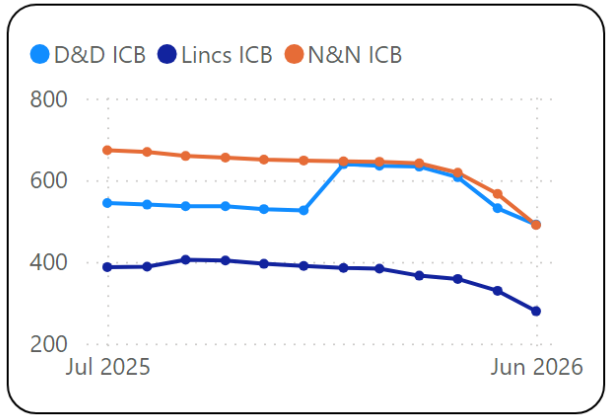
ICB Latest Turnover Rate WTE (12m)

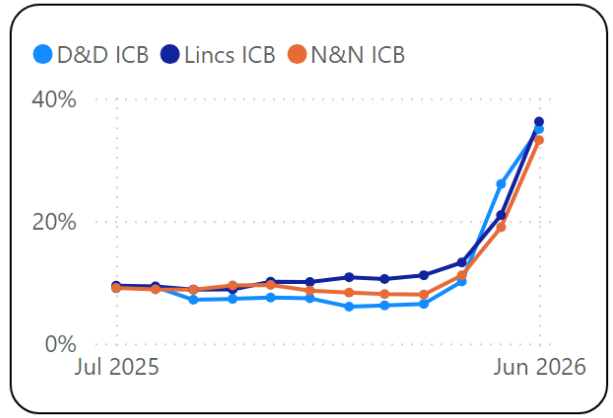
ICB	Turnover	Monthly Trend
D&D ICB	35.0%	9.0%
Lincs ICB	36.2%	15.2%
N&N ICB	33.2%	14.2%

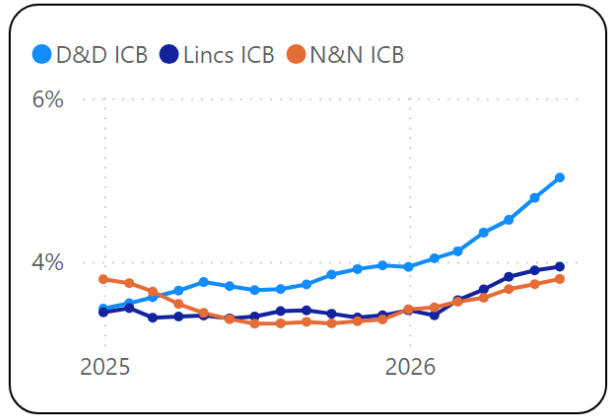
ICB Latest Absence/Sickness (12m)

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









DLN Cluster Mandatory Training & Appraisal Rate

DLN Cluster

Mandatory Training %

84.7%

ICB Mandatory Training Breakdown

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

DLN Cluster

Appraisal %

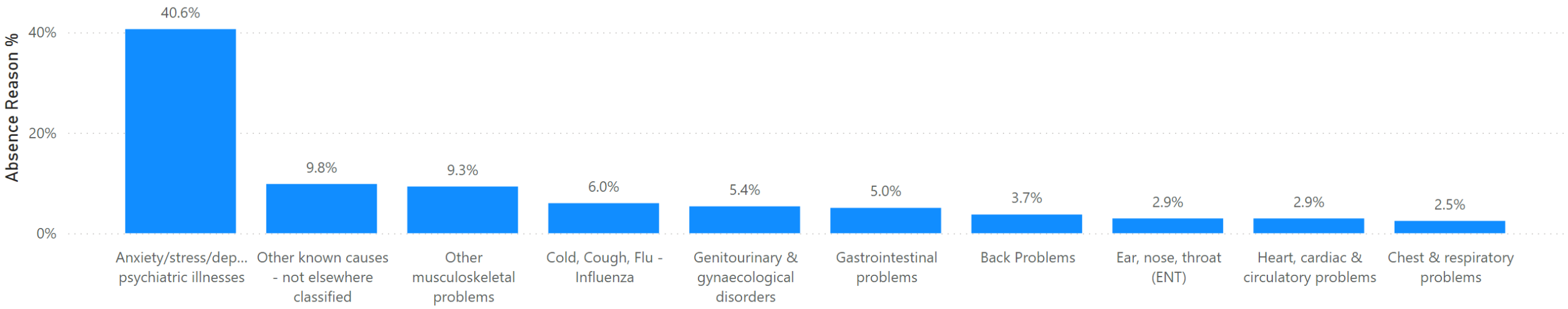
42.5%

ICB Appraisal Breakdown

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

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

Top 10 Absence Reason %



Top 10 Absence Reason by ICB

Derby and Derbyshire ICB Absence Reason

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

Nottingham and Nottinghamshire ICB Absence Reason

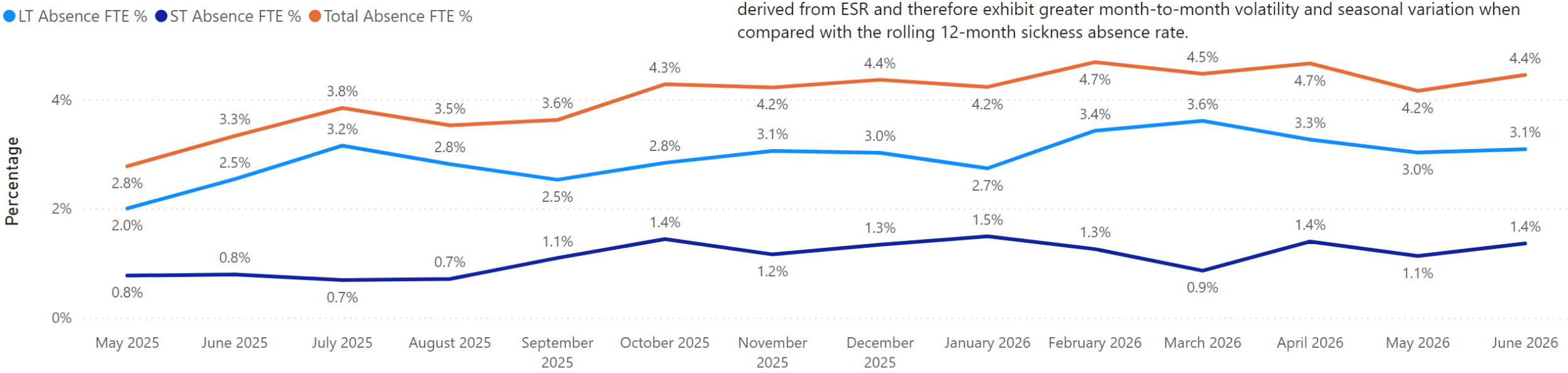
Absence Reason	Absence Reason %
Anxiety/stress/depression/other psychiatric illnesses	38.4%
Other musculoskeletal problems	10.9%
Genitourinary & gynaecological disorders	8.7%
Gastrointestinal problems	6.7%
Cold, Cough, Flu - Influenza	5.8%
Other known causes - not elsewhere classified	5.1%
Heart, cardiac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

