

Shared Agenda for the meetings in common of:
NHS Derby and Derbyshire ICB Board
NHS Lincolnshire ICB Board
NHS Nottingham and Nottinghamshire ICB Board

Thursday 19 March 2026 10:00-13:00

Derby City Council, Council House, Derby DE1 2FS

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 15 January 2026	Kathy McLean	Decision	✓	✓	✓	✓	-
5.	Action log and matters arising from the meetings in common, held on 15 January 2026	Kathy McLean	Discussion	✓	✓	✓	✓	-
Leadership and operating context								
6.	Citizen Story: Derbyshire Carers Association	Clair Raybould	Discussion	✓	-	-	✓	10:05
7.	Chair's Report	Kathy McLean	Information	✓	✓	✓	✓	10:20
8.	Chief Executive's Report	Amanda Sullivan	Information	✓	✓	✓	✓	10:35
Strategy and partnerships								
9.	Population Health Strategy and Strategic Commissioning Plan	Clair Raybould/ Maria Principe	Discussion	✓	✓	✓	✓	10:50
Delivery assurance								
10.	Dental Services: Strategic Overview and System Strategy	Maria Principe/ Caroline Goulding	Assurance	✓	✓	✓	✓	11:05

Ref	Item	Presenter	Type	DD	L	NN	Enc	Time
11.	Finance Report	Bill Shields	Assurance	✓	✓	✓	✓	11:25
12.	Quality Report	Rosa Waddingham	Assurance	✓	✓	✓	✓	11:40
13.	Commissioning Oversight Report	Maria Principe	Assurance	✓	✓	✓	✓	11:55
Governance								
14.	Updated Governance Framework for the Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire Integrated Care Boards working in partnership	Lucy Branson	Assurance	✓	✓	✓	✓	12:10
15.	Board Assurance Framework	Lucy Branson	Assurance	✓	✓	✓	✓	12:25
16.	Committee Highlight Reports	Committee Chairs	Assurance	✓	✓	✓	✓	12:40
Closing items								
17.	Risks identified during the course of the meeting	Kathy McLean	Discussion	✓	✓	✓	-	12:55
18.	Questions from members of the public	Kathy McLean	-	✓	✓	✓	-	-
19.	Any other business	Kathy McLean	-	✓	✓	✓	-	-
Meeting close								13:00

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

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	19/03/2026
Paper title:	Declaration and management of interests
Paper reference:	ICB CIC 25 039
Paper author:	Committee Secretariat
Paper sponsor:	Kathy McLean, Chair
Presenter:	Kathy McLean, Chair

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

Report summary:

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

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

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

Recommendation(s):

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

Relevant statutory duties:

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

Appendices

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

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

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

Surname	Forename	Position	Member of			Declared interest (name of organisation and nature of business)	Nature of interest	Type of Interest				Date of Interest		Action taken to mitigate risk
			NHS Derby and Derbyshire ICB	NHS Lincolnshire ICB	NHS Nottingham and Nottinghamshire ICB			Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Briggs	Dave	Director of Outcomes (Medical)	✓	✓	✓	Member of the British Medical Association	Professional association membership.		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
Dillistone	Helen	Director of Transition	✓	✓	✓	No relevant interests declared	No interests declared.					–	–	Not applicable
Dunderdale	Karen	NHS Trust/Foundation Trust Partner Member	–	✓	–	Group Chief Executive of Lincolnshire Community and Hospitals NHS Group	Role within an NHS, local authority or provider organisation.	✓				01/07/2024	Present	To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Lincolnshire Community and Hospitals NHS Group.
Dunstan	John	Non-Executive Member	✓	✓	✓	Director and Owner of John Dunstan Limited, a private unlisted company that provides strategic and financial services	Ownership and/or directorship of a private company	✓				01/04/2025	Present	This interest will be kept under review and specific actions determined as required.
Dunstan	John	Non-Executive Member	✓	✓	✓	Contracted via John Dunstan Limited as Chief Finance Officer for KnowCarbon, a Carbon Footprint consulting company in Ireland	External role or association (non-NHS), declared for transparency.	✓				01/04/2025	Present	This interest will be kept under review and specific actions determined as required.
Dunstan	John	Non-Executive Member	✓	✓	✓	Non-executive director of Our Learning Cloud Limited, a tech services company in the education sector	Non-executive director role in a private or non-NHS company.	✓				01/04/2025	19/09/2025	This interest will be kept under review and specific actions determined as required.
Dunstan	John	Non-Executive Member	✓	✓	✓	Registered patient at Lombard Medical Practice, Newark.	Use of NHS services commissioned by the ICB (registered patient).			✓		01/04/2025	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
Gildea	Margaret	Non-Executive Member	✓	✓	✓	Chair of the Melbourne Assembly Rooms, a voluntary not for profit organisation that runs the former council controlled leisure centre	Trustee or leadership role in a voluntary, charitable or community organisation		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
Gildea	Margaret	Non-Executive Member	✓	✓	✓	Trustee of Foundations Independent Living Trust Limited, which supports local authorities and home improvement agencies across England to deliver better home adaptations	Trustee or leadership role in a voluntary, charitable or community organisation		✓			01/11/2025	Present	To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Foundations Independent Living Trust Limited.
Jackson	Stephen	Non-Executive Member	✓	✓	✓	Chair of the Nottingham Business Improvement District (BID), a business-led, not for profit organisation helping to champion Nottingham.	Trustee or leadership role in a voluntary, charitable or community organisation		✓			01/07/2022	Present	To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by BID.
Jackson	Stephen	Non-Executive Member	✓	✓	✓	Governor at Nottingham High School	Governance role in an education provider (non-NHS).		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
Jackson	Stephen	Non-Executive Member	✓	✓	✓	Governor at Portland College	Governance role in an education provider (non-NHS).		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
Jackson	Stephen	Non-Executive Member	✓	✓	✓	Non-executive director at Derbyshire Health United CIC - A not for profit community interest company providing a range of health service provisions.	Role within an NHS, local authority or provider organisation.	✓				01/07/2022	01/11/2025	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by DHU CIC).
Jackson	Stephen	Non-Executive Member	✓	✓	✓	Joint Owner and Chief Executive Officer of Imperial Business Consulting Ltd - a management consultancy business, based in Leicestershire.	Ownership and/or directorship of a private company	✓				01/07/2022	Present	To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Imperial Business Consulting Ltd
Jackson	Stephen	Non-Executive Member	✓	✓	✓	Registered patient at Ravenshead Surgery (Abbey Medical Group)	Use of NHS services commissioned by the ICB (registered patient).			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
Jackson	Stephen	Non-Executive Member	✓	✓	✓	Spouse is a non-executive Director at Nottingham City Transport	Non-executive director role in a private or non-NHS company.				✓	01/11/2023	Present	This interest will be kept under review and specific actions determined as required.
Jackson	Stephen	Non-Executive Member	✓	✓	✓	Spouse is a non-executive director at Nottingham Ice Centre	Non-executive director role in a private or non-NHS company.				✓	01/11/2023	Present	This interest will be kept under review and specific actions determined as required.
Jackson	Stephen	Non-Executive Member	✓	✓	✓	Non-executive director at Birmingham Women's and Children NHS Foundation Trust	Role within an NHS, local authority or provider organisation.	✓				01/10/2024	Present	This interest will be kept under review and specific actions determined as required.
Jackson	Stephen	Non-Executive Member	✓	✓	✓	Non-executive director at Futures Housing Group	Non-executive director role in a private or non-NHS company.	✓				01/02/2025	Present	This interest will be kept under review and specific actions determined as required.
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.

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

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

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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	✓	–	–	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 activities and contract management arrangements) relating to services that currently, or could be provided by University Hospitals of Derby and Burton NHS Foundation Trust.
Posey	Stephen	NHS Trust/Foundation Trust Partner Member	✓	–	–	Partner is Chief Executive Officer at the Royal College of Obstetricians and Gynaecologists	Role within an NHS, local authority or provider organisation.				✓	01/08/2023	Present	This interest will be kept under review and specific actions determined as required.
Posey	Stephen	NHS Trust/Foundation Trust Partner Member	✓	–	–	Partner is a non-executive director at Health Innovation Kent Surrey Sussex Ltd, a health innovation network	Non-executive director role in a private or non-NHS company.				✓	01/08/2023	Present	This interest will be kept under review and specific actions determined as required.
Posey	Stephen	NHS Trust/Foundation Trust Partner Member	✓	–	–	Chair of Stakeholder Group at the National Institute for Health and Care Research East Midlands Regional Research Delivery Network	External role or association (non-NHS), declared for transparency.		✓			01/04/2025	Present	This interest will be kept under review and specific actions determined as required.
Powell	Mark	Ordinary Member - Mental Health	✓	✓	✓	Chief Executive at Derbyshire Healthcare NHS Foundation Trust, provider of mental health services	Role within an NHS, local authority or provider organisation.	✓				01/04/2023	Present	To be excluded from all commissioning decisions (including procurement activities and 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.
Samuels	Martin	Local Authority Partner Member	–	✓	–	Association of Directors of Adult Social Services	External role or association (non-NHS), declared for transparency.		✓			01/04/2023	Present	This interest will be kept under review and specific actions determined as required.
Shields	Bill	Director Finance	✓	✓	✓	Chair of Financial Recovery Group at the Healthcare Financial Management Association	External role or association (non-NHS), declared for transparency.		✓			01/04/2025	Present	This interest will be kept under review and specific actions determined as required.

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Shields	Bill	Director Finance	✓	✓	✓	Vice Chair of ICB Chief Finance Officers' Forum at the Healthcare Financial Management Association	External role or association (non-NHS), declared for transparency.		✓			01/04/2025	Present	This interest will be kept under review and specific actions determined as required.
Shields	Bill	Director Finance	✓	✓	✓	Chair of the 360 Assurance Management Board	Role within an NHS, local authority or provider organisation.		✓			01/12/2025	Present	This interest will be kept under review and specific actions determined as required.
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	Present	This interest will be kept under review and specific actions determined as required.
Waddingham	Rosa	Director of Quality (Nursing)	✓	✓	✓	Member of the Advisor Board at NHS Professionals, an NHS staff bank, owned by the Department of Health and Social Care.	Role within an NHS, local authority or provider organisation.		✓			01/09/2023	Present	This interest will be kept under review and specific actions determined as required.
Waddingham	Rosa	Director of Quality (Nursing)	✓	✓	✓	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:														

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

Surname	Forename	Position	Member of			Declared interest (name of organisation and nature of business)	Nature of interest	Type of Interest				Date of Interest		Action taken to mitigate risk
			NHS Derby and Derbyshire ICB	NHS Lincolnshire ICB	NHS Nottingham and Nottinghamshire ICB			Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Dewis	Robyn	Public Health Representative	✓	✓	✓	Director of Public Health, Derby City Council	Role within an NHS, local authority or provider organisation.	✓				01/11/2019	Present	To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Derby City Council.
Dewis	Robyn	Public Health Representative	✓	✓	✓	Member of the University Court for the University of Derby, and an Honorary Doctor of the University	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.
Garnett	Wynne	Voluntary, Community and Social Enterprise Sector Representative	✓	✓	✓	Self-employed independent contractor who could potentially undertake other work with partners	External role or association (non-NHS), declared for transparency.	✓				01/04/2021	Present	This interest will be kept under review and specific actions determined as required.
Van Dichele	Guy	Local Authority Partner Member - Deputy	–	–	✓	Trustee of United Response National Charity for People with Learning Disabilities	Trustee or leadership role in a voluntary, charitable or community organisation		✓			15/04/2024	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 United Response National Charity
Van Dichele	Guy	Local Authority Partner Member - Deputy	–	–	✓	Director at Nottinghamshire County Council	Role within an NHS, local authority or provider organisation.	✓				15/04/2024	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 Nottinghamshire County Council

Appendix B

Managing Conflicts of Interest at Meetings

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

The above categories are not exhaustive, and each situation must be considered on a case-by-case basis.

4. In advance of any formal meeting, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the

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

5. At the beginning of each formal meeting, members and others attending the meeting will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declaration will be formally recorded in the minutes for the meeting.
6. The Chair of the meeting (or person presiding over the meeting) will determine how declared interests should be managed, which is likely to involve one the following actions:
 - Requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to decision-making arrangements.
 - Allowing the individual to participate in the discussion, but not the decision-making process.
 - Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to decision-making arrangements.
 - Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.

Minutes of the meetings in common of:

NHS Derby and Derbyshire ICB Board

NHS Lincolnshire ICB Board

NHS Nottingham and Nottinghamshire ICB Board

15 January 2026, 09:00-12:30

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

		NHS Derby and Derbyshire ICB	NHS Lincolnshire ICB	NHS Nottingham and Nottinghamshire ICB
Members present:				
Dr Kathy McLean	Chair	✓	✓	✓
Dr Dave Briggs	Executive Director of Outcomes (Medical)	✓	✓	✓
Karen Dunderdale	NHS Trust/ Foundation Trust Partner Member	-	✓	-
John Dunstan	Non-Executive Director	✓	✓	✓
Margaret Gildea	Non-Executive Director (up to and including item ICB CIC 25 028)	✓	✓	✓
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	✓	-	-
Mark Powell	Ordinary Member – Mental Health	✓	✓	✓
Maria Principe	Executive Director of Commissioning	✓	✓	✓
Clair Raybould	Executive Director of Strategy and Citizen Experience	✓	✓	✓
Sharon Robson	Non-Executive Director	✓	✓	✓
Adrian Smith	Local Authority Partner Member	-	-	✓
Amanda Sullivan	Chief Executive	✓	✓	✓
Jon Towler	Non-Executive Director	✓	✓	✓
Rosa Waddingham	Executive Director of Quality (Nursing)	✓	✓	✓
In attendance:				
Alex Ball	Director of Communications and Engagement, NHS Nottingham and Nottinghamshire ICB (for item ICB CIC 25 024)	-	-	✓
Kate Baxter	Chief Executive, Children's Bereavement Centre (for item ICB CIC 25 024)	-	-	-
Lucy Branson	Director of Corporate Affairs, NHS Nottingham and Nottinghamshire ICB	✓	✓	✓
Helen Dillistone	Executive Director of Transition	✓	✓	✓
Daniel King	Chair, Nottinghamshire Voluntary and Community Sector Alliance	✓	✓	✓

		NHS Derby and Derbyshire ICB	NHS Lincolnshire ICB	NHS Nottingham and Nottinghamshire ICB
Marcus Pratt	Interim Joint System Director of Finance, NHS Derby and Derbyshire ICB and NHS Nottingham and Nottinghamshire ICB (deputising for Bill Shields)	✓	✓	✓
Sue Wass	Corporate Governance Officer, NHS Nottingham and Nottinghamshire ICB (Minutes)	✓	✓	✓
Apologies:				
Stephen Jackson	Non-Executive Director	✓	✓	✓
Martin Samuels	Local Authority Partner Member	-	✓	-
Bill Shields	Executive Director of Finance	✓	✓	✓
Dr Kevin Thomas	Primary Care Partner Member	-	✓	-

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

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

Introductory items

ICB CIC Welcome, introductions and apologies

- 25 019** The Chair welcomed members and attendees to the meetings in common of the Boards of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire ICB (hereafter referred to collectively as "the Boards" unless the item being discussed pertains to an individual ICB).
A round of introductions was then undertaken, and apologies noted as above.

ICB CIC Confirmation of quoracy

- 25 020** The meetings were confirmed as quorate.

ICB CIC Declarations and management of interests

- 25 021** 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 Minutes of the meeting held on 20 November 2025

25 022 The minutes were agreed as an accurate record of the discussions held.

ICB CIC Action log and matters arising from the meeting held on 20 November 2025

25 023 All actions were agreed as completed and no other matters were raised.

Leadership and operating context

ICB CIC Citizen Story: Children's Bereavement Centre

25 024 The Chair invited Alex Ball, Director of Communications and Engagement at NHS Nottingham and Nottinghamshire ICB, and Kate Baxter, Chief Executive of the Children's Bereavement Centre to introduce the item, and the following points were highlighted:

- a) The Children's Bereavement Centre, based in Newark-on-Trent in Nottinghamshire, was formed in 2003 and supported children and young people who were experiencing trauma or grief due to the death or terminal-illness of someone important to them. It was the only dedicated service within the County and it had been able to expand in recent years and now covered some areas of Lincolnshire, although to date it did not have a reach within Nottingham City.
- b) Kate described the potential long-term damaging impact of bereavement on children and young people, emphasising the importance and benefits of early intervention to support them at a critical and difficult time in their lives, and she provided an overview of the services offered by the charity.
- c) It was noted that the service complemented, rather than duplicated the statutory services offered by Child and Adolescent Mental Health Services, as the charity worked with children who would not normally meet the threshold for statutory services.
- d) The charity had assessed the impact of their services and had concluded that 70% of service users had demonstrated improved mental health and improved engagement at school or work. A short film was presented, which gave several testimonials from children, young people and parents on how the service had made a positive difference to their lives.
- e) Demand for the service was growing and there was an ambition to expand the service to serve a wider geographical area.

The following points were made in discussion:

- f) Discussing how the service worked with schools, GP practices and other voluntary and community organisations, Board members acknowledged the positive contribution of the service to the prevention agenda and how it complemented the objectives of Integrated Neighbourhood Team working.

- g) Noting that at the present time the charity was supported by donations and ad hoc grant funding, which limited its reach, the impact of the service on a relatively low cost base was acknowledged. Daniel King asked members to note that the Nottinghamshire Voluntary and Community Sector Alliance was developing commissioning frameworks to support voluntary and community organisations to access sustainable sources of funding.
- h) Board members agreed that bereavement services should be an important element in commissioning strategies for children and young people and end of life services, and on behalf of the Boards, the Chair thanked Kate for her presentation, asking the Boards to note that she had visited the Centre and had been inspired by the services it offered.

The Boards **noted** the Citizen Story.

ICB CIC Chair's Report

25 025 Kathy McLean introduced the item, highlighting the following points:

- a) Board members were asked to note that Paul Simpson, Chief Executive of Derby City Council had been nominated to join the Board as the Local Authority Partner Member for Derby and Derbyshire, which completed the appointments to the ICBs' Boards.
- b) National updates about the ICBs' future operating model were highlighted, including the intense work currently being undertaken to respond to the requirements of the Medium-Term Planning Framework at a challenging time for ICB staff. Gratitude was given to all staff who continued to work diligently and professionally.
- c) Attention was also drawn to several visits and meetings that Kathy had undertaken over recent months.

The following points were made in discussion:

- d) Following a query on the impact of the reform of NHS payment mechanisms, it was noted that this would be a key mechanism to enable the realisation of the commitment in the Government's Ten-Year Health Plan to move care out of hospitals into communities and to create efficiencies, thus improving outcomes for patients.

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

ICB CIC Chief Executive's Report

25 026 Amanda Sullivan introduced the item, highlighting the following points:

- a) Asking Board members to note the recent critical incident escalations within the Nottingham and Nottinghamshire system, the continuing pressure within which

staff continued to work was acknowledged and thanks were reiterated for their continued dedication.

- b) Noting that the Mental Health Act had recently received Royal Assent, its focus on the significant prevalence of mental health issues was welcomed.
- c) The announcement of the national investigation into maternity and neonatal services in England was also welcomed as a mechanism to investigate the systemic issues impacting on the delivery of maternity services.
- d) Board members were asked to endorse the signing of the Smoke Free Derby and Derbyshire Pledge, as part of a campaign to reduce smoking prevalence in the area to less than 5% by 2030.
- e) Approval of a revised counter fraud statement was also requested for inclusion on the ICBs' websites. This was noted as in response to the new 'failure to prevent fraud' offence under the Economic Crime and Corporate Transparency Act 2023, which came into force in September 2025.
- f) Several leadership appointments within the three health systems were noted.

The following points were made in discussion:

- g) With reference to the Smoke Free Pledge, members sought assurance that similar campaigns were underway in Lincolnshire and in Nottingham and Nottinghamshire, and it was noted that all campaigns in the three areas were broadly aligned.
- h) Discussing the changes signified by the Mental Health Act, it was agreed that a dedicated session should be held to review the implications of the changes once guidance was published.

The Boards **noted** the Chief Executive's Report and approved the Counter Fraud Statement for inclusion on the ICBs' websites.

The Board of NHS Derby and Derbyshire ICB **endorsed** the Smoke Free Derby and Derbyshire Pledge.

Action: Lucy Branson to schedule a future Board Development Session on the implications of the changes to services brought by the Mental Health Act.

ICB CIC ICB Transition Programme update

25 027

Helen Dillistone introduced the item, highlighting the following points:

- a) The report provided an update and overview on the progress of the ICB Transition Programme to date.
- b) The programme comprised several inter-related workstreams that aimed to support the move of ICBs to their primary role as strategic commissioners, whilst also developing a new organisational structure for the three ICBs to achieve the required running cost reductions.

- c) The wave two process for the appointment of the ICBs' senior leadership team had commenced and the recruitment process would be concluded by mid-March 2026. The wave three process for the remaining ICB staff was in the planning stage. It was anticipated that consultation would be launched in early February and recruitment to posts would commence from May onwards. A voluntary redundancy scheme had been launched and would close shortly.
- d) The Model ICB Blueprint, published in May 2025, had listed several functions for planned transfer out of ICBs. This had subsequently been updated, with fewer functions now expected to transfer and the report provided further detail on these functions. A number of functions would also need to be retained until such time as new legislation was passed. It was anticipated that new functions would also be delegated or transferred into the ICBs from NHS England and new governance structures were being developed to oversee these services.
- e) A key element of the programme was responding to the abolition of Commissioning Support Units (CSUs) to ensure that ICBs retained the required capacity and capability to undertake these functions.

The following points were made in discussion:

- f) Chair of the Joint Transition Committee, Jon Towler, asked Board members to note that the Committee had taken a high-level of assurance that robust plans and controls were in place to deliver the re-structure. However, given that the ICBs would retain the majority of their existing functions, there was a need for the ICBs to ensure that they could continue to exercise these functions proficiently with a much-reduced workforce.
- g) A request was made regarding the need to communicate any changes, including changes in functions and key personnel, to external partners, which was acknowledged and assurance was provided that this would be taken into account as the management of change programme evolved.
- h) As strategic commissioners, it was also acknowledged that ICBs would be required to change how they undertook functions in regard to safeguarding and Special Educational Needs and Disabilities. Assurance was provided that these functions had been designed into the new ICBs' structures.
- i) The need for a strong organisational development programme for those staff that continued to work for the ICBs was raised, as was the need for a refreshed ICB values and behaviours statement. It was confirmed that these elements were captured within the Transition Programme.
- j) Following a query regarding the risks relating to the abolition of CSUs, it was noted that the ICBs were currently working to understand the quantum of the CSUs' voluntary redundancy programmes and to align decision making processes. With reference to the need for communication with external partners, the requirement for communication regarding GP IT arrangements was also raised.
- k) The Chair asked for two areas, estates and research, not to be overlooked within the programme, which was acknowledged.

The Boards **noted** the report.

Action: Helen Dillistone to incorporate the requested actions relating to external communications within the Transition Programme.

Strategy and partnerships

ICB CIC Medium Term Planning update

25 028

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

- a) The report set out the requirements, progress and next steps in relation to the development of the ICBs' Medium-Term Planning Framework.
- b) Following the Boards' development session in December 2025, focused work continued to develop each of the planning outputs that the ICBs would be required to submit to NHS England; and an extraordinary meeting of the Boards had been scheduled for 10 February 2026 to approve the Five-Year Population Health Strategy, the Five-Year Strategic Commissioning Plan, and the Three-Year Operational Plan.
- c) A key priority was noted as the need to align commissioning ambitions with contract baselines, especially for urgent and emergency care in the context of the proposed blended payment model.
- d) Further work needed to be undertaken to reconcile financial assumptions, assess affordability and prioritise investment decisions within the available funding envelope. There was a strong focus on contracting as the primary mechanism for converting planning assumptions into deliverable operational and financial commitments. Up to four structured rounds of contract negotiations would be undertaken with providers to agree activity plans, contract values and performance expectations in order to reach agreement on the final commissioning and contracting position required to support the submission of the refreshed plan to NHS England by 12 February 2026.

At this point Margret Gildea left the meeting.

The following points were made in discussion:

- e) Noting that within the updated NHS Finance Business Rules, ICBs and NHS trusts no longer had a joint financial objective to deliver a system-wide breakeven position, Board members queried the potential risks that this change could generate. It was noted that there was a need to develop and maintain strong collaborative, open and transparent relationships. Furthermore, the ICBs' role as a strategic commissioner should be to commission outcomes, and commissioning approaches should be data driven. It would then be incumbent on providers to decide how best to deliver the outcomes. Further to this point,

the need to ensure that the ICBs had sufficient contracting expertise was raised.

- f) In response to a query relating to the role of General Practice, it was noted that General Practice would have a key role to deliver community services, such as early diagnostic treatments.
- g) Noting that reducing urgent and emergency care activity would prove extremely challenging, taking best practice and learning from other systems was advocated.
- h) Discussing the challenging cultural change in clinical behaviours that would be required to deliver the ambitious plans, the need for wider external engagement was raised. It was noted that the benefit of working over a wider footprint was already becoming evident, with the planning of 'frailty summit' later in the year to optimise pathways.
- i) It was noted that following the development of an Outcomes Framework, oversight would be embedded into the Boards' annual work programme to ensure visibility of progress.

The Boards **noted** the report.

Delivery and assurance

ICB CIC Finance Report

25 029

Marcus Pratt introduced the item, highlighting the following points:

- a) At month eight, the ICBs' year to date positions were noted as a variance to plan of £10 million. NHS Lincolnshire ICB was the main driver, with acute independent sector activity and prescribing pressures given as the main cause of the deficit position. A recovery plan had been enacted to mitigate the position. The loss of deficit support funding had also put increased pressure on NHS Nottingham and Nottinghamshire ICB's financial position. The continued delivery of efficiency plans was key ensuring that the ICBs remained on forecast.
- b) All systems within the Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire ICBs' footprints had demonstrated a deteriorating financial position. The overall year to date financial position for the three systems was a £95 million adverse variance to plan.
- c) Six organisations comprised the bulk of the variance and all continued to meet with the ICBs as part of a Financial Recovery Group to attempt to mitigate the deficits with this years' financial plans and enact recurrent change for future years.
- d) Although the reasons for the deteriorating positions varied, common themes were the non-delivery of both cost improvement plans and workforce plans.

The following points were made in discussion:

- e) As a member of the Joint Finance and Performance Committee, John Dunstan asked the Board to note that notwithstanding the significant risks to the achievement of financial plans within the ICBs' systems, the Committee had been assured that the ICBs were doing everything in their power to support the delivery of the plans. John also asked the Boards to acknowledge the achievement of £326 million of efficiency savings to date.
- f) Emphasising that non-delivery would be met with rigid spending controls and significant restrictions in future years, the Chair reiterated the national messaging that all organisations were expected to operate within their financial envelopes.

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

ICB CIC Quality Report

25 030

Rosa Waddingham introduced the item, highlighting the following points:

- a) Members were asked to note that this report provided a summary of the quality issues affecting services across all three ICB areas; therefore, it was for information rather than assurance.
- b) Members were also asked to note that the report had been drafted prior to the publication of the latest National Oversight Framework Ratings, which had moved Derbyshire Healthcare NHS Foundation Trust from segment four to three and Sherwood Forest Hospitals NHS Foundation Trust from segment two to three.
- c) Currently there were three providers in the highest level of NHS England's National Oversight Framework for escalated risk: Nottinghamshire Healthcare NHS Foundation Trust; Nottingham University Hospitals NHS Trust; and University Hospitals Derby and Burton NHS Foundation Trust. The status and progress of their respective improvement programmes was provided within the report.
- d) The Joint Quality and Service Improvement Committee had received a full stocktake of quality concerns across all three systems' NHS trusts and in areas of enhanced oversight, including learning disabilities and autism services; urgent and emergency care; maternity services; special educational needs and disabilities services; and infection prevention control.

The following points were made in discussion:

- e) Chair of the Joint Quality and Service Improvement Committee, Sharon Robson, observed that the Committee had found it useful to understand the ICB systems' key quality and patient safety themes and risks and how the ICBs would change their focus as strategic commissioners to address these common quality issues, with a more strategic outcomes-based approach towards improvements in safety and quality.

The Boards **noted** the report.

ICB CIC Service Delivery Performance Report

25 031 Maria Principe introduced the item, highlighting the following points:

- a) The report provided a summary of performance against the service delivery targets required for 2025/26, and the actions and recovery timeframes for those targets currently off track.
- b) All emergency and urgent care systems continued to be under significant pressure and the ICBs continued to support acute trusts to optimise flow, with a continued focus on enacting winter plans and daily oversight. Standardised approaches were starting to be used.
- c) Planned care recovery was progressing, but risks remained around 65-week wait breaches and specialty backlogs. Lincolnshire was broadly on track for year-end compliance, whilst Nottinghamshire and Derbyshire faced greater challenges. Additional sessions, workforce flexibility, and pathway redesign were being used to mitigate risks, but productivity gaps and the impact of winter and industrial action continued to present challenges.
- d) Future arrangements for performance oversight continued to evolve and the report provided further detail on how the ICBs were transitioning to a strategic commissioning and system stewardship role, prioritising outcomes, value for money, and transformation delivery through an integrated performance and assurance framework.

The following points were made in discussion:

- e) Noting that much of the data within the report related to performance as of October 2025, the Chair queried whether more up to date data could be available in future reports. Understanding the necessary time lag in data validation and reporting, Board members went on to discuss the format of the report. It was acknowledged that the current report was technical in format and did not provide Board members with a forward look. It was concluded that as the ICBs' role in performance oversight became clearer, the format of the report would change to focus on areas of ICB-commissioned services and progress towards the achievement of outcomes.

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

ICB CIC Emergency Preparedness, Resilience and Response Annual Reports

032 Maria Principe introduced the item, highlighting the following points:

- a) The annual reports on the Emergency Preparedness, Resilience and Response (EPRR) activities undertaken by each ICB to be adequately prepared to respond to major and/or business continuity incidents were presented for assurance that each ICB was fulfilling its statutory duties.

- b) The reports summarised ICB compliance against the 2024/25 Core Standards, oversight of the EPRR programmes of work, delivery against the annual Training and Exercise programme and a summary of business continuity, critical and major incidents experienced by the organisations and wider system during the year.
- c) NHS Lincolnshire ICB and NHS Derby and Derbyshire ICB were rated as substantially compliant, and NHS Nottingham and Nottinghamshire ICB was rated as partially compliant. All ICBs had in place action plans to work towards full compliance and no material risks to the positions of any of the ICBs were noted.

The Boards **received** the reports for assurance regarding the ICBs' current level of compliance.

Governance

ICB CIC 25 033 Committee Highlight Reports

The report presented an overview of the work of the Boards' committees since its last meeting in November 2025; it aimed to provide assurance that the committees were effectively discharging their delegated duties and included assessments of the levels of assurance the committees had gained from their work during the period. The Chair noted that updates from Committee Chairs had already been provided during related discussions under agenda items ICB CIC 25 027, ICB CIC 25 029, and ICB CIC 25 030.

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

- a) Chair of the Audit Committees, John Dunstan, asked Board members to note that the Committees had been assured that each ICB had in place robust arrangements regarding their EPRR responsibilities and the Committees would receive a mid-year update on progress in June 2026. The Audit Committees were also continuing to monitor risks relating to the implementation of the new finance ledger.
- b) Chair of the Joint Strategic Commissioning Committee, Jon Towler, asked Board members to note that the Committee's next meeting would be focused largely on supporting the development of the medium-term planning documents, ahead of approval by the Boards.

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

Closing items

ICB CIC 25 034 Risks identified during the course of the meeting

No new risks were identified.

ICB CIC Questions from the public relating to items on the agenda
25 035 No questions had been received.

ICB CIC Any other business
25 036 No other business was raised, and the meeting was closed.

Action Log from Board meetings in common, held on 15 January 2026

Meeting date	Agenda item	Action	Lead	Due date	Updates	Status
15.01.2026	ICB CIC 25 026: Chief Executive's Report	To schedule a future Board Development Session on the implications of the changes to services brought by the Mental Health Act.	Lucy Branson	19.03.2026	Scheduled for inclusion within the June 2026 Board Development Session.	Closed – action completed
15.01.2026	ICB CIC 25 027: ICB Transition Programme Update	To incorporate the requested actions relating to external communications within the Transition Programme.	Helen Dillistone	19.03.2026	Added to the Transition Programme, which will continue to be oversighted by the Joint Transition Committee.	Closed – action completed

Key:

Closed – Action completed or no longer required

Open – Off-track (may not be completed by expected date of completion)

Open – On-track (to be completed by expected date of completion)

Open – Off-track (has not been completed by expected completion date)

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	19/03/2026
Paper title:	Citizen Story: Derbyshire Carers Association
Paper reference:	ICB CIC 042
Paper author:	Christina Jones, Head of Communications, NHS Derby and Derbyshire ICB
Paper sponsor:	Clair Raybould, Executive Director of Strategy and Citizen Engagement
Presenter:	Clair Raybould, Executive Director of Strategy and Citizen Engagement Jude Boyle, Carer Commissioning Manager, Derbyshire County Council Helen Weston, Chief Executive, Derbyshire Carers Association

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

Report summary:
Derbyshire Carers Association (DCA) has supported unpaid carers across the county for more than three decades, providing practical, emotional and specialist help to people looking after a family member, partner, or friend. Established to recognise and champion the vital role of carers, the organisation now delivers a wide range of services for adult and young carers, including home visits, support groups, telephone advice and formal carers assessments Register of Charities. Its offer spans the Derbyshire All-Age Support Service, a Nottinghamshire service, workplace support for employed carers, and partnerships with NHS trusts and local authorities. Carers' voice and co-production are central to their mission. Young carers are supported in schools, GP practices and community drop-ins, ensuring help is available close to where they live. Many services are complementary - identifying caring roles, addressing financial pressures, tackling isolation and linking carers with wider organisations. DCA completes carers assessments, develops co-produced support plans and connects people to respite, welfare rights and legal clinics. With around 14,000 carers registered and 200 new referrals each month, some families remain with DCA for decades, including through end-of-life care. The charity prides itself on never leaving carers alone - ensuring phones are always answered. Three large recently improved offices provide space for carers, community groups and future service growth. Dr Kathy McLean visited the group recently to hear about their work, take a tour of the building in Ripley, and meet the team.

Recommendation(s):
The Boards are asked to discuss the citizen story.

Relevant statutory duties:
☒ Quality improvement ☐ Public involvement and consultation
☒ Reducing inequalities ☐ Equality and diversity
☒ Integration of services ☐ Wider effect of decisions (triple aim)

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

None.

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	19/03/2026
Paper title:	Chair's Report
Paper reference:	ICB CIC 25 043
Paper author:	Dr Kathy McLean, Chair
Paper sponsor:	Dr Kathy McLean, Chair
Presenter:	Dr Kathy McLean, Chair

Paper type:

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

Report summary:

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

Recommendation(s):

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

Relevant statutory duties:

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

Appendices

None.

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Chair's Report

Introduction

1. In what has already been a very busy start to the calendar year, I wanted to say firstly thank you to all colleagues across the three ICBs for their continued professionalism and resilience as we progress the management of change process required to achieve the nationally mandated cost reductions for ICBs.
2. This is without doubt a very challenging process for everyone involved, and while the staff affected are anxious about their futures, they continue to focus on delivering their 'business as usual' work. This has included working to challenging timescales to enable submission of the ICBs' Three-Year Operational Plan, which will underpin our Five-Year Population Health Strategy and Five-Year Strategic Commissioning Plan. The Boards had a very productive session on 10 February, where we were able to support the progress made and approve submission to NHS England. A summary of the Strategy and Commissioning Plan is on the agenda for our meeting today, and the work that has gone into getting us to this stage has been tremendous, particularly at a time of organisational change.

NHS reform

3. There remains much discussion about the shape of the upcoming Health Bill. This will set in legislation the requirements of ICBs, as well as signalling the future steps ICBs must take towards potential merger, which is likely to take place in 2027. I have been part of the working groups that are shaping the Bill, and a crucial part of the ICB landscape will be the legislative interaction of boundaries with our Mayoral Authorities. Colleagues will know that we have two authorities covering our ICB areas; the East Midlands Combined County Authority covering Nottinghamshire and Derbyshire, and the Greater Lincolnshire Combined County Authority. The outcome of those discussions will be material to the shape of the ICBs in the East Midlands.
4. I have continued to be outward facing, promoting our ICBs and wider health and care services and engaging with local and national stakeholders. It was a pleasure to be invited to give evidence to the Health and Social Care Select Committee, which held a session to explore NHS pilots on 4 February. Pilots are seen as the primary mechanism for testing new models and approaches in real-world settings before wider adoption. They are central to the NHS's ambition to innovate, "taking the best of the NHS to the rest", as set out in the Ten-Year Health Plan. Alongside Dr Claire Fuller, NHS England's Medical Director, and Professor Kath Checkland, Joint Director at the National Institute of Health Research's Policy Research Unit, I referenced the work we have

been doing in Nottingham to support people experiencing severe and multiple disadvantage as a good practice example of how you can grow a pilot into a sustainable partnership programme.

5. In addition to having the evaluation in place from the outset and being clear on what measurements constitute success, I emphasised the importance of strong partnerships, aligned incentives and empowering people to take risks. It was also important to reflect on the time it can take to see impact and the importance of having long-term investment in place to support innovation that proves successful so it can be scaled. These lessons are shaping how we are approaching the National Neighbourhood Health Implementation Programme across the ICBs.
6. Connected to this, I was invited to sit on the panel at the NHS Confederation's Care Closer to Home conference at the end of February. There was a significant focus on neighbourhood health care, with a key question on why ICBs as strategic commissioners want to be involved. We know from our Five-Year Population Health Strategy analysis that neighbourhoods are where inequalities appear earliest, where access gaps are clearest and where the NHS can intervene fastest. Strategic commissioning requires a delivery platform capable of proactive prevention, risk stratification, targeted outreach and integrated delivery, and neighbourhoods provide that platform. This work supports delivery of the Ten-Year Health Plan requirement to shift hospital care into the community, creating capacity and sustainability, and it enables shared, multi-agency action on wider determinants that the NHS cannot fix alone. Our ambition across a range of outcome measures is therefore founded on a strong neighbourhood approach.
7. The refreshed National Quality Board has now met three times, with an early focus on shaping a shared definition of high-quality care: care that is safe, effective, and provides a positive experience for patients, delivered inclusively and sustainably. This definition is an important basis for the new National Quality Strategy, which is nearing completion. This strategy will aim to support teams working in every part of the NHS to deliver improvements, including through:
 - a) Stronger leadership, clearer roles and responsibilities, and more effective quality governance, including streamlined regulation.
 - b) Harnessing rigorous use of data, transparency, technology, and embedded research and innovation to support continuous improvement.
 - c) Value-based commissioning, a better understanding of performance and outcomes, and aligned incentives to ensure finite NHS resources are deployed where they can deliver most value for patients and communities.
8. In addition to the National Quality Strategy, and work in train on patient safety and experience, NHS England is continuing to develop modern service

frameworks in priority clinical areas. The first wave, covering cardiovascular disease, severe mental illness, and sepsis, is on track for publication in the coming weeks, with a second wave underway for children and young people, frailty, dementia, and end-of-life care.

Local updates

9. The Local Government Reform agenda, part of a broader effort to improve local governance and service delivery, is reaching an important phase. The Government has now launched formal consultations on the proposals it has received from councils, and the outcome of the consultation will inform decisions on which proposals, if any, to implement. The ICBs will be considering our responses to the consultations, in collaboration with our NHS partners where appropriate.
10. The United Nations Educational, Scientific and Cultural Organisation (UNESCO) Learning Cities Network promotes lifelong learning by fostering international collaboration, sharing best practices and implementing policies that increase educational access for all residents. I was delighted to hear that Derby has been named the Chair and lead of the UK UNESCO Learning Cities Network for 2026. Work is being led by Professor Rhiannon Jones, Head of Civic and Communities at the University of Derby, and we look forward to the opportunities this presents for the city and our communities, including the role that health and the NHS can play in this agenda as an anchor organisation.
11. At the beginning of March I joined Claire Ward, Mayor of the East Midlands, on a visit to The Pythian Club to see first-hand the organisation's powerful impact on local communities and young people. Founded in 2014, The Pythian Club has grown into a respected, award-winning community organisation dedicated to empowering young people and supporting neighbourhood resilience. Based at the Heathfield Community Centre in Basford, Nottingham, they deliver programmes spanning education, mentoring, sport, behaviour support, and community safety.
12. I heard just how important the work of the Pythian Club is to the local community, including its work to support people into volunteering and employment, providing opportunities to be active, its mentoring work with young people and support for people experiencing homelessness.
13. Through our continued focus on neighbourhood development, it will be vital for us to work with grassroots organisations like the Pythian Club to ensure that they are involved in shaping future support for people living in their area. Claire and I identified some shared priorities for the future, including youth trailblazer initiatives, work to support men and boys, mental health prevention work and using data to identify risk earlier and support prevention.

14. I had an opportunity to speak with Michele Jolly, Chief Executive Officer of Age UK Lincolnshire, to discuss how we can work more closely in the future. Age UK has recently been awarded a Social Impact Framework Supplier Badge, which demonstrates the meeting of requirements to supply services to the NHS, which reduces the complexity and burden of bidding, something our charitable and voluntary sector colleagues often remind us of.
15. I also met with Dr Kaval Patel, Chief Executive Officer, and Dr Kevin Thomas, Deputy Chief Executive, of Lincolnshire Primary Care Network Alliance to discuss the Alliance's ambitions. The Alliance is focussed on how they deliver neighbourhood health and continue to build on relationships with system partners.
16. I have continued with my series of podcasts with health and care leaders from across the system. We have now amalgamated these podcast series to cover the breadth of the ICBs' work. The [latest episode](#) takes a deep dive into primary care, thinking about where it fits into the Ten Year Health Plan, how we can motivate the workforce and the opportunities and challenges for the coming year. My guests were Clive Newman, NHS Derby and Derbyshire ICB's Director of Primary Care, Dr Sunil Hindocha, Medical Director, at NHS Lincolnshire ICB and Dr Stephen Shortt, Deputy Medical Director, NHS Nottinghamshire and Nottinghamshire ICB, and we talked about access to general practice, stewardship, examples of best practice and the role of Primary Care Networks. Primary care is at a critical point in its history with huge potential for the future and working together provides much greater opportunities for sharing best practice.

Looking forward

17. It remains clear from this report and also the other items on today's agenda that a huge volume of activity is taking place across the ICBs' footprints to deliver high quality services for our populations, alongside the internal re-organisation. As ever, we must track progress on both fronts, to deliver our core aim of population health improvement, and finding stability following the period of significant change, and the organisational development that will support that, will be an important focus for the next few months.
18. Once again, I want to underline my empathy for colleagues undergoing a considerable period of change and thank them for their fortitude and resilience as we move forward.

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	19/03/2026
Paper title:	Chief Executive's Report
Paper reference:	ICB CIC 25 044
Paper author:	Amanda Sullivan, Chief Executive
Paper sponsor:	Amanda Sullivan, Chief Executive
Presenter:	Amanda Sullivan, Chief Executive

Paper type:

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

Report summary:

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

Recommendation(s):

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

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: Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire ICBs – Executive and Senior Leadership Team

Appendix B: Summary of service portfolio analyses for transferring functions

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Chief Executive's Report

Introduction

1. The ICBs' management of change process has reached a further milestone, with the second phase of our change programme for the ICBs' senior leadership team nearing completion. Appendix A provides detail of the appointments to date. The ICBs' Voluntary Redundancy Scheme, which has enabled our staff to take some control of their personal future, is also nearing conclusion.
2. The final phase of the change programme has now been launched for all remaining staff, which will put in place new structures to help deliver our ICBs' ambition. The consultation, launched on 10 February 2026, will run for 45 days, ending on 27 March 2026. Our teams have responded constructively to the consultation and there will no doubt be adjustments to final structures once the feedback from staff has been taken into account.
3. These next few months will be a period of considerable challenge for our staff and I would like to put on record my thanks for their continued hard work and resilience.

NHS National Staff Survey 2025

4. NHS England released the results of their 2025 national Staff Survey on 12 March 2026. 66% of staff responded to the survey, an increase from the previous year. Nationally, the survey indicates challenging findings on staff engagement, motivation and morale, which given the backdrop of continuing industrial action and workforce constraints is understandable. However, indicators relating to quality and experience of line management remain positive, which is welcome and demonstrates continuing staff commitment throughout a period of significant change. The national results can be found here: [NHS England Staff Survey Results 2025 - summary report](#).
5. The breakdown of the results for the ICBs will now be considered and an action plan to address areas for improvement will be presented at the April meeting of the Joint Remuneration and Human Resources Committee.

2025/26 ICB Annual Assessments

6. NHS England has outlined the arrangements for the 2025/26 ICB Annual Assessments, confirming that a lighter-touch process will be used due to the transition toward ICBs' future role as strategic commissioners. While a new assessment model is planned for implementation in 2027/28, each ICB will still receive a statutory assessment for 2025/26, culminating in a narrative outcome

letter to the Chair by the end of July 2026. The assessment will draw on existing evidence, primarily the ICBs' draft Annual Reports due on 24 April 2026, and will review performance against statutory duties, national priorities, and progress towards strategic shifts including prevention, digital transformation, and community-based care. Specific focus areas include complaints oversight, Special Educational Needs and Disabilities (SEND) duties, economic development contribution, and action on health inequalities.

7. A clear timetable has been set, covering draft submissions in April, assurance reviews in May, and finalisation through June and July. Feedback from Health and Wellbeing Board and Health Overview and Scrutiny Committee Chairs will form an important component of the qualitative assessment. NHS England will use existing intelligence and will not seek additional information beyond the Annual Reports and routine oversight mechanisms.

The Nottingham Inquiry

8. The public hearings for The Nottingham Inquiry began on 23 February 2026. The Inquiry will report by April 2027 and hearings are expected to continue until Summer 2026. The Inquiry will build a clear understanding of the events, acts and omissions that led up to Valdo Calocane carrying out brutal attacks in Nottingham on 13 June 2023. Our thoughts remain with the families of Ian Coates, Grace O'Malley-Kumar and Barnaby Webber who were killed and also with Wayne Birkett, Sharon Miller and Marcion Gawronski who were injured.
9. Extensive governance arrangements, including oversight from the ICB, regional and national NHS England teams are in place to monitor quality and regulatory concerns at Nottinghamshire Healthcare NHS Foundation Trust. Senior ICB leaders are part of this process, including the Chief Executive and Executive Director of Quality (Nursing). These arrangements provide scrutiny for operational and quality risks and provide wider stakeholders, including specialised commissioning teams within NHS England and the Care Quality Commission, with a single forum to support and challenge the progress of improvements at the Trust. We are committed to safe and high-quality services for our communities and we will continue to provide support and challenge to the Trust to ensure sustained improvements in the delivery of safe services.

2026/27 Transformation Fund

10. During February, the Boards approved the ICBs' Five-Year Population Health Strategy and Five-Year Strategic Commissioning Plan, which will put into action the aims of the Government's Ten-Year Health Plan and will set the foundations for a stronger health and care service. A key element of the strategy and commissioning plan is the ICBs' Transformation Fund, which aims to accelerate improvements in care, reduce inequalities and strengthen the

long-term sustainability of local health services. This represents a commitment of 0.5% of commissioning resource in 2026/27, equating to £33 million, rising to up to £100 million over three years.

11. The Joint Strategic Commissioning Committee approved the framework for implementing the fund in February 2026, and the ICBs are now seeking ambitious, system-level proposals that demonstrate clear return on investment, strong partnership working and sustainable impact beyond the period of non-recurrent funding.

Collaboration with Health Innovation East Midlands

12. Health Innovation East Midlands (HIEM) is a regional network, established to accelerate the adoption of new technologies and healthcare practices. During February, the ICBs were invited to speak at a HEIM Town Hall event, attended by HEIM colleagues and Board members, to provide an update on our Five-Year Population Health Strategy. The session focused on setting out the context for ICB clustering arrangements, our strategic commissioning priorities for years one and two, and how innovation and digital enablement can accelerate delivery at neighbourhood level. The discussion was positioned explicitly to build on existing collaboration with HEIM, with a view to aligning innovation support more deliberately to our priorities and scaling what works well across a wider footprint.

Lincolnshire mental health research unit

13. An investment of £11 million has been made by the National Institute for Health and Care Research into a new Lincolnshire Unit for Mental Health Research, led by the University of Lincoln with Lincolnshire Partnership NHS Foundation Trust and local partners, including NHS Lincolnshire ICB.
14. Building on the Institute's Guiding Lincolnshire's Mental Health Research programme, it is one of five new Mental Health Research Groups funded nationally in 2025/26. It will focus on improving support in rural, coastal and small urban deprived communities, aiming to reach people who have historically been under-represented in health studies, ensuring that future treatments and services are designed by, and for, the people of Lincolnshire. The Unit will formally launch in May 2026.

Direct commissioning functions

15. NHS England has written to ICBs to provide an update on plans for the transfer of their direct commissioning functions to ICBs, subject to Parliament's approval of changes in primary and secondary legislation. This is in support of the

Government's Ten Year Health Plan ambition to establish ICBs as strategic commissioners for all but the most specialised services.

16. It is anticipated, subject to parliamentary approval, that the following functions will transfer to ICBs from April 2027:
 - a) Vaccinations, child health information services and almost all components of screening services.
 - b) Health and justice services and sexual assault and abuse services, including sexual assault referral centres.
 - c) Specified specialised services, including all previously delegated services and a small number of additional services identified as suitable.
 - d) Primary care services, including all previously delegated services.
17. With the following functions being retained by the Department of Health and Social Care, subject to the abolition of NHS England:
 - a) All highly specialised services; high secure mental health services; a small number of other specialised services not currently suitable for ICB commissioning; and the continued national reimbursement of high-cost tariff excluded drugs and devices.
 - b) All services for the armed forces community currently commissioned nationally by NHS England.
 - c) Certain components of screening services that are already commissioned on a national scale.
18. In preparation for the transfer of functions, an Office for Pan ICB Commissioning (OPIC) will need to be established in each NHS region and ICBs will need to identify by the end of April 2026, one host ICB for each region. Staff currently delivering these functions within NHS England's seven regional teams will then transfer to the host ICB. NHS England has now agreed indicative funding envelopes for its regional commissioning teams and these will then flow to ICBs from April 2027 to fund the OPICs. A paper setting out proposals for the Midlands OPIC will be considered later on the agenda for today's meeting and the full list of functions can be found at Appendix B.

The National Cancer Plan for England: delivering world class cancer care

19. On 4 February 2026, the Department of Health and Social Care launched a National Cancer Plan, which sets out a long-term approach to improving cancer outcomes, experience and equity over the next decade. The Plan has been shaped through engagement with patients, partners and professionals, and details how the approach to cancer care in England will be modernised. The full plan can be found here: [The National Cancer Plan for England: delivering world class cancer care](#).

20. The headline ambition is that, by 2035, three in four people diagnosed with cancer will be cancer-free, or living well with cancer after five years. The Plan also sets out how, through improved performance, Cancer Waiting Time standards will be met by the end of this Parliament.
21. The aims and actions of the Plan are embedded in the Medium-Term Planning Framework and as such, are reflected in the ICBs' Five-Year Population Health Strategy, Five-Year Strategic Commissioning Plan, and Three-Year Operational Plan.

Re-modelling urgent and emergency care pathways

22. NHS England has recently released the first tranche of guidance focussing on the use of best practice in urgent and emergency care pathways.
23. The 'Model Emergency Department: high performing urgent and emergency care pathways guidance' is focussed on the use of best practice for internal emergency department pathways. Its aim is to improve flow within hospitals to prevent overcrowding, 'corridor care,' ambulance delays, harm to patients and to improve working conditions for staff working in emergency departments.
24. All acute trusts will be required to assess their current operating model against the key elements of the guidance to identify gaps and to develop improvement plans, with the intention for the plans to be operational by April 2027. The guidance stipulates that implementation will need to be supported by an aligned workforce, accurate counting and coding and modern estate plans.
25. To support improved performance, NHS England has simplified and strengthened a deployable improvement offer, with teams now operating under the single brand of 'Getting It Right First Time' and with revised financial incentive mechanisms.
26. The full guidance can be found here: [NHS England » The Model Emergency Department: high performing urgent and emergency care pathways](#).
27. The 'Model Acute Pathway: standards for care of acutely unwell patients in their first 72 hours in hospital' guidance focusses on standards for the first 72 hours of hospital care. The standards set out the timeframes within which patients should expect to have a full assessment, receive a specialty review and be transferred to a ward bed.
28. If implemented, the standards will reduce the time patients spend in emergency departments, improve quality, safety and patient experience and reduce unnecessary long stays in hospital.
29. Providers will be required to use a self-assessment tool to evaluate their baseline and identify areas for improvement. The outcome of this self-assessment and associated action plan should be reviewed and endorsed at

acute trust boards annually, with progress considered by a sub-committee every six months, using local metrics to track progress.

30. The full guidance can be found here: [NHS England » The Model Acute Pathway: standards for care of acutely unwell patients in their first 72 hours in hospital](#).

Standardising community health services

31. NHS England has published an overview of the core community health services that ICBs, service providers and their partners should consider when planning services for their local population. Its aims are to ensure the best use of funding to meet local needs and priorities and should be used for designing, commissioning and delivering community health services, including neighbourhood health.
32. ICBs and their local authority partners will need to adapt and develop these core components according to local need. Specifically, ICBs will be required to use this publication when designing and commissioning neighbourhood health locally and give due regard to patient flows across providers and at a neighbourhood level.
33. ICBs will also be required to work with local authorities, providers and partners to understand demand and capacity for community health services to help determine the future opportunity for community health services to work in partnership with other providers to improve outcomes, patient experience and support the shift of activity from hospital to community.
34. The guidance acknowledges that the funding of community services and its associated workforce is complex and delivered by multiple providers. It states that over the coming years, the Department of Health and Social Care will continue to work with ICBs and community service providers to align and develop community health services activity, workforce, and financial data; develop tools to support consistent analysis of community health services' demand and capacity; and develop benchmarking tools to support service improvement. The full guidance can be found here: [NHS England » Standardising community health services](#).

Consultation on the reform of the special educational needs and disabilities (SEND) system

35. The Department of Education has launched a consultation document on planned changes to improve help and support for children and young people with SEND.
36. This will be a comprehensive reform, based on the following principles:

- a) Early: Children and families should receive the support they need as soon as possible, with a quick response to changing needs.
 - b) Local: Children and young people with SEND should be able to learn at an education setting close to their home, alongside their peers, rather than travelling long distances from their family and community.
 - c) Fair: Every education setting should be resourced and able to meet common and predictable needs, including as they change over time, without parents having to fight to get support for their children.
 - d) Effective: Reforms should be grounded in evidence, ensuring all education settings know where to go to find effective practice that has excellent long-term outcomes for children and young people.
 - e) Shared: Education, health and care services should work in partnership with one another, Best Start Family Hubs, local government, families, teachers, educators, experts, the voluntary sector and representative bodies to deliver better experiences and outcomes for all our children and young people.
37. The consultation closes on 18 May 2026 and the full document can be found here: <https://consult.education.gov.uk/send-strategy-division/send-reform-putting-children-and-young-people-firs/>.

NHS Alliance

- 38. The NHS Confederation and NHS Providers have announced the name of the new national membership organisation created from their merger in January 2026. The merger brings together two established national bodies to strengthen the collective influence, insight and support for NHS trusts, primary care, integrated care boards and independent and voluntary sector providers.
- 39. The new NHS Alliance will represent and support the health system across England, Wales and Northern Ireland, bringing NHS leadership together, representing their views to government, and supporting them to improve their services at a time of significant pressure and transformation for the NHS.
- 40. The NHS Alliance will launch in April 2026 with Sir Ciarán Devane, currently chair of the Health Service Executive (HSE) in Ireland, as its inaugural chief executive.

Recent leadership appointments

- 41. Chesterfield Royal Hospital NHS Foundation Trust has announced the appointment of its new Chair, Jackie Smith, following a competitive recruitment process supported by partners. Jackie brings six years of experience chairing NHS organisations across acute, mental health, community, and specialist

services, and a track record of leading Boards through complex transformation, strengthening governance processes, and driving organisational reform in complex and politically sensitive environments across healthcare, policing, and professional regulation. We look forward to working with Jackie when she starts in post, on a date to be confirmed.

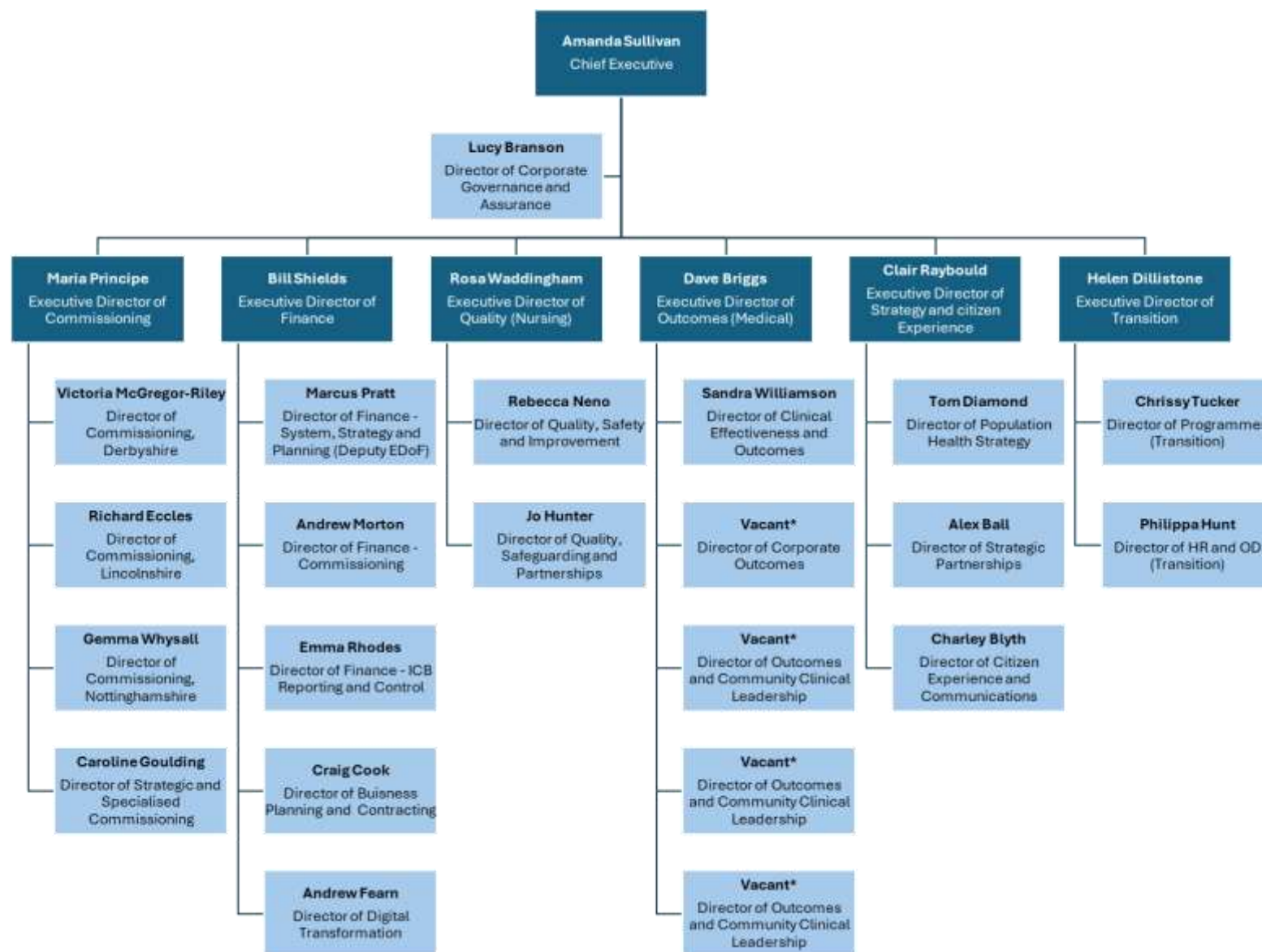
42. Nottinghamshire Healthcare NHS Foundation Trust has confirmed the appointment of its new Chair, Tom Cahill CBE. Tom, a registered mental health nurse, joined the Trust in January 2026, taking over from Paul Devlin following completion of his second and final term as Chair of the Trust. Tom brings extensive senior leadership experience across the NHS, including 12 years as Chief Executive of Hertfordshire Partnership NHS Foundation Trust, where he led the organisation to an 'Outstanding' CQC rating in 2019. Since 2021, Tom has served as NHS England's National Director for Autism and Learning Disability, driving national improvement in outcomes, inclusion, and life opportunities for autistic people and those with learning disabilities.
43. Nottingham CityCare Partnership has announced the appointment of Vicky Bailey as its new Chair, with Vicky joining the organisation on 7 April 2026. Vicky brings extensive experience of senior leadership, governance and system working, alongside a deep understanding of community-based health care in Nottingham. She has spent much of her career working within the NHS locally, holding a range of senior and executive roles across Nottinghamshire.

Health and Wellbeing Board updates

44. Derby City Health and Wellbeing Board met on 13 March 2026 and received updates on the NHS immunisation programme in the City; progress on their joint Derby and Derbyshire childhood obesity plan; and an update on the Derby and Derbyshire Drugs and Alcohol Strategic Partnership. Papers for the meeting can be found here: [Health and Wellbeing Board - Derby City Council](#).
45. Derbyshire Health and Wellbeing Board met on 29 January 2026. The agenda focussed on support to young people who vape; an update on their strategic priority relating to tackling child poverty; and an update report on Neighbourhood Health Model and the role of the Health and Wellbeing Board. Papers for the meeting can be found here: [Browse meetings - Health and Wellbeing Board - Derbyshire County Council](#).
46. Lincolnshire Health and Wellbeing Board met on 10 March 2026 to discuss an update on the NHS Joint Forward Plan; refreshed Joint Strategic Needs Assessments; an annual report on the Public Health case for quality employment; and an update on the Lincolnshire Better Care Fund. Papers for the meeting can be found here: [Browse meetings - Lincolnshire Health and Wellbeing Board](#).

47. Nottingham City Health and Wellbeing Board met on 25 February 2026 and received reports on their learning disabilities joint strategic needs assessment; an update on the Better Care Fund and a planning update on neighbourhood health. Papers for the meeting can be found here: [Browse meetings - Nottingham City Health and Wellbeing Board - Nottingham City Council](#).
48. Nottingham County Health and Wellbeing Board met on 11 March 2026. Items on the agenda included an update on the delivery of the Joint Health and Wellbeing Strategy and the Better Care Fund; progress on the Integrated Neighbourhood Plan; and endorsement of the Nottinghamshire Domestic Abuse Strategy 2026-2029. Papers for the meeting can be found here: [Health and Wellbeing Board | Nottinghamshire County Council](#).

Appendix A: Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire ICBs – Executive and Senior Leadership Team



*Will be subject to external recruitment

Appendix B: Summary of service portfolio analyses for transferring functions

Vaccinations, screening and child health information services (CHIS)

As public health functions of the Secretary of State for Health and Social Care, commissioning responsibility for the services listed below will be directly delegated to ICBs (in the same way they are currently delegated to NHS England):

- a) Section 7A vaccination services
- b) abdominal aortic aneurysm screening service
- c) breast screening services
- d) diabetic eye screening services
- e) bowel cancer screening hubs
- f) bowel cancer screening centres
- g) cervical screening HPV cytology laboratory services
- h) newborn bloodspot screening laboratory services
- i) CHIS

Local co-ordination of vaccine response to outbreaks is already the responsibility of ICBs and will remain so.

Health and justice services and sexual assault and abuse services

Responsibility and accountability for all health and justice services will transfer from NHS England to ICBs (subject to legislation).

Health and justice is the collective term used to describe NHS England commissioned healthcare services for children and adults throughout the welfare and youth justice and the criminal justice systems in England.

Health and justice services are commissioned to the 'principle of equivalence', which means that the health needs of a population constrained by their circumstances are not compromised and that they receive a level of service equal to that offered to the rest of the population. Partnership agreements and memoranda of understanding are in place with stakeholders to facilitate joint working arrangements for pathways of care.

Health and justice can broadly be split into 6 component cohorts or pathways of care:

- a) custodial adults
- b) children and young people secure estate
- c) vanguards commissioned through the framework for integrated care (community)

- d) non-custodial (pre and post custody services)
- e) immigration removal centres and migrant health
- f) sexual assault and abuse services

Specialised services

Where services are already delegated to ICBs, full accountability will transfer from NHS England to ICBs and a further set of specialised services will also transfer from April 2027 (subject to legislation). These additional services are:

- a) orthopaedic surgery: joint preservation surgery (adults)
- b) adult specialist pulmonary hypertension services
- c) Tier 4 CAMHS (children's service)
- d) Tier 4 CAMHS (MSU)
- e) mental health service for deaf children and adolescents
- f) severe intestinal failure service (adults)
- g) severe intestinal failure service HPN on-costs (adults)
- h) specialist burn care services (adults)
- i) specialist burn care services (children)
- j) spinal cord injury services (adults and children)
- k) Infected Blood Psychological Service (IBPS)

Commissioning accountability and responsibility for all 'highly' specialised services, high secure mental health services and a small number of specialised services will transfer to DHSC. The national reimbursement of high-cost tariff excluded drugs and devices will also transfer to DHSC.

Primary care services

Primary care is the collective term used for primary medical services, community pharmacy, primary dental services and ophthalmic services. These services were delegated to ICBs in July 2022 and April 2023, and accountability will transfer from NHS England to ICBs (subject to legislation).

The full list of services already delegated can be found in the primary care delegation agreement. It includes aspects such as:

- a) commissioning general practice, primary dental, community pharmacy and ophthalmic services and contract management
- b) commissioning enhanced services and local incentive schemes
- c) managing poorly performing practices

- d) procuring new contracts and approving mergers, closures (and market entrance and exit in community pharmacy)
- e) handling complaints
- f) responding to Freedom of Information Act and subject matter access requests, and whistleblowing

A number of related primary care functions will continue to be managed nationally and will become the responsibility of DHSC:

- a) Performers List for England
- b) responsible officers
- c) controlled drugs
- d) capital expenditure functions
- e) national contracts
- f) national support services (such as pensions and payments)

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	19/03/2026
Paper title:	Five-Year Population Health Strategy and Five-Year Strategic Commissioning Plan (2026/27-2030/31)
Paper reference:	ICB CIC 045
Paper author:	Maria Principe, Executive Director of Commissioning Tom Diamond, Director of Population Health Strategy Charley Blyth, Director of Citizen Experience and Communications
Paper sponsor:	Clair Raybould, Executive Director of Strategy and Citizen Experience Maria Principe, Executive Director of Commissioning
Presenter:	Clair Raybould, Executive Director for Strategy and Citizen Experience Maria Principe, Executive Director of Commissioning

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

Report summary:

This report provides an overview of the ICBs' Five-Year Population Health Strategy and Five-Year Strategic Commissioning Plan (2026/27–2030/31), both formally approved in private session on 10 February 2026 and submitted to NHS England on 12 February 2026. It presents the strategy and plan in public session and outlines the immediate next steps for continued engagement with stakeholders and citizens.

The Population Health Strategy sets out a long-term vision for improving outcomes, reducing inequalities and ensuring equitable access across Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire. It responds to significant challenges, including deep deprivation, worsening healthy life expectancy and rising multimorbidity. Segmentation analysis shows that just 7% of the population—those living with frailty, end of life needs or 3+ long term conditions—account for a disproportionate share of costs and emergency activity, underscoring the need for a shift towards prevention, proactive care and strengthened neighbourhood services.

The Strategy identifies five 'Population Segment Priorities' and three 'Cross Cutting Priorities' aligned to the national "three shifts" of the 10 Year Health Plan. Neighbourhood Health is positioned as the core delivery engine, supported by proportionate universalism, digital enablement and productivity improvements.

The Strategic Commissioning Plan translates the strategy into a coherent commissioning framework across five major transformation programmes, embedding outcomes focused planning, financial sustainability and market stewardship. Immediate next steps include the development of public facing versions of the documents, a structured engagement schedule, and ongoing feedback loops.

Recommendation(s):

The Boards are asked to **receive** the ICBs' Five-Year Population Health Strategy and Five-Year Strategic Commissioning Plan in public, following their formal approval by the Boards in private session ahead of their submission to NHS England on 12 February 2026.

Relevant statutory duties:

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

Appendices

Appendix 1: Five-Year Population Health Strategy (2026/27 – 2030/31)

Appendix 2: Five-Year Population Health Strategy (2026/27 – 2030/31) Appendices

Appendix 3: Five-Year Strategic Commissioning Plan (2026/27 – 2030/31)

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Five-Year Population Health Strategy and Five-Year Strategic Commissioning Plan (2026/27-2030/31)

Background and context

1. In March 2025, NHS England informed Integrated Care Boards (ICBs) of the requirement to reduce their running costs by 50% and provided them with a target allocation of £19.40 per head of population by 2026/27.
2. To support delivery of the strategic commissioning skills and capabilities set out in NHS England's Model ICB Blueprint (published May 2025) within a significantly reduced operating budget, the Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire ICBs came together to achieve efficiencies at scale by operating in a 'cluster' arrangement.
3. It is important to note that whilst the three ICBs are working as one to improve efficiency and strengthen strategic commissioning, they are still currently three separate organisations.
4. In the summer of 2025, NHS England published the *10 Year Health Plan for England* which clearly sets out the expectations for the NHS in the coming years in relation to their 'three shifts' of sickness to prevention, hospital to community, and analogue to digital.
5. The *10 Year Health Plan* sets out the need for a significant change to the way the NHS organises, delivers and funds services. To support this transformation, NHS England has developed a new approach to planning, which was initially outlined in the *Planning framework for the NHS in England* published in September 2025.
6. This planning guidance was subsequently followed by the publication of the *Medium-Term Planning Framework – delivering change together 2026/27 to 2028/29* in October 2025 and the *Strategic Commissioning Framework* in November 2025.
7. The table below highlights the specific deliverables of ICBs and Providers as set out in the new planning approach documentation published by NHS England.

Integrated Care Boards	Providers
➤ Five-Year Population Health Strategy ➤ Five-Year Commissioning Plan ➤ Three-Year Operational Plan	➤ Five-Year Integrated Delivery Plan ➤ Three-Year Operational Plan

8. Final plans were submitted to NHS England for review on 12 February 2026.

9. Given the 'cluster' arrangement for the three ICBs, the new planning approach introduced by NHS England and the short timescales for submitting the Five-Year Population Health Strategy and Five-Year Strategic Commissioning Plan to NHS England, five principles were adopted for their development.
 - a) To build on the existing ICB Joint Forward Plans (JFPs) and Integrated Care System (ICS) strategies and align them with the Health and Wellbeing Board strategies within the ICBs' geographies.
 - b) To draw on existing engagement and feedback from the public in relation to NHS services from across the three ICBs, and these insights will continue to evolve through the 'cluster' arrangements.
 - c) They will be anchored to the 'three shifts' in the 10 Year Health Plan.
 - d) To clearly define a manageable number of outcomes and priorities, alongside the key performance indicators (KPIs).
 - e) To be 'living documents': Engagement and testing will be ongoing; the underpinning data, analysis and insights will continue to be refined; there will be a continual focus on execution; and feedback loops will be established to understand what is working and what is not.

The Five-Year Population Health Strategy

10. The purpose of the Five-Year Population Health Strategy is to set out the ICBs' long-term vision and priorities for improving health outcomes, reducing inequalities and strengthening equitable access to high-quality care.
11. Within the ICBs' geographies there are 3.25 million people living across cities, towns, rural and coastal communities. Although a large proportion of the population live in urban areas, the ICBs' geographies are mainly rural and coastal. These differences shape health needs and require tailored, neighbourhood-based solutions to deliver equitable, effective care for all communities.
12. 720,000 people, almost a quarter of our population, live in England's most deprived areas, concentrated in inner-city neighbourhoods, former industrial towns and along the Lincolnshire coast.
13. Deprivation increases exposure to risk factors (smoking, obesity, poor housing, fuel poverty), reduces uptake of prevention and accelerates early onset of long-term conditions, multimorbidity and poorer outcomes.
14. Healthy life expectancy is declining across Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire, for both men and women, with people (on average) spending 18-26 years in poor health depending on where they live.

15. The gap between life expectancy and healthy life expectancy is widening, meaning earlier onset of long-term conditions, multimorbidity and frailty, particularly in more deprived communities.
16. This in turn drives quicker progression to planned healthcare (diagnostics and tests, elective surgeries, chronic condition management), and means people experience more crises (exacerbations, falls, infections, mental health) resulting in more urgent primary care usage, ambulance usage, emergency admissions and bed days.
17. Segmentation analysis by one of the ICBs in their area identified that just 7% of the population account for:
 - a) Circa 35% of healthcare costs.
 - b) Circa 30% of elective activity.
 - c) Circa 50% of ambulance calls, emergency admissions and bed days.
18. A significant shift to prevention, proactive and community-based delivery is required, together with a shift in the pattern of healthcare spending so the share of expenditure on hospital care falls with proportionally greater investment in out of hospital care.
19. Engagement with our citizens and communities has told us people want more control over their care, timely access to local services and clear, joined-up communication. They value digital tools, but only if inclusive, simple and optional.
20. Feedback highlights the need for equity, cultural sensitivity and continuity. These insights have shaped our priorities and ensure our strategy reflects what matters most to people.
21. Without action, faces worsening outcomes will worsen, inequalities will become wider and activity growth will become unaffordable.
22. Improving Healthy Life Expectancy is not only a public health goal, it is also a core demand management strategy for the NHS.
23. The national 10 Year Health Plan makes prevention, neighbourhood health a digital modernisation central to the future of NHS sustainability. The Population Health Strategy sets out how the ICBs will improve the health and wellbeing of their populations over the next five years and reduce unfair differences between groups and neighbourhoods, in line with the ambitions set out in the 10 Year Health Plan.
24. The strategy sets out five Population Segment Priorities and three 'Cross-Cutting' Priorities for Years one and two. These have been shaped by population health intelligence and citizen engagement feedback, and by the discussions and outputs of the ICBs' Board Development Session in December 2025.

25. These priorities seek to provide a balance of addressing 'upstream' health needs, whilst also addressing the need to provide better quality, accessible, integrated care that tackles the significant operational and financial pressures the NHS faces 'here and now'.
26. The five Population Segment Priorities are:
 - a) Children and Young People's Obesity (0-19)
 - b) Children and Young People's Mental Health (0-19)
 - c) Early Multimorbidity (40-64)
 - d) Frailty
 - e) End of Life
27. The three 'Cross-Cutting' Priorities are:
 - a) Vaccination and Screening
 - b) Strong General Practice
 - c) Outpatient and Follow-Up Redesign
28. Neighbourhood health is the 'engine room' for delivering population health strategy priorities, combining an NHS delivery platform and a place-based health improvement model.
29. The NHS delivery platform sets out how health services integrate at a neighbourhood level. The health improvement model aligns partners around lifestyle, early years, social connection and inclusion health.
30. The approach to implementing population health strategy priorities is based on proportionate universalism, to improve health outcomes for the entire population whilst ensuring those with the greatest unmet need and poorest outcomes receive the most support, making sure service provision remains within available NHS financial resources and provides best value for money.
31. Improved productivity and efficiency will be central to delivering population health strategy priorities. A focus on eradicating 'low value' activity, reducing unwarranted variation, improving pathways and maximising digital and workforce transformation, will release capacity, improve system finances and redirect scarce resources towards interventions that deliver the greatest population health benefit.

Five-Year Strategic Commissioning Plan

32. The purpose of the Five-Year Strategic Commissioning Plan is to set out how the ICBs will fulfil their role as strategic commissioners to improve population health outcomes, reduce inequalities, deliver constitutional standards and secure long-term financial sustainability.

33. The Plan is a mandated system output under NHS England's Strategic Commissioning Framework and Mid-Term Financial Planning guidance, alongside the Five-Year Population Health Strategy and the Three-Year Operational Plan.
34. It should be read alongside the Population Health Strategy, which sets out the overarching case for change, population priorities and outcomes framework. The Strategic Commissioning Plan translates this strategy into a coherent commissioning response.
35. The Strategic Commissioning Plan provides a single, integrated framework covering the full commissioning cycle across the ICBs. Its key components include:
 - a) Strategic commissioning priorities aligned to the Population Health Strategy, focusing on areas of greatest need, inequality and opportunity for impact across the life course.
 - b) Five core transformation programmes: Neighbourhood and Community Transformation (including primary care), Urgent and Emergency Care, Planned Care (including cancer), Mental Health, Learning Disability and Autism, and Children and Young People.
 - c) Clear outcomes and headline delivery ambitions for each programme, avoiding unnecessary operational detail while maintaining a strong line of sight to impact. Commissioning system-wide targets and trajectories, supporting delivery of national standards, productivity expectations and medium-term financial sustainability.
 - d) Key enablers including population health intelligence, quality and clinical governance, financial framework and allocative efficiency, contracting and market stewardship, digital and data enablement, workforce and estates, citizen engagement, evaluation and risk management.
36. The Plan reflects the ICBs' evolution towards a mature, outcomes-focused commissioning operating model consistent with the Model ICB Blueprint. This includes:
 - a) Moving from activity-based planning to a population health and outcomes-focused commissioning approach, informed by benchmarking, productivity opportunities and population need.
 - b) KPI framework to systematically track advancements in health outcomes, address inequalities, and enhance system performance.
 - c) Provides a clear framework for prioritisation, recognising that resources are finite and that delivery must balance national requirements, system financial sustainability and opportunities to improve population outcomes.

- d) Commissioning at Cluster scale where this adds value, consistency and efficiency, while enabling place and neighbourhood leadership for delivery.
 - e) A shift from activity management to a “should cost / should deliver” approach, informed by benchmarking, productivity opportunities and population need.
 - f) Use of multi-year planning, proportionate risk-sharing and modern contracting mechanisms to support transformation and avoid double-running costs.
 - g) Strong stewardship of a provider market, including NHS, independent and voluntary and community partners, with primary care as a foundational delivery partner.
 - h) Neighbourhoods are positioned as the core delivery engine for population outcomes, supported by integrated neighbourhood teams, shared digital infrastructure and aligned incentives.
 - i) Embeds financial sustainability through a sustained shift from hospital activity to prevention and community services; improved provider productivity and efficiency; and reduction of unwarranted variation and low-value activity.
 - j) Supports delivery of constitutional standards, improved patient access and better patient experience.
37. The NHS planning guidance published to date identifies that:
- a) Neighbourhood health plans are to be drawn up by local government, the NHS and its partners at single or upper tier authority level under the leadership of the Health and Wellbeing Board, incorporating public health, social care, and the Better Care Fund.
 - b) ICB Strategic Commissioning Plans are to take account of Neighbourhood Health Plans produced by Health and Wellbeing Boards.
38. The planning framework for the NHS published in September 2025 that outlined this stated that Department of Health and Social Care will publish separate guidance to support the development of Neighbourhood Health plans, however this has not been published yet.
39. In preparation for the publication of the national Neighbourhood Health guidance the ICBs have developed a framework to set out their strategic commissioning approach for Neighbourhood Health. It provides partners with a clear statement of intent relating to:
- a) The vision for neighbourhood working, building on the progress in each Place and recognising the differential starting points across the ICBs.
 - b) Core components of Neighbourhood Health in line with national policy.

- c) The developing ICB outcomes framework that sets out ambitions for improvements in population health.
 - d) The financial and contractual arrangements that will be put in place with providers.
 - e) The need for provider development and appropriate governance arrangements.
40. This framework will be reviewed once the national guidance has been released and updated as necessary.
41. Key outcomes will be:
- a) More people living longer in good health, fewer preventable crises.
 - b) Reduced inequalities in access, experience and outcomes.
 - c) Significant hospital to community shift: fewer outpatient appointments, emergency department attendances, non-elective admissions and bed days.
 - d) Better use of NHS resources and improved financial sustainability.