Lincoln ICB Absence Reason

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

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

DLN In-Month Absence FTE %



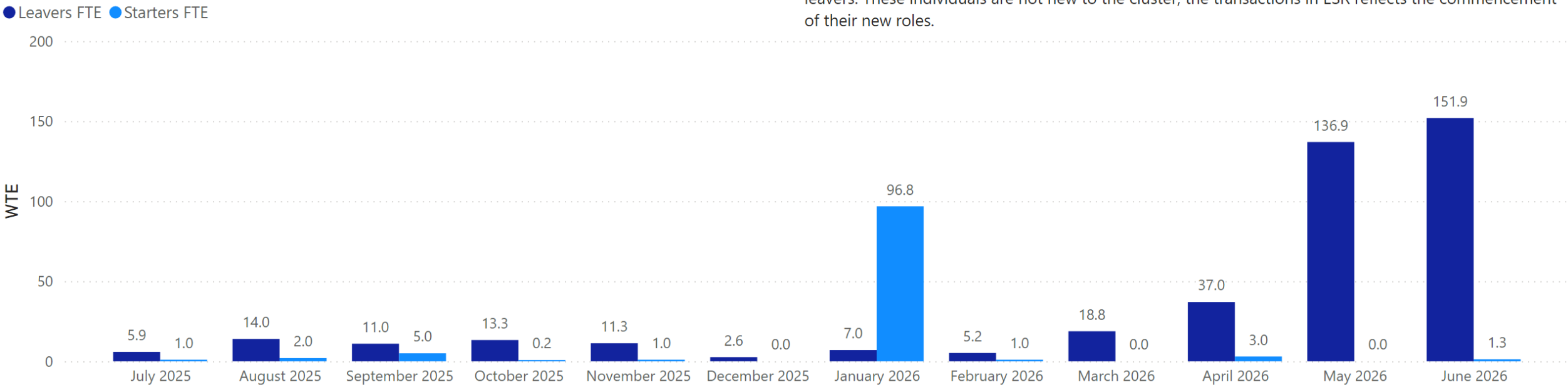
Long-term, Short-term and Total Absence figures are calculated as single-month (in-month) measures derived from ESR and therefore exhibit greater month-to-month volatility and seasonal variation when compared with the rolling 12-month sickness absence rate.

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

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

Cluster Starters and Leavers

DLN Starters and Leavers by Month



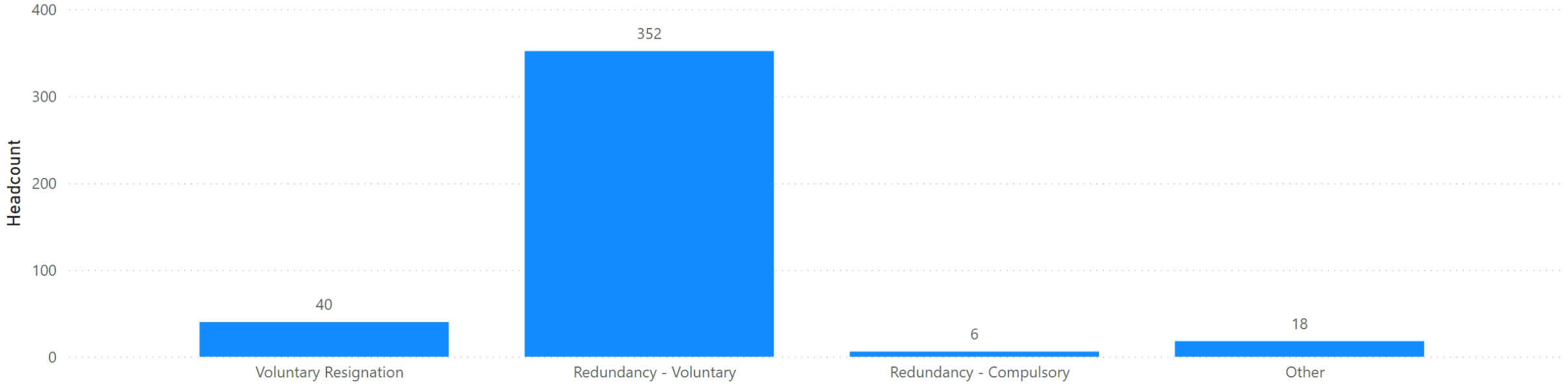
Following the new cluster arrangement, some roles previously aligned to an ICB have transitioned to new roles covering the cluster. These changes will appear in ESR as new starters; and in some instances leavers. These individuals are not new to the cluster, the transactions in ESR reflects the commencement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

Starters and Leavers by ICB

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

Cluster Reasons for Leaving - January 2026 onwards

DLN Reasons for Leaving



Reason for Leaving Headcount by ICB

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

Reason for Leaving Headcount by Band

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

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

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

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

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

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

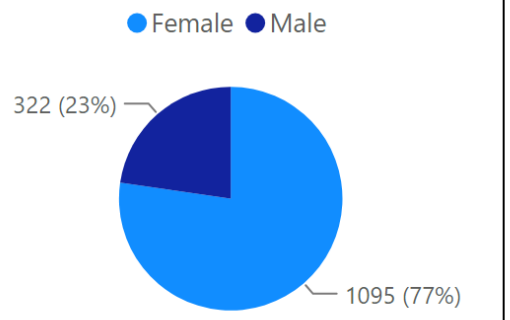
- The rate of completed of mandatory training stands at 84.7%, a decrease of 1.1% compared to May, with Nottingham and Nottinghamshire above 90% and Lincolnshire at 89%.