Stakeholder and citizen involvement: Immediate next steps

42. A key next step will be the development and publication of a public-facing version of the Five-Year Population Health Strategy and Five-Year Strategic Commissioning Plan. This is to encourage and enable people across communities, both stakeholders and the general public, to not only understand the purpose and content of the documents but also why they should consider them personally relevant and important.
43. Both documents will be 'living', i.e. engagement and testing will be ongoing; the underpinning data; analysis and insights will continue to be refined; there will be a continual focus on execution; and feedback loops will be established to understand what is working and what is not.
44. The process of continual feedback has already started with ICB staff, and is now broadening out to ensure that stakeholders, with their various and valuable focuses, are fully involved in this loop. To date staff and stakeholder briefing materials have been developed, including overview presentations, a two-page summary, and a feedback survey to simplify this process and encourage response and engagement.
45. ICB intranets house all staff facing materials, and the three public websites house all public facing materials, with stakeholder information being shared directly with partners. These portals will be continuously updated as more assets are developed and feedback received. Notably a public facing version will be published on or before week commencing 23 March.

46. These activities are underpinned by a schedule of socialisation and invitation to comment. Communication with each audience will be clear about the unique roles they may deliver in testing and improving the strategy, and how they can do so. Feedback will be reported through governance process for broad awareness, as well as directly into the strategic workstream to influence.
47. The table below provides an overview of the immediate next steps in relation to the ongoing Five-Year Population Health Strategy and Five-Year Strategic Commissioning Plan stakeholder and citizen involvement.

Date	Involvement	Supporting materials
10 March	ICB Staff Briefing: An Introduction to the Strategy and Plan Discussion detail: ICB Strategy	• Summary presentation • Full doc publication • Intranet feedback mechanism (survey)
10 March onwards (subject to committee dates)	systems-wide: • Health and Wellbeing Board Briefings • Health Overview and Scrutiny Briefings • Provider Board Briefings • Primary Care Alliance and Network Briefings • Local Authority Briefings • VCSFE Alliance and Organisation Briefings • MP Briefings	• Associated board papers • Summary presentation • Link: Public web portal of information • Access to full suite of documents inc. public facing • Feedback invitation and process outline
19 March	ICB Public Boards • Full virtual stakeholder briefing cascade commences	• Summary presentation • Link: Public web portal of information • Access to full suite of documents inc. public facing • Feedback invitation and process outline
23 March onwards	Full Public Launch	• Promotion activity (media etc) • Engagement schedule commences
24 March	ICB Staff Briefing: Refresher session Discussion detail: Commissioning Plan	• Summary presentation • Intranet feedback mechanism (reminder)

Derby and Derbyshire

Lincolnshire

Nottingham and Nottinghamshire

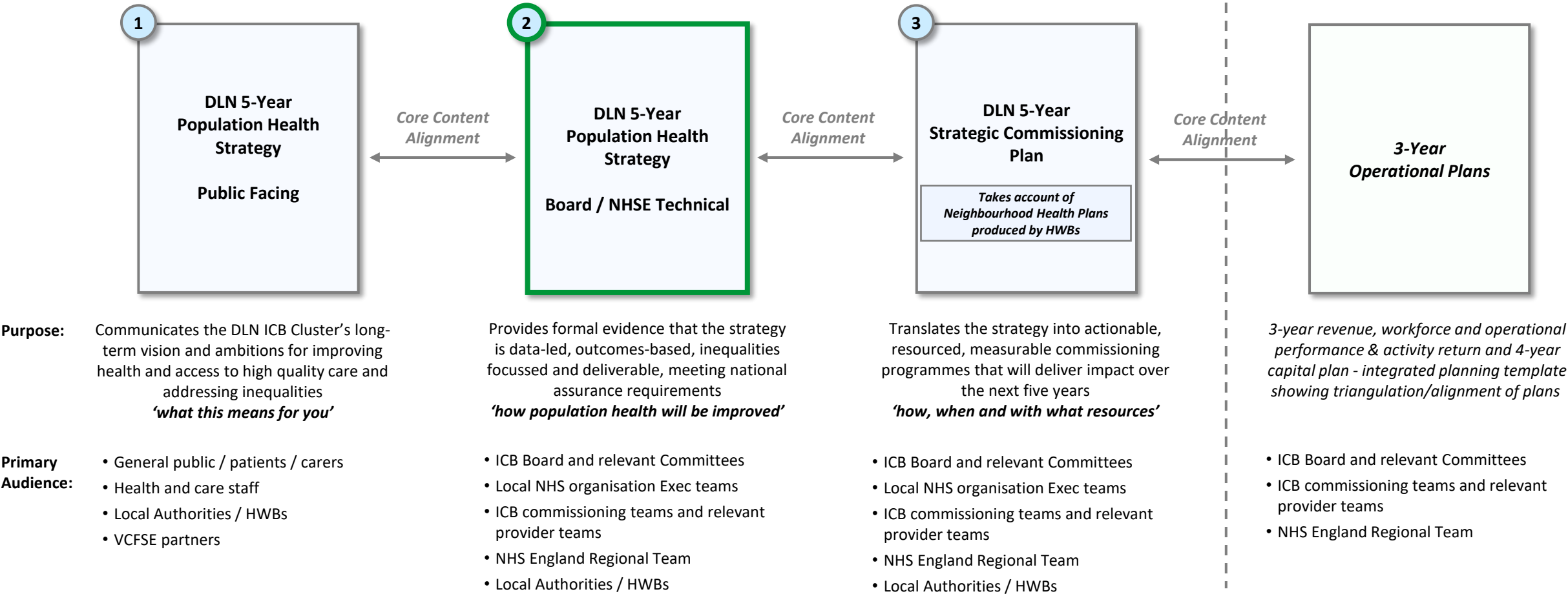
Five-Year Population Health Strategy

2026/27 – 2030/31

Version: ICB Boards and NHS England Technical Document

Document purpose

This document sets out the Derby & Derbyshire, Lincolnshire and Nottingham & Nottinghamshire (DLN) ICB Cluster’s 5-Year Population Health Strategy. It is one of three documents that together form the DLN ICB Cluster’s suite of 5-Year Strategic Planning Outputs. This document is publicly available but is not a public facing document.



Contents

Section	Page Number
1. Executive Summary	04
2. Introduction	07
3. Case for Change	13
4. Our ‘North Star’	22
5. Our Priorities	30
6. Our Key Enablers	39

1. Executive Summary

Our population health challenge and why change is needed

What our citizens are telling us

- Engagement with our citizens and communities has told us people want more control over their care, timely access to local services and clear, joined-up communication. They value digital tools – but only if inclusive, simple and optional. Feedback highlights the need for equity, cultural sensitivity and continuity. These insights have shaped our priorities and ensure our strategy reflects what matters most to people.

A diverse population with different needs

- Within the DLN ICB Cluster's geography there are 3.25 million people living across cities, towns, rural and coastal communities. Although a large proportion of the population live in urban areas, the Cluster is mainly rural and coastal. These differences shape health needs and require tailored, neighbourhood-based solutions to deliver equitable, effective care for all communities.

Deep and concentrated inequalities

- 720,000 people – almost a quarter of our population – live in England's most deprived areas, concentrated in inner-city neighbourhoods, former industrial towns and along the Lincolnshire coast.
- Deprivation increases exposure to risk factors (smoking, obesity, poor housing, insecurity), reduces uptake of prevention and accelerates early onset of long-term conditions, multimorbidity and poorer outcomes.

Worsening healthy life expectancy and rising years in poor health

- Healthy Life Expectancy (HLE) is declining across Derby & Derbyshire, Lincolnshire and Nottingham and Nottinghamshire, for both men and women, with people (on average) spending 18-26 years in poor health depending on where they live.
- The gap between Life Expectancy and Healthy Life Expectancy is widening, meaning earlier onset of long-term conditions, multimorbidity and frailty – particularly in more deprived communities.

- This in turn drives quicker progression to planned healthcare (diagnostics and tests, elective surgeries, chronic condition management), and means people experience more crises (exacerbations, falls, infections, mental health) resulting in more urgent primary care usage, ambulance usage, A&E attendances, emergency admissions & bed days.

An unsustainable care delivery model

- Segmentation analysis by one of the ICBs in the DLN Cluster identified that just 7% of the population account for:
 - c.35% of healthcare costs
 - c.30% of elective activity
 - c.50% of ambulance calls, emergency admissions and bed days
- A significant shift to prevention, proactive and community-based delivery is required, together with a shift in the pattern of healthcare spending so the share of expenditure on hospital care falls with proportionally greater investment in out of hospital care.

Why we must act now

- Without action, the DLN system faces worsening outcomes, widening inequalities and unaffordable activity growth.
- Improving Healthy Life Expectancy is not only a public health goal – it is a core demand management strategy for the NHS.
- The national 10-Year Health Plan makes prevention, neighbourhood health a digital modernisation central to the future of NHS sustainability. This Strategy sets out how we will improve the health and wellbeing of our population over the next 5 years and reduce unfair differences between groups and neighbourhoods, in line with the ambitions set out in the 10 Year Health Plan.

Our 5-Year Population Health Strategy and what we will deliver

Our vision

- **Every Person in every community will live longer and healthier lives**
- We will improve population health outcomes, reduce inequalities and ensure equitable access across Dery & Derbyshire, Lincolnshire and Nottingham and Nottinghamshire.

Three 'shifts'

Our strategy is underpinned by the three shifts set out in the 10-Year Health Plan.

- Sickness to Prevention
 - Scale prevention, early detection and proactive care.
- Hospital to Community
 - Shift activity, resource and capability into neighbourhood health services.
- Analogue to Digital
 - Modernise access, reduce admin burden and support personalised, data-driven care.

Our priorities (Years 1 & 2)

- Five Population Segment Priorities and three 'Cross-Cutting' Priorities have been identified for the next 2 years.
- These priorities seek to provide a balance of addressing 'upstream' health needs whilst also addressing the need to provide better quality, accessible, integrated care that tackles the significant operational and financial pressures the NHS faces 'here and now'.
- Our five Population Segment Priorities are:
 - Children & Young People's Obesity (0-19)
 - Children & Young People's Mental Health (0-19)
 - Early Multimorbidity; 2+ LTCs (40-64)
 - Frailty
 - End of Life

- Our three 'Cross-Cutting' Priorities are:

- Vaccination & Screening
- Strong General Practice
- Outpatient & Follow-Up Redesign

Neighbourhood Health: The Engine Room

- Neighbourhood health is the 'engine room' for delivering our population health priorities - combining an NHS delivery platform and a place-based health improvement model.
- The NHS delivery platform sets out how health services integrate at a neighbourhood level; the health improvement model aligns partners around lifestyle, early years, social connection and inclusion health.

Proportionate universalism and improved productivity and efficiency

- The approach we will adopt to implementing our population health strategy priorities is based on proportionate universalism, as we look to improve health outcomes for the entire population while ensuring those with the greatest need receive the most support – making sure service provision remains within available NHS financial resources and provides best value for money.
- Improved productivity and efficiency will be central to delivering our population health strategy priorities. By focusing on eradicating 'low value' activity, reducing unwarranted variation, improving pathways and maximising digital and workforce transformation, we can release capacity, improve system finances and redirect scarce resources towards interventions that deliver the greatest population health benefit.

Expected system-wide impact

- More people living longer in good health, fewer preventable crises.
- Reduced inequalities in access, experience and outcomes.
- Significant hospital to community shift: fewer outpatient appointments, ED attendances, non-elective admissions and bed days.
- Better use of NHS resources and improved financial sustainability.

2. Introduction

Contents:

- *National Context: The 10 Year Health Plan for England*
- *National Context: Our role as a strategic commissioner*
- *The focus of our Population Health Strategy*
- *What people have told us matters*
- *Our approach to the DLN ICB Cluster Population Health Strategy*

See Appendix 1 for NHS England Planning Architecture

National context: The 10 Year Health Plan for England

'Fit for the Future: The NHS 10 Year Plan for England', published in July 2025, outlines a comprehensive strategy to reform the National Health Service (NHS) in England. It aims to transform healthcare delivery in England by addressing inequalities, focussing on community-based care and leveraging technology.

Direct extracts from Fit for the future: 10 Year Health Plan for England:



From Sickness to Prevention

- People are living too long in ill health, the **gap in healthy life expectancy between rich and poor is growing** and nearly **1 in 5 children leave primary school with obesity**.
- Our overall goal is to **halve the gap in healthy life expectancy between the richest and poorest regions**, whilst increasing it for everyone, and to **raise the healthiest generation of children ever**. This will **boost our health but also ensure the future sustainability of the NHS** and support economic growth.
- We will achieve our goals by **harnessing a huge cross-societal energy on prevention**. We will work with business, employers, investors, local authorities and mayors to create a healthier country together.



From Hospital to Community

- If the NHS does not feel like a single, coordinated, patient-orientated service, that is for a simple reason: it is not one. It is **hospital-centric, detached from communities and organises its care into multiple, fragmented siloes**. We need to shift to provide continuous, accessible and integrated care.
- The **neighbourhood health service is our alternative**. It will **bring care into local communities, convene professionals into patient-centred teams** and end fragmentation. In doing so, it will **revitalise access to general practice and enable hospitals to focus on providing world class specialist care** to those who need it.
- At its core, **the neighbourhood health service will embody our new preventative principle** that care should happen as locally as it can: digitally by default, in a patient's home if possible, in a neighbourhood health centre when needed, in a hospital if necessary.



From Analogue to Digital

- Modern technology has given us more power over our everyday lives. But that same scale of change has yet to come to the NHS. **This Plan will take the NHS from the 20th century technological laggard it is today, to the 21st century leader it has the potential to be.**
- To do this, we will use the unique advantages of the NHS' healthcare model - world-leading data, its power in procurement and its means to deliver equal access - **to create the most digitally accessible health system in the world.**
- Patients will have a 'doctor in their pocket' in the form of the **NHS App**, while **staff will be liberated from a burden of bureaucracy and administration.**

The 10 Year Health Plan sets out a new commissioning framework for NHS Integrated Care Boards (ICBs) to turn the ambition of them becoming strategic commissioners into reality.

Central to this new role for ICBs is the development of a [Population Health Strategy](#).

National context: Our role as a strategic commissioner

The Model ICB Blueprint published by NHS England in May 2025 marked the first step in a programme of work to reshape the purpose of integrated care boards (ICBs) as strategic commissioners, laying the foundations for delivery of the 10 Year Health Plan. This was subsequently built on by the publication of the NHSE ‘Strategic Commissioning Framework’ in November 2025.

National context

- Strategic commissioning is a continuous evidence-based process to **plan, purchase, monitor and evaluate services** over the longer term and with this **improve population health, reduce health inequalities and improve equitable access** to consistently high-quality healthcare.
- ICBs, as strategic commissioners, are accountable for creating the **best value for the public from their NHS budget**, by considering how this should be spent within their population to secure high quality accessible healthcare now and in the future.
- ICBs will **continue to work in partnerships**. They will use their ability to **bring together providers, local government and other stakeholders** to best improve healthcare and the health and wellbeing of their local population, prioritising the achievement of system goals within total available resources.
- The national model for strategic commissioning set out by NHS England in its **‘Strategic Commissioning Framework’ comprises four stages:**
 1. Understanding the context
 2. Developing long-term population health strategy
 3. Delivering through payor function and resource allocation
 4. Evaluating impact

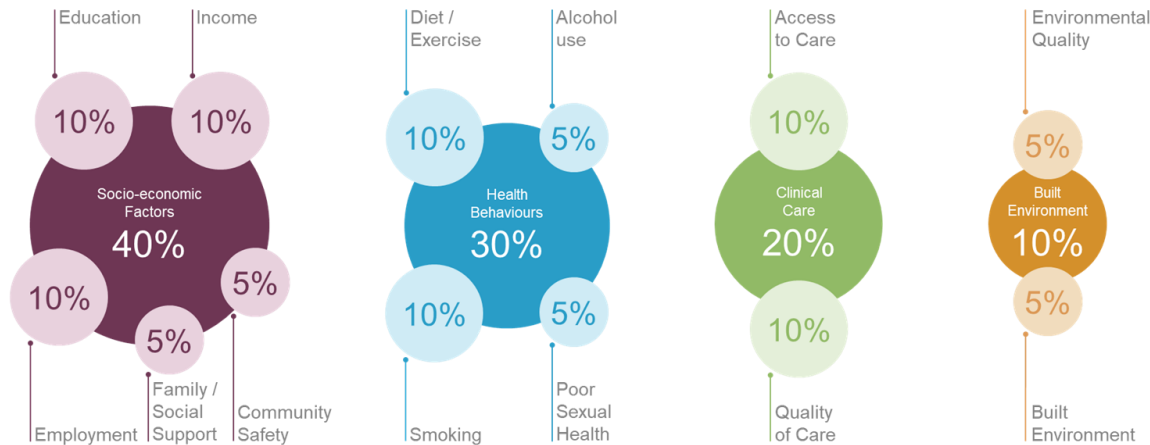
This will require an adaptive and learning commissioning culture: Agile, evidence-led/informed and responsive commissioning; Ability to operate in uncertainty and manage change at pace; Continuous learning, reflection and improvement mindset

The 4 Stages of Strategic Commissioning	Approach and Outputs
1. Understanding the context	ICBs use joined-up, person-level data and intelligence (including service user feedback) to develop a deep understanding of their local population needs, and the biological, psychological and social drivers of risk and demand, proactively identifying underserved communities and assessing quality, performance and productivity of all existing provision.
2. Developing long-term population health strategy	ICBs, acting as strategic commissioners, set an overall 5-year strategy. The overall strategy should describe the ICB’s vision for improving health and healthcare, including access to high quality care, and addressing health inequalities by improving experience, safety and outcomes across the life course. The strategy should clearly define a manageable number of outcomes and any supporting sub-outcomes, outputs and the actions, alongside the key performance indicators (KPIs). ICB 5-Year Population Health Improvement Plans / Strategic Commissioning Plans translate national and local strategic priorities into deliverable actions that recognise the need to deliver immediate NHS priorities around finance, productivity, performance and quality improvement, as well as longer-term priorities on improving population health outcomes.
3. Delivering through payor function and resource allocation	ICBs will allocate resources in contracting and procuring services, shape and manage the provider market, and have an increased focus on the longer term in their ongoing contractual management of commissioned services to deliver the outcomes set out in the ICB 5-Year Population Health Strategy and Population Health Improvement Plan / Strategic Commissioning Plan.
4. Evaluating impact	ICBs will rigorously evaluate the outcomes from commissioned services, care models and proactive interventions. This includes tracking and responding to healthcare use, clinical risk markers, patient and staff reported experience, outcome metrics and wider feedback and intelligence.

The focus of our Population Health Strategy

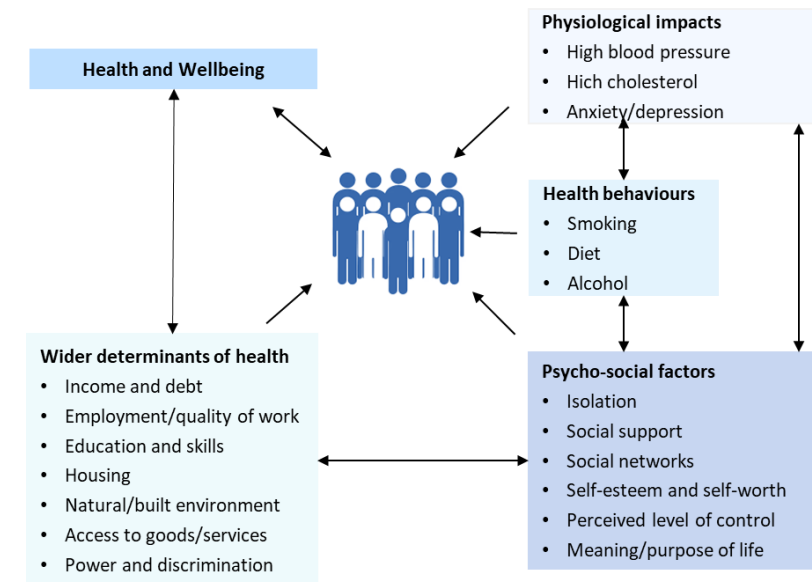
The focus of our Population Health Strategy is on those elements of health and wellbeing and its associated inequalities that the NHS within the DLN ICB Cluster can have the greatest impact on, thereby effectively contributing to the collective ambitions of our local Integrated Care Systems (ICSs) whilst also tackling the increasing financial pressures faced by the NHS.

- The **determinants of health model** highlights how a person's health is shaped not just by the care they receive, but also by their behaviours, social and economic circumstances and the environment they live in.
- The NHS has a strong and direct impact on the clinical care component and can also directly influence health behaviours; however its influence on socio-economic and wider environmental factors is more limited.



Source: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute

- The **adapted Labonte model** below shows how wider determinants of health interact with psycho-social factors to influence behaviours and physiology, which in turn have impact on health and wellbeing.



Three important considerations from this model have informed our Population Health Strategy:

1. People do not have the same opportunities to be healthy.
2. Interventions that solely rely on individual behaviour change are likely to widen inequalities.
3. Resources should be allocated proportionately to address the levels of need for specific communities to achieve equitable outcomes for all.

Source: Public Health England 'Place-based approaches for reducing health inequalities: main report 2021'

What people have told us matters

Our communities have told us clearly what matters most to them. Across Derby & Derbyshire, Lincolnshire and Nottingham & Nottinghamshire people consistently emphasised the need for timely access, clear communication, care closer to home and greater control over their health and care.

1. Control & Personalised Care

- ✓ Greater involvement in decisions about their care & treatment
- ✓ Clear, jargon-free information on conditions & self-care
- ✓ Prevention, early help & support to stay well
- ✓ Carers to be included & recognised

2. Timely Access & Joined-Up Local Services

- ✓ Waiting times for GP appointments, diagnostics & elective care
- ✓ Care closer to home, including neighbourhood hubs
- ✓ Integrated care to avoid duplication & repeating their story
- ✓ Improved access for rural & coastal areas



3. Digital Tools (that enable but don't exclude)

- ✓ Support digital tools (NHS App, virtual consultations, online forms) when optional, simple and safe
- ✓ Concerns about digital exclusion – especially older people, those with low digital literacy and rural communities
- ✓ Want choice between digital and face-to-face options

4. Clear, Inclusive, Consistent Communication

- ✓ Transparent communication about waiting times, referrals & discharge
- ✓ Information in multiple formats
- ✓ Plain language and culturally competent communication
- ✓ Ongoing engagement, visible action on feedback & simpler ways to share feedback

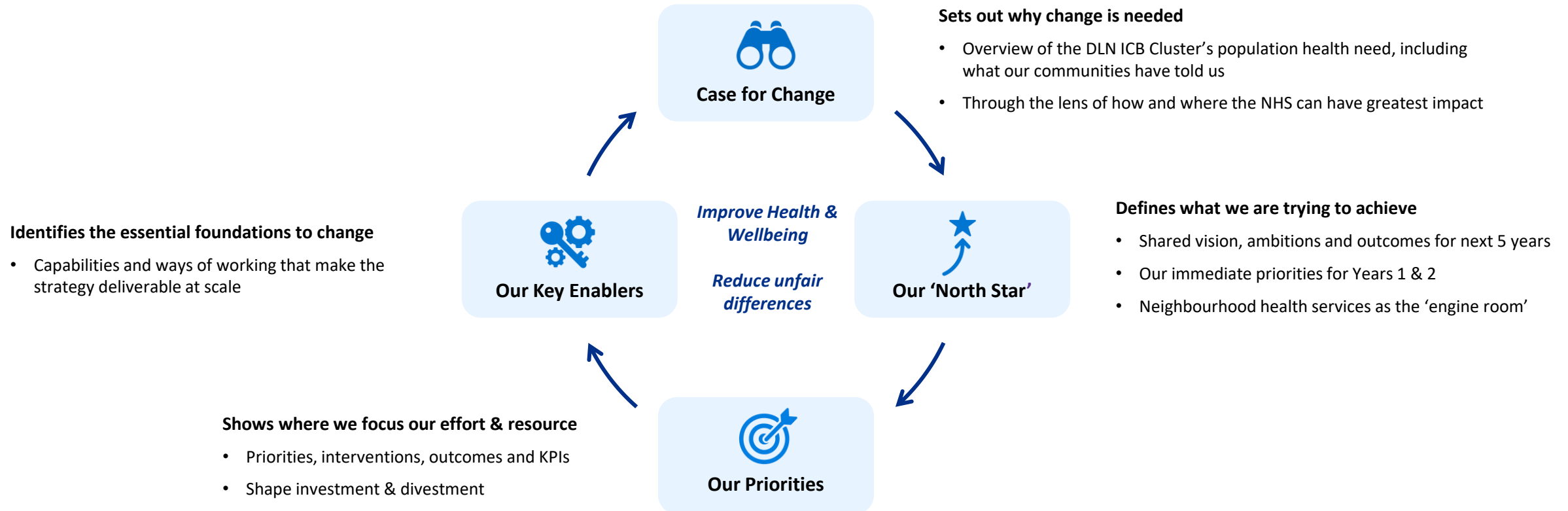
The lived experience, expectations and priorities of citizens across the DLN ICB Cluster have directly shaped the development of this 5-Year Population Health Strategy. These insights are reflected through this Population Health Strategy.

Our approach to the DLN ICB Cluster Population Health Strategy

The DLN ICB Cluster Population Health Strategy sets out how we will improve the health and wellbeing of our population over the next 5 years and reduce unfair differences between groups and neighbourhoods, in line with the ambitions set out in the 10 Year Health Plan.

The DLN ICB Cluster Definition of Population Health:

- I. The health outcomes of a defined group of people and how fairly those outcomes are shared; and
- II. The determinants and interventions that shape those outcomes



3. Case for Change

Contents:

- *Voice of our citizens and communities*
- *Our population at a glance*
- *Deprivation and inequality*
- *The health gap*
- *What this means for NHS services*
- *How this translates into healthcare utilisation*
- *Children and young people*
- *Where and how the NHS can influence*

See Appendix 2 for full Case for Change

Voice of our citizens and communities

Engagement with our citizens and communities has told us people want more control over their care, timely access to local services and clear, joined-up communication. They value digital tools – but only if inclusive, simple and optional. Feedback highlights the need for equity, cultural sensitivity and continuity. These insights have shaped our priorities and ensure our strategy reflects what matters most to people.

Patient Empowerment	Access To Services	Communication with Services
Shared Decision-Making & Personalised Care - Citizens want more control and decision-making in their care, including being fully informed about what to expect and the support available, and expect to see others taking responsibility for their own health - Carers should be actively involved in decision-making - People value community-based specialist clinics (e.g. diabetes, respiratory) to avoid unnecessary hospital visits	Timely & Flexible Access - Ongoing frustration with long waits for GP appointments, elective procedures, and diagnostics, often pushing patients to A&E - Citizens want same-day or next-day access for urgent needs, better triage systems, and extended hours - Calls for streamlined referral processes and co-located services to reduce delays and improve safety	Clear & Accessible Information - Citizens want timely and transparent communication that meets their need, waiting times, and discharge plans Information should be available in multiple formats (Easy Read, BSL, translated) and repeated as needed for accessibility - People continually stress the importance of plain language and culturally appropriate communication to build trust
Self-Management & Proactive Care - Citizens stressed the need for clear, jargon-free information about conditions, treatments, and self-care options - Strong support for prevention and proactive care, including health checks, lifestyle support, and early intervention for long-term condition - People want education and awareness campaigns to improve NHS literacy and reduce misinformation	Localised & Integrated Care - People want care closer to home, including community hubs offering multiple services under one roof, and more use of lower acuity appointments - Strong support for joined-up care pathways between hospitals, GPs, and social care to reduce duplication and improve continuity - Positive experiences with providers outside of the NHS are broad, with lots of citizens advocating better use of the VSFSE sector	Joined-Up Care & Interoperability - Citizens are frustrated as having to repeat ‘their story’ multiple times repeating medical history and poor information sharing between providers - Citizens want consistent digital systems across practices to avoid confusion and improve care coordination - Better integration between health and social care is seen as critical to reducing delays and improving patient experience
Digital Inclusion & Choice - Citizens support digital tools (NHS App, AskMyGP, virtual consultations) but want user-friendly systems and consistency Concerns about digital exclusion for older adults, rural communities, those with low digital literacy; and misdiagnosis - People want choice between digital and face-to-face appointments, ensuring inclusivity for all preferences	Equity & Transport Solutions Rural and coastal communities face transport barriers, requesting improved public transport links or mobile health units - Citizens call for interpreters and culturally sensitive care to overcome language and cultural barriers - Digital inclusion initiatives are needed to ensure online services do not widen inequalities, especially for older and disabled people	Continuous Engagement & Feedback Loops - Citizens want ongoing engagement opportunities, not one-off consultations, and visible action on feedback - Calls for simplified feedback routes (QR codes, SMS) and public reporting of changes made based on feedback - People value co-production of services with local communities and seldom-heard groups to ensure inclusivity

Source: NHS Derby and Derbyshire Commissioning Intentions Insight 2025; NHS Lincolnshire ICB Commissioning Intentions Insights September 2025; Nottingham and Nottinghamshire NHS wants and needs v2 December 2025

Our population at a glance

Within the DLN ICB Cluster's geography there are 3.25 million people living across cities, towns, rural and coastal communities. Although a large proportion of the population live in urban areas, the Cluster is mainly rural and coastal. These differences shape health needs and require tailored, neighbourhood-based solutions to deliver equitable, effective care for all communities.

- **We serve 3.25 million people across a diverse geography.** The geographical area covered by the DLN ICB Cluster is around **4,500 square miles**, which is approximately **75% of the whole East Midlands region**.
- Although a **large proportion of our population live in the urban corridor from Derby through Nottingham to Mansfield and Chesterfield**, most of the Cluster is **rural or coastal**. Lincolnshire is around 25% larger geographically than Derbyshire and Nottinghamshire combined, however its population is around a third of their size.
- **Our 55 Primary Care Networks span populations from c.30k to c.140k** and cover major cities, former industrial towns and extensive rural and coastal communities.

Our health and care delivery models need to reflect and accommodate the specific needs of our different communities



- ✓ 'Hub' role for wider rural catchment
- ✓ Ageing populations
- ✓ Legacy of industry decline



- ✓ Higher deprivation & multi-morbidity
- ✓ Mental health & substance misuse
- ✓ Significant child poverty



- ✓ Mixed deprivation profiles
- ✓ Working-age LTCs
- ✓ Transport & air quality issues

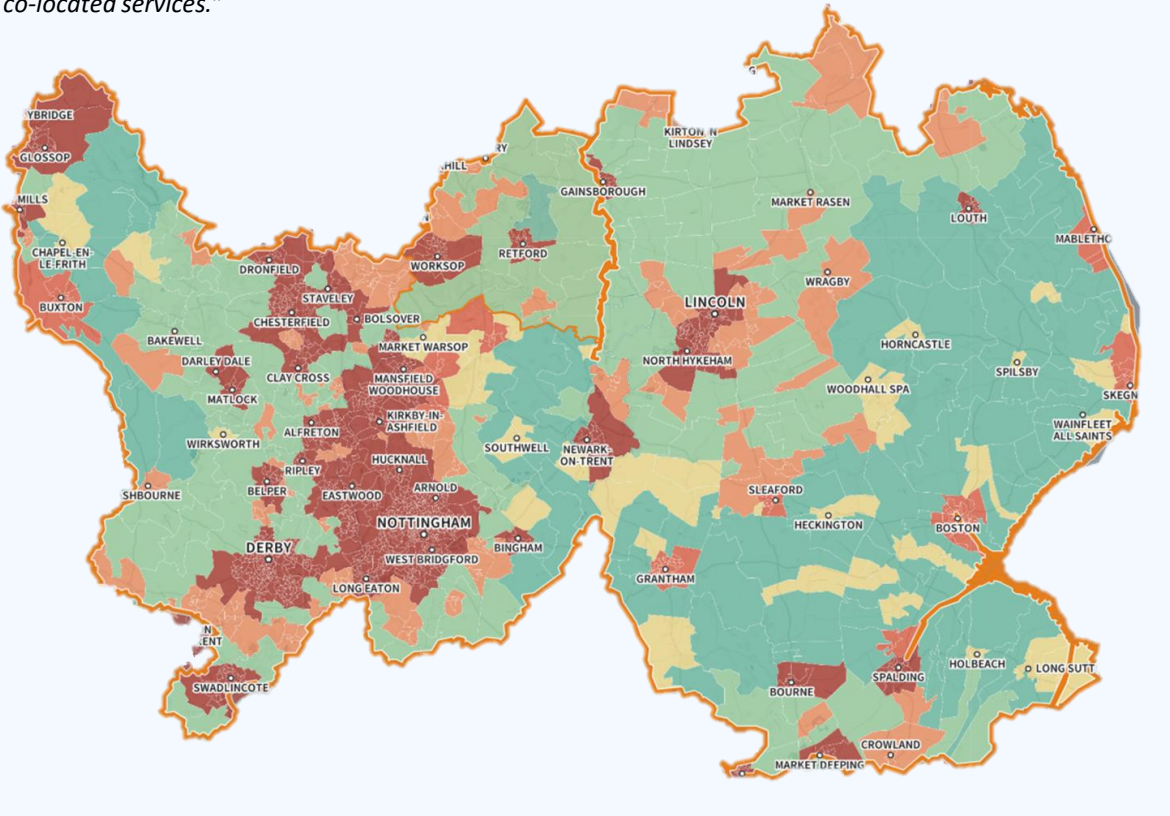


- ✓ Older age structure
- ✓ Average outcomes mask small pockets of significant poor health
- ✓ Hidden mental ill-health & isolation



- ✓ High deprivation and poor outcomes
- ✓ Older and transient populations
- ✓ Long travel times for specialist services

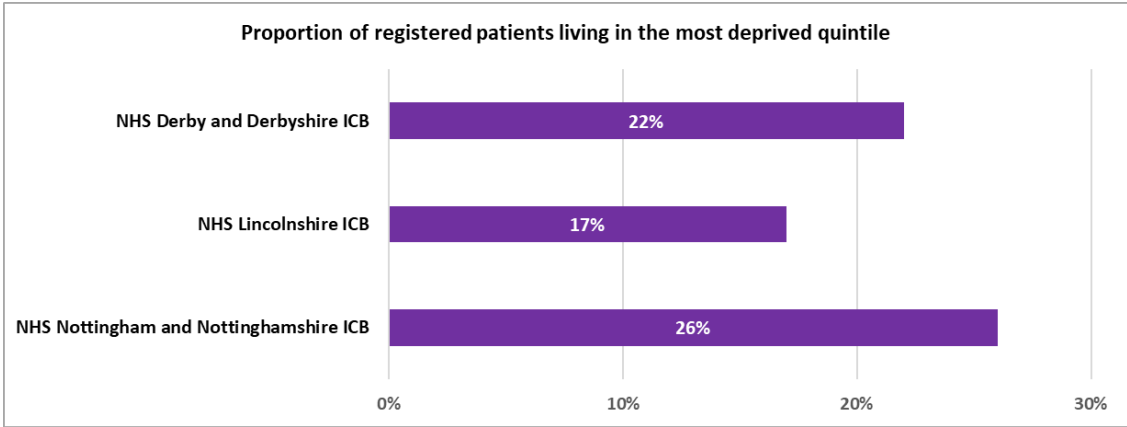
The operating implications are clear: one size will not fit all.
"Citizen engagement feedback from coastal and rural communities specifically called for more local and co-located services."



Deprivation and inequality

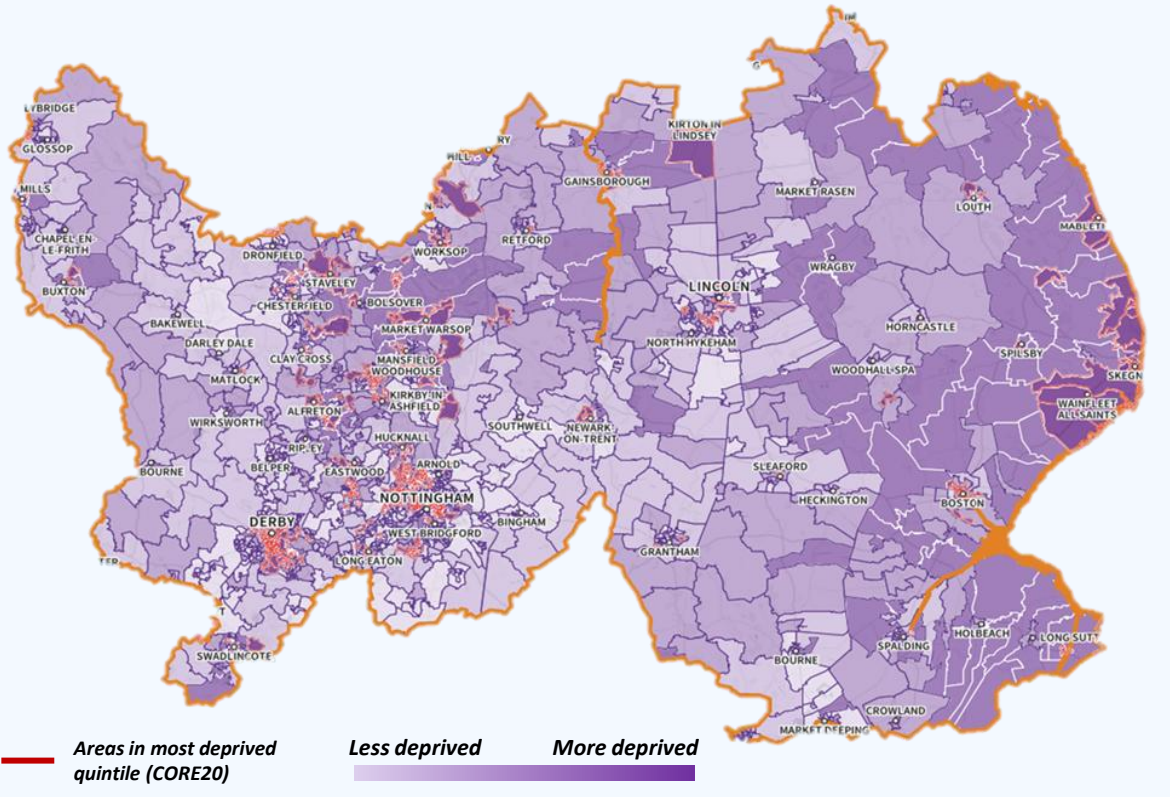
720,000 people – almost a quarter of our population – live in England’s most deprived areas. Deprivation drives earlier illness, higher multimorbidity and poorer outcomes. Tackling this means targeting prevention, designing for equity and measuring progress to ensure improvements are fairly shared across all communities.

- **Deprivation is the strongest local driver of poor health outcomes.** Around 720,000 people (22%) in our cluster live in England’s most deprived quintile, **concentrated in inner-city areas, former industrial towns across the counties, and along the Lincolnshire coast.**
- **Deprivation increases exposure to risk factors** (smoking, obesity, harmful alcohol, poor housing and insecure work), **reduces uptake of prevention and early help** (screening, vaccinations, health checks), and **accelerates the onset of long-term conditions.**
- **This combination leads to earlier multimorbidity, higher rates of psychological distress, and lower healthy life expectancy.** Addressing this means doing three things consistently:
 1. **Targeting prevention and proactive care** where need is highest;
 2. **Designing for equity** (tailored invitations, reasonable adjustments, flexible access); and
 3. **Measuring the gap** (deprivation, ethnicity, rural/coastal) to ensure improvement is fair.



There are wide differences in where deprivation is located across the DLN ICB Cluster.

“Citizen engagement told us appointment systems and care delivery don’t always work for families facing language, access or work barriers.”

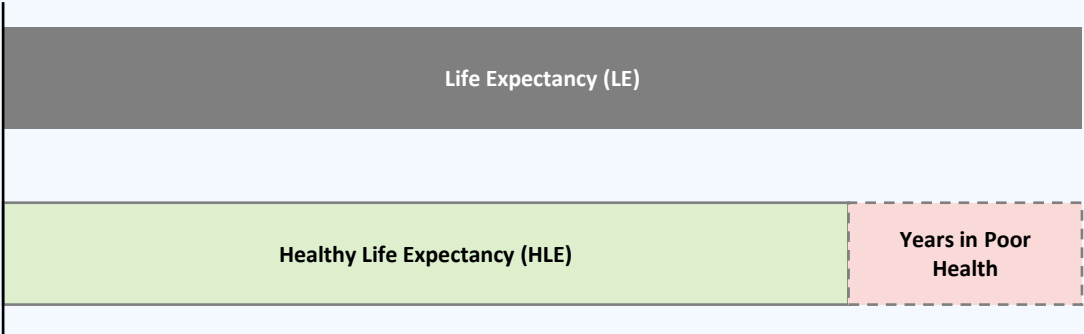


The health gap

Across the DLN ICB Cluster people are spending more years in poor health. Healthy Life Expectancy is falling, and inequalities are widening between the richest and poorest across the DLN ICB Cluster. This drives increasing demand on an already stretched NHS and without change outcomes will continue to worsen.