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

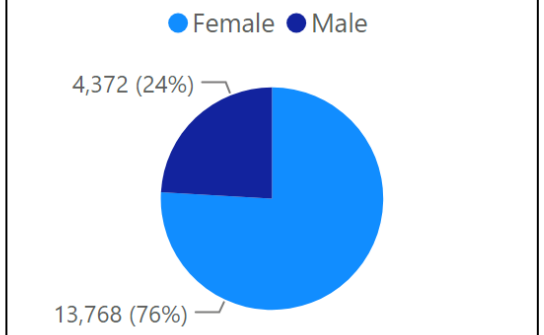
DLN Cluster Workforce EDI metrics

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

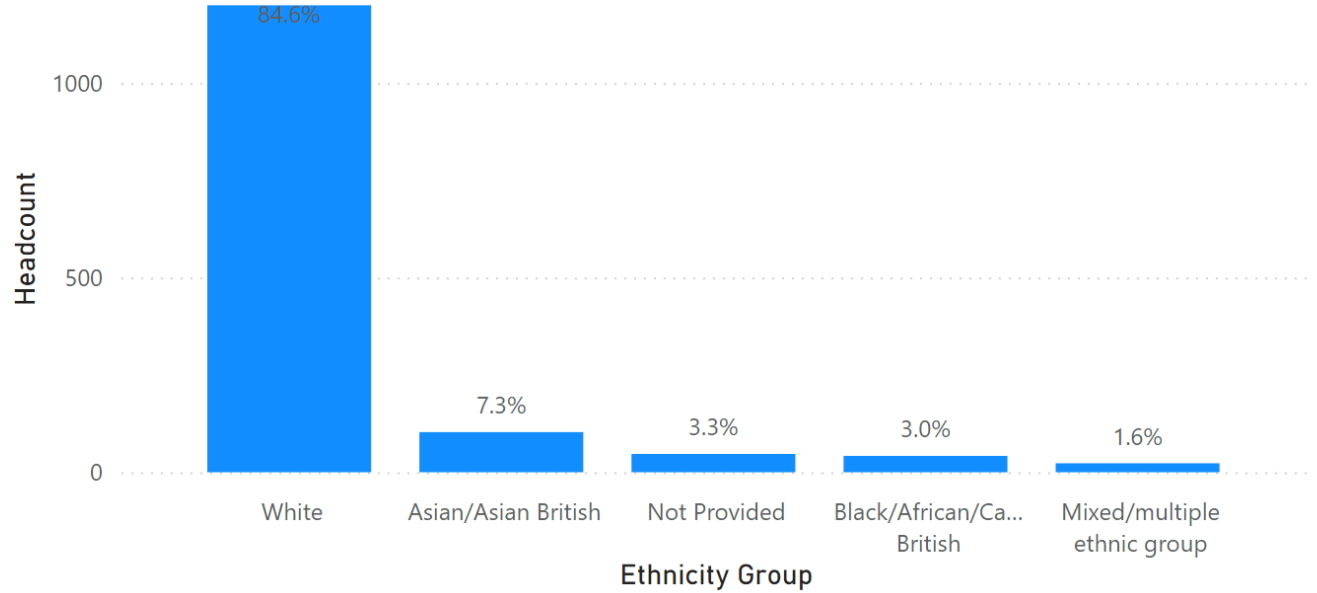
DLN Cluster Gender



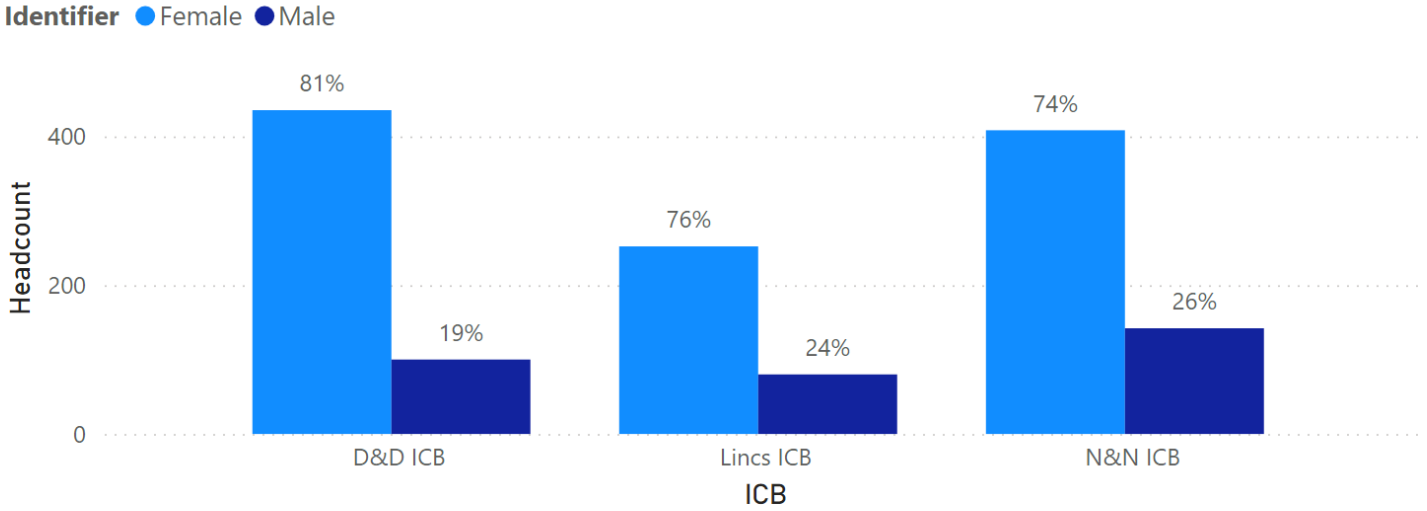
NHSE All ICBs Total Gender



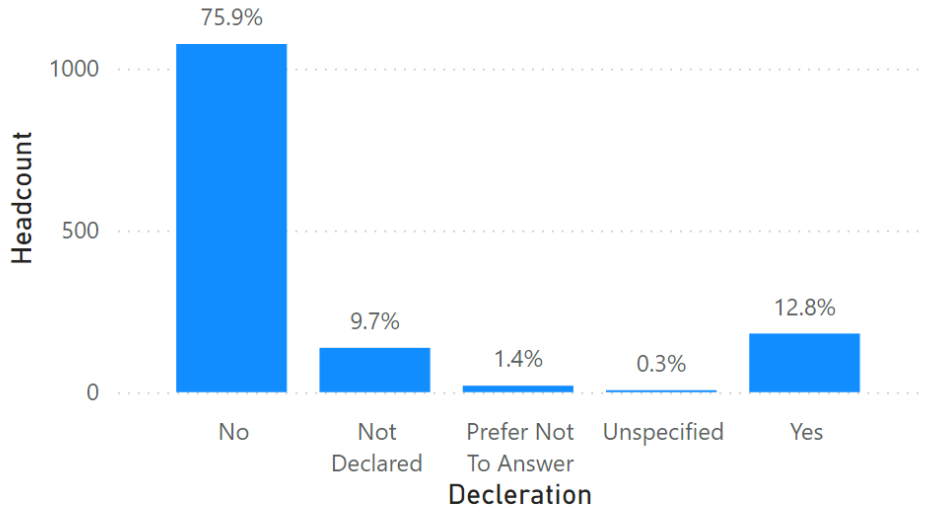
DLN Ethnicity Grouped



ICBs Gender Headcount

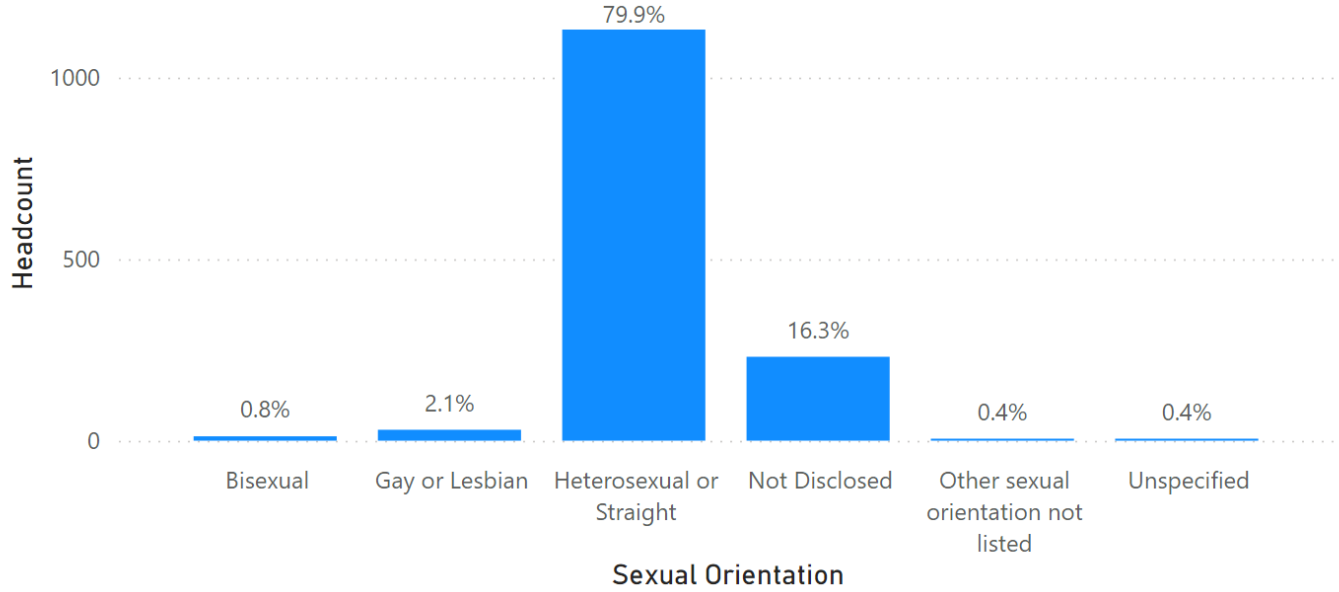


DLN Disability or Long Term Condition

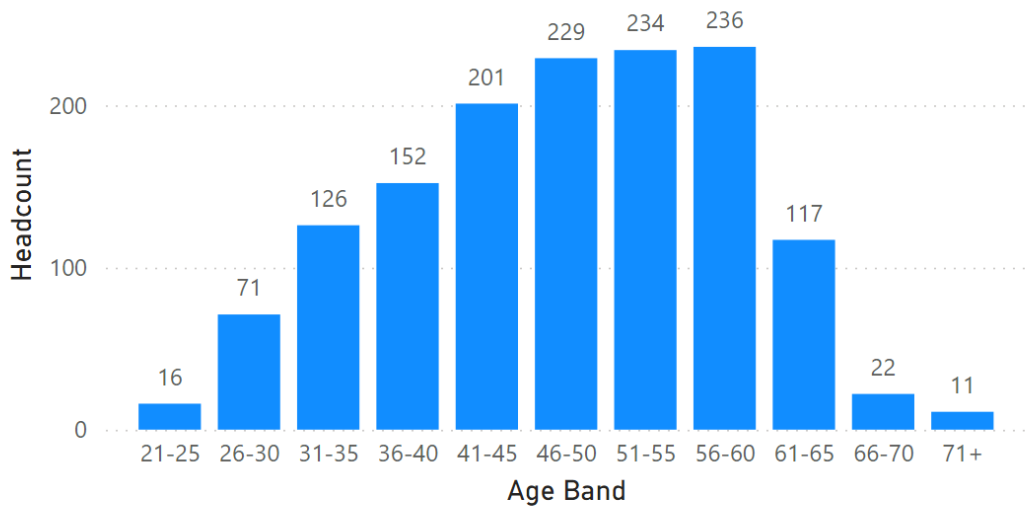


DLN Cluster Workforce EDI metrics

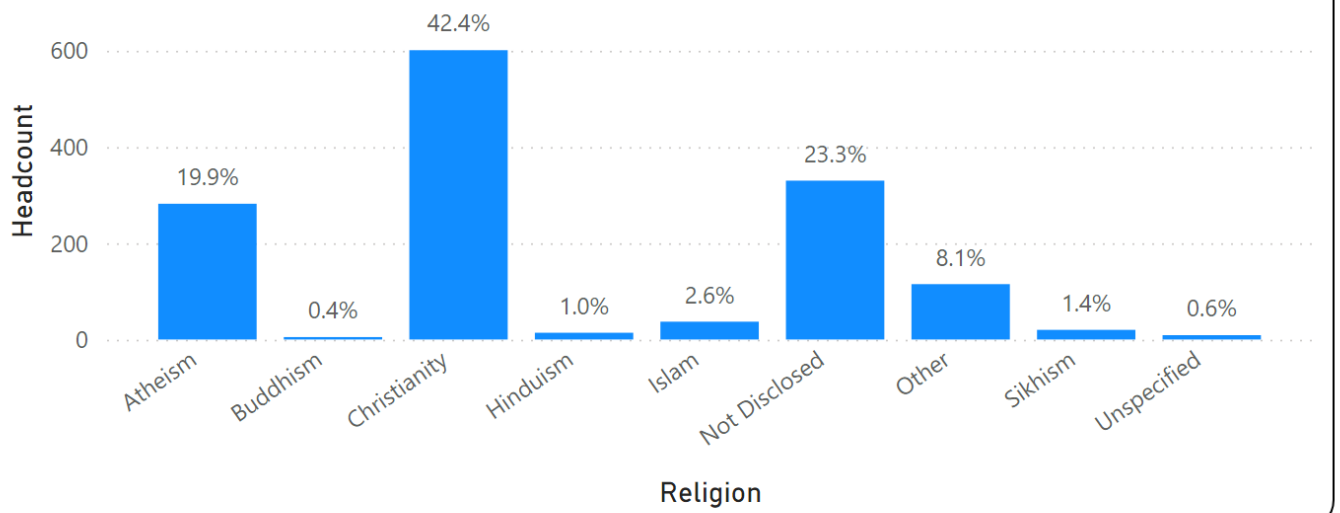
DLN Sexual Orientation



DLN Age Band



DLN Religious Belief



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

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

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

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

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

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

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

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

ICB Chief Executive
ICB Chair

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

8 September 2026

Dear Kathy and Amanda

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely

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

Annex:

Single slide summary

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

4 September 2026

ICB at a glance

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

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

Places

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

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

Examples of best practice across places

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

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

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

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

Enablers (Section 4)

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

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

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

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

Forward look - Key actions over next 6 months:

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

Forward look – Key actions over next 18 months

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

Derby and Derbyshire Integrated Care Board

Lincolnshire Integrated Care Board

Nottingham and Nottinghamshire Integrated Care Board

Meeting title	Integrated Care Boards: Open Session (meeting in common)
Meeting date	17/09/2026
Paper title	**Population Health Strategy Progress Report: Neighbourhood Health**
Paper reference	ICB CIC 26 047
Paper author	Tom Diamond, Director of Population Health Strategy Fiona Callaghan – Deputy Director of Neighbourhood Commissioning, NHS Nottingham and Nottinghamshire ICB
Paper sponsor	Clair Raybould, Executive Director for Strategy and Citizen Experience Maria Principe, Executive Director of Commissioning Dr Dave Briggs, Executive Director of Outcomes (Medical)
Presenter	Clair Raybould

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

Report summary

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

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

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

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

Report summary

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

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

Recommendation(s)

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

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

Appendices

None.

Board Assurance Framework

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

- Failure to develop and maintain a comprehensive, evidence-based understanding of local population health needs
- Failure to deliver a coordinated transformation of commissioned services, including prevention, community care models, and digital enablement
- Failure to systematically improve the quality of healthcare services

Relevant statutory duties

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

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Population Health Strategy Progress Report: Neighbourhood Health

Purpose and strategic position

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

Current architecture and delivery foundations

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

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

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

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

8. Progress achieved:

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

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

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

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

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

Readiness and the implementation gap

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

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

Priority populations and delivery model

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

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

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

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

Phased roadmap

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

Related delivery programmes

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

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

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

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

Outcomes, infrastructure and financial model

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

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

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

Key risks and assurance

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

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

Overall position

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

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

Derby and Derbyshire Integrated Care Board

Lincolnshire Integrated Care Board

Nottingham and Nottinghamshire Integrated Care Board

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

Paper type:

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

Report summary:

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

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

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

Recommendation(s):

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

Relevant statutory duties:

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

Appendices

None

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No

Citizen experience: Maternity families

Introduction

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

Sarah's experience

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

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

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

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

Engagement with maternity families

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

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

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

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

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

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

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

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

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

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

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

Report summary:

This report provides the Boards with assurance on the quality and safety of services across the Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire Integrated Care Systems. It sets out the current position in relation to providers' and system pathways subject to enhanced or escalated oversight, in line with the NHS Oversight Framework and National Quality Board guidance.

It highlights key risks, areas of focus, and the mitigating actions in place to address quality concerns and confirms how assurance is obtained through established governance arrangements.

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

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

Recommendation(s):

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

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

Appendices

Appendix 1: Quality Performance Report August 2026

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Quality Report

Introduction

1. This report provides assurance on quality oversight across the Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire ICBs' footprints for the period 28 May to 30 June 2026. It summarises intelligence from the System Quality Group, highlights organisations and programmes subject to escalated or enhanced oversight and identifies key quality risks and mitigating actions requiring the Boards' awareness.
2. The ICBs' approach to quality remains aligned to the National Quality Board's single shared view of quality and its recent guidance reinforcing the importance of maintaining a focus on quality, safety and leadership during a period of system change and operational pressure.
3. The ICBs continue to discharge their statutory duty through clear provider accountability, system oversight, and proportionate escalation arrangements in line with the NHS Oversight Framework.