- Over the last decade, **Life Expectancy (LE)** has been broadly flat, while **Healthy Life Expectancy (HLE)** has decreased, especially for women, meaning **people are spending more of their life in ill health**.
- This pattern is ‘**steepest**’ in our **most deprived neighbourhoods**, where people experience markedly **earlier onset of long-term conditions and multimorbidity**.
- The result is a consistent rise in healthcare utilisation, **often underpinned by urgent care demand, emergency admissions and hospital bed days**, with care too often delivered in the **costliest settings i.e. hospitals**.
- The conditions that bite hardest into LE and HLE are:
 - LE = Cardiovascular disease, respiratory disease and cancer**
 - HLE = Cancer (lung, bowel, breast), MSK/chronic pain, Cardiovascular disease, respiratory disease and anxiety/depression**
- In practice, this means **earlier onset, longer time with symptoms and disability** (breathlessness, pain, functional limitations), and **higher frailty at older ages**.
- If unaddressed, these trends **risk widening inequalities**, sustained pressure on workforce and **unaffordable activity growth** in acute services.
- Rising NHS demand is outpacing financial resources, **embedding a sustainability challenge for the health service**. Without significant change, the system will **struggle to maintain quality and timely access to care**, particularly for those with the most complex needs.

Across the DLN ICB Cluster, **Healthy Life Expectancy is declining**, and people are spending longer in poor health - which is driving increased healthcare utilisation



	Male		Female	
Area	HLE	Years in Poor Health	HLE	Years in Poor Health
Derby	-5%	21.1	-7%	25.7
Derbyshire	-2%	17.7	-3%	21.5
Lincolnshire	-6%	18.0	-7%	22.1
Nottingham	-3%	19.0	-5%	23.8
Nottinghamshire	-3%	18.9	-5%	23.2

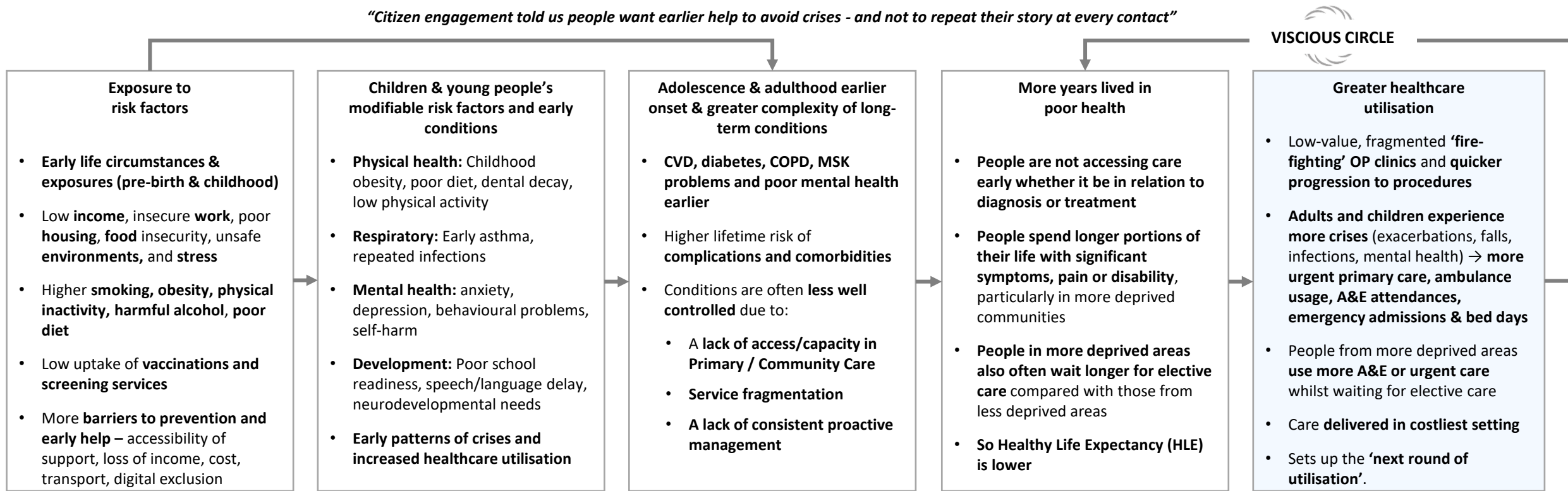
Source: OHID Fingertips, HLE Data is for period 2011-13 to 2021-23, Years in Poor Health is for 2021-23

What this means for NHS services

An increasing gap between Life Expectancy (LE) and Healthy Life Expectancy (HLE) across our ICB Cluster, particularly in the most deprived areas, means i) earlier onset of long-term conditions and multimorbidity ii) more years with functional limitations such as mobility, pain, breathlessness and cognitive issues iii) higher rates of frailty and dependence on others for daily activities.

Improving Healthy Life Expectancy (HLE), especially in deprived communities, is a core demand management strategy for NHS services not just a population health outcome goal

"Citizen engagement told us people want earlier help to avoid crises - and not to repeat their story at every contact"



This pathway is steeper and starts earlier in our most deprived communities

How this translates into healthcare utilisation

Analysis by the Nottingham and Nottinghamshire ICB identified that three population segments in the local segmentation model equate to c.7% of the total population but account for around 35% of healthcare costs, 30% of elective activity and over half of all ambulance calls, emergency admissions and emergency bed days – a similar picture can be expected across the other ICB's in the cluster.*

Population Segment	% Patients	Total Cost	% Total Cost	% Outpatient Att.	% Day Cases	% Elective Adm.	% Ambulance Calls	% Emerg. Adm.	% Emerg Bed Days
Segment 1 - End or Life	2%	£302,766,148	16%	9%	11%	9%	25%	25%	34%
Segment 2 - Frailty or Dementia	1%	£131,196,439	7%	3%	3%	4%	13%	11%	17%
Segment 3 - LTC 3 or more	4%	£261,687,333	14%	16%	18%	18%	15%	15%	16%
Segment 4 - LTC 2	6%	£223,182,866	12%	14%	16%	15%	10%	10%	9%
Segment 5 - LTC 1	15%	£332,433,700	18%	21%	24%	25%	13%	13%	9%
Segment 6 - Common MH	9%	£140,185,381	7%	7%	5%	6%	7%	5%	2%
Segment 7 - Risk Factors	16%	£124,803,822	7%	9%	7%	6%	5%	5%	3%
Segment 8 - Healthy	35%	£191,836,384	10%	13%	7%	8%	4%	9%	3%
Unknown Segment	12%	£189,238,109	10%	10%	10%	9%	8%	8%	8%
ALL SEGMENTS	100%	£1,897,330,182	100%	100%	100%	100%	100%	100%	100%

3 Segments account for c.7% of the total population, but around:

- 35% of healthcare costs
- 30% of elective activity
- 50% of ambulance calls
- 50% emergency admissions
- 65% emergency bed days

Segment 1 End of Life	Segment 2 Frailty or Dementia	Segment 3 LTC 3 or more	Segment 4 LTC 2	Segment 5 LTC 1	Segment 6 Common MH	Segment 7 Risk Factors	Segment 8 Healthy
• End of life register • GSF stage • Organ failure • Palliative care	• CFS 6-8 (patients aged 65+) • Dementia	• 3 or more LTC from: • Cancers (diagnosed in last 10 years) • Long-term physical conditions • Learning disabilities • Serious mental illness	• 2 LTC from: • Cancers (diagnosed in last 10 years) • Long-term physical conditions • Learning disabilities • Serious mental illness	• 1 LTC from: • Cancers (diagnosed in last 10 years) • Long-term physical conditions • Learning disabilities • Serious mental illness	• Depression or Anxiety (with medication in last 5 years) • Eating disorders • Neurodivergence • Stress reactions	• Alcohol or substance misuse • Cancers (diagnosed over 10 years ago) • Depression or Anxiety (without medication in last 5 years) • Hypercholesterol • Hypertension • Obesity • Pre-diabetes • Smoking	• Patients not appearing in any of the above segments

Source: Nottingham and Nottinghamshire ICB System Analytics Intelligence Unit

*This working hypothesis is under ongoing review

Children and young people

Within population health management segmentation models children and young people are usually ‘embedded’ within one of the segments. Their overall healthcare utilisation is comparably low compared to adults and older people, however analysis by the Lincolnshire ICB suggests a higher usage of urgent and emergency care services by children and young people from more deprived areas – a pattern that is expected across the other ICBs in the cluster.*

0-9 Year Olds	Deprivation Decile	1	2	3	4	5	6	7	8	9	10
Physical Health											
Asthma		3.5%	3.7%	3.5%	4.3%	3.3%	3.1%	3.6%	2.9%	3.0%	3.2%
Diabetes		0.2%	0.1%	0.2%	0.2%	0.2%	0.1%	0.1%	0.1%	0.2%	0.3%
Hypertension		0.1%	0.2%	0.2%	0.1%	0.1%	0.2%	0.2%	0.1%	0.1%	0.1%
Obesity**		0.8%	0.7%	0.7%	0.7%	0.8%	0.7%	0.6%	0.9%	0.5%	0.8%
Mental Health & Learning Disability											
Anxiety		0.2%	0.2%	0.2%	0.2%	0.3%	0.2%	0.2%	0.2%	0.3%	0.2%
Depression		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Learning Disability		0.6%	0.5%	0.3%	0.5%	0.4%	0.3%	0.4%	0.3%	0.4%	0.3%
Cost Per Person Per Year											
Urgent & Emergency		£444	£439	£426	£381	£403	£398	£395	£340	£350	£303
Acute Planned		£198	£192	£179	£212	£197	£187	£182	£180	£186	£152
Primary Care		£151	£157	£152	£184	£159	£170	£162	£143	£148	£137
Community Health		£275	£259	£247	£235	£221	£213	£217	£197	£196	£187
Mental Health & Learning Disability		£36	£29	£41	£32	£38	£36	£37	£36	£42	£46

Urgent and Emergency Care:

- More deprived communities have a higher average cost per child per year
- Suggesting children are more likely to ‘tip’ into emergency care – most likely for ambulatory care sensitive conditions such as asthma and infections

Community Health Care:

- More deprived communities have a higher average cost per child per year
- However, this usage may not always be proportionate to need which could potentially cause late presentation / more severe episodes

Source: Lincolnshire ICB PHM Analytics Team

10-19 Year Olds	Deprivation Decile	1	2	3	4	5	6	7	8	9	10
Physical Health											
Asthma		8.7%	8.5%	8.2%	9.2%	8.4%	8.7%	8.9%	8.4%	9.3%	9.1%
Diabetes		0.5%	0.4%	0.5%	0.5%	0.6%	0.6%	0.5%	0.4%	0.4%	0.5%
Hypertension		0.2%	0.3%	0.3%	0.2%	0.3%	0.2%	0.2%	0.2%	0.1%	0.1%
Obesity**		3.8%	3.3%	3.4%	3.2%	3.6%	2.7%	2.5%	2.3%	2.1%	1.9%
Mental Health & Learning Disability											
Anxiety		5.7%	5.4%	5.0%	5.7%	6.4%	5.7%	5.1%	4.9%	5.4%	5.4%
Depression		1.6%	1.6%	1.6%	1.4%	1.5%	1.4%	1.3%	1.3%	1.2%	1.2%
Learning Disability		1.1%	1.3%	0.8%	1.3%	1.0%	1.1%	1.3%	0.7%	0.7%	0.6%
Cost Per Person Per Year											
Urgent & Emergency		£246	£251	£216	£220	£170	£181	£194	£177	£155	£185
Acute Planned		£175	£148	£166	£188	£174	£164	£177	£187	£222	£196
Primary Care		£128	£126	£127	£152	£129	£145	£140	£125	£141	£120
Community Health		£59	£55	£50	£51	£48	£48	£46	£40	£40	£35
Mental Health & Learning Disability		£491	£476	£382	£375	£428	£436	£492	£304	£403	£231

Urgent and Emergency Care:

- More deprived communities generally have a higher average cost per 10-19 year-old per year
- Suggesting adolescents and older children are more likely to ‘tip’ into emergency care – most likely for long term conditions and mental health

Community Health Care and Mental Health & Learning Disability:

- More deprived communities have a higher average cost per 10-19 year-old per year
- However, this usage may not always be proportionate to need which could potentially cause late presentation, more severe episodes and more crisis

**This working hypothesis is under ongoing review*

**** Obesity data is drawn from GP records which is known to under report prevalence compared to national surveys 20**

Where and how the NHS can influence

There are a range of 'levers' that can have a positive impact on Healthy Life Expectancy and can therefore also act as demand management interventions for healthcare. These can be grouped into i) those the NHS can largely control through how it organises and delivers care ii) those the NHS can influence together with partners and iii) those where the NHS has more limited influence.

Where the NHS can directly influence	Where the NHS can influence together with partners	Where the NHS has more limited influence
A. Identification, clinical risk management & LTC optimisation incl. MH ➤ Early detection • NHS Health Checks, all screening programmes, BP and AF case-finding, diabetes/CKD case-finding, COPD/asthma diagnosis ➤ Risk factor treatment • Hypertension, lipids, renal (CKD) anticoagulation, glucose control, vaccinations, smoking/weight/alcohol support ➤ Optimising long-term condition • Evidence-based pathways for CVD, heart failure, cardiac rehabilitation, pulmonary rehabilitation, diabetes, respiratory disease, MSK, frailty, and anxiety/depression • Structured education, rehabilitation, medication optimisation/deprescribing B. Care model & utilisation pattern ➤ Access, continuity and quality of primary care • Appointment models, workforce mix, continuity of GP ➤ Proactive and planned care • PHM case-finding, recalls, LTC reviews, virtual wards, anticipatory care plans • Multidisciplinary outpatient pathways ➤ Reactive community-based care • Reactive integrated multifunctional urgent care support • Consistent access & assessment to urgent / on the day care ➤ Hospital care and transitions / step-down care • Same day emergency care, discharge to assess, in-reach teams	A. Behaviour change at scale ➤ Smoking, diet, physical activity, alcohol, weight management • NHS: Behavioural support, pharmacotherapies, medication • Partners: Commission lifestyle services, provide places to be active, regulate licensing, shape food environment B. Social & environmental determinants ➤ Housing, fuel poverty, homelessness, home safety • NHS: Identify risk, share data, make housing part of discharge and frailty plans e.g. refer to fuel poverty support services • Partners: Fix housing stock, improve standards ➤ Work, income welfare & debt • NHS: Social prescribing, anchor employment practices • Partners: Drive the underlying conditions C. Community, social connection & resilience ➤ Loneliness, carer support, community participation • NHS: Social prescribers, VCFSE grants, carer identification • Partners: VCFSE and councils provide networks/activities D. Child development & early years including 'First 1000 days' ➤ Perinatal mental health, health visiting, school nursing • NHS: Plays core role ➤ School readiness, family support, early years provision • Partners: Rely heavily on LA children's services & education	A. Upstream structural drivers ➤ Macro-economy and labour market • Recessions, wage levels, regional industrial decline/growth ➤ National tax, welfare and benefit policy • Levels of Universal Credit, disability benefits, conditionality rules ➤ Regional and national housing and planning policy • Scale of social housing, national planning rules B. <u>However, the NHS can:</u> ➤ Provide data and narratives on local health impact ➤ Act as an anchor institution (it is a significant employer) ➤ Advocate through local Integrated Care Systems (ICSs) <i>Prevention, proactive care, reliable same-day assessment and joined-up communication - so people don't repeat their history - reflects direct citizen and community feedback</i>
Vast majority of NHS activity should be delivered through Neighbourhood Health Services, that are reflective of the communities they serve		

4. Our 'North Star'

Contents:

- *Our DLN ICB Cluster Strategy Map*
- *Our population health strategy priorities for Years 1 and 2*
- *Neighbourhood Health: The heart of our population health strategy*
- *A proportionate universalism approach*
- *Our 'higher-need' primary care networks / neighbourhoods*
- *Our focus on productivity and efficiency*

See Appendix 3 and 4 for more detail on the DLN ICB Cluster Outcomes Framework and specific Key Performance Indicators (KPIs)

Our DLN ICB Cluster Strategy Map

Our Strategy Map sets out how the DLN ICB Cluster will build on the strong foundations set by our individual ICBs. Our strategy positions the DLN ICB Cluster to continue to focus on improving the length and quality of people's lives and tackling underlying inequalities, whilst ensuring best use of NHS financial resources.

Our Vision



Every person in every community will live longer and healthier lives

Our Mission



We will commission healthcare services across Derby & Derbyshire, Lincoln & Lincolnshire and Nottingham & Nottinghamshire to improve population health, reduce health inequalities and improve equitable access

Population Health Outcomes*



Start Well

Children enjoy good health so they can grow, learn and develop to their full potential

Live Well

Adults stay healthier for longer, with well managed conditions to reduce the risk of progression so they can work, care and take part in life without their health holding them back

Age Well

Older people stay as well, active and independent as possible to reduce the risk of progression so that they spend more time living in their own homes and communities

Die Well

People approaching the end of life are cared for with comfort and dignity, spending as much time as possible in their usual place of residence

System Level Outcomes*



People live longer and fewer die early from preventable causes

People spend more years in good health & fewer years with avoidable poor health

Inequalities in life expectancy and healthy life expectancy are reduced

Ambitions



Sickness to prevention

Make staying well the default

Hospital to community

Shift resources & capacity into integrated neighbourhood teams

Analogue to digital

Give people more control, free up staff time & spot risk earlier

Financial sustainability

Ensure best use of NHS financial resources and value for money

People and Staff Feel Empowered to Make Decisions

* See Appendix 3 and 4 for more detail on the DLN ICB Cluster Outcomes Framework and specific Key Performance Indicators (KPIs)

Our population health strategy priorities for years 1 and 2

Building on the analysis of our population's health need and in line with our strategy, five Population Segment Priorities and three 'Cross-Cutting' Priorities have been identified for the next 2 years.

These priorities seek to provide a balance of addressing 'upstream' health needs whilst also addressing the need to provide better quality, accessible, integrated care that tackles the significant operational and financial pressures the NHS faces 'here and now'.

	Start Well	Live Well	Age Well	Die Well
Segment 1 – End of Life				PS 5. End of Life
Segment 2 – Frailty or Dementia			PS 4. Frailty	
Segment 3 – LTC 3 or more**		PS 3. Early Multimorbidity (40-64)		
Segment 4 – LTC 2**				
Segment 5 – LTC 1**				
Segment 6 – Common MH	PS 2. Children & Young People Mental Health (0-19)			
Segment 7 – Risk Factors	PS 1. Children & Young People Obesity (0-19)			
Segment 8 - Healthy				
All segments – 'cross-cutting'	CC 1. Vaccinations and Screening CC 2. Strong General Practice CC 3. Outpatient and Follow Up Appointments Redesign			

Rationale for prioritisation

Seeking a balance of:

- Early support to help reduce future health and care utilisation
- Addressing current health and care utilisation that is providing poor care and poor experience often in the costliest setting

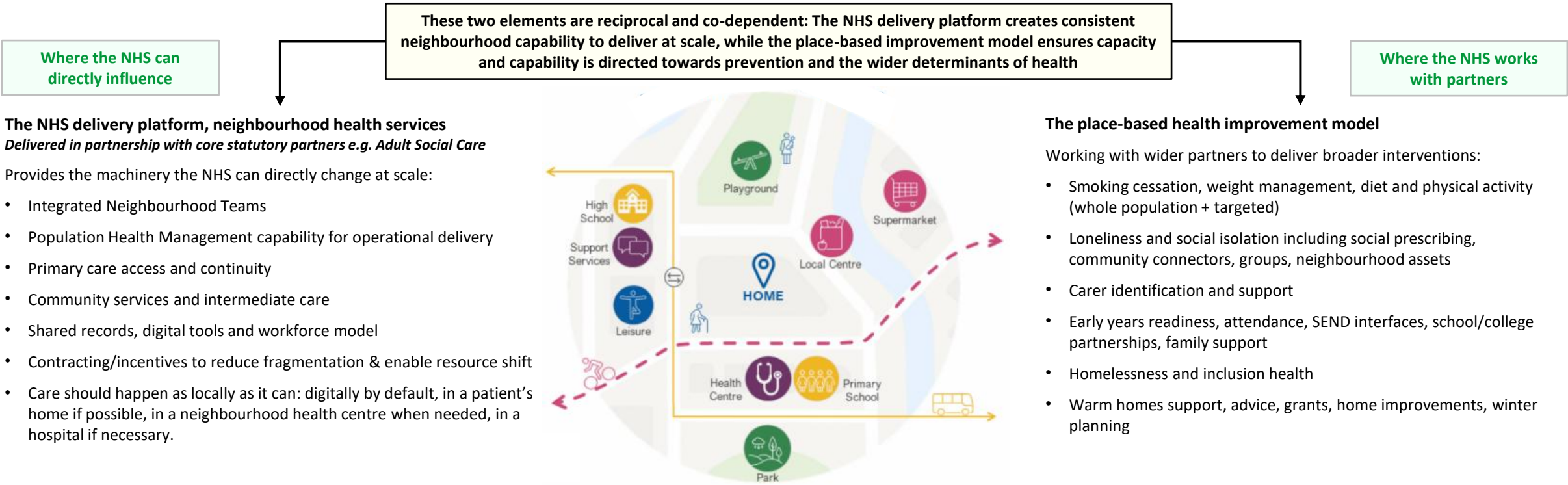


**See Appendix 4 for more detail on why these priorities matter*

*** Includes learning disabilities and serious mental illness*

Neighbourhood Health: the heart of our population health strategy

Neighbourhood health is the ‘engine room’ for delivering our population health priorities, combining an NHS delivery platform, the neighbourhood health service, and a place-based health improvement model. The NHS delivery platform sets out how health services integrate at a neighbourhood level; the health improvement model aligns partners to prevent ill-health and improve the wider determinants of health.



Headline Hospital to Community Shift 5-Year Ambitions

 Outpatient Redesign	Acute 1 st outpatient activity	-25%	 Proactive Care	Population case managed	5%	 Reactive Care	Non-elective admissions	-35%
	Acute follow-up outpatient activity	-25%		People condition managed	20%		Non-elective occupied bed days	-10%

A proportionate universalism approach

The approach we will adopt to implementing our population health strategy priorities through neighbourhood health services is one based on proportionate universalism, as we look to improve health outcomes for the entire population while ensuring those with the greatest need receive the most support – making sure service provision remains within available NHS financial resources and provides best value for money.

- In practice, proportionate universalism means a **clear universal service offer for all citizens**, alongside a planned and measurable **increase in the scale and/or intensity** of support **for communities and cohorts with the greatest unmet need and poorest outcomes**.
- We will use a population health management approach to **identify those Primary Care Networks (PCNs) / Neighbourhoods with higher-needs for each priority** and look for a **set of levers - reach, access, intensity, coordination and enablement** – to be applied through commissioned neighbourhood health services.
- Success will be judged by **narrowing gaps in access, experience and outcomes, alongside reductions in avoidable crisis utilisation** for high-need cohorts.
- **Using proportionate universalism** to implement our population health strategy is a **new approach for the DLN ICB Cluster** and will continue to **develop and evolve through its ongoing application**.

DLN ICB Cluster framework for proportionate universalism (which is subject to ongoing testing, review and refinement)

	 Universal Core Offer for everyone	 Enhanced Support for higher-need PCNs/Neighbourhoods c.25-30% for each priority
Definition	Every Primary Care Network (PCN) / Neighbourhood receives the universal core offer for each priority	A subset of Primary Care Networks (PCN) / Neighbourhoods receive 'enhanced' support for each priority
'Triggers'	None – all PCNs / Neighbourhoods receive the offer	PCNs / Neighbourhoods receive 'enhanced' support based on three lenses: • Need / disadvantage: High deprivation; higher prevalence; inclusion health concentration • Inequality gap / under-coverage: Lower uptake of core interventions; late presentation / poor continuity indicators • Avoidable utilisation / pressure: Higher A&E attendances / emergency admissions; high repeat attendances / admissions; short-stay admissions suggesting preventable escalation
'Response'	A standard minimum pathway for each priority, with: • Identification, risk stratification & segmentation • Structured review • Medicines optimisation • Self-management / prevention support • Clear escalation routes	Enhanced support delivered, for example: • Enablement: Targeted removal of barriers: transport, translation; welfare / debt /housing linkages; carer support • Reach: More outreach attempts; proactive call/recall; trusted community touchpoints • Access: Additional clinics in community venues; evening/weekend options; non-digital routes; interpretation • Intensity: Longer appointments; proactive follow-ups; named clinician/team for complex cohorts • Coordination: Increased pharmacy, care coordination, mental health and therapy inputs; more frequent MDTs

Our 'higher-need' primary care networks / neighbourhoods (1)

In line with our proportionate universalism approach, an initial set of 'higher-need' PCNs/Neighbourhoods has been identified for each of our priorities based on our existing population health management data and local 'soft' intelligence - the strategic intent is these will receive more 'enhanced' support.*

PROTOTYPE OUTPUT: This is a new approach to implementation which requires the methodology to identifying these 'higher-need' PCNs/Neighbourhoods to be kept under rigorous review and refinement

KEY:	4 = PS4 Frailty
1 = PS1 Children & Young People's Obesity	5 = PS5 End of Life
2 = PS2 Children & Young People's MH	6 = CC1 Vaccinations and Screening
3 = PS3 Multimorbidity 2+ LTCs	7 = CC2 Strong General Practice

Derby and Derbyshire										
Primary Care Network	Pop. (k)	IMD Q	Community Type	1	2	3	4	5	6	7
Derby City North	66.8	1	Urban Core	•		•			•	•
PCCO	46.8	1	Urban Core						•	
Erewash	102.5	2	Suburb	•		•				•
Glossop	33.6	2	Market Town						•	
High Peak	61.5	2	Market Town/Rural	•						
North Derbyshire	32.2	2	Urban Core/Suburb			•		•		
North-East Derbyshire	40.9	2	Market Town/Rural					•		
North Hardwick/Bolsover	51.9	2	Market Town/Rural	•				•		•
South Hardwick	71.0	2	Market Town/Rural				•			
Chesterfield & Dronfield	104.1	3	Urban Core/Market Town			•	•	•		•
Derby City South	105.2	3	Urban Core/Rural				•		•	
Greater Derby	107.9	3	Urban Core				•			

Lincolnshire										
Primary Care Network	Pop. (k)	IMD Q	Community Type	1	2	3	4	5	6	7
First Coastal	83.8	1	Coastal/Rural			•	•	•	•	•
Boston	77.5	2	Market Town/Rural	•		•	•	•	•	•
Trent	40.4	2	Market Town/Rural	•		•		•	•	
Lincoln Health P'ship	38.4	2	Urban Core	•		•	•		•	
Meridian	39.5	2	Market Town/Rural	•						
East Lindsey	54.9	3	Rural/Market Town					•		
IMP Healthcare	73.7	3	Urban Core/Rural							•
South Lincolnshire Rural	99.4	3	Rural/Market Town							•
Spalding	44.3	3	Market Town/Rural				•			

** For each of the three ICBs in the DLN Cluster, for each priority (except Outpatient and Follow-up Appointment Redesign) the 25% of PCNs with the highest need and/or greatest inequality impact potential*

Our 'higher-need' primary care networks / neighbourhoods (2)

In line with our proportionate universalism approach, an initial set of 'higher-need' PCNs/Neighbourhoods has been identified for each of our priorities based on our existing population health management data and local 'soft' intelligence - the strategic intent is these will receive more 'enhanced' support.*

PROTOTYPE OUTPUT: This is a new approach to implementation which requires the methodology to identifying these 'higher-need' PCNs/Neighbourhoods to be kept under rigorous review and refinement

KEY:	4 = PS4 Frailty
1 = PS1 Children & Young People's Obesity	5 = PS5 End of Life
2 = PS2 Children & Young People's MH	6 = CC1 Vaccinations and Screening
3 = PS3 Multimorbidity 2+ LTCs	7 = CC2 Strong General Practice

Nottingham and Nottinghamshire										
Primary Care Network	Pop. (k)	IMD Q	Community Type	1	2	3	4	5	6	7
Aspire	45.0	1	Urban Core	●		●	●	●	●	●
Bulwell & Top Valley	48.3	1	Urban Core	●		●			●	●
Nottingham City East	69.1	1	Urban Core	●			●		●	
Radford & Mary Potter	37.4	1	Urban Core	●		●		●	●	●
Raleigh	29.8	1	Urban Core			●	●	●	●	
Ashfield North	52.4	2	Market Town	●		●		●		
Bestwood & Sherwood	55.9	2	Urban Core						●	
Clifton & Meadows	35.2	2	Suburb/Urban Core			●	●			
Mansfield North	59.6	2	Market Town	●				●		●
Rosewood (Mansfield)	52.4	2	Market Town	●					●	
Ashfield South	41.2	3	Market Town			●	●			
Byron	39.6	3	Suburb				●			
Larwood & Bawtry	38.7	3	Market Town							●
Eastwood/Kimberley	38.2	4	Suburb					●		
Newark	80.1	4	Market Town/Rural							●
Synergy Health	36.1	4	Suburb				●			●
Beeston	50.4	5	Suburb					●		

* For each of the three ICBs in the DLN Cluster, for each priority (except Outpatient and Follow-up Appointment Redesign) the 25% of PCNs with the highest need and/or greatest inequality impact potential

Our focus on productivity and efficiency

Improved productivity and efficiency will be central to delivering our population health strategy priorities given the sustained financial pressures facing the NHS across the DLN ICB Cluster. By focusing on eradicating 'low value' activity, reducing unwarranted variation, improving pathways and maximising digital and workforce transformation, we can release capacity, improve system finances and redirect scarce resources towards interventions that deliver the greatest population health benefit.

Productivity & efficiency <i>Before and after transformation</i>	• Purpose: (1) drive immediate productivity from existing services to create capacity and affordability for change; then (2) ensure 'productivity by design' is locked into the transformed neighbourhood and outpatient models • Core interventions: pathway discipline now; demand/capacity management; admin reduction; then standard INT operating model, digital automation and redesigned OP pathways

Productivity & Efficiency: Population Segment Priorities				
CYP Obesity (0-19)	CYP Mental Health (0-19)	Multimorbidity (40-64)	Frailty	End of Life
• Pre: reduce duplication across school/GP/community; improve referral quality and attendance • Post: standardised prevention offer at scale with clear throughput and outcomes per £ invested	• Pre: reduce waits and DNAs via triage/single front door • Post: stepped-care models with productivity KPIs (contacts resolved at 1st point, time-to-interventions, outcomes)	• Pre: tighten structured reviews, medicines optimisation, reduce avoidable OP/UEC attendance • Post: proactive model reducing crises and stabilising demand; productivity measured as reduced escalation and fewer low-value contacts	• Pre: reduce variation in frailty reviews and discharge delays; improve intermediate care flow • Post: 7-day INT response and standard pathways reducing bed days and improving functional outcomes	• Pre: earlier Advanced Care Planning and coordination to reduce crisis admissions • Post: reliable community palliative care model reducing unwanted escalation and improving experience and place-of-death outcomes

Productivity & Efficiency: Cross-Cutting Priorities		
Strong General Practice	Vaccinations & Screening	Outpatient & Follow-Up Redesign
• Pre: immediate GP productivity actions (workflow, telephony, task-shift, admin reduction) • Post: team-based neighbourhood model and shared record reduce duplication; sustained access and continuity standards	• Pre: reduce wasted slots and improve call/recall quality • Post: automated booking/reminders + target outreach sustaining higher uptake and lower DNAs with equity monitoring	• Pre: reduce DNAs, follow-up backlog and low value reviews now • Post: Advice and Guidance/Patient Initiated Follow Up/remote review/PROMs as default with explicit productivity and safety KPIs; standard clinic templates and referral thresholds

5. Our Priorities

Contents:

- *Segment Priority 1: Children and Young People's Obesity (0-19)*
- *Segment Priority 2: Children and Young People Mental Health (0-19)*
- *Segment Priority 3: Early Multimorbidity; 2+LTC (40-64)*
- *Segment Priority 4: Frailty*
- *Segment Priority 5: End of Life*
- *Cross-Cutting Priority 1: Vaccination and Screening*
- *Cross-Cutting Priority 2: Strong General Practice*
- *Cross-Cutting Priority 3: Outpatient and follow-up redesign*

See Appendix 4 for more detail on each of the priorities

Segment Priority 1: Children and Young People's Obesity (0-19)

Children and young people's obesity drives early ill-health, deepens inequalities and increases lifelong risk of diabetes, heart disease and poor mental wellbeing. High rates strain families, schools and health services, while early prevention improves long-term health and wellbeing.

Evidence-based Interventions*

Approach	Intervention	3 Shifts**
NHS Led	1. Pregnancy and early years prevention: Consistent healthy eating (maternal nutrition)/physical activity advice in pregnancy, high-BMI booking pathway and targeted support. Breastfeeding support to improve breastfeeding rates.	1
	2. Tier 2 child & family weight management as scalable 'volume engine': Family-based, multi-component programmes (diet, activity, behaviour change) with active engagement to drive starts and completions; delivered flexibly (community venues, evenings/weekends, culturally competent formats) and support by PCN link workers / health & wellbeing coaches.	1
	3. Specialist pathway for severe/complex obesity (Tier 3 and wider specialist support): Clear criteria + triage + escalation routes for severe obesity, complications and complex psychosocial needs; Integrate paediatrics, dietetics, psychology/CAMHS where indicated, and safeguarding/children's services interfaces.	1
NHS in Partnership	4. Targeted NCMP-triggered outreach into support (Reception + Year 6): A defined 'NCMP follow-up workflow' for overweight/obese/severe obesity results, prioritising the highest-need neighbourhoods/schools clusters; warm handoffs into Tier 2 (and wrap-around support) to raise uptake in deprived groups	1,3
Multi-Agency Led	5. Whole-school and whole-neighbourhood package in priority school clusters: A coherent 'school cluster offer' (daily activity culture, family engagement, consistency healthy food norms, strong referral links to Tier 2); Parallel neighbourhood actions on the food environment (planning/licensing levers) and access to physical activity opportunities	1

Priority focus on Primary Care Networks / Neighbourhoods with:

- Highest obesity rates (and absolute numbers) in Reception and Year 6, especially where coincides with high deprivation, high free-school-meal eligibility and higher UEC activity
- Particular consideration / focus: 'first 1000 days', children in care, children with additional needs and families living in most disadvantaged areas

* These do not constitute investment guarantees to providers – they need to be delivered within available financial resource and provide value for money

** 1. Sickness to Prevention; 2. Hospital to Community; 3. Analogue to Digital

System Outcomes Framework Impact

'Top 5' KPIs to inform ICB Board Reporting ^{1 2 3}
1. % of pregnant women with a BMI>30 weight management service start and completion rate & % pregnant women recorded as smoking at booking/delivery
2. Breast feeding initiation and continue to exclusively breastfeed
3. Tier 2 / Tier 2+ / Tier 3 weight management service start and completion rates
4. NCMP Year 6 excess weight prevalence & proportion of children with Asthma who are overweight/obese and have greater than one exacerbation in the past 12 months
5. Prevalence of Type 2 diabetes and proportion receiving recommended NICE care processes ⁴



Start Well		
Children enjoy good health so they can grow, learn and develop to their full potential		
Babies and children have a good start to life	Children develop well that sets up future good-health and well-being	Children & young people are supported to be as well as they can be

¹ PCN level, 'Top-15' PCNs aggregate vs all other PCNs. DLN total

² Report by IMD Quintile + ethnicity + SMI/LD + SEND + 'Plus groups' where appropriate and feasible to evidence equity of reach and impact

³ Additional KPIs may be included in individual PCN 'dashboards'

⁴ Aligned to CORE20PLUS indicators

Segment Priority 2: Children and Young People's Mental Health (0-19)

Children and young people's mental health is fundamental to lifelong wellbeing, educational attainment and reduced health inequalities. Prioritising early intervention strengthens resilience, prevents escalation of need and improves outcomes for future populations.

Evidence-based Interventions*

Approach	Intervention	3 Shifts**
NHS Led	1. Single CYP MH access and navigation ('front door') using a needs-based model: Clear routes in, rapid triage, brief intervention where appropriate, active navigation to the right help; consistent thresholds and escalation.	1,2,3
	2. Harm prevention + crisis response: Self-harm psychosocial assessment by appropriately skilled CYP MH clinicians, safety planning and reliable crisis response with step-down/back-to-front-door.	1,2,3
	3. Evidence-based talking therapies at scale for common presentations: Standardised stepped-care for anxiety/depression with routine outcomes measurement and escalation criteria.	1,2,3
NHS in Partnership	4. Schools/colleges early intervention partnership: Whole-setting approach, MH Support Team interface, consultation/advice and clear escalation routes into NHS services.	1,2,3
	5. Priority specialist pathways with interim support while waiting: Neurodevelopmental assessment pathways with appropriate interim support/parent programmes, eating disorder pathways, consistent referral criteria and pathway discipline.	1,2,3
Priority focus on Primary Care Networks / Neighbourhoods with: - Highest deprivation, crisis presentation (self-harm, ED attend), poor school outcomes and weak access to CYP MH services - Particular consideration / focus: 'first 1000 days', children in care, neurodivergent children and other high-risk groups		

* These do not constitute investment guarantees to providers – they need to be delivered within available financial resource and provide value for money

** 1. Sickness to Prevention; 2. Hospital to Community; 3. Analogue to Digital

System Outcomes Framework Impact

'Top 5' KPIs to inform ICB Board Reporting ^{1 2 3}
1. Access rates to CYP MH services ⁴
2. CYP Eating Disorder access standard ⁴
3. CYP Autism & ADHD diagnostic pathway waiting time ⁴
4. Proportion of CYP with obesity experiencing MH difficulties e.g. anxiety/self-esteem
5. CYP A&E attendance for MH-related presentation & hospital admissions as a result of self-harm



Start Well		
Children enjoy good health so they can grow, learn and develop to their full potential		
Babies and children have a good start to life	Children develop well that sets up future good-health and well-being	Children & young people are supported to be as well as they can be

¹ PCN level, 'Top-15' PCNs aggregate vs all other PCNs. DLN total

² Report by IMD Quintile + ethnicity + SMI/LD + SEND + 'Plus groups' where appropriate and feasible to evidence equity of reach and impact

³ Additional KPIs may be included in individual PCN 'dashboards'

⁴ Aligned to CORE20PLUS5 indicators

Segment Priority 3: Early Multimorbidity; 2+ LTCs (40-64)

Early multimorbidity in adults drives poorer health outcomes, reduced quality of life and higher service demand. Addressing it through proactive care and community-based alternatives to hospital admissions for crisis delays progression and supports long-term sustainability.