Quality Performance (data to the end of August 2026)

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

Areas of Escalated Oversight

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

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

Areas of Enhanced Oversight

Theme	Current Position	Key Assurance
Learning Disability and Autism	Performance variable across Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire	Improvement work underway
Children and Young People	Special Educational Needs and Disabilities reform progressing	Continued oversight required
Infection Prevention and Control	Health Care Associated Infection performance mixed	System improvement actions in place
Maternity	Ongoing improvement	National oversight continues

Urgent and Emergency Care

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

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

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

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

Maternity

8. Maternity data shows significant variation between providers.

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

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

Infection, Prevention and Control

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

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

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

Continuing Healthcare

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

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

Prevention of Future Deaths

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

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

Conclusion

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

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

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NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Quality Performance Report

August 2026

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

NHS
Derby and Derbyshire
Integrated Care Board

NHS
Lincolnshire
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NHS
Nottingham and
Nottinghamshire
Integrated Care Board

Service Delivery Access

August 2026 Published Data

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NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

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

Headline Priorities

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

National Oversight Framework

Quarter 4 2025/26

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ICB Assessments 2025-26

Derby and Derbyshire Integrated Care Board

Lincolnshire Integrated Care Board

Nottingham and Nottinghamshire Integrated Care Board

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

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

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

DDICB Summary

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

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

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

LICB Summary

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

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

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

NNICB Summary

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

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

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

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ICB Assessments Q4 2025-26

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

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

NOF Domains	DDICB	LICB	NNICB
Access	Above Average	Below Average	Lowest scoring quartile
Experience	Highest scoring quartile	Below Average	Lowest scoring quartile
Safety	Above Average	Highest scoring quartile	Above Average
Finance	Lowest scoring quartile	Highest scoring quartile	Lowest scoring quartile
Workforce	Above Average	Below Average	Below Average
Population Health	Below Average	Highest scoring quartile	Below Average

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

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ICB Assessments Q4 2025-26

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NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

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

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

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

Provider NOF Assessments Q4 2025-26

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Provider Assessments:

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

Select Quarter	Q4 2025-26

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

Provider NOF Assessments Q4 2025-26

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

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

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

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

Colour with number = confirmed Tiering Q4

Colour alone = Q3 tiering

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Patient Safety

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Patient Safety - Regulation 28 Reports

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Q1 – 2026/27

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

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

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

Notes

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

LICB Summary (0)

Reports: 0 total.

Position: No Regulation 28 reports recorded in this dataset.

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

DDICB Summary (0)

Reports: 0 total.

Themes: No Regulation 28 reports recorded.

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

NNICB Summary (6)

Reports: 3 total — highest volume across the cluster.

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

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

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Patient Safety - SHMI

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

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

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

Local provider view with national baseline comparison

Provider	Position	Provider spells	Obs. deaths	Exp. deaths	SHMI value	vs baseline	Obs. vs exp.
Nottingham University Hospitals*	Higher than exp.	164,135	4,350	3,725	**1.1677**	+0.168	+625
Sherwood Forest Hospitals	As expected	65,630	2,215	2,075	**1.0680**	+0.068	+140
United Lincolnshire Teaching Hospitals	As expected	91,045	3,510	3,375	**1.0398**	+0.040	+135
Chesterfield Royal Hospital	As expected	49,690	1,895	1,785	**1.0618**	+0.062	+110
UH Derby & Burton	As expected	141,820	4,570	4,815	**0.9490**	−0.051	−245

Note: Nottingham University Hospitals NHS Trust has a high percentage of invalid diagnosis codes; values should be interpreted with caution.

Source: NHS England SHMI trust-level dataset https://digital.nhs.uk/data-and-information/publications/statistical/shmi/2026-06/shmi-data National calculations based on 118 trusts in the provided file.

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Urgent and Emergency Care

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Corridor care: daily averages (July returns)

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

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Why this matters

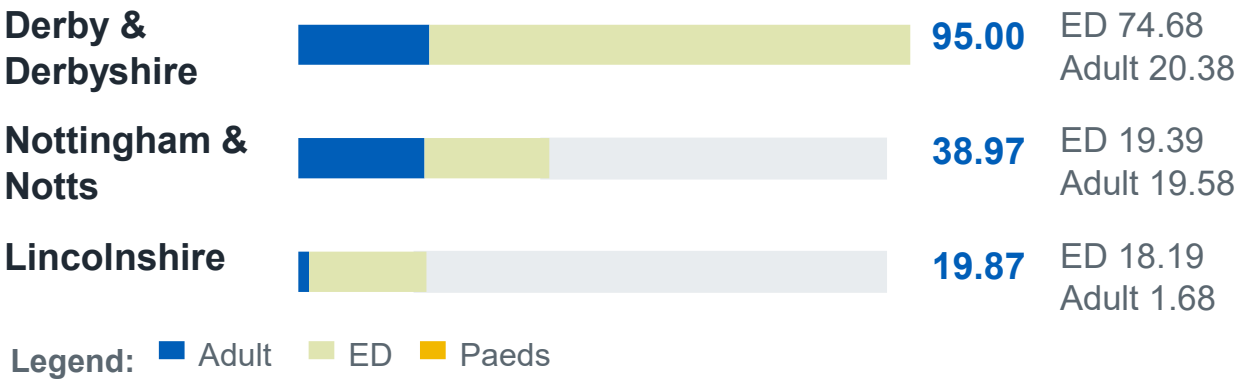
National publication creates visibility of patients cared for in **non-designated areas**, where privacy and safe, dignified care can be compromised.

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

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

Daily average by ICB and subject

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



Provider daily averages

Provider-level detail

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

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

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

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Corridor care by provider and subject

July 2026 experimental data – Total figures

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NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Derby & Derbyshire **2,945**

ED 2,315 | Adult 630 | Paeds 0

Lincolnshire **616**

ED 564 | Adult 52 | Paeds 0

Nottingham & Notts **1,208**

ED 601 | Adult 607 | Paeds 0

Provider matrix — Adult, Peads and ED

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

All selected providers

4,769 **total corridor care entries**

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

Key readouts

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

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

Urgent and Emergency Care

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Headlines

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

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

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

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Maternity

DLN Cluster view

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

Indicative RAG
Green Amber Red

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

Executive narrative

🟢 **Strongest overall**

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

🔴 **Broadest concern**

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

🟠 **Mixed profiles**

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

🔵 **Targeted focus**

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

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

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Nottingham University Hospitals NHS Trust

NUH's neonatal mortality (1.99 per 1,000 live births) and stillbirth rate (3.42 per 1,000 births) remain below MBRRACE group averages, demonstrating continued improvement in key mortality outcomes. However, performance remains challenging in relation to early booking (61%), 3rd/4th degree tears (49.0 per 1,000 births) and severe postpartum haemorrhage (36.0 per 1,000 births), all of which exceed national and peer group benchmarks.

An NUH deep dive has shown that 20% of women are self-referring into the service after 8 weeks making it difficult to arrange a booking appointment before 10 weeks. They will now work to support earlier engagement with maternity services.

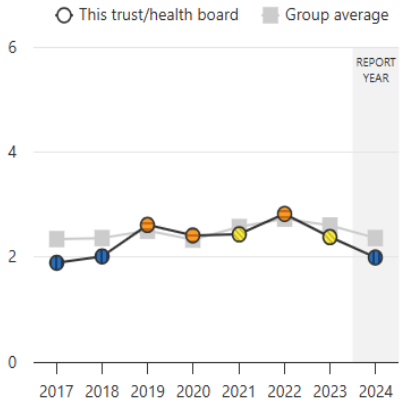
NUH has demonstrated a small improvement in rates PPH over the last 12 months compared to the previous 12 months. Rates of 3rd/4th degree perineal tears have increased slightly; however, the Trust is not currently identified as a national outlier. Improvement activity has included engagement with regional partners and higher-performing organisations to share best practice, alongside the relaunch of the Obstetric Anal Sphincter Injury (OASI) Care Bundle and continued embedding of the Perinatal Pelvic Health Service to support improved maternal outcomes.

Bookings at 10 weeks	Neonatal Deaths	Stillbirths	3rd/4th Degree Tears	PPH >= 1,500 ml
% of total bookings	Per 1,000 live births	Per 1,000 births	Per 1,000 births	Per 1,000 births
May 2026	2024	2024	May 2026	May 2026
61%	1.99	3.42	49.0	36.0

Neonatal Deaths

Mortality rates, by year

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

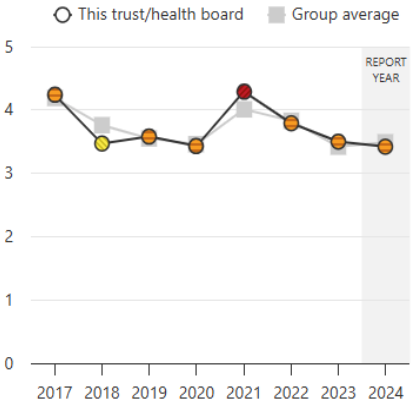


2024
This trust/health board: **1.99**
Group average: **2.36**

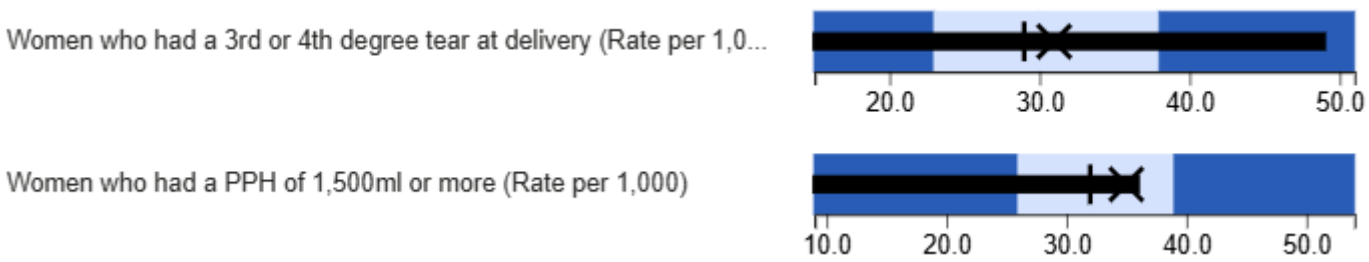
Stillbirths

Mortality rates, by year

Stabilised & adjusted stillbirth rate per 1,000 total births



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



Trust value	49.0
National value	29.0
MBRRACE group value	31.0

Trust value	36.0
National value	32.0
MBRRACE group value	35.0

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NHS Nottingham and Nottinghamshire Integrated Care Board

Maternity

Sherwood Forest Hospitals NHS Foundation Trust

SFHFT continues to demonstrate positive performance across several key maternity outcomes. The stillbirth rate of 2.87 per 1,000 births is broadly in line with comparable organisations, while the neonatal mortality rate of 1.01 per 1,000 live births remains below the MBRRACE group average. Early access to maternity care remains a focus, with 68% of women booked by 10 weeks gestation, below the NMPA ambition of 80%.

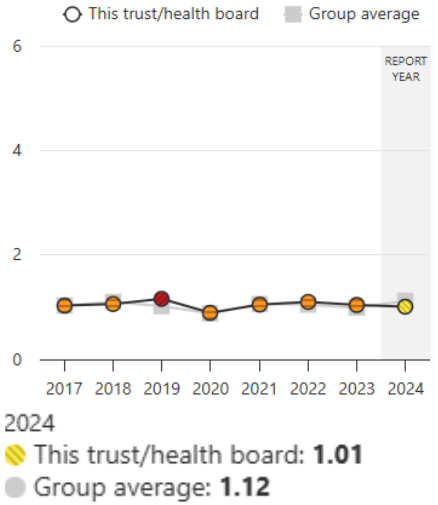
The Trust has demonstrated strong performance in relation to PPH, with rates lower than both national and peer group benchmarks. However, rates of 3rd/4thdegree perineal tears remain above national and MBRRACE averages, and improvement activity continues through implementation of the OASI Care Bundle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

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

Neonatal Deaths

Mortality rates, by year

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

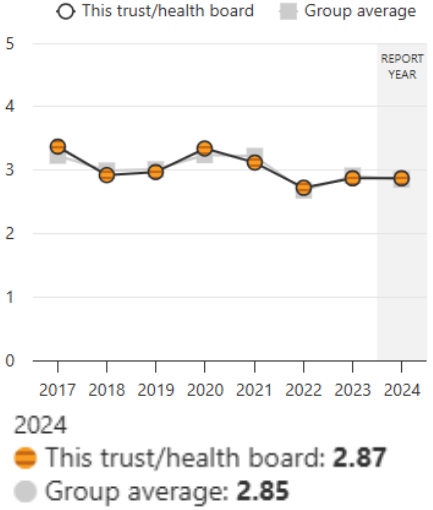


2024
This trust/health board: **1.01**
Group average: **1.12**

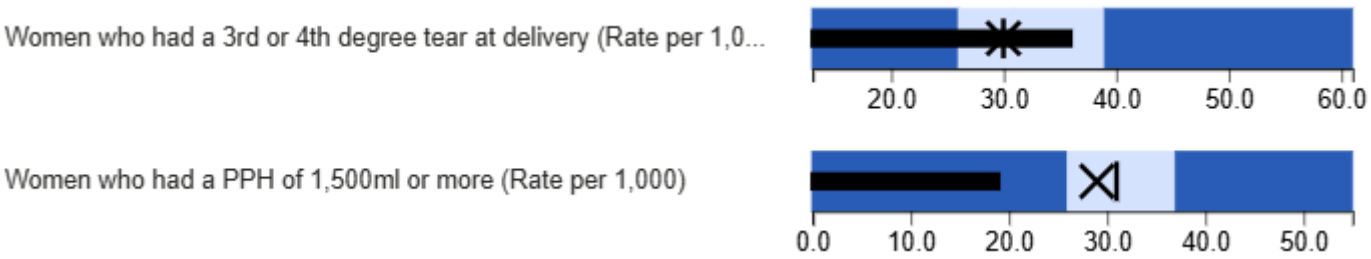
Stillbirths

Mortality rates, by year

Stabilised & adjusted stillbirth rate per 1,000 total births



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



Trust value 36.0
National value 30.0
MBRRACE group value 30.0

Trust value 19.0
National value 31.0
MBRRACE group value 29.0

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United Lincolnshire Teaching Hospitals NHS Trust

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

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

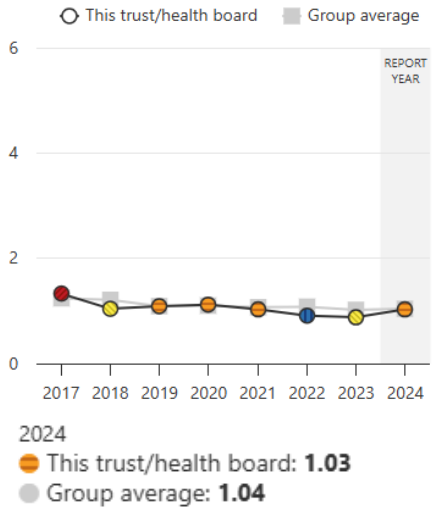
3rd and 4th degree rates are slightly above the national average and MBRRACE group value but not an outlier. PPH Rates over 1500mls is under the national and MBRRACE group comparator average. A thematic analysis involving human factors, themes and trends rather than looking at individual cases was recently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

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

Neonatal Deaths

Mortality rates, by year

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

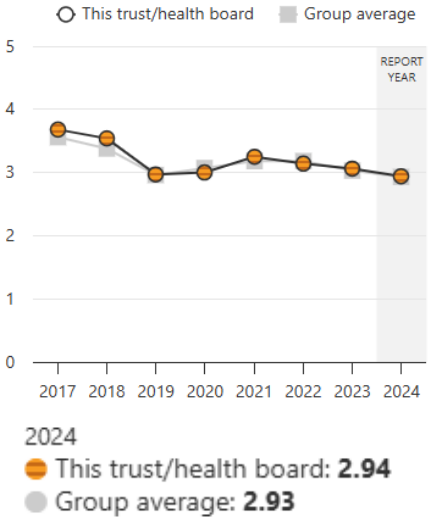


2024
This trust/health board: **1.03**
Group average: **1.04**

Stillbirths

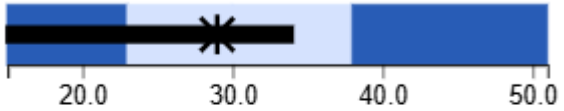
Mortality rates, by year

Stabilised & adjusted stillbirth rate per 1,000 total births



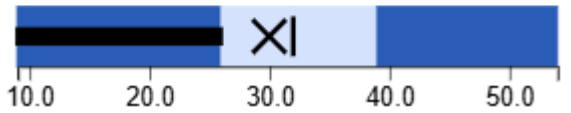
2024
This trust/health board: **2.94**
Group average: **2.93**