Evidence-based Interventions*

Approach	Intervention	3 Shifts**
NHS Led	1. Proactive cohort management and integrated care planning: Identify/segment the 40-64 2+ LTC cohort; proactive recall; structured multimorbidity reviews; single personalised care plan; integrated MDT, coordinated follow-up; structured medication reviews and polypharmacy optimisation, cardiac and pulmonary rehabilitation (integration), immunisation & vaccination, digital and telehealth-based care, carer identification and support for carers	1,2,3
	2. Community alternatives to admission for crisis deterioration: Urgent community response; community-based ambulatory urgent care capability; virtual ward / hospital-at-home for selected crises; High Intensity User and complex case management to reduce crisis-driven ED use.	2,3
NHS in Partnership	3. Cardiometabolic prevention and optimisation at scale: Systematic CVD risk assessment; hypertension case-finding and rapid treatment optimisation; lipid optimisation (statins where indicated); Non-Diabetic Hyperglycaemia (NDH) identification and diabetes prevention pathway (Healthier You); NHS Health Checks with 'conversation to action', long-term condition management and optimisation of multi-morbidity conditions, digital and telehealth-based care.	1,2,3
	4. Integrated mental health and inclusion health within multimorbidity care: Embed access to Talking Therapies / psychologically informed LTC support; targets support for the SMI/LD sub-cohorts including SMI annual '6 checks' and follow-on actions; trauma-informed engagement and reasonable adjustments as well as social isolation.	1,2,3
Multi-Agency Led	5. Lifestyle risk reduction with practical support (smoking, weight, alcohol) using neighbourhood assets: Evidence-based smoking cessation; weight management pathways; alcohol screening/brief interventions; social prescribing / link worker support to address behavioural and social drivers (including debt, housing, employment support). Patient education through health literacy, self management, community engagement and utilisation of community assets.	1,3

Priority focus on Primary Care Networks / Neighbourhoods with:

- High prevalence of 2 and 3+ long-term conditions in 40-64 age band, where risk factors and early disease are both poorly managed, high chronic ACSC emergency admissions, high ED attendances and high sickness certification
- Particular consideration / focus: people from most deprived quintile, people with severe mental illness and/or harmful alcohol use (MH parity of esteem), people with learning disabilities and people with caring responsibilities (unpaid carers)

* These do not constitute investment guarantees to providers – they need to be delivered within available financial resource and provide value for money

** 1. Sickness to Prevention; 2. Hospital to Community; 3. Analogue to Digital

System Outcomes Framework Impact

'Top 5' KPIs to inform ICB Board Reporting ^{1 2 3}
1. % of high-risk patients engaged in prevention (smoking, weight, alcohol) & up to date with screening (health checks, CVD, diabetes, cancer) ⁴
2. % patients with controlled blood pressure, controlled HbA1c and appropriate lipid management, alongside case-finding for undiagnosed hypertension/diabetes ⁴
3. % with SMI + ≥1 other LTC receiving all 6 elements of the physical health check in 12 months ⁴
4. Reduction in A&E attendances and NEL admissions for Ambulatory Care Sensitive conditions per 1,000 total patients 40-64 (explicitly to include COPD exacerbations, pneumonia, asthma and bronchitis) ⁴
5. Emergency bed days rate

Live Well

Adults stay healthier for longer, with well managed conditions to reduce the risk of progression so they can work, care and take part in life without their health holding them back

Adults maintain good health, with risks picked up early	Adults with long-term conditions have their health well managed and remain stable	People with a learning disability or severe mental illness have good physical health	People with care needs and their carers are supported to stay independent and well

¹ PCN level, 'Top-15' PCNs aggregate vs all other PCNs. DLN total

² Report by IMD Quintile + ethnicity + SMI/LD + SEND + 'Plus groups' where appropriate and feasible to evidence equity of reach and impact

³ Additional KPIs may be included in individual PCN 'dashboards'

⁴ Aligned to CORE20PLUS5 indicators

Segment Priority 4: Frailty

Frailty in older adults increases vulnerability to poor health outcomes, loss of independence and avoidable hospitalisation. Preventing and managing frailty supports healthier ageing, reduces inequalities and helps ensure sustainable use of health and care resource s.

Evidence-based Interventions*

Approach	Intervention (focus on moderate/severe frailty)	3 Shifts**
NHS Led	1. Frailty (and dementia) identification and segmentation (clinical frailty score, efi or similar): with an actively managed moderate/severe frailty register with the cohort receiving proactive care; PHM risk stratification to identify pre frailty in 50-64s.	1,2,3
	2. Proactive frailty bundle for moderate/severe frailty (MDT + holistic/CGA-level assessment + personalised care plan + coordination): Core model to stabilise, prevent crises and coordinate services (includes care home delivery via Enhanced Health in Care Homes expectations). Medicines optimisation for frailty (structured medication review; high-risk medicines reduction; post fall review): Reduces falls/delirium risk, readmissions and instability. Carer identification and support for carers.	1,2,3
NHS in Partnership	3. Falls and functional decline prevention pathway (multifactorial assessment + strength/balance interventions + home/environment actions): Reduces recurrent falls, fear of falling and deconditioning	1,2,3
	4. Crisis avoidance and functional recovery pathway (urgent community response + intermediate care/rehab/reablement): Admission avoidance, faster recovery, improved discharge outcomes and reduced long-term care need	1,2,3
Multi-Agency Led	5. Lifestyle risk reduction with practical support to maintain health and independence for longer: Personalised prevention; tailored guidance to older people supporting access a range of local services that address key personal wellbeing factors such as nutrition, physical activity, smoking cessation, bereavement, loneliness, and carer support. Improved access to preventative health services: offer clear advice on how to access preventative health services, including vaccinations, routine health checks, and screening programmes, with a focus on early intervention and disease prevention. Community engagement signpost individuals to directories of services and community hubs. Health inequalities: use insights to refine/enhance services, ensuring they are inclusive, equitable, and responsive to the diverse needs of older people.	1,2,3

Priority focus on Primary Care Networks / Neighbourhoods with:

- High moderate/severe frailty prevalence, high frailty-related utilisation (e.g. care-home admission rates, OBDs), weak proactive frailty care, high care-home bed density and poor quality/unsuitable housing

* These do not constitute investment guarantees to providers – they need to be delivered within available financial resource and provide value for money

** 1. Sickness to Prevention; 2. Hospital to Community; 3. Analogue to Digital

System Outcomes Framework Impact

'Top 5' KPIs to inform ICB Board Reporting ^{1 2 3}
1. Patient records with CFS score recorded and personalised care plan in place & % of people with Dementia receiving annual dementia care plan review ⁴
2. % primary care records showing eFI (or equivalent) status & number of people with frailty receiving CGA incl. structured medical review ⁴
3. % patients with 2 or more falls in one year & and rate of falls-related NEL admissions – view for moderate/severe (indicator to include uptake of evidence-based falls-prevention interventions within target population ⁴
4. ED attendances & NEL admissions for frailty multiple LTCS (65+) split by care home / non-care home admission – view for moderate/severe ⁴
5. Non-elective bed days – view for moderate/severe

Age Well

Older people stay as well, active and independent as possible to reduce the risk of progression so that they spend more time living in their own homes and communities

Older people with long-term conditions have their health well managed and remain stable

People living with frailty are supported to stay active and independent at home

When older people have a crisis, they get home quickly to stay independent

¹ PCN level, 'Top-15' PCNs aggregate vs all other PCNs. DLN total

² Report by IMD Quintile + ethnicity + SMI/LD + SEND + 'Plus groups' where appropriate and feasible to evidence equity of reach and impact

³ Additional KPIs may be included in individual PCN 'dashboards'

⁴ Aligned to CORE20PLUS5 indicators

Segment Priority 5: End of Life

End of life care affects quality, dignity and symptom control for people in their final phase of life. Improving current care delivery arrangements ensures equitable access, supports families, reduces avoidable hospital use and enables compassionate, person-centred care.

Evidence-based Interventions*

Approach	Intervention	3 Shifts**
NHS Led	1. Identify the last year of life cohort and manage a live palliative/EoL register and advanced care planning & shared-decision making as standard: systematic identification (including non-cancer), routine register reviews, clear triggers for review/escalation. Regular ACP conversations; documented preferences and escalation decisions including a ReSPECT conversation; family/carer involvement where appropriate	1,2,3
	2. Last days of life clinical reliability (including medicines and equipment): Standardised symptom assessment/management; anticipatory prescribing of 'just in case' medicines; reliable access to medicines; equipment and verification processes (including out of hours).	1,2,3
NHS in Partnership	3. Coordinated personalised care with a shared coordination record: Named coordinator/key worker; single, accessible care plan/record shared across GP, community, acute ambulance and OOH to avoid repeated story telling and fragmented response.	1,2,3
	4. 24/7 advice plus rapid community response (including care homes) and specialist care where more complex need: 24/7 advice line for patients/carers/professionals; reliable same-day visiting/urgent response; access to specialist care where needed, consistent care-home EoL support package in priority PCNs.	2,3
Multi-Agency Led	5. Enhanced care – Self Care; Self Management: People, their families and carers supported to access enhanced care including complimentary therapies, support groups, practical support in accessing housing or the benefits system and emotional and psychological support including bereavement services provided by experienced work force. Patient education through health literacy, self-management, physical activity, community engagement and utilisation of community assets.	1,2,3

Priority focus on Primary Care Networks / Neighbourhoods with:

- Highest levels of crisis / hospital-death profile, low levels of proactive planning, high frailty prevalence / care-home density and high multi-morbidity
- Particular consideration / focus: non-cancer conditions and people with learning disabilities or severe mental illness (MH parity of esteem)

* These do not constitute investment guarantees to providers – they need to be delivered within available financial resource and provide value for money

** 1. Sickness to Prevention; 2. Hospital to Community; 3. Analogue to Digital

System Outcomes Framework Impact

'Top 5' KPIs to inform ICB Board Reporting ^{1 2 3}
1. People who died with a recorded EoL care plan (ReSPECT) and/or treatment-escalation decision ⁴
2. Number of people accessing end of life care support services ⁴
3. Deaths occurring in hospital / preferred place of death ⁴
4. Deaths with 3+ NEL admissions in last 90 days of life
5. Unplanned bed days in last 90 days of life



Die Well		
People approaching the end of life are cared for with comfort and dignity, spending as much time as possible in their usual place of residence		
People likely in their last year of life are identified early and supported in a planned, proactive way	People at the end of life have clear plans that protect their comfort and independence	People at the end of life are supported to spend more time in their usual place of residence

¹ PCN level, 'Top-15' PCNs aggregate vs all other PCNs. DLN total

² Report by IMD Quintile + ethnicity + SMI/LD + SEND + 'Plus groups' where appropriate and feasible to evidence equity of reach and impact

³ Additional KPIs may be included in individual PCN 'dashboards'

⁴ Aligned to CORE20PLUS5 indicators

'Cross-Cutting' Priority 1: Vaccination and Screening

Vaccination and screening are two of the most effective population health interventions available. Together they prevent illness, detect disease earlier, reduce avoidable hospital activity and narrow inequalities in healthy life expectancy.

Life-Course Focus

Life-Course	Focus of Action	Neighbourhood Delivery Model
Children & Young People: Childhood vaccinations and HPV	- Strengthen universal delivery through maternity, health visiting, primary care and school age immunisation – with proactive call/recall and 'mop-up' for missed doses. - Improve HPV uptake through school programmes and follow-up for non-attenders and out-of-school cohorts. - Introduction of MMRV Programme. - Reduce inequalities by tailoring delivery for families facing barriers (e.g. unstable housing, language needs, digital exclusion, access barriers).	- Shared lists and joint outreach across PCNs, 0-19 services, school nursing and VSFSE. - Micro-planning at neighbourhood level: identify low-coverage schools/communities and deploy pop-ups, after school clinics and trusted messengers.
Adults and mid-life: Cancer and non-Cancer screening (to include health checks) and working age vaccinations	- Increase uptake across the adult cancer (specific focus on lung cancer) and non-Cancer screening pathway (invitation – attendance – results – follow up), with targeted approaches for lower-uptake groups and neighbourhoods. - Support development of integrated end to end pathways from screening to treatment e.g. Lung Cancer Screening (previously TLHC) - Align working age vaccination delivery with routine primary care and opportunistic contacts (e.g. focus on understanding hesitancy and barriers, community pharmacy, occupational health where appropriate). - Maximise uptake on vaccinations for clinical risk groups prioritising those with multi morbidity, COPD and people with complex needs. - Use population health management to segment 'never responders' and design tailored engagement (e.g. culturally competent outreach, flexible appointments, outreach clinics)	- PCN-led coordination with community pharmacy and VCFSE partners to extend access (evenings/weekends, community venues) - Data-driven outreach at LSOA/neighbourhood/GP practice/ethnicity level, consistent navigation and follow-up so that non-attendance triggers active support
Older people and frailty: Vaccinations to reduce severe illness and admissions	- Maximise uptake on vaccinations relevant to older age and clinical risk groups, prioritising those with frailty, COPD, care home residents, housebound patients and people with complex needs. - Embed vaccination status checks into proactive care (frailty identification, care planning, falls clinics, community geriatric services, virtual wards, intermediate care)	- Data-driven outreach at LSOA/neighbourhood/GP practice/ethnicity level, consistent navigation and follow-up so that non-attendance triggers active support 'One list' approach across primary care, community services and care homes to reduce duplication and close gaps.



'Top 5' KPIs to inform ICB Board Reporting ^{1 2 3}
1. MMR coverage at Age 2 % of children at aged 2 who have received at least one dose of MMR/MMRV
2. HPV vaccination uptake (Year 8 cohort) % of Year 8 cohort receiving the HPV vaccine (with a separate catch-up drill-down for those vaccinated later) include a drill down for gender (need for both male and female) to link with cervical cancer elimination plan
3. Cancer screening uptake: % uptake across the three core adult screening programmes, reported as a single composite headline with drill-downs for ⁴ : - Bowel screening (completion /FIT kit return) - Breast screening (attendance) - Cervical screening (in-date coverage) - Lung Cancer Screening (previously targeted lung checks)
4. Early cancer diagnosis ⁴ % of cancers diagnosed at Stage 1 or Stage 2 (breast, lung, colorectal and prostate cancer) & proportion of urgent referrals meeting 2WW/FDS/62-day standard
5. 'Winter protection' vaccination uptake as per UEC plan % of the seasonal respiratory vaccination offer in older people and frailty/risk cohorts (with focus on COPD) ⁴

¹ PCN level, 'Top-15' PCNs aggregate vs all other PCNs. DLN total

² Report at PCN level, Equity Gap (IMD Q1 vs Q5), best-worst PCN range

³ Additional KPIs may be included in individual PCN 'dashboards'

⁴ Additional KPIs may be included in individual PCN 'dashboards'

⁴ CORE20PLUS aligned

‘Cross-Cutting’ Priority 2: Strong General Practice

Strong general practice (sufficient capacity, equitable access, continuity, high-quality proactive management) is a critical enabler of improved population health outcomes and reduced inequalities. It is crucial for earlier identification, proactive long-term condition management, continuity for complex patients and timely access to appropriate care.

Prioritisation – Three ‘lenses’

Lens and Strategic Intent	Focus
1. Where health gain is highest (need/risk) <i>Target proactive care to the highest-need cohorts to improve control and reduce inequalities</i>	• High CYP underlying need (asthma/wheeze, obesity neurodevelopmental/SEND, emerging mental health) where early identification, coordinated support and planned follow-up improve longer-term outcomes and inequalities • High burden of chronic illness and rising risk (multimorbidity, high r-risk LTC prevalence, obesity, smoking, deprivation) where strengthening routine access and structured reviews will improve control and slow progression over years. (specific consideration given to CORE20PLUS) • High frailty and functional decline risk (older people, moderate/severe frailty, care homes, polypharmacy) where continuity, anticipatory care and proactive reviews prevent deterioration and maintain independence.
2. High avoidable / crisis utilisation and complexity <i>Cut failure demand by improving rapid access and coordination for high utilisers</i>	• High CYP escalation signals (recurrent A&E for asthma exacerbations, frequent acute presentations, mental health crisis contacts/self-harm) indicating unmet need or delayed intervention rather than simply high prevalence. • High urgent care reliance disproportionate to expected need (frequent A&E attenders, high out-of-hours use, short-stay/low acuity presentations) indicating access gaps, low confidence in alternatives or poor front-door processes. • High potentially avoidable admissions and repeats (ACS admissions, repeat non-elective admissions/bed days) suggesting inconsistent proactive management, weak continuity for complexity or poor coordination across services.
3. Structurally under-resources or hard to access <i>Remove workforce, estates and inclusion barriers that cap access and capacity</i>	• Workforce capacity and stability constraints (vacancies, turnover, locum reliance, limited MDT deployment) that cap appointment supply and ability to protect time for proactive care. • Access barriers that create inequity (digital exclusion, language, transport/parking, limited after-school access for families, lack of youth-friendly routes) where ‘availability’ does not translate into real-world access. • Estate and infrastructure constraints (insufficient consulting rooms, poor layout/flow, limited space for immunisation of MDT clinics, inadequate connectivity) that ‘hard-cap’ concurrent clinics and restrict service scope



‘Top 5’ KPIs to inform ICB Board Reporting ^{1 2 3}
1. Delivered appointment capacity Appointments per 1,000 patients (weighted & registered)
2. Timely access to clinical assessment (in-hours) % of clinically urgent appointments seen on the same day
3. Patient-reported access GP Patient Survey: % reporting overall experience as good/very good experience of contacting the practice/getting an appointment
4. Patient-reported continuity GP Patient Survey: % able to see/speak to preferred GP HCP (where have one) – this is in line with SoS report metric, national average benchmark
5. Proactive long-term condition control QOF composite for hypertension BP control and diabetes HbA1c control (reported as an overall ‘% achieving control’ headline)

¹ PCN level, ‘Top-15’ PCNs aggregate vs all other PCNs. DLN total

² Report at PCN level, Equity Gap (IMD Q1 vs Q5), best-worst PCN range

³ Additional KPIs may be included in individual PCN ‘dashboards’

‘Cross-Cutting’ Priority 3: Outpatient and follow-up redesign

We will redesign outpatient pathways using a two-group prioritisation model. Group 1 targets high-volume specialties to improve RTT performance, Group 2 focuses on long-term conditions and addressing associated burdens of disease. Outpatient redesign will be done in the context of whole pathway redesign and transformation.

Key elements of a redesigned outpatient model

Lever		These ‘levers’ will be considered on a specialty basis by specialty basis as part of whole pathway redesign and transformation
1	Patient activation as the default	- Embed supported self-management, shared decision-making and personalised care planning so that patients understand their condition, triggers and when/how to seek help. - This includes structured education, coaching and consistent use of care navigation and health coaching with neighbourhood teams
2	Advice and Guidance	- High impact where referrals are high-volume and triage able (e.g. MSK, dermatology, ENT). - Lower impact where referrals require specialist diagnostics as a first step
3	PCN/INT protocol-led MDT first attendances	Expand neighbourhood-based clinics delivered by MDTs (e.g. advanced clinical practitioners, specialist nurses, pharmacists, AHPs and GPs with extended roles), with specialist input via advice-and-guidance, virtual MDTs and outreach sessions (e.g. MSK FCP, community respiratory, diabetes support, frailty MDT/CGA)
4	Patient-initiated Follow-Up (PIFU) with rapid re-access	- Replace routine follow-ups for suitable cohorts with PIFU pathways that provide clear criteria for re-contact, times ‘backstop’ safety reviews where needed, and swift access to advice, diagnostics or specialist review when deterioration occurs. - Greatest impact where follow-ups are surveillance-heavy and can be protocolised with rapid-access (e.g. ophthalmology, MSK, dermatology).
5	Virtual reviews and remote monitoring	Use virtual consultations, remote physiological monitoring (where appropriate) and patient-reported outcome/symptom tracking to reduce unnecessary face-to-face follow-up while maintain safety and continuity



Group 1: Prioritised primarily through 18-week (RTT) performance pressures
- These align to high volume specialties that national programmes target because they represent a large proportion of elective waiting list activity and are a core focus for accelerating RTT improvement through pathway redesign (triage, straight-to-test, one-stop models, improved booking rules and standardised follow-up reduction). - They are well suited to standardised, ‘industrialised’ outpatient redesign that reduces ‘unseen’ patients and improves flow into diagnostics and treatments, directly supporting the 18-week recovery agenda. Includes: Dermatology, T&O/MSK, Gynaecology, Paediatrics, Gastroenterology, Ophthalmology, Urology and ENT (redesign needs to consider whole pathway)



Group 2: Prioritised by population segment needs and Long-Term Condition burden
- These specialties carry a disproportionate share of long-term condition burden and interact heavily with multimorbidity and frailty. The opportunity is less about elective throughput alone and more about reducing fragmented repeat follow-ups, improving proactive management and enabling rapid re-access when patients destabilise. - Redesign should emphasise protocol-led MDT follow-up, stronger neighbourhood (PCN/INT) delivery, virtual reviews/remote monitoring and PIFU where appropriate – reducing duplication across multiple specialty clinics and improving experience for high-need cohort. Includes: Geriatric Medicine, Cardiology, Respiratory Medicine, Diabetes, Renal Medicine and Oncology/Haematology (redesign needs to consider whole pathway)

KPIs on PIFU, avoided 1st OP appointments and care setting / modality shifts will require more investigations about possible data sources and methodologies for calculating ‘Top-5’ metrics.

6. Our Key Enablers

Contents:

- *Key enablers*
- *Digital technology*

See Appendix 5 for more detail on each of the key enablers

Key enablers

Six capabilities and ways of working have been identified that make this population health strategy deliverable at scale. These key enablers provide the systemwide capabilities required to operationalise the priorities set out in this document, ensuring consistent delivery through aligned pathways, shared data, digital tools, neighbourhood models, and coordinated multi-agency approaches at scale

Key enablers	Focus
1. Communications (hearts & minds)	• Purpose: align partners and build public/staff confidence in the 'neighbourhood offer' and the 3 shifts (prevention, community, digital) • Core interventions: unified narrative, targeted inequality comms; 'what will change' pathway comms; feedback loops
2. Digital Technology	• Purpose: enable analogue to digital shift while supporting community delivery prevention; release staff time through automation; ensure digital inclusion • Core interventions: NHS App pathways; interoperable/shared record; remote monitoring; automation/AI for admin; messaging; digital call/recall; cyber/IG assurance.
3. Individual & Family Case Finding	• Purpose: systematically identify unmet need and prevention gaps, enabling proactive outreach and earlier intervention • Core interventions: PHM segmentation; consistent triggers; 'no wrong door'; gap lists; proactive invitations; shared record/data triggers

Key enablers	Focus
4. Personalisation	• Purpose: embed 'what matters' care, activation and shared decisions to improve outcomes and reduce low-value activity • Core interventions: personalised care & support planning; shared decision making; social prescribing; carer inclusion
5. Resource shift hospital to community	• Purpose: make the hospital to community shift real by moving money, capacity and accountability into neighbourhood delivery; hardwire prevention and digital requirements; explicitly use the new PCN and multi-PCN contract approach when available (procurement rules/laws will need to be followed) • Core interventions: outcomes-based specifications, equity weighting; gainshare; invest-to-save; single/multi-neighbourhood contracts
6. Integrated Neighbourhood Teams	• Purpose: deliver prevention, proactive and reactive care, anchored in strong general practice and neighbourhood health centres, reducing reliance on hospital care (community care 'delivery engine') • Core interventions: MDT cadence; pathway standardisation; extended access; rapid response; co-location/virtual integration; VCSE integration; shared governance and metrics (7-day services)

Given it is one of the '3 shifts' set out in the 10 Year Health Plan for England, more detail on the 'Digital Technology' enabler is provided on the next page, with more detail on the other key enablers in Appendix 5

Digital technology

Digital technology is central to delivering the NHS’s analogue-to-digital shift—one of the three national system shifts—and enables the NHS to scale proactive, personalised, and data-driven care. Modernised access, shared records, remote monitoring and automated workflows create the digital foundations needed to deliver core population health priorities.

Digital Technology: Population Segment Priorities				
CYP Obesity (0-19)	CYP Mental Health (0-19)	Multimorbidity (40-64)	Frailty	End of Life
- Digital behaviour-change tools; NHS App signposting to local offers - Digital tacking and prompts; integrate service directory and self-referral - Targeted device / assisted-digital support for families who need it	- Digital self-referral where appropriate; online triage - Curated digital therapeutics and moderated tools 24/7 crisis information; secure messaging for follow-up & engagement	- Remote monitoring (BP, glucose where relevant) - Asynchronous support and digital coaching - Automation for recalls/reviews; dashboards for rising-risk cohorts	- Remote monitoring and alerting for deterioration; shared record across MDT - Scheduling tools; digital support for carers - Integrate care home information sharing where feasible	- Shared coordination record and visibility of ACP - Digital access to plans for patients/carers; rapid communication across providers - Anticipatory medication workflows and out-of-hours visibility

Digital Technology: Cross-Cutting Priorities		
Strong General Practice	Vaccinations & Screening	Outpatient & Follow-Up Redesign
- Cloud telephony, e-consult/online advice, workflow automation - Shared record ‘do once’ data; reduce admin burden; assisted-digital routes for access equity	- Digital booking, reminders and automated call/recall; targeted communications by cohort - Analytics to monitor uptake gaps and refine outreach	- A&G platforms, asynchronous messaging, remote review, PROMs; PIFU enablement; automated scheduling and discharge - Reduce duplicate testing and improve referral quality

Derby and Derbyshire

Lincolnshire

Nottingham and Nottinghamshire

Appendices

Five-Year Population Health Strategy 2026/27 – 2030/31

Version: ICB Boards and NHS England Technical Document

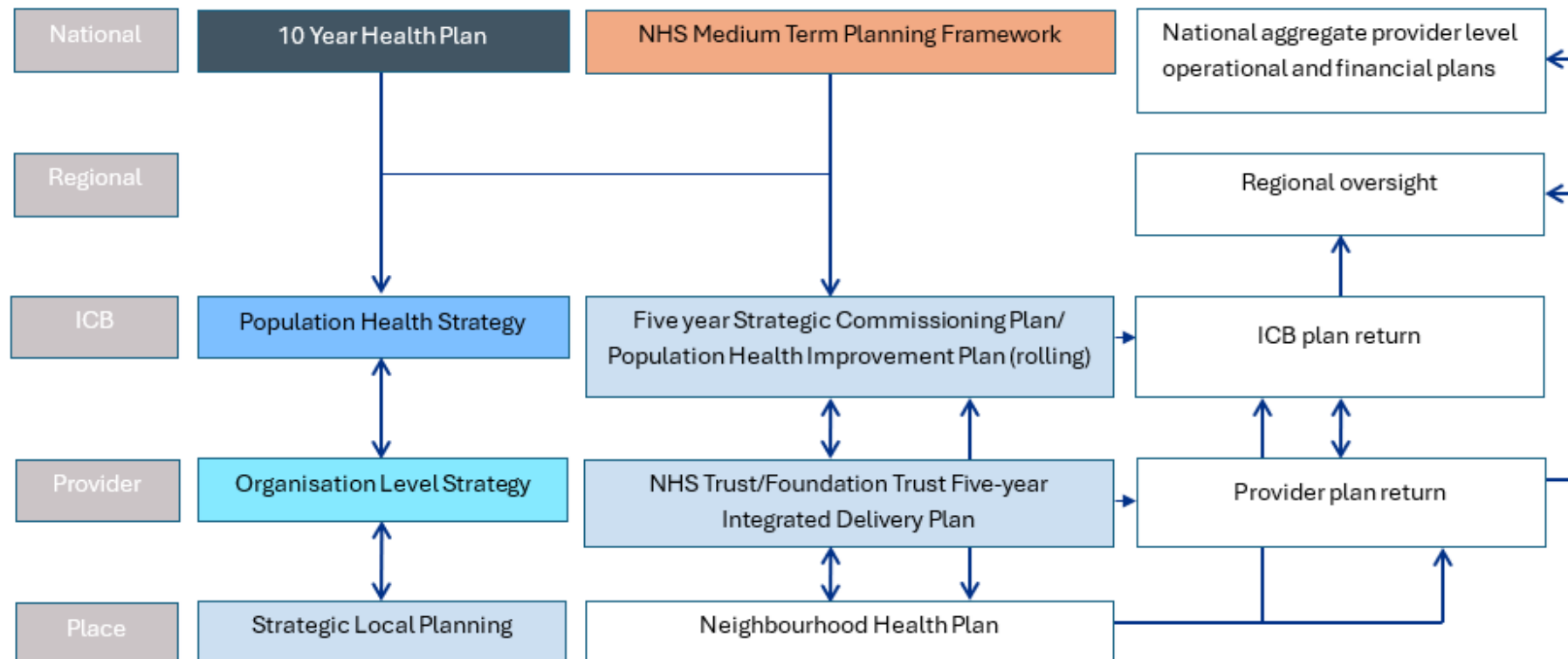
Contents

Section	Page Number
Appendix 1 – NHS England Planning Architecture	03
Appendix 2 - Case for Change	05
Appendix 3 - Population Health Strategy Priorities	17
Appendix 4 - Alignment of KPIs for Population Health Strategy Priorities to DLN ICB Cluster Outcomes Framework	33
Appendix 5 – Key Enablers of the Population Health Strategy	41

Appendix 1

NHS England Planning Architecture

NHS England Planning Architecture



Appendix 2

Case for Change

Voices of our communities

Engagement with our communities has told us people want more control over their care, timely access to local services and clear, joined-up communication. They value digital tools – but only if inclusive, simple and optional. Feedback highlights the need for equity, cultural sensitivity and continuity. These insights have shaped our priorities and ensure our strategy reflects what matters most to people.

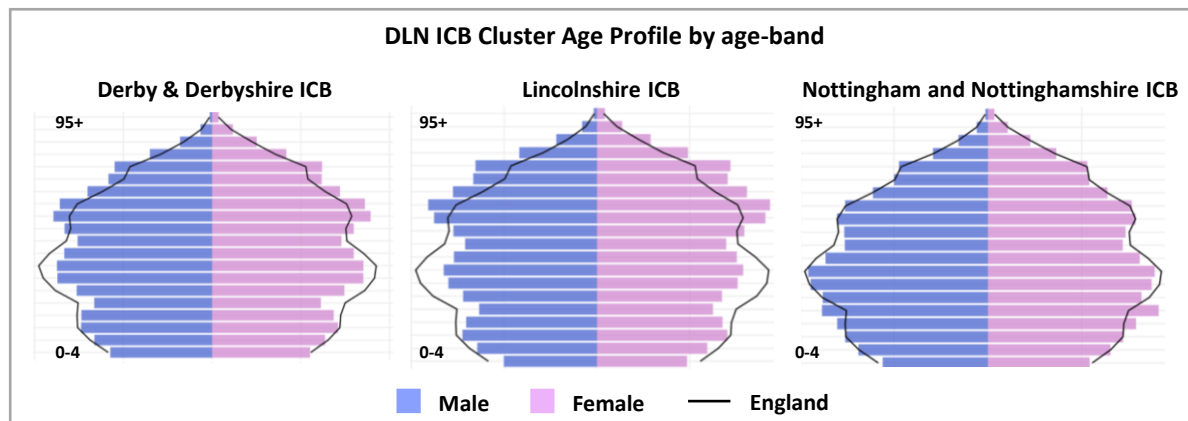
Patient Empowerment	Access To Services	Communication with Services
Shared Decision-Making & Personalised Care - Citizens want more control and decision-making in their care, including being fully informed about what to expect and the support available, and expect to see others taking responsibility for their own health - Carers should be actively involved in decision-making - People value community-based specialist clinics (e.g. diabetes, respiratory) to avoid unnecessary hospital visits	Timely & Flexible Access - Ongoing frustration with long waits for GP appointments, elective procedures, and diagnostics, often pushing patients to A&E - Citizens want same-day or next-day access for urgent needs, better triage systems, and extended hours - Calls for streamlined referral processes and co-located services to reduce delays and improve safety	Clear & Accessible Information - Citizens want timely and transparent communication that meets their need, waiting times, and discharge plans Information should be available in multiple formats (Easy Read, BSL, translated) and repeated as needed for accessibility - People continually stress the importance of plain language and culturally appropriate communication to build trust
Self-Management & Proactive Care - Citizens stressed the need for clear, jargon-free information about conditions, treatments, and self-care options - Strong support for prevention and proactive care, including health checks, lifestyle support, and early intervention for long-term condition - People want education and awareness campaigns to improve NHS literacy and reduce misinformation	Localised & Integrated Care - People want care closer to home, including community hubs offering multiple services under one roof, and more use of lower acuity appointments - Strong support for joined-up care pathways between hospitals, GPs, and social care to reduce duplication and improve continuity - Positive experiences with providers outside of the NHS are broad, with lots of citizens advocating better use of the VSFSE sector	Joined-Up Care & Interoperability - Citizens are frustrated as having to repeat ‘their story’ multiple times repeating medical history and poor information sharing between providers - Citizens want consistent digital systems across practices to avoid confusion and improve care coordination - Better integration between health and social care is seen as critical to reducing delays and improving patient experience
Digital Inclusion & Choice - Citizens support digital tools (NHS App, AskMyGP, virtual consultations) but want user-friendly systems and consistency Concerns about digital exclusion for older adults, rural communities, those with low digital literacy; and misdiagnosis - People want choice between digital and face-to-face appointments, ensuring inclusivity for all preferences	Equity & Transport Solutions Rural and coastal communities face transport barriers, requesting improved public transport links or mobile health units - Citizens call for interpreters and culturally sensitive care to overcome language and cultural barriers - Digital inclusion initiatives are needed to ensure online services do not widen inequalities, especially for older and disabled people	Continuous Engagement & Feedback Loops - Citizens want ongoing engagement opportunities, not one-off consultations, and visible action on feedback - Calls for simplified feedback routes (QR codes, SMS) and public reporting of changes made based on feedback - People value co-production of services with local communities and seldom-heard groups to ensure inclusivity

Source: NHS Derby and Derbyshire Commissioning Intentions Insight 2025; NHS Lincolnshire ICB Commissioning Intentions Insights September 2025; Nottingham and Nottinghamshire NHS wants and needs v2 December 2025

Our geography and population

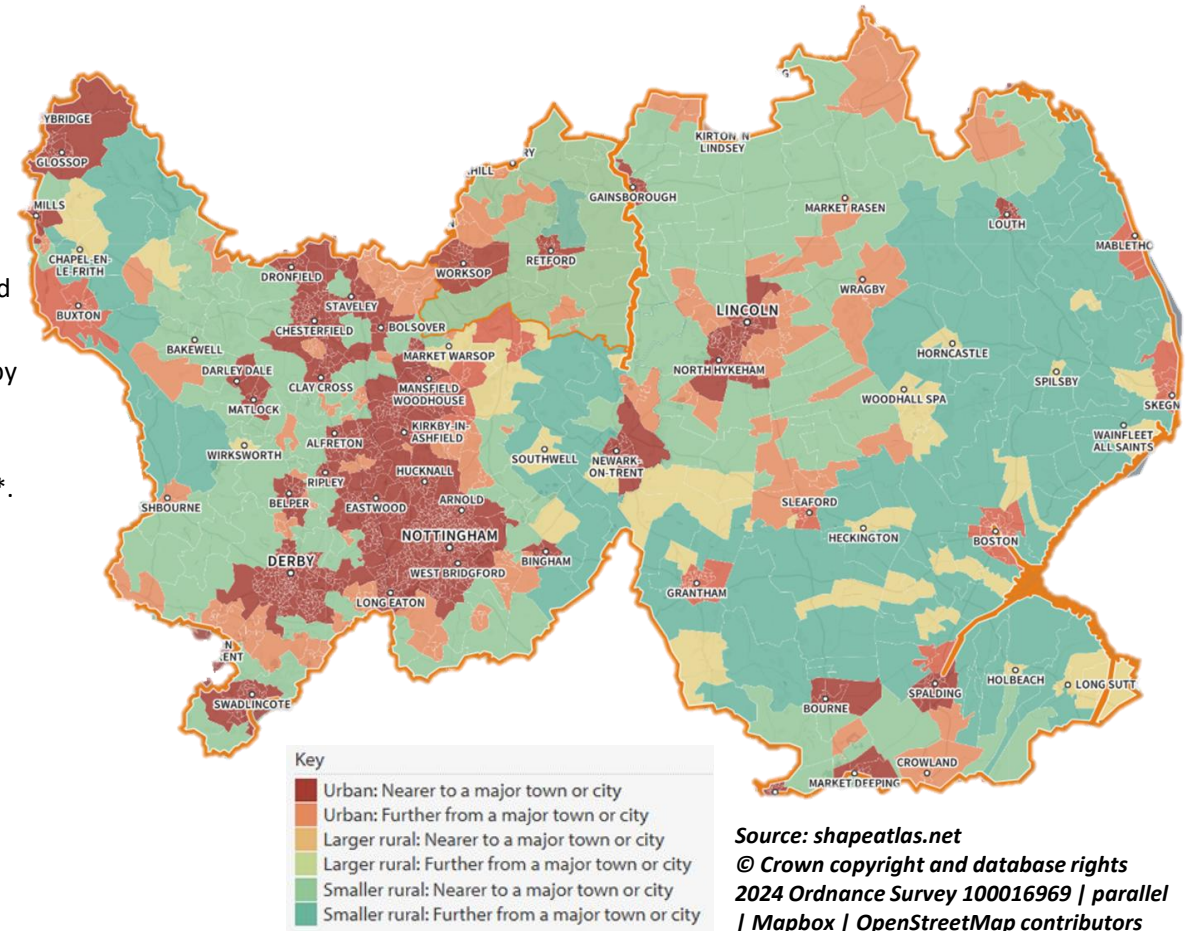
Our ICB Cluster's geography is highly varied, encompassing the cities of Nottingham, Derby and Lincoln, a network of former industrial and market towns, and extensive rural and coastal communities. It's home to 3.25m people.

- The geographical area covered by the DLN ICB Cluster is around **4,500 square miles**, which is approximately **75% of the whole East Midlands region**. There are **3,250,150 people** registered with general practitioners (GPs).
- The Cluster is split into **55 Primary Care Networks (PCNs)** that range in population size from **29,806 to 142,672**.
- Although a **large proportion of our population live in the urban corridor from Derby through Nottingham to Mansfield and Chesterfield**, most of the Cluster is **rural or coastal**. Lincolnshire is around 25% larger geographically than Derbyshire and Nottinghamshire combined.
- The ICB with the **highest percentage of patients aged 65+ is Lincolnshire with 24.1%**, compared to Derby & Derbyshire with 20.9% and Nottingham and Nottinghamshire with 18.2%.
- The ICB with the **largest proportion of non-white ethnic population groups is Nottinghamshire with 14.6%** of the total population, compared to Derby and Derbyshire with 9.3% and Lincolnshire with 4.0%*.



Source: NHSE Patients Registered at a GP Practice October 2025

* White ethnic group includes: English, Welsh, Scottish, Northern Irish, British, Irish, Gypsy or Irish Traveller, Roma and Other White



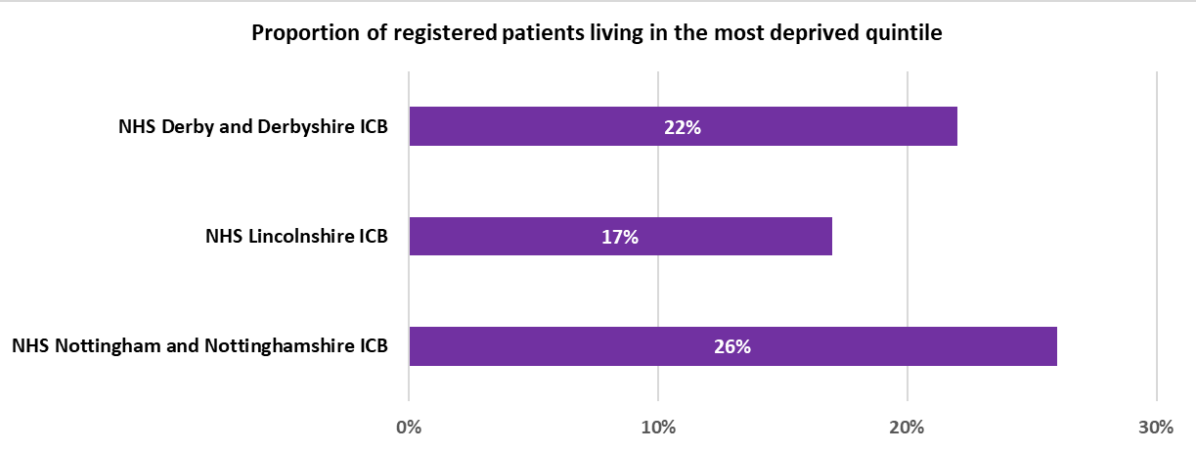
Source: shapeatlas.net

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2024 Ordnance Survey 100016969 | parallel
| Mapbox | OpenStreetMap contributors

Our patterns of deprivation

There are also wide differences in where deprivation is located across our ICB Cluster. The urban centres of Derby and Nottingham have large populations living in deprived areas, there are towns and villages across the whole Cluster area that are severely deprived, and parts of the Lincolnshire coast are among the most deprived areas of England.

- Across the DLN ICB Cluster around **720,000 people live in the 20% most deprived areas in England.** This is approximately 22% of residents.
- Many areas of **Derby** are highly deprived, there are also pockets of deprivation in the county's towns, including **Chesterfield, Bolsover, Alfreton** and **Eastwood**.
- Many areas of **Nottingham** are also highly deprived, with pockets of deprivation in the county's towns, including **Worksop, Mansfield, Ashfield** and **Newark-on-Trent**.
- **Lincoln, Boston** and **Grantham** have areas of high deprivation, as do parts of the east coast of Lincolnshire particularly **nearby the seaside towns of Skegness and Mablethorpe**.
- The ICB that has the **largest proportion of registered patients living in the most deprived areas is Nottingham and Nottinghamshire ICB with 26%.**



Source: MHCLG English Indices of Deprivation 2025, NHSE, Patients Registered at a GP Practice (October 2025)



Source: shapeatlas.net
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| Mapbox | OpenStreetMap contributors

Our different types of communities

The health and wellbeing challenges our population faces are rooted in the specific needs of the different types of communities across the DLN ICB Cluster, and therefore our health and care delivery models need to reflect and accommodate this.

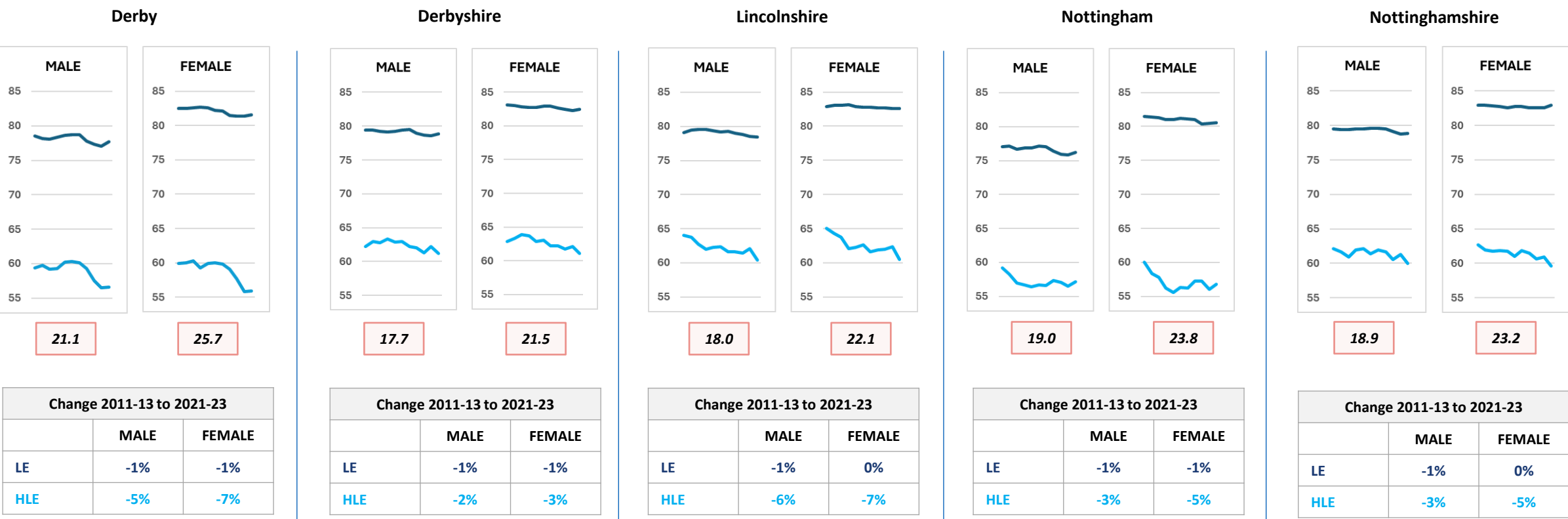
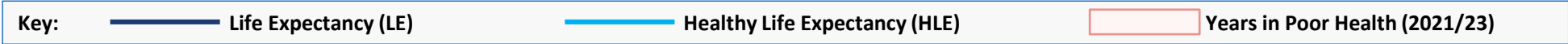
The table below describes the different types of communities across the DLN ICB Cluster together with examples of where they are and key population health considerations

	1. Urban core	2. Suburbs	3. Market Towns	4. Rural Communities	5. Coastal communities
Examples	- Central Nottingham, Derby and Lincoln - Inner areas of Chesterfield, Mansfield, Boston	- Fringes of Nottingham, Derby and Lincoln - Arnold, West Bridgeford, Long Eaton, North Hykeham	- Chesterfield, Alfreton, Ripley, Ilkeston, Buxton, Glossop - Boston, Grantham, Spalding, Sleaford, Gainsborough, Stamford - Mansfield, Worksop, Kirkby-in-Ashfield, Sutton-in-Ashfield, Newark	- Peak District (e.g. Bakewell area), Derbyshire Dales (e.g. Matlock) - South Kesteven villages, West Lindsey villages, parts of Wolds - Bassetlaw rural (villages around Retford), Newark & Sherwood rural (e.g. Southwell)	Skegness, Mablethorpe, Sutton-on-Sea/Long Sutton, Wainfleet All Saints, coastal villages in East Lindsey and along The Wash
Key population health considerations	➤ Higher deprivation and multi-morbidity – earlier onset of CVD, diabetes, respiratory disease, poor maternal and child health, higher smoking and obesity rates. ➤ Mental health and substance misuse – higher prevalence of severe mental illness, alcohol and drug harms, rough sleeping and homelessness. ➤ Significant child poverty – low vaccination uptake, low levels of school readiness, obesity, emotional disorders, poor dental health, high levels of ED attendance	➤ Mixed deprivation profiles – pockets of deprivation alongside more affluent areas; “left behind” estates can be hidden within average levels of deprivation ➤ Working-age LTCs – Musculoskeletal problems, depression/anxiety, CVD risk in commuting populations; preventative checks often under-used. ➤ Transport and air quality – congestion, car dependency, and air-quality issues affecting respiratory and cardiovascular health.	➤ “Hub” role for wider rural catchments – daytime population larger than resident population; primary, community, diagnostic and outpatient services serving surrounding villages. ➤ Ageing populations – rising frailty, falls, polypharmacy, dementia; pressure on social care, care homes and carers. ➤ Economic transition – legacy of industry decline, low-paid service employment, limiting long-term health and wellbeing.	➤ Older age structure and frailty – higher proportions of over-65s and over-80s, often with multiple conditions and carer dependency. ➤ Average outcomes can mask small pockets of significant poor health – health outcomes such as life expectancy, infant mortality and premature mortality tend to be better than average ➤ Hidden mental ill-health and isolation – loneliness, carer stress, suicide risk (particularly among farming communities), lower visibility of need.	➤ High deprivation and poor outcomes – “left behind” coastal profile: low wages, seasonal work, poor housing, high smoking and alcohol use, lower life expectancy. ➤ Older and transient populations – mix of retired residents, people with complex needs who have relocated to cheaper housing, and seasonal workers/tourists; challenges for continuity of care ➤ Access to specialist services – long travel times inland for acute, specialist MH and diagnostics, compounding late presentation / ED attendance

* Outer estates and villages linked to cities and large town

Life Expectancy and Healthy Life Expectancy

Across our ICB Cluster, over the last 10 years both Life Expectancy (LE) and Healthy Life Expectancy (HLE) have generally decreased. However, HLE has decreased at a larger rate meaning people are living longer in poor health – therefore the amount of time in people’s lives when they need health and care support is rising. On average women are living longer and spending more time in ill health than men.

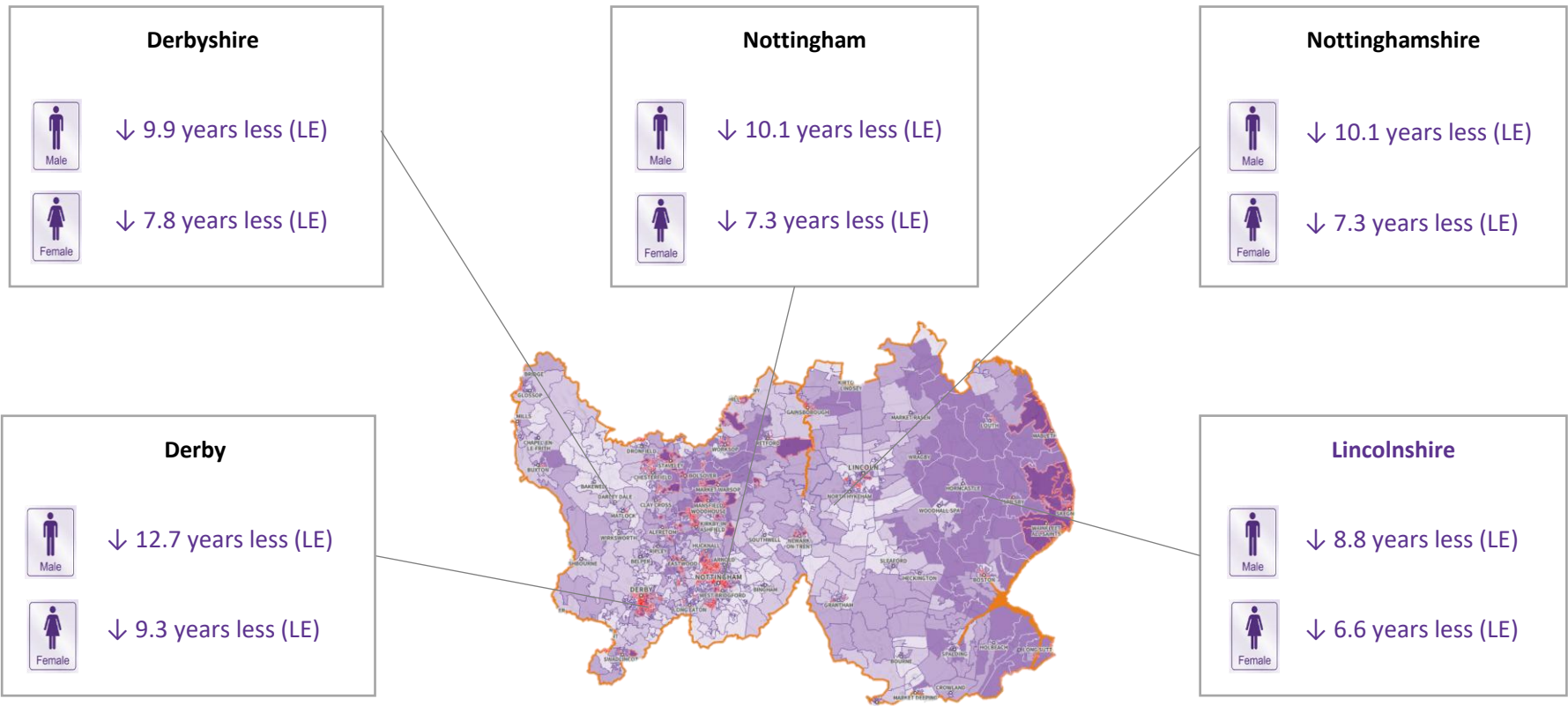


Source: OHID Fingertips: Data is for period 2011-13 to 2021-23

Inequalities in Life Expectancy and Healthy Life Expectancy

We know it is our more deprived communities across our ICB Cluster that have greatest exposure to a range of factors that impact adversely on Life Expectancy (LE) and Healthy Life Expectancy (HLE), leading to increased inequalities and shorter lifespans. Individuals in these areas therefore experience more years living with chronic conditions and disabilities, resulting in higher demand for healthcare services over an extended period.

The figures below show how many fewer years of life (Life Expectancy) people from the most deprived areas are expected to have on average compared with those from the least deprived. The England average figures for Males is 10.5 years less and Females 8.3 years less.



Source: OHID Fingertips: Data is for period 2021-23 (values are based on provisional population data)

Key drivers of inequalities across the cluster

Life expectancy (LE)

- 1 Cardiovascular disease
- 2 Respiratory disease
- 3 Cancer

Healthy Life Expectancy (HLE)

- 1 Cancer (lung, bowel, breast)
- 2 MSK / Chronic Pain
- 3 Cardiovascular disease
- 4 Respiratory disease
- 5 Anxiety / Depression

Multimorbidity has a significant and compounding negative impact on LE and HLE

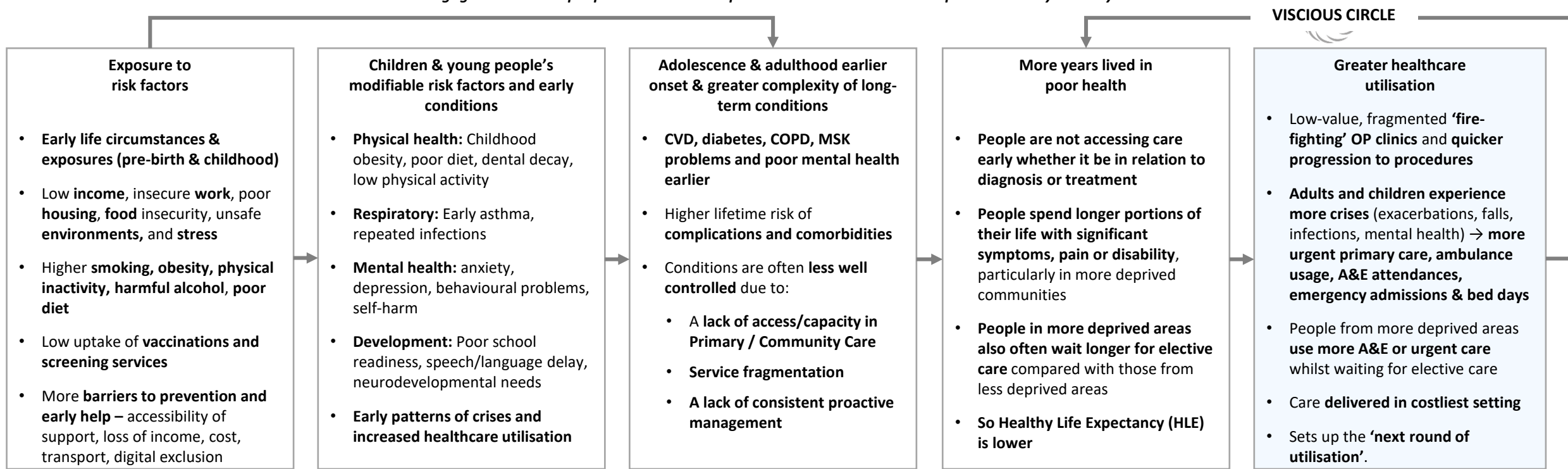
Early intervention and prevention in childhood can avoid expensive and longer-term interventions in adulthood

What this means for NHS services

An increasing gap between Life Expectancy (LE) and Healthy Life Expectancy (HLE) across our ICB Cluster, particularly in the most deprived areas, means i) earlier onset of long-term conditions and multimorbidity ii) more years with functional limitations such as mobility, pain, breathlessness and cognitive issues iii) higher rates of frailty and dependence on others for daily activities.

Improving Healthy Life Expectancy (HLE), especially in deprived communities, is a core demand management strategy for NHS services not just a population health outcome goal

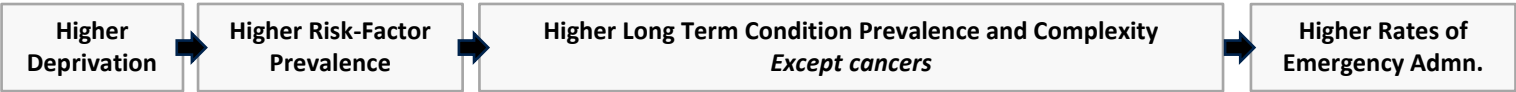
"Citizen engagement told us people want earlier help to avoid crises - and not to repeat their story at every contact"



This pathway is steeper and starts earlier in our most deprived communities

The causal story in practice

Analysis by the Nottingham and Nottinghamshire ICB clearly shows the link between higher deprivation, higher risk-factor prevalence, higher long term condition prevalence and higher rates of emergency admissions - a similar picture can be expected across the other ICBs in the cluster*.



Period: 202509

Direction arrows compare the latest value to the same period in the previous year.

PCN Neighbourhood	No of patients	The stark differences between our PCN / neighbourhoods															
		Deprivation	Risk Factors: age-adjusted prevalence per 1,000 people			Long Term Conditions: age-adjusted prevalence per 1,000 people								Age-adjusted rates per 100,000 people		Life expectancy in Years	
		IMD Quintile 1 Most Deprived 5 Least Deprived	Obesity	Current Smoker	Hyper-tension	Diabetes Type 2	COPD	Heart Failure	Stroke	CHD	Cancers	Serious Mental Illness	Severe Frailty	Emergency Admissions (1 + bed days length of stay)	Avoidable deaths	Life exp. at birth (M)	Life exp. at birth (F)
Raleigh	29,562	1	242.3 ↑	177.8 ↓	206.1 ↑	87.3 ↑	34.7 ↑	20.0 ↑	18.4 ↑	39.3 ↓	43.2 ↑	12.5 ↓	15.1 ↑	8,839 ↑	328.8 ↓	78.1 ↓	80.5 ↓
Radford & Mary Potter	37,214	1	204.6 ↑	180.4 ↓	199.3 ↑	114.0 ↑	27.3 ↑	13.4 ↓	16.6 ↓	44.6 ↓	34.3 ↓	15.1 ↓	25.6 ↑	8,418 ↑	381.8 ↑	76.3 ↓	82.9 ↑
Aspire	39,343	1	241.4 ↑	171.4 ↓	184.6 ↑	85.0 ↑	34.0 ↑	16.4 ↑	16.8 ↓	37.3 ↓	40.9 ↑	9.2 ↑	12.8 ↑	9,300 ↑	323.7 ↓	78.7 ↑	79.5 ↓
Bulwell & Top Valley	47,780	1	263.6 ↑	190.4 ↓	184.3 ↑	73.2 ↑	35.4 ↑	14.9 ↑	17.1 ↑	34.4 ↓	45.4 ↑	10.8 ↑	7.6 ↑	8,838 ↑	334.5 ↑	76.6 ↓	80.2 ↓
Nottingham City East	68,872	1	208.4 ↓	179.4 ↓	165.9 ↑	75.4 ↑	31.1 ↑	13.5 ↓	16.8 ↑	33.9 ↓	41.8 ↑	15.2 ↑	17.5 ↑	8,555 ↑	362.9 ↑	78.6 ↑	83.3 ↑
Newgate Medical Group	30,025	2	256.9 ↑	153.8 ↓	152.7 ↑	68.2 ↑	34.3 ↑	15.9 ↑	12.8 ↑	29.1 ↓	43.4 ↑	7.8 ↑	8.9 ↓	6,657 ↑	277.4 ↓	80.6 ↑	80.5 ↓
Clifton & Meadows	35,162	2	246.6 ↑	174.3 ↓	190.3 ↑	78.0 ↑	35.7 ↑	14.3 ↓	19.0 ↑	36.3 ↓	42.2 ↑	10.1 ↑	9.8 ↑	8,541 ↑	301.0 ↓	77.9 ↓	80.3 ↑
Ashfield North	52,135	2	285.2 ↑	152.5 ↓	176.1 ↑	70.6 ↑	28.0 ↑	18.5 ↑	15.2 ↑	36.1 ↓	50.2 ↑	7.5 ↑	8.2 ↓	8,185 ↑	292.3 ↓	76.9 ↓	83.1 ↑
Rosewood	52,223	2	240.6 ↑	168.4 ↓	159.6 ↑	66.1 ↑	29.9 ↑	13.4 ↑	14.2 ↑	35.3 ↓	44.8 ↑	8.4 ↑	8.1 ↓	8,120 ↑	297.2 ↑	77.9 ↓	82.1 ↓
Bestwood & Sherwood	55,776	2	213.6 ↑	147.7 ↓	160.5 ↑	66.1 ↑	24.0 ↑	12.8 ↑	16.1 ↓	32.2 ↓	43.9 ↑	10.7 ↑	10.2 ↑	7,735 ↑	271.9 ↓	79.5 ↓	83.2 ↑
Mansfield North	59,519	2	262.9 ↑	142.0 ↓	179.4 ↑	69.6 ↑	28.8 ↑	14.0 ↑	13.2 ↓	35.6 ↓	45.2 ↑	6.3 ↑	8.9 ↓	7,689 ↑	272.5 ↓	78.9 ↓	82.6 ↑
Larwood & Bawtry	38,568	3	253.1 ↑	124.5 ↓	185.5 ↑	69.4 ↑	32.4 ↑	20.6 ↑	15.2 ↑	32.8 ↓	47.7 ↑	7.6 ↑	10.1 ↓	6,533 ↑	241.8 ↓	79.8 ↑	83.8 ↑
City South	39,567	3	182.3 ↑	104.0 ↓	154.9 ↑	59.3 ↑	18.6 ↑	8.8 ↑	13.2 ↑	32.6 ↓	44.8 ↑	7.4 ↑	7.4 ↑	7,272 ↑	212.7 ↑	81.9 ↓	84.5 ↑
Byron	39,575	3	256.9 ↑	132.0 ↓	169.4 ↑	62.6 ↑	27.1 ↑	13.5 ↑	14.8 ↑	33.7 ↑	49.1 ↑	6.6 ↑	19.3 ↑	7,975 ↑	264.2 ↓	78.2 ↓	81.4 ↑
Ashfield South	41,181	3	282.5 ↑	146.2 ↓	159.3 ↑	70.2 ↑	29.2 ↑	12.4 ↑	14.5 ↓	34.2 ↑	48.0 ↑	7.0 ↑	5.8 ↓	7,888 ↑	306.1 ↓	77.6 ↑	81.4 ↑
Retford And Villages	60,171	3	261.5 ↑	122.1 ↓	160.1 ↑	59.9 ↑	25.2 ↑	11.9 ↑	12.3 ↑	27.6 ↓	47.0 ↑	6.0 ↑	9.5 ↑	5,871 ↑	238.3 ↓	79.7 ↓	83.4 ↓
Sherwood	64,593	3	256.9 ↑	127.6 ↓	177.5 ↑	65.5 ↑	26.9 ↑	14.2 ↑	14.0 ↑	35.4 ↓	48.7 ↑	6.0 ↑	9.6 ↓	7,224 ↑	226.0 ↓	80.8 ↑	84.4 ↑
Stapleford	22,256	4	247.0 ↑	126.9 ↓	169.3 ↑	61.1 ↑	23.6 ↑	10.2 ↑	13.1 ↑	27.9 ↓	44.4 ↓	6.4 ↑	6.1 ↑	6,966 ↑	203.1 ↓	81.9 ↑	86.8 ↑
Arnold & Calverton	34,604	4	229.8 ↑	117.2 ↓	149.5 ↑	50.0 ↑	21.0 ↑	9.6 ↑	15.8 ↑	28.3 ↓	49.0 ↑	6.8 ↑	7.9 ↓	6,940 ↑	195.1 ↓	80.9 ↑	84.2 ↑
Synergy Health	35,985	4	239.0 ↑	139.3 ↓	159.3 ↑	55.3 ↑	20.7 ↑	12.3 ↑	15.9 ↑	29.7 ↓	48.1 ↓	8.5 ↓	22.5 ↓	8,008 ↑	252.5 ↓	78.0 ↓	83.6 ↑
Eastwood/Kimberley	38,160	4	250.7 ↑	114.9 ↓	160.8 ↑	57.5 ↑	21.6 ↑	14.3 ↓	14.3 ↑	31.6 ↓	48.0 ↑	5.9 ↑	6.8 ↓	7,254 ↑	215.0 ↓	80.3 ↓	82.8 ↓
Newark	80,045	4	222.4 ↑	128.7 ↓	154.2 ↑	52.3 ↑	16.6 ↑	12.0 ↑	12.7 ↑	29.4 ↓	51.1 ↑	5.9 ↑	7.0 ↓	6,020 ↑	222.2 ↓	80.8 ↑	84.3 ↑
Arrow Health	40,744	5	204.6 ↑	111.3 ↓	151.4 ↑	47.0 ↑	17.3 ↑	10.1 ↑	13.2 ↑	27.6 ↓	47.8 ↑	6.8 ↑	4.9 ↓	6,606 ↑	221.4 ↓	79.8 ↓	83.7 ↓
Rushcliffe North	43,393	5	199.4 ↑	90.3 ↓	144.0 ↑	40.8 ↑	15.5 ↑	9.7 ↑	12.5 ↑	27.2 ↓	49.2 ↑	4.5 ↑	7.1 ↑	5,690 ↑	162.5 ↑	82.8 ↑	84.6 ↑
Rushcliffe South	44,995	5	195.3 ↑	82.6 ↓	143.1 ↑	41.3 ↑	12.2 ↑	9.7 ↑	12.6 ↑	25.2 ↓	47.4 ↑	4.5 ↑	5.9 ↑	5,671 ↑	166.3 ↓	81.5 ↓	85.5 ↑
Beeston	50,417	5	200.4 ↑	103.2 ↓	156.3 ↑	52.4 ↑	17.8 ↑	11.4 ↑	14.0 ↑	27.0 ↓	48.3 ↑	7.5 ↑	11.1 ↓	6,381 ↑	206.0 ↓	79.7 ↓	83.6 ↑
Rushcliffe Central	53,696	5	151.2 ↑	64.7 ↑	140.1 ↑	42.5 ↑	11.3 ↑	9.9 ↑	12.4 ↑	26.0 ↓	49.4 ↑	6.1 ↑	6.4 ↑	5,518 ↑	162.0 ↓	83.7 ↑	85.4 ↓
Unity (Nottm)	45,870	4	127.0 ↑	63.3 ↓	152.8 ↑	37.1 ↓	10.0 ↓	9.8 ↑	8.0 ↓	23.4 ↑	48.6 ↑	3.5 ↓		4,205 ↑	75.3 ↑		

Bassetlaw Place
Nottingham City Place
South Nottinghamshire Place
Mid Nottinghamshire Place

IMD value is the index of multiple deprivation (calculated based on weighted average of registered patients' Lower Super Output Areas declines as per GP Repository for Clinical Care).

Higher Prevalence

Lower Prevalence

Unity's population is almost entirely university students and is presented separately due to its atypical population demographics.

Higher rates / Lower Life Expectancy

Lower rates / Higher Life Expectancy

COPD = Chronic obstructive pulmonary disease
CHD = Congestive heart disease

Source: Nottingham and Nottinghamshire ICB System Analytics Intelligence Unit

*This working hypothesis is under ongoing review

How this translates into healthcare utilisation

Continuing with the Nottingham and Nottinghamshire ICB example, three population segments in the local segmentation model that equate to c.7% of the total population account for around 35% of healthcare costs, 30% of elective activity and over half of all ambulance calls, emergency admissions and emergency bed days – once again a similar picture can be expected across the other ICB's in the cluster.*

Population Segment	% Patients	Total Cost	% Total Cost	% Outpatient Att.	% Day Cases	% Elective Adm.	% Ambulance Calls	% Emerg. Adm.	% Emerg Bed Days
Segment 1 - End of Life	2%	£302,766,148	16%	9%	11%	9%	25%	25%	34%
Segment 2 - Frailty or Dementia	1%	£131,196,439	7%	3%	3%	4%	13%	11%	17%
Segment 3 - LTC 3 or more	4%	£261,687,333	14%	16%	18%	18%	15%	15%	16%
Segment 4 - LTC 2	6%	£223,182,866	12%	14%	16%	15%	10%	10%	9%
Segment 5 - LTC 1	15%	£332,433,700	18%	21%	24%	25%	13%	13%	9%
Segment 6 - Common MH	9%	£140,185,381	7%	7%	5%	6%	7%	5%	2%
Segment 7 - Risk Factors	16%	£124,803,822	7%	9%	7%	6%	5%	5%	3%
Segment 8 - Healthy	35%	£191,836,384	10%	13%	7%	8%	4%	9%	3%
Unknown Segment	12%	£189,238,109	10%	10%	10%	9%	8%	8%	8%
ALL SEGMENTS	100%	£1,897,330,182	100%	100%	100%	100%	100%	100%	100%

3 Segments account for c.7% of the total population, but around:

- 35% of healthcare costs
- 30% of elective activity
- 50% of ambulance calls
- 50% emergency admissions
- 65% emergency bed days

Segment 1 End of Life	Segment 2 Frailty or Dementia	Segment 3 LTC 3 or more	Segment 4 LTC 2	Segment 5 LTC 1	Segment 6 Common MH	Segment 7 Risk Factors	Segment 8 Healthy
• End of life register • GSF stage • Organ failure • Palliative care	• CFS 6-8 (patients aged 65+) • Dementia	• 3 or more LTC from: • Cancers (diagnosed in last 10 years) • Long-term physical conditions • Learning disabilities • Serious mental illness	• 2 LTC from: • Cancers (diagnosed in last 10 years) • Long-term physical conditions • Learning disabilities • Serious mental illness	• 1 LTC from: • Cancers (diagnosed in last 10 years) • Long-term physical conditions • Learning disabilities • Serious mental illness	• Depression or Anxiety (with medication in last 5 years) • Eating disorders • Neurodivergence • Stress reactions	• Alcohol or substance misuse • Cancers (diagnosed over 10 years ago) • Depression or Anxiety (without medication in last 5 years) • Hypercholesterol • Hypertension • Obesity • Pre-diabetes • Smoking	• Patients not appearing in any of the above segments

Children and young people

Within population health management segmentation models children and young people are usually ‘embedded’ within one of the segments. Their overall healthcare utilisation is comparably low compared to adults and older people, however analysis by the Lincolnshire ICB suggests a higher usage of urgent and emergency care services by children and young people from more deprived areas – a pattern that is expected across the other ICBs in the cluster.*

0-9 Year Olds	Deprivation Decile	1	2	3	4	5	6	7	8	9	10
Physical Health											
Asthma		3.5%	3.7%	3.5%	4.3%	3.3%	3.1%	3.6%	2.9%	3.0%	3.2%
Diabetes		0.2%	0.1%	0.2%	0.2%	0.2%	0.1%	0.1%	0.1%	0.2%	0.3%
Hypertension		0.1%	0.2%	0.2%	0.1%	0.1%	0.2%	0.2%	0.1%	0.1%	0.1%
Obesity**		0.8%	0.7%	0.7%	0.7%	0.8%	0.7%	0.6%	0.9%	0.5%	0.8%
Mental Health & Learning Disability											
Anxiety		0.2%	0.2%	0.2%	0.2%	0.3%	0.2%	0.2%	0.2%	0.3%	0.2%
Depression		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Learning Disability		0.6%	0.5%	0.3%	0.5%	0.4%	0.3%	0.4%	0.3%	0.4%	0.3%
Cost Per Person Per Year											
Urgent & Emergency		£444	£439	£426	£381	£403	£398	£395	£340	£350	£303
Acute Planned		£198	£192	£179	£212	£197	£187	£182	£180	£186	£152
Primary Care		£151	£157	£152	£184	£159	£170	£162	£143	£148	£137
Community Health		£275	£259	£247	£235	£221	£213	£217	£197	£196	£187
Mental Health & Learning Disability		£36	£29	£41	£32	£38	£36	£37	£36	£42	£46

Urgent and Emergency Care:

- More deprived communities have a higher average cost per child per year
- Suggesting children are more likely to ‘tip’ into emergency care – most likely for ambulatory care sensitive conditions such as asthma and infections

Community Health Care:

- More deprived communities have a higher average cost per child per year
- However, this usage may not always be proportionate to need which could potentially cause late presentation / more severe episodes

10-19 Year Olds	Deprivation Decile	1	2	3	4	5	6	7	8	9	10
Physical Health											
Asthma		8.7%	8.5%	8.2%	9.2%	8.4%	8.7%	8.9%	8.4%	9.3%	9.1%
Diabetes		0.5%	0.4%	0.5%	0.5%	0.6%	0.6%	0.5%	0.4%	0.4%	0.5%
Hypertension		0.2%	0.3%	0.3%	0.2%	0.3%	0.2%	0.2%	0.2%	0.1%	0.1%
Obesity**		3.8%	3.3%	3.4%	3.2%	3.6%	2.7%	2.5%	2.3%	2.1%	1.9%
Mental Health & Learning Disability											
Anxiety		5.7%	5.4%	5.0%	5.7%	6.4%	5.7%	5.1%	4.9%	5.4%	5.4%
Depression		1.6%	1.6%	1.6%	1.4%	1.5%	1.4%	1.3%	1.3%	1.2%	1.2%
Learning Disability		1.1%	1.3%	0.8%	1.3%	1.0%	1.1%	1.3%	0.7%	0.7%	0.6%
Cost Per Person Per Year											
Urgent & Emergency		£246	£251	£216	£220	£170	£181	£194	£177	£155	£185
Acute Planned		£175	£148	£166	£188	£174	£164	£177	£187	£222	£196
Primary Care		£128	£126	£127	£152	£129	£145	£140	£125	£141	£120
Community Health		£59	£55	£50	£51	£48	£48	£46	£40	£40	£35
Mental Health & Learning Disability		£491	£476	£382	£375	£428	£436	£492	£304	£403	£231

Urgent and Emergency Care:

- More deprived communities generally have a higher average cost per 10-19 year old per year
- Suggesting adolescents and older children are more likely to ‘tip’ into emergency care – most likely for long term conditions and mental health

Community Health Care and Mental Health & Learning Disability:

- More deprived communities have a higher average cost per 10-19 year old per year
- However, this usage may not always be proportionate to need which could potentially cause late presentation, more severe episodes and more crisis

Where and how the NHS can influence

There are a range of 'levers' that can have a positive impact on Healthy Life Expectancy and can therefore also act as demand management interventions for healthcare. These can be grouped into i) those the NHS can largely control through how it organises and delivers care ii) those the NHS can influence together with partners and iii) those where the NHS has more limited influence.

Where the NHS can directly influence	Where the NHS can influence together with partners	Where the NHS has more limited influence
A. Identification, clinical risk management & LTC optimisation incl. MH ➤ Early detection • NHS Health Checks, all screening programmes, BP and AF case-finding, diabetes/CKD case-finding, COPD/asthma diagnosis ➤ Risk factor treatment • Hypertension, lipids, renal (CKD) anticoagulation, glucose control, vaccinations, smoking/weight/alcohol support ➤ Optimising long-term condition • Evidence-based pathways for CVD, heart failure, cardiac rehabilitation, pulmonary rehabilitation, diabetes, respiratory disease, MSK, frailty, and anxiety/depression • Structured education, rehabilitation, medication optimisation/deprescribing B. Care model & utilisation pattern ➤ Access, continuity and quality of primary care • Appointment models, workforce mix, continuity of GP ➤ Proactive and planned care • PHM case-finding, recalls, LTC reviews, virtual wards, anticipatory care plans • Multidisciplinary outpatient pathways ➤ Reactive community-based care • Reactive integrated multifunctional urgent care support • Consistent access & assessment to urgent / on the day care ➤ Hospital care and transitions / step-down care • Same day emergency care, discharge to assess, in-reach teams	A. Behaviour change at scale ➤ Smoking, diet, physical activity, alcohol, weight management • NHS: Behavioural support, pharmacotherapies, medication • Partners: Commission lifestyle services, provide places to be active, regulate licensing, shape food environment B. Social & environmental determinants ➤ Housing, fuel poverty, homelessness, home safety • NHS: Identify risk, share data, make housing part of discharge and frailty plans e.g. refer to fuel poverty support services • Partners: Fix housing stock, improve standards ➤ Work, income welfare & debt • NHS: Social prescribing, anchor employment practices • Partners: Drive the underlying conditions C. Community, social connection & resilience ➤ Loneliness, carer support, community participation • NHS: Social prescribers, VCFSE grants, carer identification • Partners: VCFSE and councils provide networks/activities D. Child development & early years including 'First 1000 days' ➤ Perinatal mental health, health visiting, school nursing • NHS: Plays core role ➤ School readiness, family support, early years provision • Partners: Rely heavily on LA children's services & education	A. Upstream structural drivers ➤ Macro-economy and labour market • Recessions, wage levels, regional industrial decline/growth ➤ National tax, welfare and benefit policy • Levels of Universal Credit, disability benefits, conditionality rules ➤ Regional and national housing and planning policy • Scale of social housing, national planning rules B. However, the NHS can: ➤ Provide data and narratives on local health impact ➤ Act as an anchor institution (it is a significant employer) ➤ Advocate through local Integrated Care Systems (ICSs) <i>Prevention, proactive care, reliable same-day assessment and joined-up communication - so people don't repeat their history - reflects direct citizen and community feedback</i>
Vast majority of NHS activity should be delivered through Neighbourhood Health Services, that are reflective of the communities they serve		

Appendix 3

Population Health Strategy Priorities

Our population health strategy priorities for years 1 and 2

Building on the analysis of our population's health need and in line with our strategy, five Population Segment Priorities and three 'Cross-Cutting' Priorities have been identified for the next 2 years.

These priorities seek to provide a balance of addressing 'upstream' health needs whilst also addressing the need to provide better quality, accessible, integrated care that tackles the significant financial pressures the NHS faces 'here and now'.