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



Trust value 34.0
National value 29.0
MBRRACE group value 29.0

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



Trust value 26.0
National value 32.0
MBRRACE group value 30.0

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Maternity

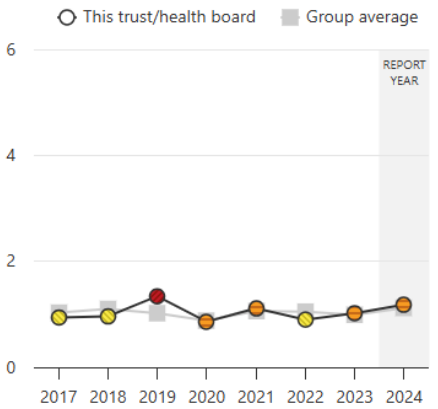
Chesterfield Royal Hospital NHS Foundation Trust

- Perinatal mortality rates remain below national average.
- PPH >1500mls remains raised and is under trust review. Guideline reviewed to recognise early identification, risk assessment and early escalation . OBSUK has led to more accurate measurement and a decrease in blood product use and ICU admission. Assurance required of embedded actions
- 3rd/4Th degree tears reducing following improved staff education and support for new staff at CRH but remains under review. Assurance required of embedded actions
- NHS Midlands perinatal team supporting the trust to review theatre capacity for caesarean sections
- An increase in maternity leave is affecting midwifery workforce. Trust support for recruitment of newly qualified midwives. Birthrate plus report pending.
- Bookings under 10 weeks under review as screening data suggests compliance of 83%. Investigation into data entry, access to booking appointments and notification through My Pregnancy Notes.

Neonatal Deaths

Mortality rates, by year

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

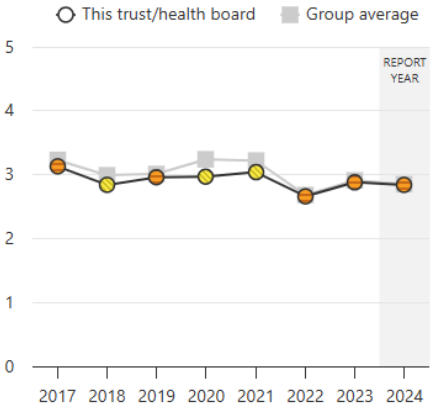


2024
This trust/health board: **1.18**
Group average: **1.12**

Stillbirths

Mortality rates, by year

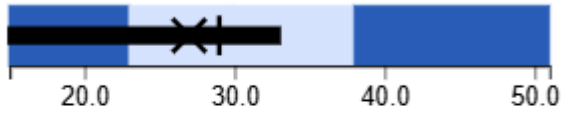
Stabilised & adjusted stillbirth rate per 1,000 total births



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

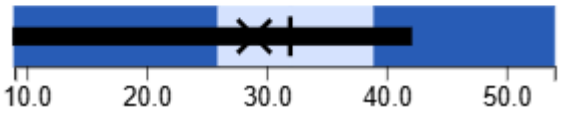
Bookings at 10 weeks	Neonatal Deaths	Stillbirths	3rd/4th Degree Tears	PPH >= 1,500 ml
% of total bookings May 2026	Per 1,000 live births 2024	Per 1,000 births 2024	Per 1,000 births May 2026	Per 1,000 births May 2026
65%	1.18	2.84	33.0	42.0

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



Trust value 33.0
National value 29.0
MBRRACE group value 27.0

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



Trust value 42.0
National value 32.0
MBRRACE group value 29.0

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NHS Nottingham and Nottinghamshire Integrated Care Board

Maternity

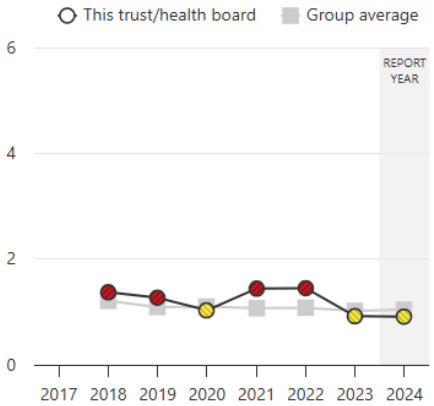
University Hospitals of Derby and Burton NHS Foundation Trust

- NHSE Maternity and Neonatal Improvement Support Team provided targeted support until July 2026
- Perinatal mortality rates remain below national average
- NHS Midlands working with ICB to support implementation of Perinatal Pelvic Health Service by September 2026. Behind national trajectory but progress being made. Assurance required that the service will meet trajectory.
- Community transformation project underway to review service offer including continuity of carer and homebirth service to improve service user experience and staff satisfaction.

Neonatal Deaths

Mortality rates, by year

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

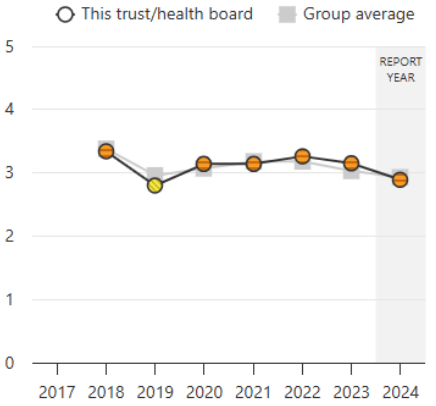


2024
This trust/health board: **0.91**
Group average: **1.04**

Stillbirths

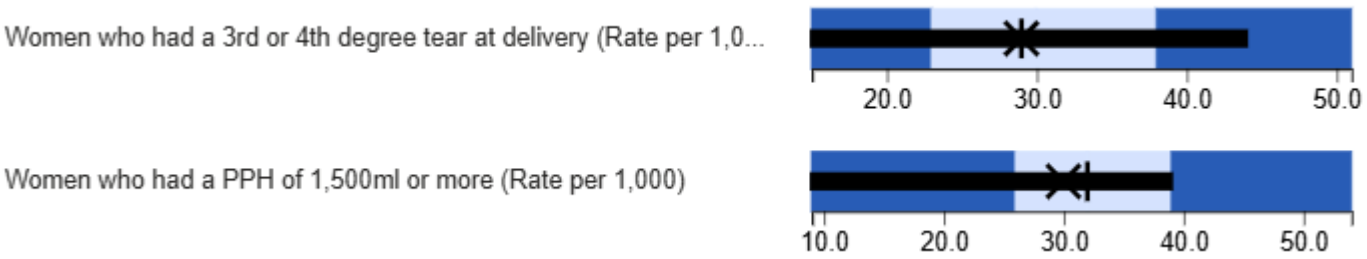
Mortality rates, by year

Stabilised & adjusted stillbirth rate per 1,000 total births



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

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



Trust value	44.0
National value	29.0
MBRRACE group value	29.0

Trust value	39.0
National value	32.0
MBRRACE group value	30.0

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Infection, Prevention and Control

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Infection, Prevention and Control

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

June 2026

Priority **Cluster-level IP&C assurance model and shared HCAI reduction work plan.**

The DLN Cluster quality directorate has developed an interim model for IP&C work at cluster level with a single combined resource. Plans are now being developed to create a new approach to IP&C assurance, oversight and support are being developed to ensure provider organisations maintain their focus on Healthcare Associated Infections (HCAI) reduction programmes. The ICB Cluster IP&C team has met with the IP&C Regional Lead within NHSE to develop a shared understanding of the priorities of work that will form the work plan for the cluster going forward.

Trust / ICB	C.Difficile							MRSA			MSSA		
	Month			YTD			12m rate	Month Actual	YTD Actual	12m rate	Month Actual	YTD Actual	12m rate
	Actual	Plan	Var	Actual	Plan	Var							
DDICB Chesterfield Royal Hospital NHS Foundation Trust	7	4	**+3**	15	11	**+4**	**30.31** ↑	0	0	**0.00** -	1	4	**12.76** ↓
NNICB Nottingham University Hospitals NHS Trust	13	13	**0**	46	38	**+8**	**34.93** ↓	1	2	**1.59** -	10	36	**23.64** ↑
NNICB Sherwood Forest Hospitals NHS Trust	5	6	**-1**	18	17	**+1**	**35.78** ↓	1	1	**1.21** ↑	4	10	**12.86** ↑
LICB United Lincolnshire Teaching Hospitals NHS Trust	12	8	**4**	27	23	**+4**	**34.28** ↓	0	0	**1.21** -	4	13	**16.38** ↑
DDICB University Hospitals of Derby and Burton NHS Foundation Trust	20	14	**+6**	45	40	**+5**	**34.60** ↓	0	0	**0.77** -	5	13	**12.50** ↓

Source: Workbook: Healthcare Associated Infections (HCAI) Dashboard

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Learning Disabilities and Autism

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Learning Disability and Autism

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

Headlines

The monitoring and reporting of inpatients with a Learning Disability and/or Autism continues. Derby and Derbyshire ICB remain the real outlier in the Cluster, not achieving many of the National Key Performance Indicators. Work is underway to support the Provider with best practice and developing a much firmer grip on the monitoring processes. Moving forwards the monitoring and reporting processes for ICB and NHSE (Midlands) will be streamlined across the Cluster.

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Mental Health

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Mental Health

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

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NHS Nottingham and Nottinghamshire Integrated Care Board

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

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

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

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

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

What the 28-day clock means

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

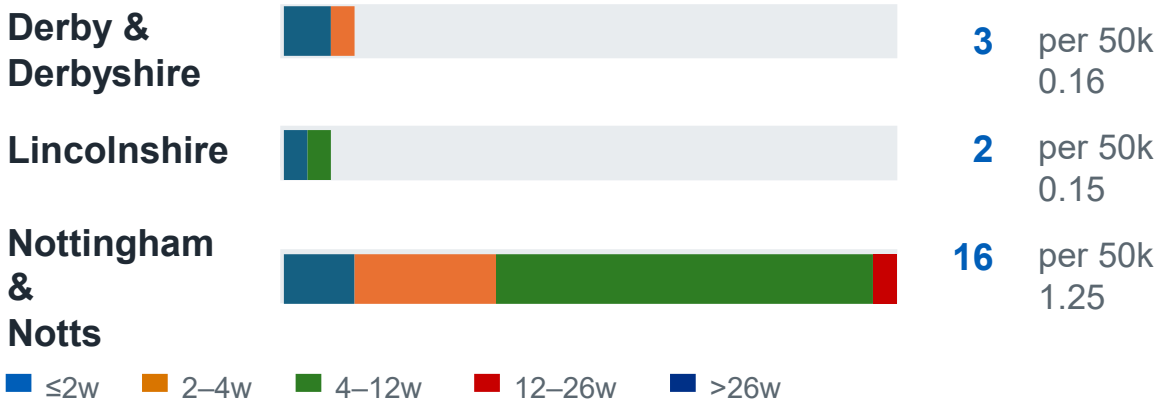
31
Q1 total
incomplete >28d

1
Over 12 weeks
Q1 across the cluster

26
Notts Q1
highest ICB

+63%
Notts change
from Q4 2025/26

Latest quarter: where the >28-day backlog sits



Quarterly trend by ICB

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

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

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

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

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Care Homes

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Care Homes

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NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Lincolnshire ICB

Lincolnshire's care home comprises approximately 282 registered care homes distributed across a large and predominantly rural county, covering the districts of Lincoln, Boston, East Lindsey, South Holland, South Kesteven, West Lindsey and North Kesteven, with additional provision in the neighbouring unitary authorities of North Lincolnshire and North East Lincolnshire with continued monitoring and support provided through the ICB Quality Team to maintain safe, effective care and minimise impacts on placement availability. Approximately 282 care homes across Lincolnshire, providing residential, nursing, dementia and specialist care services. Currently 2 care homes are suspended to new admissions and 3 care homes currently operating with admission restrictions.

Derby and Derbyshire ICB

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

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

Currently one home has restrictions in place for admissions, one home under a voluntary suspension and one home formally suspended. All have actions plans in place and regular monitoring.

Nottingham and Nottinghamshire ICB

Oversight levels remain stable, with a small reduction in high-risk (enhanced oversight) homes in the County and no high-risk homes in the City.

County services show growing operational pressures, particularly in contract suspensions, safeguarding alerts, complaints, and patient safety incidents.

City services demonstrate comparatively stable and improving performance, with low escalation levels and reductions in safety incidents.

There are currently 2 nursing homes with formal contract suspensions and 1 nursing home with a voluntary pause on admissions.

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Care Quality Commission (CQC)

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

CQC Provider Ratings

DLN at a glance

1,126
provider locations in view

76%
rated Good or Outstanding

170
Require improvement / Inadequate

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

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

Notes

1. New CQC rules mean some multi-service locations (such as adult social care, independent health and primary care) no longer receive location-level ratings. [1]

2. Nottinghamshire Healthcare NHS Foundation Trust is excluded from these figures as CQC ratings are currently suspended. [2]

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

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NHS Nottingham and Nottinghamshire Integrated Care Board

CQC Provider Ratings

Nottingham and Nottinghamshire

Organisation	Report Published	Safe	Effective	Caring	Responsive	Well-led	Overall
Nottingham University Hospitals NHS Trust	13 September 2023	Requires improvement	Requires improvement	Outstanding ☆	Requires improvement	Requires improvement	Requires improvement
Sherwood Forest Hospitals NHS Foundation Trust	14 May 2020	Good	Good	Outstanding ☆	Good	Good	Good
Nottinghamshire Healthcare NHS Foundation Trust	During the 2023/24 period, the CQC conducted 9 assessments of various services within the Trust. One of these inspections was carried out under Section 48 of the NHS Act 2008, commissioned by the Secretary of State for Health and Social Care. This review looked at patient safety and quality of care in the services provided by the Trust. While the review is underway, the CQC ratings for the Trust have currently been suspended.						

Organisation type	Total number of providers	Outstanding ☆	Good	Requires improvement	Inadequate	Not rated
Care Homes	289	28	211	47	2	1
GP Practices	112	16	93	3	0	0

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CQC Provider Ratings

Derby and Derbyshire

Organisation	Report Published	Safe	Effective	Caring	Responsive	Well-led	Overall
Chesterfield Royal Hospital NHS Foundation Trust	29 May 2020	Good	Good	Good	Good	Good	Good
Derbyshire Community Health Services NHS Foundation Trust	12 September 2019	Good	Good	Outstanding ☆	Good	Outstanding ☆	Outstanding ☆
University Hospitals of Derby and Burton NHS foundation Trust	6 June 2019	Good	Good	Good	Good	Good	Good
Derbyshire Healthcare NHS Foundation Trust	6 March 2020	Requires improvement	Good	Good	Good	Good	Good

Organisation type	Total number of providers	Outstanding ☆	Good	Requires improvement	Inadequate	Not rated
Care Homes	279	11	215	50	0	3
GP Practices	106	16	84	5	0	0

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NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

CQC Provider Ratings

Lincolnshire

Organisation	Report Published	Safe	Effective	Caring	Responsive	Well-led	Overall
United Lincolnshire Teaching Hospitals NHS Trust	8 February 2022	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Lincolnshire Partnership NHS Foundation Trust	19 August 2026	Inspected under the new assessment criteria. Provider domains unavailable.					Good
Lincolnshire Community Health Services NHS Trust	22 June 2019	Good	Good	Good	Outstanding ☆	Outstanding ☆	Outstanding ☆

Organisation type	Total number of providers	Outstanding ☆	Good	Requires improvement	Inadequate	Not rated
Care Homes	259	16	182	50	3	3
GP Practices	77	2	66	9	0	0

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