	Start Well	Live Well	Age Well	Die Well
Segment 1 – End of Life				PS 5. End of Life
Segment 2 – Frailty or Dementia			PS 4. Frailty	
Segment 3 – LTC 3 or more**		PS 3. Early Multimorbidity (40-64)		
Segment 4 – LTC 2**				
Segment 5 – LTC 1**				
Segment 6 – Common MH	PS 2. Children & Young People Mental Health (0-19)			
Segment 7 – Risk Factors	PS 1. Children & Young People Obesity (0-19)			
Segment 8 - Healthy				
All segments – 'cross-cutting'	CC 1. Vaccinations and Screening CC 2. Strong General Practice CC 3. Outpatient and Follow Up Appointments Redesign			

Rationale for prioritisation

Seeking a balance of:

- Early support to help reduce future health and care utilisation
- Addressing current health and care utilisation that is providing poor care and poor experience often in the costliest setting



**See Appendix 4 for more detail on why these priorities matter*

*** Includes learning disabilities and serious mental illness*

Segment Priority 1: Children and Young People's Obesity (0-19)

Why this matters and 'higher-need' primary care networks/neighbourhoods

Why Children and Young People's Obesity Matters*

- i. **Scale and trajectory of need – obesity rates are high and rising**
 - Derby City: 38% Yr 6 excess weight, 24% obesity; Derbyshire County: 36% and 22%
 - Lincolnshire: 33% Yr 6 excess weight, 23% obesity
 - Nottingham City: 44% Yr 6 excess weight; 29% obesity; Nottinghamshire County: 36% and 22%
- ii. **Major inequalities issue – a strong deprivation gradient is evident in every system**
 - Obesity is far higher in most deprived quintile = plus groups have higher obesity risk and lower access to lifestyle support
 - Derby City: 31% Yr 6 obesity in most deprived vs 14% in least deprived areas; Derbyshire County: 25% vs 14%
 - Lincolnshire highest Yr 6 obesity in more deprived districts – Boston (26%) and East Lindsey (26%)
 - Nottinghamshire County has significant variation Mansfield (40% excess weight) versus Rushcliffe (28%)
 - First 1000 days: Inequalities begin before birth. Maternal health, access to healthy food, breastfeeding and early-life environments strongly influence lifelong obesity risk, amplifying disparities seen by school age.
- iii. **Tracks into adulthood and drives wider health burdens**
 - Childhood obesity dramatically increases risk of asthma, Type 2 diabetes, poor oral health and MH problems
 - Children with obesity face 2-3x higher risk of adult obesity and early-onset LTCs (e.g. type 2 diabetes, CVD, liver disease, poorer mental health)
- iv. **Early intervention is high impact**
 - Evidence shows early community-based family interventions provide strong return on investment and reduces the need for specialist services
- v. **System pressures & safeguarding interface**
 - Paediatric and community teams describe obesity as a growing complexity factor, requiring stronger pathways between school nursing, weight management and primary care
 - Current inequity of services available across the cluster

'Higher-need' Primary Care Networks / Neighbourhoods – 'Top 15'**

ICB	Primary Care Network	Deprivation Q.	Community Type
Derby & Derbyshire	Derby City North	1	Urban Core
	Erewash	2	Suburb
	High Peak	2	Market Town/Rural
	North Hardwick/Bolsover	2	Market Town/Rural
Lincolnshire	Boston	2	Market Town/Rural
	Trent	2	Market Town/Rural
	Lincoln Health P'ship	2	Urban Core
	Meridian	2	Market Town/Rural
Nottingham & Nottinghamshire	Aspire	1	Urban Core
	Bulwell & Top Valley	1	Urban Core
	Nottingham City East	1	Urban Core
	Radford & Mary Potter	1	Urban Core
	Ashfield North	2	Market Town
	Mansfield North	2	Market Town
	Rosewood (Mansfield)	2	Market Town

* Based on 25% of PCNs in each ICB with greatest need

*Obesity is directly linked to the Core20PLUS groups for all 5 clinical conditions for CYP (Asthma, Diabetes, Epilepsy, Oral Health, Mental Health)

Segment Priority 1: Children and Young People's Obesity (0-19)

Evidence based interventions and impact

Evidence-based Interventions*

Approach	Intervention	3 Shifts**
NHS Led	1. Pregnancy and early years prevention: Consistent healthy eating (maternal nutrition)/physical activity advice in pregnancy, high-BMI booking pathway and targeted support. Breastfeeding support to improve breastfeeding rates.	1
	2. Tier 2 child & family weight management as scalable 'volume engine': Family-based, multi-component programmes (diet, activity, behaviour change) with active engagement to drive starts and completions; delivered flexibly (community venues, evenings/weekends, culturally competent formats) and support by PCN link workers / health & wellbeing coaches.	1
	3. Specialist pathway for severe/complex obesity (Tier 3 and wider specialist support: Clear criteria + triage + escalation routes for severe obesity, complications and complex psychosocial needs; Integrate paediatrics, dietetics, psychology/CAMHS where indicated, and safeguarding/children's services interfaces.	1
NHS in Partnership	4. Targeted NCMP-triggered outreach into support (Reception + Year 6): A defined 'NCMP follow-up workflow' for overweight/obese/severe obesity results, prioritising the highest-need neighbourhoods/schools clusters; warm handoffs into Tier 2 (and wrap-around support) to raise uptake in deprived groups	1,3
Multi-Agency Led	5. Whole-school and whole-neighbourhood package in priority school clusters: A coherent 'school cluster offer' (daily activity culture, family engagement, consistency healthy food norms, strong referral links to Tier 2); Parallel neighbourhood actions on the food environment (planning/licensing levers) and access to physical activity opportunities	1
Priority focus on Primary Care Networks / Neighbourhoods with: - Highest obesity rates (and absolute numbers) in Reception and Year 6, especially where coincides with high deprivation, high free-school-meal eligibility and higher UEC activity - Particular consideration / focus: 'first 1000 days', children in care, children with additional needs and families living in most disadvantaged areas		

System Outcomes Framework Impact

'Top 5' KPIs to inform ICB Board Reporting ^{1 2 3}
1. % of pregnant women with a BMI>30 weight management service start and completion rate & % pregnant women recorded as smoking at booking/delivery
2. Breast feeding initiation and continue to exclusively breastfeed
3. Tier 2 / Tier 2+ / Tier 3 weight management service start and completion rates
4. NCMP Year 6 excess weight prevalence & proportion of children with Asthma who are overweight/obese and have greater than one exacerbation in the past 12 months
5. Prevalence of Type 2 diabetes and proportion receiving recommended NICE care processes ⁴



Start Well		
Children enjoy good health so they can grow, learn and develop to their full potential		
Babies and children have a good start to life	Children develop well that sets up future good-health and well-being	Children & young people are supported to be as well as they can be

¹ PCN level, 'Top-15' PCNs aggregate vs all other PCNs. DLN total

² Report by IMD Quintile + ethnicity + SMI/LD + SEND where appropriate and feasible to evidence equity of reach and impact

³ Additional KPIs may be included in individual PCN 'dashboards'

⁴ Aligned to CORE20PLUS5 indicators

* These do not constitute investment guarantees to providers – they need to be delivered within available financial resource and provide value for money

** 1. Sickness to Prevention; 2. Hospital to Community; 3. Analogue to Digital

Segment Priority 2: Children and Young People Mental Health (0-19)

Why this matters and ‘higher-need’ primary care networks/neighbourhoods

Why Children and Young People’s Mental Health Matters*

i. Scale and trajectory of need – prevalence is high and rising

- Derby City and Derbyshire County experience high and rising levels of CYP MH demand and complexity, and report significant gaps in provision
- Across Lincolnshire around 21,000 CYP estimated to have diagnosable MH condition, less than half are thought to be in contacts with services
- Nottingham City & Nottinghamshire JSNAs show steep increases in emotional disorders, anxiety and low wellbeing across 0-25 population, with CYP MH one of the fastest-deteriorating domains

ii. Life-course impact and prevention return on investment (ROI)

- Local systems report earlier and more complex presentations,
- Rising MH disorders increases pressures on education, safeguarding and young adult services.

iii. Inequalities are material and place-patterned

- Derby & Derbyshire: CYP mental health strongly linked with deprivation and rural isolation
- Lincolnshire: Lower service utilisation in higher deprived areas suggesting possible structural barriers and unmet need
- Nottingham & Nottinghamshire: Strong links between poverty, SEND and mental health
- First 1000 days: Inequalities begin before birth; deprivation-linked stressors in pregnancy and infancy increase the likelihood of later poor mental health

iv. Harm prevention and crisis demand

- Long and variable waits drive escalation
- Rising self-harm related attendances and crisis episodes

v. Alignment to NHS expectation

- NHS has identified children and young person’s mental health as a long-term priority, including expanding access closer to home and reducing delays.

*Strong evidence links obesity with low self-esteem, depression, anxiety and body image concerns in CYP

‘Higher-need’ Primary Care Networks / Neighbourhoods – ‘Top 15’**

ICB	Primary Care Network	Deprivation Q.	Community Type
Derby & Derbyshire			
Lincolnshire			
Nottingham & Nottinghamshire			

** Based on 25% of PCNs in each ICB with greatest need

Segment Priority 2: Children and Young People MH (0-19)

Evidence based interventions and impact

Evidence-based Interventions*

Approach	Intervention	3 Shifts**
NHS Led	1. Single CYP MH access and navigation ('front door') using a needs-based model: Clear routes in, rapid triage, brief intervention where appropriate, active navigation to the right help; consistent thresholds and escalation.	1,2,3
	2. Harm prevention + crisis response: Self-harm psychosocial assessment by appropriately skilled CYP MH clinicians, safety planning and reliable crisis response with step-down/back-to-front-door.	1,2,3
	3. Evidence-based talking therapies at scale for common presentations: Standardised stepped-care for anxiety/depression with routine outcomes measurement and escalation criteria.	1,2,3
NHS in Partnership	4. Schools/colleges early intervention partnership: Whole-setting approach, MH Support Team interface, consultation/advice and clear escalation routes into NHS services.	1,2,3
	5. Priority specialist pathways with interim support while waiting: Neurodevelopmental assessment pathways with appropriate interim support/parent programmes, eating disorder pathways, consistent referral criteria and pathway discipline.	1,2,3
Priority focus on Primary Care Networks / Neighbourhoods with: - Highest deprivation, crisis presentation (self-harm, ED attend), poor school outcomes and weak access to CYP MH services - Particular consideration / focus: 'first 1000 days', children in care, neurodivergent children and other high-risk groups		

System Outcomes Framework Impact

'Top 5' KPIs to inform ICB Board Reporting ^{1 2 3}
1. Access rates to CYP MH services ⁴
2. CYP Eating Disorder access standard ⁴
3. CYP Autism & ADHD diagnostic pathway waiting time ⁴
4. Proportion of CYP with obesity experiencing MH difficulties e.g. anxiety/self-esteem
5. CYP A&E attendance for MH-related presentation & hospital admissions as a result of self-harm



Start Well		
Children enjoy good health so they can grow, learn and develop to their full potential		
Babies and children have a good start to life	Children develop well that sets up future good-health and well-being	Children & young people are supported to be as well as they can be

¹ PCN level, 'Top-15' PCNs aggregate vs all other PCNs. DLN total

² Report by IMD Quintile + ethnicity + SMI/LD + SEND where appropriate and feasible to evidence equity of reach and impact

³ Additional KPIs may be included in individual PCN 'dashboards'

⁴ Aligned to CORE20PLUS5 indicators

* These do not constitute investment guarantees to providers – they need to be delivered within available financial resource and provide value for money

** 1. Sickness to Prevention; 2. Hospital to Community; 3. Analogue to Digital

Segment Priority 3: Early Multimorbidity: 2+ LTCs (40-64)

Why this matters and ‘higher-need’ primary care networks/neighbourhoods

Why Early Multimorbidity Matters

i. It is a major inequalities mechanism (earlier onset in deprivation)

- Strong deprivation gradient (Core20) the most deprived adults experience multimorbidity 10-15 years earlier than the least deprived. People with long term conditions are ‘plus’ groups and therefore priority focus aligned to CORE20PLUS5. This is directly relevant to parts of the DLN ICB Cluster with entrenched deprivation.
- Multimorbidity and SMI are tightly linked with depression and anxiety among the earliest second LTC acquired. Adults with 2 or more LTC have much higher rates of undiagnosed or untreated SMI.

ii. It is a high-leverage ‘window’ before frailty accelerates

- For many people, ages 40-64 is when risk factors (smoking, obesity, inactivity, hypertension), mental ill health and MSK conditions interact and begin to drive repeated contacts, polypharmacy and deconditioning. Intervening here is materially more effective than waiting until 65+ when complexity and frailty increase.

iii. Strong alignment with national direction: Prevention and shifting care out of hospital

- The 10-Year Health Plan (‘Fit for the Future’) explicitly prioritises the shift from *sickness to prevention* and *hospital to community*. Early multimorbidity provides a practical ‘through-line’ priority that operationalises those shifts through neighbourhood and primary care.
- Obesity is a major driver of multimorbidity (diabetes, CVD, MSK, liver disease) and a key prevention lever for reducing hospital activity

iv. It matches the NHS inequalities delivery architecture

- The national CORE20PLUS5 provides a ready-made population targeting frame (most deprived 20% + inclusion groups + five clinical areas) that maps well to working –age multimorbidity patterns and supports consistent governance assurance across the three ICBs.

v. It is economically material (working-age participation)

- Working-age people with multimorbidity area t increased risk of exiting paid employment (or reducing hours), which compounds deprivation and healthcare demand. This is relevant to wider system objectives on economic participation and the sustainability of public services.

‘Higher-need’ Primary Care Networks / Neighbourhoods – ‘Top 15’*

ICB	Primary Care Network	Deprivation Q.	Community Type
Derby & Derbyshire	Derby City North	1	Urban Core
	Erewash	2	Suburb
	North Derbyshire	2	Urban Core/Suburb
	Chesterfield & Dronfield	3	Urban Core/Market Town
Lincolnshire	First Coastal	1	Coastal/Rural
	Boston	2	Market Town/Rural
	Trent	2	Market Town/Rural
	Lincoln Health P’ship	2	Urban Core
Nottingham & Nottinghamshire	Aspire	1	Urban Core
	Bulwell & Top Valley	1	Urban Core
	Radford & Mary Potter	1	Urban Core
	Raleigh	1	Urban Core
	Ashfield North	2	Market Town
	Clifton & Meadows	2	Suburb/Urban Core
	Ashfield South	3	Market Town

* Based on 25% of PCNs in each ICB with greatest need

Segment Priority 3: Early Multimorbidity: 2+ LTCs (40-64)

Evidence based interventions and impact

Evidence-based Interventions*

Approach	Intervention	3 Shifts**
NHS Led	1. Proactive cohort management and integrated care planning: Identify/segment the 40-64 2+ LTC cohort; proactive recall; structured multimorbidity reviews; single personalised care plan; integrated MDT, coordinated follow-up; structured medication reviews and polypharmacy optimisation, cardiac and pulmonary rehabilitation (integration), immunisation & vaccination, digital and telehealth-based care, carer identification and support for carers	1,2,3
	2. Community alternatives to admission for crisis deterioration: Urgent community response; community-based ambulatory urgent care capability; virtual ward / hospital-at-home for selected crises; High Intensity User and complex case management to reduce crisis-driven ED use.	2,3
NHS in Partnership	3. Cardiometabolic prevention and optimisation at scale: Systematic CVD risk assessment; hypertension case-finding and rapid treatment optimisation; lipid optimisation (statins where indicated); Non-Diabetic Hyperglycaemia (NDH) identification and diabetes prevention pathway (Healthier You); NHS Health Checks with 'conversation to action', long-term condition management and optimisation of multi-morbidity conditions, digital and telehealth-based care.	1,2,3
	4. Integrated mental health and inclusion health within multimorbidity care: Embed access to Talking Therapies / psychologically informed LTC support; targets support for the SMI/LD sub-cohorts including SMI annual '6 checks' and follow-on actions; trauma-informed engagement and reasonable adjustments as well as social isolation.	1,2,3
Multi-Agency Led	5. Lifestyle risk reduction with practical support (smoking, weight, alcohol) using neighbourhood assets: Evidence-based smoking cessation; weight management pathways; alcohol screening/brief interventions; social prescribing / link worker support to address behavioural and social drivers (including debt, housing, employment support). Patient education through health literacy, self management, community engagement and utilisation of community assets.	1,3
Priority focus on Primary Care Networks / Neighbourhoods with: - High prevalence of 2 and 3+ long-term conditions in 40-64 age band, where risk factors and early disease are both poorly managed, high chronic ACSC emergency admissions, high ED attendances and high sickness certification - Particular consideration / focus: people from most deprived quintile, people with severe mental illness and/or harmful alcohol use (MH parity of esteem), people with learning disabilities and people with caring responsibilities (unpaid carers)		

* These do not constitute investment guarantees to providers – they need to be delivered within available financial resource and provide value for money

** 1. Sickness to Prevention; 2. Hospital to Community; 3. Analogue to Digital

System Outcomes Framework Impact

'Top 5' KPIs to inform ICB Board Reporting ^{1 2 3}
1. % of high-risk patients engaged in prevention (smoking, weight, alcohol) & up to date with screening (health checks, CVD, diabetes, cancer) ⁴
2. % patients with controlled blood pressure, controlled HbA1c and appropriate lipid management, alongside case-finding for undiagnosed hypertension/diabetes ⁴
3. % of 40-64s with SMI + ≥1 other LTC receiving all 6 elements of the physical health check in 12 months ⁴
4. Reduction in A&E attendances and NEL admissions for Ambulatory Care Sensitive conditions per 1,000 total patients 40-64 (explicitly to include COPD exacerbations, pneumonia, asthma and bronchitis) ⁴
5. Emergency bed days rate

Live Well

Adults stay healthier for longer, with well managed conditions to reduce the risk of progression so they can work, care and take part in life without their health holding them back			
Adults maintain good health, with risks picked up early	Adults with long-term conditions have their health well managed and remain stable	People with a learning disability or severe mental illness have good physical health	People with care needs and their carers are supported to stay independent and well

¹ PCN level, 'Top-15' PCNs aggregate vs all other PCNs. DLN total

² Report by IMD Quintile + ethnicity + SMI/LD + SEND where appropriate and feasible to evidence equity of reach and impact

³ Additional KPIs may be included in individual PCN 'dashboards'

⁴ Aligned to CORE20PLUS5 indicators

Segment Priority 4: Frailty

Why this matters and ‘higher-need’ primary care networks/neighbourhoods

Why Frailty Matters

i. It is a high-growth demand driver with outsized system impact

- The rate and concentration of older people is particularly acute in part of Lincolnshire, rural Derbyshire and rural Nottinghamshire. In Lincolnshire 24% of the population are aged 65+, above regional and national averages, and the Derbyshire Dales has one of the oldest age profiles in the region.
- NIHR evidence shows that people from most deprived areas are twice as likely to experience frailty compared with least deprived. Frailty also develops earlier.
- If frailty present by early 50s, delaying intervention until 65+ allows preventable decline. Frailty interacts heavily with multimorbidity which reinforces the need for earlier intervention.

ii. It is strongly linked to avoidable emergency admissions, bed days and long waits

- Frailty-related deterioration (falls, delirium, deconditioning, medication harm) is a major driver of unplanned activity. Across the DLN ICB Cluster people aged 65+ make up 20% of the population but account for c.50% of emergency admissions.

iii. It is a principal cause of delayed discharge and ‘stranded’ beds.

- There is a large avoidable cost from frail older patients remaining in hospital when they no longer need acute hospital care. Across the DLN ICB Cluster around 20% of acute hospital bed base is classified as discharge ready, many of these beds are occupied by frail patients.

iv. Dementia carries very high cost and carer burden, and diagnosis/care planning gaps remain material

- Dementia costs are forecast to rise steeply over the next 15 years, with unpaid care and social care the biggest components. Improving diagnosis, post-diagnostic support and crisis prevention provides both positive outcomes for people and sustainability for health and care services.

v. There is a credible, evidence-backed delivery model in primary/community care

- NHS England has published practical guidance for proactive care for people with moderate or severe frailty (risk stratification, personalised care planning, MDT working, anticipatory response).
- This is a manageable ‘neighbourhood’ agenda – one where PCNs can lead delivery with measurable impact in 12-18 months (admissions, conveyances, care home crises, length of stay, patient/carer experience)

‘Higher-need’ Primary Care Networks / Neighbourhoods – ‘Top 15’*

ICB	Primary Care Network	Deprivation Q.	Community Type
Derby & Derbyshire	South Hardwick	2	Market Town/Rural
	Chesterfield & Dronfield	3	Urban Core/Market Town
	Derby City South	3	Urban Core/Rural
	Greater Derby	3	Urban Core
Lincolnshire	First Coastal	1	Coastal/Rural
	Boston	2	Market Town/Rural
	Lincoln Health P’ship	2	Urban Core
	Spalding	3	Market Town/Rural
Nottingham & Nottinghamshire	Aspire	1	Urban Core
	Nottingham City East	1	Urban Core
	Raleigh	1	Urban Core
	Clifton & Meadows	2	Suburb/Urban Core
	Ashfield South	3	Market Town
	Byron	3	Suburb
	Synergy Health	4	Suburb

* Based on 25% of PCNs in each ICB with greatest need

Segment Priority 4: Frailty

Evidence based interventions and impact

Evidence-based Interventions*

Approach	Intervention (focus on moderate/severe frailty)	3 Shifts**
NHS Led	1. Frailty (and dementia) identification and segmentation (clinical frailty score, efi or similar): with an actively managed moderate/severe frailty register with the cohort receiving proactive care; PHM risk stratification to identify pre frailty in 50-64s.	1,2,3
	2. Proactive frailty bundle for moderate/severe frailty (MDT + holistic/CGA-level assessment + personalised care plan + coordination): Core model to stabilise, prevent crises and coordinate services (includes care home delivery via Enhanced Health in Care Homes expectations). Embed frailty checks with multimorbidity reviews and vaccination optimisation. Medicines optimisation for frailty (structured medication review; high-risk medicines reduction; post fall review): Reduces falls/delirium risk, readmissions and instability. Carer identification and support for carers.	1,2,3
NHS in Partnership	3. Falls and functional decline prevention pathway (multifactorial assessment + strength/balance interventions + home/environment actions): Reduces recurrent falls, fear of falling and deconditioning	1,2,3
	4. Crisis avoidance and functional recovery pathway (urgent community response + intermediate care/rehab/reablement): Admission avoidance, faster recovery, improved discharge outcomes and reduced long-term care need	1,2,3
Multi-Agency Led	5. Lifestyle risk reduction with practical support to maintain health and independence for longer: Personalised prevention; tailored guidance to older people supporting access a range of local services that address key personal wellbeing factors such as nutrition, physical activity, smoking cessation, bereavement, loneliness, and carer support. Improved access to preventative health services: offer clear advice on how to access preventative health services, including vaccinations, routine health checks, and screening programmes, with a focus on early intervention and disease prevention. Community engagement signpost individuals to directories of services and community hubs. Health inequalities: use insights to refine/enhance services, ensuring they are inclusive, equitable, and responsive to the diverse needs of older people.	1,2,3
Priority focus on Primary Care Networks / Neighbourhoods with: High moderate/severe frailty prevalence, high frailty-related utilisation (e.g. care-home admission rates, OBDs), weak proactive frailty care, high care-home bed density and poor quality/unsuitable housing		

* These do not constitute investment guarantees to providers – they need to be delivered within available financial resource and provide value for money

** 1. Sickness to Prevention; 2. Hospital to Community; 3. Analogue to Digital

System Outcomes Framework Impact

'Top 5' KPIs to inform ICB Board Reporting ^{1 2 3}
1. Patient records with CFS score recorded and personalised care plan in place & % of people with Dementia receiving annual dementia care plan review ⁴
2. % primary care records showing eFI (or equivalent) status & number of people with frailty receiving CGA incl. structured medical review ⁴
3. % patients with 2 or more falls in one year & and rate of falls-related NEL admissions – view for moderate/severe (indicator to include uptake of evidence-based falls-prevention interventions within target population ⁴
4. ED attendances & NEL admissions for frailty multiple LTCS (65+) split by care home / non-care home admission – view for moderate/severe ⁴
5. Non-elective bed days – view for moderate/severe

Age Well		
Older people stay as well, active and independent as possible to reduce the risk of progression so that they spend more time living in their own homes and communities		
Older people with long-term conditions have their health well managed and remain stable	People living with frailty are supported to stay active and independent at home	When older people have a crisis, they get home quickly to stay independent

¹ PCN level, 'Top-15' PCNs aggregate vs all other PCNs. DLN total

² Report by IMD Quintile + ethnicity + SMI/LD + SEND where appropriate and feasible to evidence equity of reach and impact

³ Additional KPIs may be included in individual PCN 'dashboards'

⁴ Aligned to CORE20PLUS indicators

Segment Priority 5: End of Life

Why this matters and ‘higher-need’ primary care networks/neighbourhoods

Why End of Life Matters

i. Quality and experience are highly variable

- Nationally and locally, there is wide variation in place of death (including the proportion dying in hospital versus at home/care home), which is a practical proxy for whether people are being supported to die in their preferred place with appropriate community capacity.

ii. It is a nationally defined improvement agenda with a clear ‘what good looks like’

- The ‘*Ambitions for Palliative and End of Life Care, 2021-2026*’, provides an accepted national framework for local action across health, social care and the VCSE/hospice sector.

iii. It is one of the most avoidable pressure points in urgent care and bed capacity

- A material proportion of late-stage deterioration and hospital utilisation can be mitigated through earlier identification, anticipatory care planning, 24/7 community response and reliable care-home/hospice/community pathways (particularly in last 90 days of life).

iv. Financial stewardship and opportunity cost

- End of life care is typically one of the most resource-intensive periods of care, particularly when pathways default to repeated crisis attendance, ambulance conveyance and inpatient stays rather than planned, coordinated community support. It is a credible ‘lever’ to:
 - Reduce high cost, low-value healthcare utilisation in last weeks/months of life
 - Release capacity (e.g. beds, clinical time) back into urgent care and elective recovery
 - Reinvest into scalable community and hospice-at-home models that improve experience and equity

v. It protects carers and the wider system

- Better PEOLC reduces carer breakdown, improves bereavement outcomes and stabilises demand across community services, ambulance conveyances and acute admissions

‘Higher-need’ Primary Care Networks / Neighbourhoods – ‘Top 15’*

ICB	Primary Care Network	Deprivation Q.	Community Type
Derby & Derbyshire	North Derbyshire	2	Urban Core/Suburb
	North-East Derbyshire	2	Market Town/Rural
	North Hardwick/Bolsover	2	Market Town/Rural
	Chesterfield & Dronfield	3	Urban Core/Market Town
Lincolnshire	First Coastal	1	Coastal/Rural
	Boston	2	Market Town/Rural
	Trent	2	Market Town/Rural
	East Lindsey	3	Rural/Market Town
Nottingham & Nottinghamshire	Aspire	1	Urban Core
	Radford & Mary Potter	1	Urban Core
	Raleigh	1	Urban Core
	Ashfield North	2	Market Town
	Mansfield North	2	Market Town
	Eastwood/Kimberley	4	Suburb
	Beeston	5	Suburb

* Based on 25% of PCNs in each ICB with greatest need

Segment Priority 5: End of life

Evidence based interventions and impact

Evidence-based Interventions*

Approach	Intervention	3 Shifts**
NHS Led	1. Identify the last year of life cohort and manage a live palliative/EOL register and advanced care planning & shared-decision making as standard: systematic identification (including non-cancer), routine register reviews, clear triggers for review/escalation. Regular ACP conversations; documented preferences and escalation decisions including a ReSPECT conversation; family/carer involvement where appropriate	1,2,3
	2. Last days of life clinical reliability (including medicines and equipment): Standardised symptom assessment/management; anticipatory prescribing of 'just in case' medicines; reliable access to medicines; equipment and verification processes (including out of hours).	1,2,3
NHS in Partnership	3. Coordinated personalised care with a shared coordination record: Named coordinator/key worker; single, accessible care plan/record shared across GP, community, acute ambulance and OOH to avoid repeated story telling and fragmented response.	1,2,3
	4. 24/7 advice plus rapid community response (including care homes) and specialist care where more complex need: 24/7 advice line for patients/carers/professionals; reliable same-day visiting/urgent response; access to specialist care where needed, consistent care-home EoL support package in priority PCNs.	2,3
Multi-Agency Led	5. Enhanced care – Self Care; Self Management: People, their families and carers supported to access enhanced care including complimentary therapies, support groups, practical support in accessing housing or the benefits system and emotional and psychological support including bereavement services provided by experienced work force. Patient education through health literacy, self-management, physical activity, community engagement and utilisation of community assets.	1,2,3

Priority focus on Primary Care Networks / Neighbourhoods with:

- Highest levels of crisis / hospital-death profile, low levels of proactive planning, high frailty prevalence / care-home density and high multi-morbidity
- Particular consideration / focus: non-cancer conditions and people with learning disabilities or severe mental illness (MH parity of esteem)

System Outcomes Framework Impact

'Top 5' KPIs to inform ICB Board Reporting^{1 2 3}

1. People who died with a recorded EoL care plan (ReSPECT) and/or treatment-escalation decision⁴
2. Number of people accessing end of life care support services⁴
3. Deaths occurring in hospital / preferred place of death⁴
4. Deaths with 3+ emergency admissions in last 90 days of life
5. Unplanned bed days in last 90 days of life



Die Well

People approaching the end of life are cared for with comfort and dignity, spending as much time as possible in their usual place of residence

People likely in their last year of life are identified early and supported in a planned, proactive way

People at the end of life have clear plans that protect their comfort and independence

People at the end of life are supported to spend more time in their usual place of residence

¹ PCN level, 'Top-15' PCNs aggregate vs all other PCNs. DLN total

² Report by IMD Quintile + ethnicity + SMI/LD + SEND where appropriate and feasible to evidence equity of reach and impact

³ Additional KPIs may be included in individual PCN 'dashboards'

⁴ Aligned to CORE20PLUS5 indicators

* These do not constitute investment guarantees to providers – they need to be delivered within available financial resource and provide value for money

** 1. Sickness to Prevention; 2. Hospital to Community; 3. Analogue to Digital

'Cross-Cutting' Priority 1: Vaccination and Screening

Vaccination and screening are two of the most effective population health interventions available. Together they prevent illness, detect disease earlier, reduce avoidable hospital activity and narrow inequalities in healthy life expectancy.

Life-Course Focus

Life-Course	Focus of Action	Neighbourhood Delivery Model
Children & Young People: Childhood vaccinations and HPV	- Strengthen universal delivery through maternity, health visiting, primary care and school age immunisation – with proactive call/recall and 'mop-up' for missed doses. - Improve HPV uptake through school programmes and follow-up for non-attenders and out-of-school cohorts. - Introduction of MMRV Programme. - Reduce inequalities by tailoring delivery for families facing barriers (e.g. unstable housing, language needs, digital exclusion, access barriers).	- Shared lists and joint outreach across PCNs, 0-19 services, school nursing and VSFSE. - Micro-planning at neighbourhood level: identify low-coverage schools/communities and deploy pop-ups, after school clinics and trusted messengers.
Adults and mid-life: Cancer and non-Cancer screening (to include health checks) and working age vaccinations	- Increase uptake across the adult cancer (specific focus on lung cancer) and non-Cancer screening pathway (invitation – attendance – results – follow up), with targeted approaches for lower-uptake groups and neighbourhoods. - Support development of integrated end to end pathways from screening to treatment e.g. Lung Cancer Screening (previously TLHC) - Align working age vaccination delivery with routine primary care and opportunistic contacts (e.g. focus on understanding hesitancy and barriers, community pharmacy, occupational health where appropriate). - Maximise uptake on vaccinations for clinical risk groups prioritising those with multi morbidity, COPD and people with complex needs. - Use population health management to segment 'never responders' and design tailored engagement (e.g. culturally competent outreach, flexible appointments, outreach clinics)	- PCN-led coordination with community pharmacy and VCFSE partners to extend access (evenings/weekends, community venues) - Data-driven outreach at LSOA/neighbourhood/GP practice/ethnicity level, consistent navigation and follow-up so that non-attendance triggers active support
Older people and frailty: Vaccinations to reduce severe illness and admissions	- Maximise uptake on vaccinations relevant to older age and clinical risk groups, prioritising those with frailty, COPD, care home residents, housebound patients and people with complex needs. - Embed vaccination status checks into proactive care (frailty identification, care planning, falls clinics, community geriatric services, virtual wards, intermediate care)	- Data-driven outreach at LSOA/neighbourhood/GP practice/ethnicity level, consistent navigation and follow-up so that non-attendance triggers active support 'One list' approach across primary care, community services and care homes to reduce duplication and close gaps.



'Top 5' KPIs to inform ICB Board Reporting ^{1 2 3}
1. MMR coverage at Age 2 % of children at aged 2 who have received at least one dose of MMR/MMRV
2. HPV vaccination uptake (Year 8 cohort) % of Year 8 cohort receiving the HPV vaccine (with a separate catch-up drill-down for those vaccinated later) include a drill down for gender (need for both male and female) to link with cervical cancer elimination plan
3. Cancer screening uptake: % uptake across the three core adult screening programmes, reported as a single composite headline with drill-downs for ⁴ : - Bowel screening (completion /FIT kit return) - Breast screening (attendance) - Cervical screening (in-date coverage) - Lung Cancer Screening (previously targeted lung checks)
4. Early cancer diagnosis ⁴ % of cancers diagnosed at Stage 1 or Stage 2 (breast, lung, colorectal and prostate cancer) & proportion of urgent referrals meeting 2WW/FDS/62-day standard
5. 'Winter protection' vaccination uptake as per UEC plan % of the seasonal respiratory vaccination offer in older people and frailty/risk cohorts (with focus on COPD) ⁴

¹ PCN level, 'Top-15' PCNs aggregate vs all other PCNs. DLN total

² Report at PCN level, Equity Gap (IMD Q1 vs Q5), best-worst PCN range

³ Additional KPIs may be included in individual PCN 'dashboards'

⁴ Additional KPIs may be included in individual PCN 'dashboards'

⁴ CORE20PLUS aligned

'Cross-Cutting' Priority 2: Strong General Practice

Strong general practice (sufficient capacity, equitable access, continuity, high-quality proactive management) is a critical enabler of improved population health outcomes and reduced inequalities. It is crucial for earlier identification, proactive long-term condition management, continuity for complex patients and timely access to appropriate care.

Prioritisation – Three 'lenses'

Lens and Strategic Intent	Focus
1. Where health gain is highest (need/risk) <i>Target proactive care to the highest-need cohorts to improve control and reduce inequalities</i>	• High CYP underlying need (asthma/wheeze, obesity neurodevelopmental/SEND, emerging mental health) where early identification, coordinated support and planned follow-up improve longer-term outcomes and inequalities • High burden of chronic illness and rising risk (multimorbidity, high r-risk LTC prevalence, obesity, smoking, deprivation) where strengthening routine access and structured reviews will improve control and slow progression over years (specific consideration given to CORE20PLUS) • High frailty and functional decline risk (older people, moderate/severe frailty, care homes, polypharmacy) where continuity, anticipatory care and proactive reviews prevent deterioration and maintain independence.
2. High avoidable / crisis utilisation and complexity <i>Cut failure demand by improving rapid access and coordination for high utilisers</i>	• High CYP escalation signals (recurrent A&E for asthma exacerbations, frequent acute presentations, mental health crisis contacts/self-harm) indicating unmet need or delayed intervention rather than simply high prevalence. • High urgent care reliance disproportionate to expected need (frequent A&E attenders, high out-of-hours use, short-stay/low acuity presentations) indicating access gaps, low confidence in alternatives or poor front-door processes. • High potentially avoidable admissions and repeats (ACS admissions, repeat non-elective admissions/bed days) suggesting inconsistent proactive management, weak continuity for complexity or poor coordination across services.
3. Structurally under-resources or hard to access <i>Remove workforce, estates and inclusion barriers that cap access and capacity</i>	• Workforce capacity and stability constraints (vacancies, turnover, locum reliance, limited MDT deployment) that cap appointment supply and ability to protect time for proactive care. • Access barriers that create inequity (digital exclusion, language, transport/parking, limited after-school access for families, lack of youth-friendly routes) where 'availability' does not translate into real-world access. • Estate and infrastructure constraints (insufficient consulting rooms, poor layout/flow, limited space for immunisation of MDT clinics, inadequate connectivity) that 'hard-cap' concurrent clinics and restrict service scope



'Top 5' KPIs to inform ICB Board Reporting ^{1 2 3}
1. Delivered appointment capacity Appointments per 1,000 patients (weighted & registered)
2. Timely access to clinical assessment (in-hours) % of clinically urgent appointments seen on the same day
3. Patient-reported access GP Patient Survey: % reporting overall experience as good/very good experience of contacting the practice/getting an appointment
4. Patient-reported continuity GP Patient Survey: % able to see/speak to preferred GP HCP (where have one) – this is in line with SoS report metric, national average benchmark
5. Proactive long-term condition control QOF composite for hypertension BP control and diabetes HbA1c control (reported as an overall '%achieving control' headline)

¹ PCN level, 'Top-15' PCNs aggregate vs all other PCNs. DLN total

² Report at PCN level, Equity Gap (IMD Q1 vs Q5), best-worst PCN range

³ Additional KPIs may be included in individual PCN 'dashboards'

Strong General Practice and Vaccination and Screening 'Higher-Need' Primary Care Networks / Neighbourhoods

Vaccination and Screening – 'Top 15'

ICB	Primary Care Network	Deprivation Q.	Community Type
Derby & Derbyshire	Derby City North	1	Urban Core
	PCCO	1	Urban Core
	Glossop	2	Market Town
	Derby City South	3	Urban Core/Rural
Lincolnshire	First Coastal	1	Coastal/Rural
	Boston	2	Market Town/Rural
	Trent	2	Market Town/Rural
	Lincoln Health P'ship	2	Urban Core
Nottingham & Nottinghamshire	Aspire	1	Urban Core
	Bulwell & Top Valley	1	Urban Core
	Nottingham City East	1	Urban Core
	Radford & Mary Potter	1	Urban Core
	Raleigh	1	Urban Core
	Bestwood & Sherwood	2	Urban Core
	Rosewood (Mansfield)	2	Market Town

Strong General Practice – 'Top 15'

ICB	Primary Care Network	Deprivation Q.	Community Type
Derby & Derbyshire	Derby City North	1	Urban Core
	Erewash	2	Suburb
	North Hardwick/Bolsover	2	Market Town/Rural
	Chesterfield & Dronfield	3	Urban Core/Market Town
Lincolnshire	First Coastal	1	Coastal/Rural
	Boston	2	Market Town/Rural
	IMP Healthcare	3	Urban Core/Rural
	South Lincolnshire Rural	3	Rural/Market Town
Nottingham & Nottinghamshire	Aspire	1	Urban Core
	Bulwell & Top Valley	1	Urban Core
	Radford & Mary Potter	1	Urban Core
	Mansfield North	2	Market Town
	Larwood & Bawtry	3	Market Town
	Newark	4	Market Town/Rural
	Synergy Health	4	Suburb

‘Cross-Cutting’ Priority 3: Outpatient and follow-up redesign

We will redesign outpatient pathways using a two-group prioritisation model. Group 1 targets high-volume specialties to improve RTT performance, Group 2 focuses on long-term conditions and addressing associated burdens of disease. Outpatient redesign will be done in the context of whole pathway redesign and transformation.

Key elements of a redesigned outpatient model

Lever		These ‘levers’ will be considered on a specialty basis by specialty basis as part of whole pathway redesign and transformation
1	Patient activation as the default	- Embed supported self-management, shared decision-making and personalised care planning so that patients understand their condition, triggers and when/how to seek help. - This includes structured education, coaching and consistent use of care navigation and health coaching with neighbourhood teams
2	Advice and Guidance	- High impact where referrals are high-volume and triage able (e.g. MSK, dermatology, ENT). - Lower impact where referrals require specialist diagnostics as a first step
3	PCN/INT protocol-led MDT first attendances	Expand neighbourhood-based clinics delivered by MDTs (e.g. advanced clinical practitioners, specialist nurses, pharmacists, AHPs and GPs with extended roles), with specialist input via advice-and-guidance, virtual MDTs and outreach sessions (e.g. MSK FCP, community respiratory, diabetes support, frailty MDT/CGA)
4	Patient-initiated Follow-Up (PIFU) with rapid re-access	- Replace routine follow-ups for suitable cohorts with PIFU pathways that provide: clear criteria for re-contact, times ‘backstop’ safety reviews where needed, and swift access to advice, diagnostics or specialist review when deterioration occurs. - Greatest impact where follow-ups are surveillance-heavy and can be protocolised with rapid-access (e.g. ophthalmology, MSK, dermatology).
5	Virtual reviews and remote monitoring	Use virtual consultations, remote physiological monitoring (where appropriate) and patient-reported outcome/symptom tracking to reduce unnecessary face-to-face follow-up while maintain safety and continuity



Group 1: Prioritised primarily through 18-week (RTT) performance pressures

- These align to **high volume specialties** that national programmes target because they represent a **large proportion of elective waiting list** activity and are a core focus for accelerating RTT improvement through pathway redesign (triage, straight-to-test, one-stop models, improved booking rules and standardised follow-up reduction).
- They are **well suited to standardised, ‘industrialised’ outpatient redesign** that reduces ‘unseen’ patients and improves flow into diagnostics and treatments, directly supporting the 18-week recovery agenda.
- Includes: Dermatology, T&O/MSK, Gynaecology, Paediatrics, Gastroenterology, Ophthalmology, Urology and ENT** (redesign needs to consider whole pathway)



Group 2: Prioritised by population segment needs and Long-Term Condition burden

- These specialties **carry a disproportionate share of long-term condition burden and interact heavily with multimorbidity and frailty**. The opportunity is less about elective throughput alone and more about reducing fragmented repeat follow-ups, **improving proactive management** and **enabling rapid re-access** when patients destabilise.
- Redesign should emphasise **protocol-led MDT follow-up, stronger neighbourhood (PCN/INT) delivery, virtual reviews/remote monitoring** and PIFU where appropriate – reducing duplication across multiple specialty clinics and improving experience for high-need cohort.
- Includes: Geriatric Medicine, Cardiology, Respiratory Medicine, Diabetes, Renal Medicine and Oncology/Haematology** (redesign needs to consider whole pathway)

KPIs on PIFU, avoided 1st OP appointments and care setting / modality shifts will require more investigations about possible data sources and methodologies for calculating ‘Top-5’ metrics.

Appendix 4

Alignment of KPIs for Population Health Strategy

Priorities to DLN ICB Cluster Outcomes Framework

DLN ICB Cluster Population Health Strategy outcomes framework approach, definitions and design principles

1. The **approach** is **iterative and staged**:
 - a. **Phase 1 (to March 2026)**: Develop a '**single cluster outcomes framework**' using existing ICB outcomes and citizen insight as the primary evidence base, sufficient to support the initial Population Health Strategy and national submissions.
 - b. **Phase 2 (from April 2026)**: Deepen co-production with citizens, partners and clinicians and refine outcomes, sub-outcomes and indicators over time as part of ongoing strategy refinement, implementation and annual planning.
2. The following **definition framework** has been developed:
 - a. **Outcomes** – Describe the desired 'big end-results' long-term changes in health and wellbeing for the population.
Big, long-term population changes
 - b. **Sub-Outcomes** – Break the Outcomes down into specific aspects that need to change to achieve it – they are more focussed but still describe 'real world' change not activity.
Specific dimensions of those outcomes – what changes, for whom
 - c. **Key Performance Indicators** – The specific, quantifiable measures used to track progress towards Outcomes and Sub-outcomes.
Concrete measures with a direct line of sight to the outcome / Sub-outcome
3. The **design principles (draft)** that have been applied to date are:
 - a. **Population and life-course based** – for example organised around Start Well, Live Well, Age Well, Die Well, with **cross-cutting focus on health inequalities**.
 - b. **Evidence-led and pragmatic** – starting from existing ICB strategies, outcomes frameworks, Health & Wellbeing Board priorities and national success measures, rather than starting from a blank page.
 - c. **Neighbourhood-anchored** – capable of being disaggregated to neighbourhood (e.g. PCN / INT footprints) to support local improvement and accountability.
 - d. **Citizens' priorities informed** – incorporating what citizens have already told each ICB about what matters most and strengthened through further engagement in 2026.
 - e. **Balanced** – combining long-term health outcomes (e.g. healthy life expectancy) with medium-term service and inequality outcomes that are **realistic for the NHS to influence** within five years.

DLN ICB Cluster Population Health Strategy Outcomes Framework: Overview

Whole Population		
People live longer and healthier lives		
People live longer and fewer die early from preventable causes	People spend more years in good health and fewer years with avoidable poor health	Inequalities in life expectancy and healthy life expectancy are reduced

Start Well			Live Well				Age Well			Die Well		
Children enjoy good health so they can grow, learn and develop to their full potential			Adults stay healthier for longer, with well managed conditions so they can work, care and take part in life without their health holding them back				Older people stay as well, active and independent as possible to reduce the risk of progression so that they spend more time living in their own homes and communities			People approaching the end of life are cared for with comfort and dignity, spending as much time as possible in their usual place of residence		
Babies and children have a good start to life	Children develop well that sets up future good-health and well-being	Children & young people are supported to be as well as they can be	Adults maintain good health, with risks picked up early	Adults with long-term conditions have their health well managed and remain stable	People with a learning disability or severe mental illness have good physical health	People with care needs and their carers are supported to stay independent and well	Older people with long-term conditions have their health well managed and remain stable	People living with frailty are supported to stay active and independent at home	When older people have a crisis, they get home quickly to stay independent	People likely in their last year of life are identified early and supported in a planned, proactive way	People at the end of life have clear plans that protect their comfort and independence	People at the end of life are supported to spend more time in their usual place of residence

Whole Population

Whole Population		
OUTCOME: People live longer and healthier lives		
SUB-OUTCOMES		
People live longer and fewer die early from preventable causes	People spend more years in good health and fewer years with avoidable poor health	Inequalities in life expectancy and healthy life expectancy are reduced
KEY PERFORMANCE INDICATORS		
- Life expectancy (LE) at birth - Under-75 mortality rates from preventable causes - Under-75 avoidable mortality rate including CVD, cancer, respiratory disease and alcohol - Infant mortality rate - Neonatal mortality rate	- Healthy life expectancy (HLE) at birth - Healthy life expectancy at age 65 <i>Multimorbidity-free life expectancy (by sex) (measurement to be developed across the cluster for future years based on N&N ICB testing of indicator)</i>	- Gap in life expectancy (LE) at birth between most and least deprived quintiles/deciles - Gap in healthy life expectancy (HLE) at birth between most and least deprived quintiles/deciles

Start Well

Start Well (0-5 and 5-19)		
OUTCOME: Children enjoy good health so they can grow, learn and develop to their full potential		
SUB-OUTCOMES		
Babies and children have a good start to life	Children develop well that sets up future good-health and well-being	Children and young people are supported to be as healthy as they can be
KEY PERFORMANCE INDICATORS		
DLN ICB Cluster Priority: Children & Young People's Obesity % of pregnant women with a BMI>30 weight management service start and completion rate & % pregnant women recorded as smoking at booking/delivery - Breast feeding initiation and continue to exclusively breastfeed DLN ICB Cluster Priority: Vaccination and Screening - MMR coverage at age 2	DLN ICB Cluster Priority: Children & Young People's Obesity - Tier 2 / Tier 2+ / Tier 3 weight management service start and completion rates - NCMP Year 6 excess weight prevalence & proportion of children with Asthma who are overweight/obese and have greater than one exacerbation in the past 12 months - Prevalence of Type 2 diabetes and proportion receiving recommended NICE care processes*	DLN ICB Cluster Priority: Children & Young People's Mental Health - Access rates to CYP MH services* - CYP Eating Disorder access standard* - CYP Autism & ADHD diagnostic pathway waiting time* - Proportion of CYP with obesity experiencing MH difficulties e.g. anxiety/self-esteem - CYP A&E attendance for MH-related presentation & hospital admissions as a result of self-harm DLN ICB Cluster Priority: Vaccination and Screening - HPV vaccination uptake (Year 8 cohort)

* Aligned to CORE20PLUS5 indicators

Live Well

Live Well			
OUTCOME: Adults stay healthier for longer, with well managed conditions to reduce the risk of progression so they can work, care and take part in life without their health holding them back			
SUB-OUTCOMES			
Adults maintain good health, with risks picked up early	Adults with long-term conditions have their health well managed and remain stable	People with a learning disability or severe mental illness have good physical health	People with care needs and their carers are supported to stay independent and well
KEY PERFORMANCE INDICATORS			
DLN ICB Cluster Priority: Multimorbidity (2+ LTCs, 40-64) % of high-risk patients engaged in preventative (smoking, weight, alcohol) & up to date with screening (health checks, CVD, diabetes, cancer)* DLN ICB Cluster Priority: Vaccination and Screening - Cancer screening uptake (Bowel, Breast, Cervical, Lung)* - Early cancer diagnosis (Stage 1-2)* 'Winter protection' vaccination uptake as per UEC plan - % of the seasonal respiratory vaccination offer in older people and frailty/risk cohorts (with focus on COPD)*	DLN ICB Cluster Priority: Multimorbidity (2+ LTCs, 40-64) % patients with controlled blood pressure, controlled HbA1c and appropriate lipid management, alongside case-finding for undiagnosed hypertension/diabetes* - Reduction in A&E attendances and NEL admissions for Ambulatory Care Sensitive conditions per 1,000 total patients 40-64 (explicitly to include COPD exacerbations, pneumonia, asthma and bronchitis)* - Emergency bed days	DLN ICB Cluster Priority: Multimorbidity (2+ LTCs, 40-64) % patients with controlled blood pressure, controlled HbA1c and appropriate lipid management, alongside case-finding for undiagnosed hypertension/diabetes* - Reduction in A&E attendances and NEL admissions for Ambulatory Care Sensitive conditions per 1,000 total patients 40-64 (explicitly to include COPD exacerbations, pneumonia, asthma and bronchitis)* - Emergency bed days % with SMI + ≥1 other LTC receiving all 6 elements of the physical health check in 12 months*	

* Aligned to CORE20PLUS5 indicators

Age Well

Age Well		
OUTCOME: Older people stay as well, active and independent as possible, spending more time living in their own homes and communities		
SUB-OUTCOMES		
Older people with long-term conditions have their health well managed and remain stable	People living with frailty are supported to stay active and independent at home	When older people have a crisis, they get home quickly to stay independent
KEY PERFORMANCE INDICATORS		
DLN ICB Cluster Priority: Vaccination and Screening - Cancer screening uptake (Bowel, Breast, Cervical, Lung)* - Early cancer diagnosis (Stage 1-2)* ‘Winter protection’ vaccination uptake as per UEC plan - % of the seasonal respiratory vaccination offer in older people and frailty/risk cohorts (with focus on COPD)*	DLN ICB Cluster Priority: Frailty - Patient records with CFS score recorded and personalised care plan in place & % of people with Dementia receiving annual dementia care plan review * % primary care records showing eFI (or equivalent) status & number of people with frailty receiving CGA incl. structured medical review* % patients with 2 or more falls in one year & and rate of falls-related NEL admissions – view for moderate/severe (indicator to include uptake of evidence-based falls-prevention interventions within target population* - ED attendances & NEL admissions for frailty multiple LTCS (65+) split by care home / non-care home admission – view for moderate/severe*	DLN ICB Cluster Priority: Frailty Non-elective bed days – view for moderate/severe

* Aligned to CORE20PLUS5 indicators

Die Well

Die Well		
OUTCOME: People approaching the end of life are cared for with comfort and dignity, spending as much time as possible in their usual place of residence		
SUB-OUTCOMES		
People likely in their last year of life are identified early and supported in a planned, proactive way	People at the end of life have clear plans that protect their comfort and independence	People at the end of life are supported to spend more time in their usual place of residence
KEY PERFORMANCE INDICATORS		
DLN ICB Cluster Priority: End of Life Number of people accessing end of life care support services*	DLN ICB Cluster Priority: End of Life People who died with a recorded EoL care plan (ReSPECT)and/or treatment-escalation decision*	DLN ICB Cluster Priority: End of Life - Deaths occurring in hospital / preferred place of death* - Deaths with 3+ emergency admissions in last 90 days of life - Unplanned bed days in last 90 days of life

* Aligned to CORE20PLUS5 indicators

Appendix 5

Key Enablers of the Population Health Strategy

Key enablers

Six capabilities and ways of working have been identified that make this population health strategy deliverable at scale. These key enablers provide the systemwide capabilities required to operationalise the priorities set out in this document, ensuring consistent delivery through aligned pathways, shared data, digital tools, neighbourhood models, and coordinated multi-agency approaches at scale

Key enablers	Focus
1. Communications (hearts & minds)	• Purpose: align partners and build public/staff confidence in the 'neighbourhood offer' and the 3 shifts (prevention, community, digital) • Core interventions: unified narrative, targeted inequality comms; 'what will change' pathway comms; feedback loops
4. Digital Technology	• Purpose: enable analogue to digital shift while supporting community delivery prevention; release staff time through automation; ensure digital inclusion • Core interventions: NHS App pathways; interoperable/shared record; remote monitoring; automation/AI for admin; messaging; digital call/recall; cyber/IG assurance.
2. Individual & Family Case Finding	• Purpose: systematically identify unmet need and prevention gaps, enabling proactive outreach and earlier intervention • Core interventions: PHM segmentation; consistent triggers; 'no wrong door'; gap lists; proactive invitations; shared record/data triggers

Key enablers	Focus
3. Personalisation	• Purpose: embed 'what matters' care, activation and shared decisions to improve outcomes and reduce low-value activity • Core interventions: personalised care & support planning; shared decision making; social prescribing; carer inclusion
5. Resource shift hospital to community	• Purpose: make the hospital to community shift real by moving money, capacity and accountability into neighbourhood delivery; hardwire prevention and digital requirements; explicitly use the new PCN and multi-PCN contract approach when available (procurement rules/laws will need to be followed) • Core interventions: outcomes-based specifications, equity weighting; gainshare; invest-to-save; single/multi-neighbourhood contracts
6. Integrated Neighbourhood Teams	• Purpose: deliver prevention, proactive and reactive care, anchored in strong general practice and neighbourhood health centres, reducing reliance on hospital care (community care 'delivery engine') • Core interventions: MDT cadence; pathway standardisation; extended access; rapid response; co-location/virtual integration; VCSE integration; shared governance and metrics (7-day services)

Key enablers

Four of the enablers underpin delivery of the population segment priorities: aligned communications, systematic individual and family case finding, personalised care and support planning, and digital technology to enable proactive, coordinated, neighbourhood-based care

	CYP Obesity	CYP Mental Health	Multimorbidity (40-64)	Frailty	End of Life (all ages)
1. Communications (hearts & minds)	- Target 'healthy weight' comms through schools, Family Hubs and VCSE - Culturally tailored messaging in high-need neighbourhoods - Clear 'how to access' and what support looks like	- Anti-stigma and 'how to get help' campaigns; single front door comms - Comms for parents/carers on early signs and routes - Crisis alternatives messaging (who to call, what happened next)	'Know your numbers' (BP, diabetic risk, smoking, weight) and be 'proactive' - Targeted messaging to working-age groups in deprived areas - Explain benefits of proactive care vs crisis care	'Ask for a frailty review' and falls-prevention comms - Explain rapid response/reablement and what to expect - Comms on how to avoid deterioration and when to seek help	- Normalise early conversation and Advance Care Planning (ACP) - Consistent messaging on 24/7 advice, - Public-facing clarity on preferred place of care and avoiding unwanted hospitalisation
2. Individual & family case finding	- Use NCMP/school nursing/GP data to identify risk trajectories - Proactive outreach to families / targeted referrals to weight management / healthy lifestyle offers - Ensure focus on SEND and deprived neighbourhoods where risk highest	- Systematic identification via schools, GPs and community services; consistent triage thresholds - Proactive follow-up of non-attenders - Targeted outreach for groups less likely to present (e.g.. neurodiversity, trauma exposure, looked-after children)	- Risk stratification to create 'rising risk' cohorts (multiple LTCs, high BMI/smoking, repeated UEC use) - Proactive interventions for structured reviews - Identify those missing key checks (BP, HbA1c, lipids) and trigger action.	- Frailty identification, falls risk, polypharmacy/high-risk meds and care-home registers - Proactive structured meds reviews; - Trigger anticipatory care planning and rapid response links for those with recent deterioration	- Early identification using clinical triggers (repeated admissions, progressive disease, decline) - Proactive ACP initiation; flag carers - Identify patients likely in last year of life to coordinate care and reduce crisis escalation
3. Personalisation	- Family-centred goal plans and culturally competent coaching - Link to community assets - Work with partners of wider determinants (food access, activity etc.)	- Shared decision making; personalised plan including family context - Choice of evidence-based interventions; crisis/safety planning - Tailored approaches for neurodiversity and trauma-informed care	- Personalised care plans with activation coaching; medicines optimisation aligned to goals - Supported self-management (including digital) - Target smoking cessation and weight	- CGA-informed goal planning incl. functional goals (e.g. mobility) - Carer assessment and contingency planning - Falls prevention & meds optimisation; personalised escalation plans	- ACP as standard: preferred place of care/death, escalation limits, DNACPR where appropriate - Carer support/bereavement planning - Focus on reducing unwanted hospital interventions
4. Digital technology	- Digital behaviour-change tools; NHS App signposting to local offers - Digital tacking and prompts; integrate service directory and self-referral - Targeted device / assisted-digital support for families who need it	- Digital self-referral where appropriate; online triage - Curated digital therapeutics and moderated tools 24/7 crisis information; secure messaging for follow-up & engagement	- Remote monitoring (BP, glucose where relevant) - Asynchronous support and digital coaching - Automation for recalls/reviews; dashboards for rising-risk cohorts	- Remote monitoring and alerting for deterioration; shared record across MDT - Scheduling tools; digital support for carers - Integrate care home information sharing where feasible	- Shared coordination record and visibility of ACP - Digital access to plans for patients/carers; rapid communication across providers - Anticipatory medication workflows and out-of-hours visibility

Key enablers

The remaining three enablers make change real at scale: Integrated Neighbourhood Teams as the local delivery engine, aligned incentives and contracting to shift resources from hospital to community and productivity improvements before and after transformation.

	CYP Obesity	CYP Mental Health	Multimorbidity (40-64)	Frailty (65+)	End of Life (all ages)
5. Integrated Neighbourhood Teams	• INT school/community pathway: dietetics/PA/behavioural support + VCSE; clear referral routes • Family engagement • Targeted offers in high-need neighbourhoods; link to wider determinates support	• INT-led early help with MH practitioners, schools link role, VCSE supports • Step-up/step-down pathways; crisis alternatives • Consistent MDT review of complex cases	• MDT reviews for complex LTCs; structured annual/semi-annual reviews • Medicines optimisation; social care + MH integration • Proactive care coordination to reduce UEC demand	• Frailty MDT with proactive reviews • Falls response; rapid reablement; community rehab; care home support • 7-day responsiveness for deterioration and discharge support	• 7-day community palliative response; coordinated GP/community/hospice working • Rapid access to symptom control support; carer support • Prevent avoidable admissions
6. Resource shift hospital to community	• Use PCN/neighbourhood contracts to fund prevention at scale (school/community offers) • Clear outcomes and equity weighting • Align LA/education contributions as much as possible	• Commission early help/community MH via neighbourhood contracts with access and outcomes standards • Scale support in high-need communities • Ensure VCSE roles are funded and stable	• Use multi-PCN/multi-neighbourhood contracts to fund at-scale proactive care capability (analytics, QI, workforce back-office) • Enable through gainshare from reduced admissions and improved outcomes	• Contract anticipatory care + rapid response/reablement and community rehab • Clear activity/cost-shift metrics and gainshare from reduced bed days and delayed discharges	• Contract 7-day palliative coordination and home/hospice-first capacity (including night support where needed) • Linked to reduced crisis admissions and preferred place of death outcomes

Key enablers

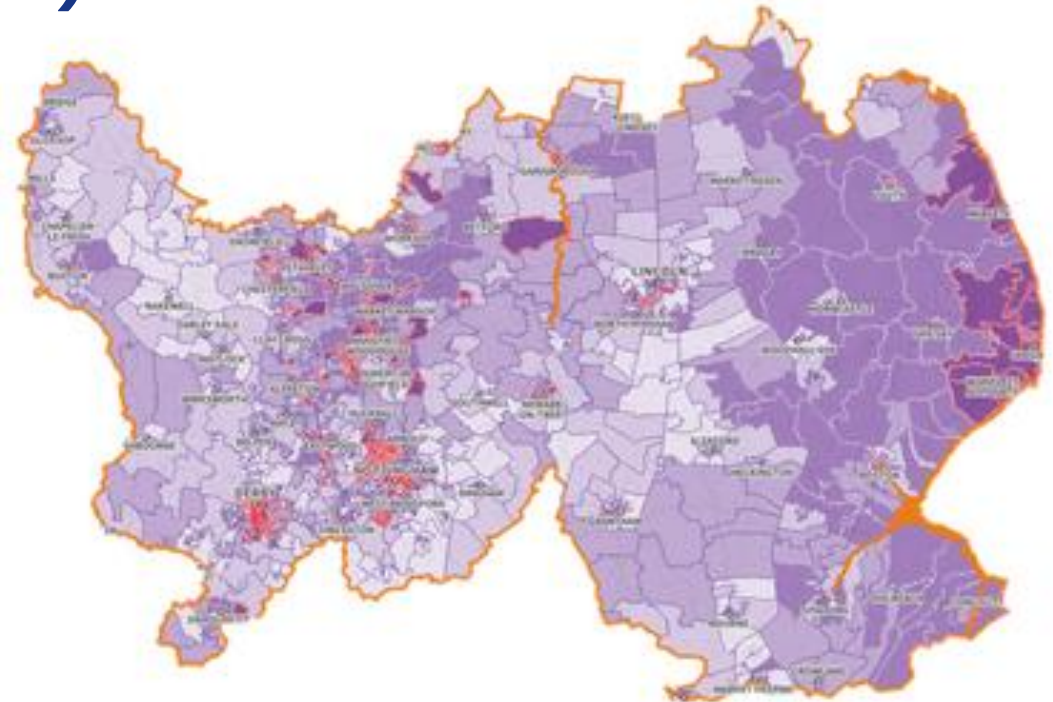
The seven enablers support delivery of the three Cross-Cutting Priorities through aligned communications, proactive case finding, personalisation, digital, neighbourhood teams, incentive/contract levers and sustained productivity

	Strong General Practice	Vaccinations & Screening	Outpatient & Follow-Up Redesign
1. Communications (hearts & minds)	- Publish access standards (telephony, online, F2F); explain team-based model and continuity for complex cohorts - Proactive comms to reduce '8am scramble' perception/improve trust	- Myth-busting; trusted messengers; accessible booking instructions; targeted comms to low-uptake communities - Clear 'why it matters' for each vaccine/screening programme	- Explain 'less routine follow-up' as safe; describe PIFU, remote review, PROMs, safety netting and escalation - Publish pathway changes by specialty
2. Individual & family case finding	- Segmentation & 'top of list' (complex, 'frequent flyers', safeguarding); proactive continuity of lists; care navigation triggers - Active follow-up of non-attenders to reduce inequalities	'Gap lists' for under-immunised and overdue screening; proactive call; outreach for housebound, migrants, learning disability - Reasonable adjustment to convert invites into attendance	- Trigger advice and guidance before referral; identify specialties/clinics with highest low-value follow up rates - Identify candidates for PIFU/remote monitoring
3. Personalisation	- Personalised access and continuity for complex cohorts; tailored support for those with barriers (language, digital exclusion) 'One plan' across MDT; shared decision making	- Tailored invitation and motivational conversations; reasonable adjustments for disability/LD - Personalised reminders/accessible information to improve uptake	- PIFU built around agreed outcomes, triggers and escalation; use of PROMs to guide follow-up - Shared decisions on when follow-up adds value; clear safety-netting
4. Digital technology	- Cloud telephony, e-consult/online advice, workflow automation - Shared record 'do once' data; reduce admin burden; assisted-digital routes for access equity	- Digital booking, reminders and automated call/recall; targeted communications by cohort - Analytics to monitor uptake gaps and refine outreach	- A&G platforms, asynchronous messaging, remote review, PROMs; PIFU enablement; automate scheduling and discharge - Reduce duplicate testing and improve referral quality
5. Integrated Neighbourhood Teams	- GP as anchor: care navigation, team-based care, continuity for complex cohorts; MDT huddles - Neighbourhood leadership and performance oversight	- INT outreach sessions/pop-up clinics; targeted campaigns; home visits as needed; integrate with community diagnostics/pharmacy - Monitor uptake and conversion rates	- Specialist outreach into community /INTs; one-stop clinics; strong interface processes; A&G embedded - Reduce hand-offs and ensure safety-netting as follow-ups reduce
6. Resource shift hospital to community	- Make neighbourhood/PCN contract the 'spine' for access, continuity, MDT delivery and navigation - Align incentives to reduce avoidable UEC and admin burden through shared infrastructure	- Contract call/recall and outreach capacity (mobile/pop-ups), with inequality-weighted funding - Include performance measures for uptake, conversion and reduction in missed appointments	- Re-wire incentives away from volume: expand A&G, PIFU, remote review and community specialist follow-up - Commission multi-neighbourhood at-scale capability to standardise pathways and manage demand

Five Year Strategic Commissioning Plan

(Population Health Improvement Plan)

2026/7 to 2030/31



Contents

Section	Slide	Content
Executive Summary	4	Overview of the ICB's Commissioning Strategy including vision and desired outcome How the Strategic Commissioning plan will seek to deliver the outcomes and key points of the plan
1. Understanding our Strategic Commissioning Context	5	Commissioning challenges/opportunities Health Inequalities and Inequity Population growth and change Productivity and Efficiency Performance Neighbourhood and community transformation
2. Core commissioning Priorities and Ambitions	18	Our Strategic Commissioning Plan “On a Page” Core commissioning ambitions and priorities “On a Page” Core Commissioning System Level Deliverables “At a Glance” (2026–2031) Commissioning System Headline Delivery Targets: 2026/7-2030/31 Outcomes framework (aligned with national metrics and local KPIs/success measures)
3. Commissioning Delivery 2026/7 - 2030/31	24	Framework setting out priority commissioning intentions over the five-year period Summary priority/commissioning outcomes Delivery oversight and governance arrangements
4. Creating the conditions for success	44	Enabling and supporting frameworks and functions that create the conditions for successful delivery of our strategic commissioning responsibilities
5. Risk and Mitigations	49	Risk model High-level risk analysis

Contents

Appendices	Slide		Slide
Appendix 1: Health inequality, inequity, population growth and change Challenges	53	Appendix 8: Workforce, Organisational Development and Estates	70
Appendix 2: Current resource utilisation variation	54	Appendix 9: Evaluation Framework	72
Appendix 3: Productivity and Opportunity Pack data	58	Appendix 10: Citizen Engagement	73
Appendix 4: Quality and Clinical Governance	60	Appendix 11: Summary Operational Delivery Plans	75
Appendix 5: Population Health Intelligence	61	Appendix 12: Addressing the Challenge	98
Appendix 6: Financial Framework, Contract and Market Stewardship	63	Appendix 13: Delivering Improved Outcomes	99
Appendix 7: Shift from Analogue to Digital	69	Appendix 14: Equality Impact Assessment Compliance Summary	100

Executive Summary

We are entering a critical period for health and care, where national, regional, and local ambitions are aligning to create a clear mandate for change. As a new Cluster operating under the NHS Commissioning Framework, we will evolve our operating model to meet the expectations of the Model ICB Blueprint — commissioning at scale for consistency, quality, and value, while enabling providers to work together across Places and Neighbourhoods to lead delivery.

This Five-Year Commissioning Plan spans 2026/27–2030/31 to provide a stable, long-term commissioning direction. It is explicitly aligned to NHS England’s Medium Term Planning Framework (2026/27–2028/29) and will be refreshed through the national planning cycle, with 2026/27–2028/29 treated as the committed delivery and financial trajectory, and 2029/30–2030/31 set out as the indicative direction of travel, subject to annual review, system performance, and updated national guidance.

The Plan brings together the aims of the NHS Long Term Plan, NHS England’s Operational Planning Guidance, the Integrated Care Strategies for Derbyshire, Lincolnshire, and Nottinghamshire, and the expectations set out in our DLN Cluster Strategic Population Health Strategy. It is grounded in Joint Strategic Needs Assessments, Joint Health and Wellbeing Strategies and aligned with the priorities of the East Midlands and Lincolnshire Combined County Authorities.

As a strategic commissioner serving 3.4 million people, we will use our collective influence to create the conditions for system-wide change. This includes a decisive shift from traditional commissioning to a “should cost / should deliver” model, alongside a clear focus on the three strategic shifts: treatment to prevention, hospital to home, and analogue to digital. We will expect improvements in productivity, reductions in avoidable and low-value activity, and action on unwarranted variation — without compromising the quality of primary, community, mental health, or acute care. This Plan is therefore deliberately different from previous approaches: it makes explicit choices, sets measurable outcomes, aligns ambition with affordability, and places neighbourhoods, equity and value at the centre of commissioning decision-making.

Strengthened data, intelligence, and digital innovation will underpin this more mature population health management approach, enabling targeted action to improve outcomes and reduce inequalities. Services will be designed around local needs, rooted in communities, and co-produced with citizens, staff, and partners. Throughout this transformation we will continue to listen actively to the people we serve and ensure their insight shapes the future of health and care. This includes a clear commitment to patient choice, ensuring people are supported to make informed decisions about their care, access services in ways that work for them, and exercise greater control over how care is planned and delivered.

The Plan is delivered in full compliance with the Public Sector Equality Duty under the Equality Act 2010. Equality, health inequality reduction and human rights considerations will be embedded throughout commissioning decision-making, service design, procurement, mobilisation and evaluation, ensuring that improvements in outcomes and efficiency are achieved equitably across all population groups.

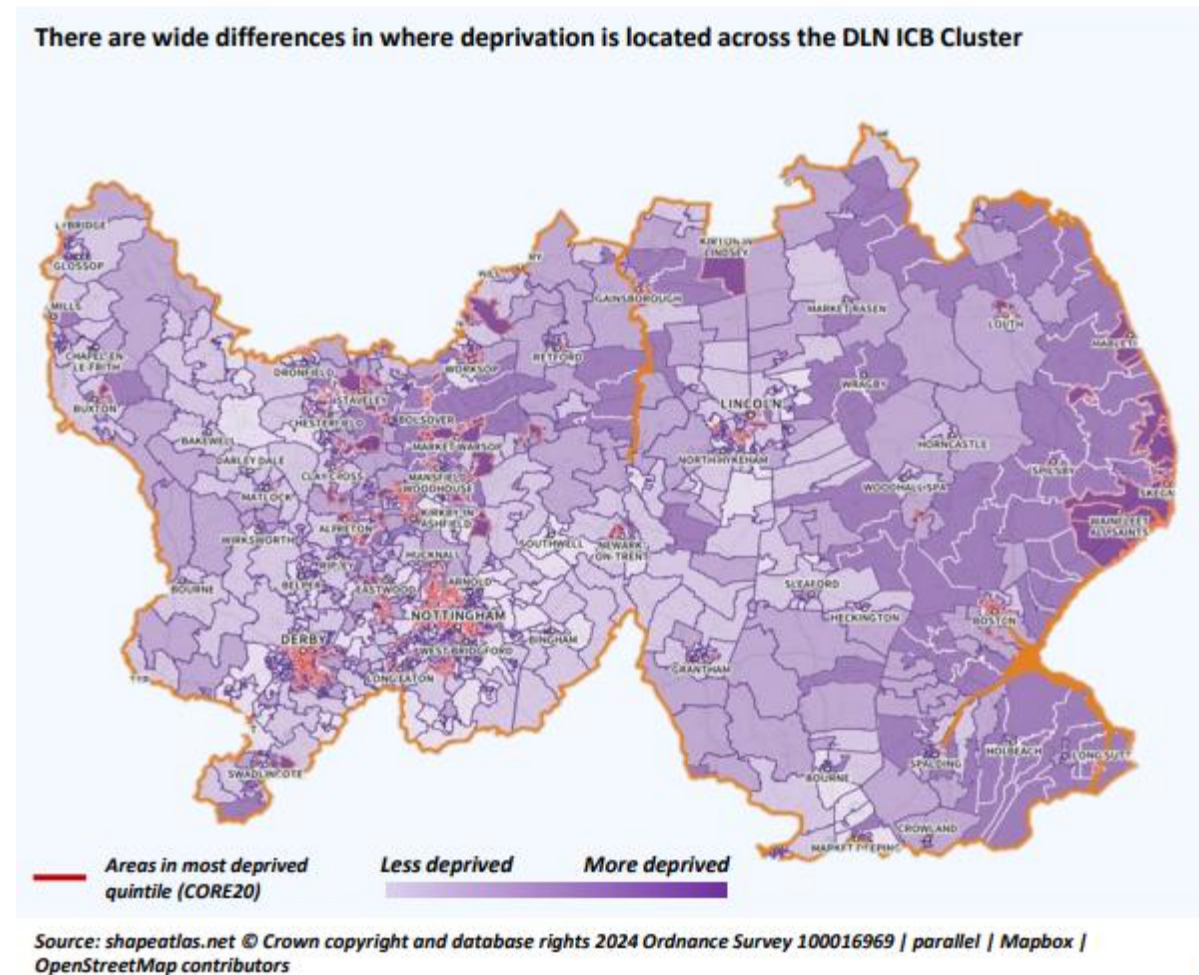
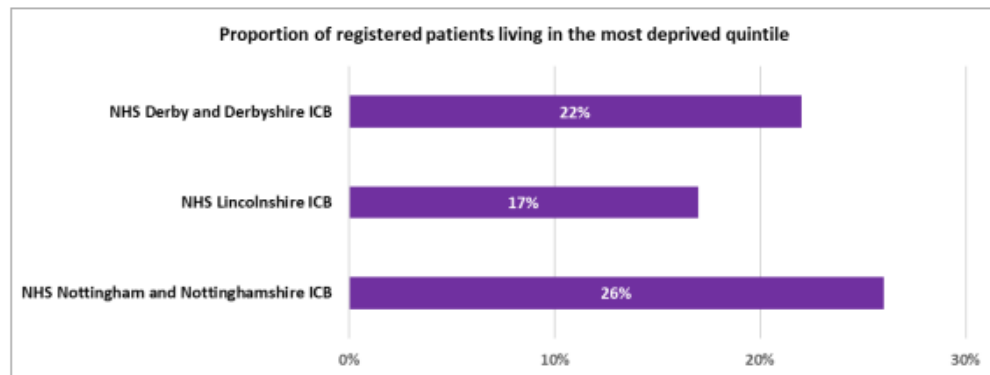
Maria Principe, Executive Director for Commissioning, DLN Cluster

1. Understanding our Strategic Commissioning context

The Cluster Population Health Strategy articulates population need, system challenges and near-term priorities. This section explores how this context shapes our commissioning responses, turning challenge into opportunity to deliver improved outcomes for our population

Strategic Context: Health Inequalities and Inequity Challenges

- There is considerable variation in health inequalities and inequity across our newly established DLN Cluster. This contributes significantly to poor outcomes and has a profound impact on the use of our health and care resources.
- Healthcare can play a role in narrowing (or widening) health inequalities in the population.
- Our ambition is to address health inequalities in healthcare by closing the gap between groups at the same time as improving overall outcomes and quality of care.
- Top causes for years of life lost to death and disability across our Cluster include cardio-vascular disease (inc. stroke), cancer (esp. lung), respiratory diseases (inc. COPD), liver disease. Top risk factors linked to these causes are smoking, high blood pressure, poor diet/nutrition, obesity and wider determinants such as housing, employment and access.
- Some of the villages and towns across the cluster are highly deprived, particularly in North Derbyshire and Nottinghamshire.
- Parts of the Lincolnshire coast are among the most deprived areas of England. About 54% of people Lincolnshire consume about 86% of resources due to long term condition management (incl. frailty).
- Nottingham and Nottinghamshire ICB's population overall is more deprived than the other ICBs in the cluster (28% living in CORE20, Derbys 20%, Lincs 15%)
- Lincolnshire's population is less deprived, but significantly older – resulting in higher crude prevalence of many long-term conditions, including COPD, diabetes, and CVD – although there are pockets of high prevalence across the Cluster (e.g. Bolsover as significantly high mortality rates from CVD).



The changing needs of our population, combined with wider inflationary pressures and cost constraints are driving a highly challenging financial position for our Cluster. It is therefore imperative for financial sustainability that our system operates within its affordability limits. Our future commissioning approach will therefore be focussed on delivery of improved outcomes whilst simultaneously securing in-year financial balance.

Strategic Context: Health Inequality and Inequity driving population health challenges

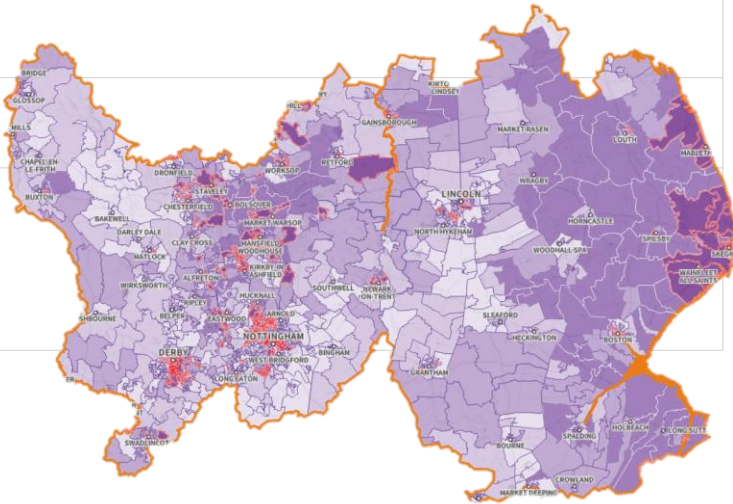
Inherent inequality and inequity, combined with population growth and change, is driving considerable variation in health outcomes and use of resources across Derbyshire, Lincolnshire and Nottinghamshire. We need to reassess our models of care, placing more emphasis on the delivery of improved outcomes rather than operational inputs.

DLN ICB Cluster	Derby	Derbyshire	Lincolnshire	Nottingham	Nottinghamshire
• Wider Determinants: High deprivation and inequality (especially urban areas), low income, low school readiness, poor educational attainment in children, social isolation (adults and vulnerable groups). • Health Improvement: obesity (adults and children), low activity, smoking/pregnancy, high alcohol use and associated admissions • Health Protection: low vaccination, poor oral health, gaps in preventive care (e.g. health checks, substance use support) • Healthcare & Mortality: lower life expectancy, high premature mortality (cancer, SMI, CVD), MSK problems, hip fractures and age-related health burden. • Hospital Utilisation: 15-20% NEL Bed Variation compared to peers. 20–30% of acute beds occupied by people medically fit for discharge. Significant variation and opportunity in high-volume, high-cost services	• High child poverty, contributing to obesity, low vaccination uptake, high infant mortality, poor speech and language development, and high emergency department attendance. • Elevated alcohol-related harm, including high rates of hospital admissions and premature liver-related mortality. • A diverse population, with cultural and language barriers limiting access to services. • Severe local inequalities, with up to an 11.2-year gap in male life expectancy within a small geographic area.	• Substance misuse: Chesterfield significantly higher substance misuse harms, including above-average hospital admissions in 15–24 year olds, one of highest drug-related death rates nationally. • Health inequalities: Marked variation in outcomes across Derbyshire, with hotspots such as higher bowel cancer incidence in Gamesley and increased suicide rates in Belper and Long Eaton. • Community IPC gaps: Lack of comprehensive community infection prevention and control provision, impacting vulnerable groups. • Smoking prevalence: Continued investment in tobacco dependency treatment essential, particularly for maternity services and high-prevalence communities. • Cross-border care: High levels of cross-border patient flow underlining the importance of strong inter-system collaboration.	• Pregnancy, Early Years & Childhood: Challenges include smoking in pregnancy, low breastfeeding rates, childhood obesity, injuries, and emotional wellbeing concerns. • Lifestyle & Adult Health: Poor diet, low physical activity, and high obesity rates contribute to long-term health risks. Early cancer diagnosis is lower than average. • Musculoskeletal & Injuries: MSK conditions are prevalent; hip fractures are high, especially concerning given the ageing population. • Overall: Health inequalities across the life course persist, with early disadvantage compounding risks in adulthood. • High frailty prevalence with fragmented services • High outpatient musculoskeletal activity across multiple providers • Orthopaedic spend above peers with slightly poorer outcomes	• Widespread deprivation driving health inequalities. • High adult smoking rates (18.2%) (although now reducing) and elevated smoking in pregnancy. • Many children in low-income families, with low school readiness and educational attainment. • Low childhood vaccination uptake and poor dental health. • Rising alcohol-related hospital admissions and deaths. • High childhood overweight/obesity (24% reception, 42.5% Year 6).	• Significant north–south health inequalities; ageing population increasing service demand. • Life expectancy and disability-free life years below national averages; premature mortality high for cancer and severe mental illness. • Early years challenges for low-income families, including lower childhood vaccination uptake. • People with SMI and learning disabilities have poorer health outcomes. • High prevalence of overweight/obesity, musculoskeletal problems, and alcohol-related hospital admissions. • Low uptake of adult health checks and substance use treatment completions.
	• Higher staffing spend in diabetes and orthopaedics without proportional outcomes • Stroke mortality above national average • Frailty driving a large share of emergency, community and ambulance demand			• Ageing population driving +60,000 acute bed days by 2030 (do nothing scenario) • Higher emergency demand and missed appointments in most deprived areas • Lower early cancer diagnosis and higher premature mortality in deprived communities Appendices 1-3 provide further detail in respect to impact and opportunities to address variation across our Cluster	

Strategic Context: Health Inequality and Inequity Strategic themes across DLN

Without a fundamental shift in how we commission and deliver health and care, these challenges will continue to shape outcomes for our population. This Commissioning Plan sets out a new, outcomes-focused approach—moving towards more responsive, neighbourhood-based commissioning that better reflects the needs of our local communities.

Challenges	Impact
Entrenched deprivation and inequality	Deprivation is the dominant driver of poor outcomes across the cluster, shaping health from birth to old age and driving variation in life expectancy and healthy life years.
Poor early years outcomes	Early life disadvantage is consistently setting poorer long-term health trajectories, reinforcing intergenerational inequality across DLN.
High prevalence of modifiable health behaviours	Smoking, obesity, physical inactivity and alcohol misuse remain common across DLN, driving preventable disease and avoidable admissions.
High burden of long-term conditions and multimorbidity	Increasing numbers of people are living with multiple long-term conditions, placing sustained pressure on primary, community and acute services.
Inequitable access to prevention and early intervention	Preventive services are least accessed by those at greatest risk, worsening outcomes and increasing downstream cost.
Poor outcomes for people with SMI and learning disabilities	People with SMI and learning disabilities experience consistently poorer physical health outcomes and reduced life expectancy across DLN.
Ageing population and frailty	Ageing populations are increasing frailty, falls and complex care needs, particularly in rural and deprived areas.
Avoidable pressure on urgent and emergency care	High demand on urgent and emergency services reflects unmet need upstream across prevention, primary and community care.



Strategic Context: Productivity and Efficiency Challenges

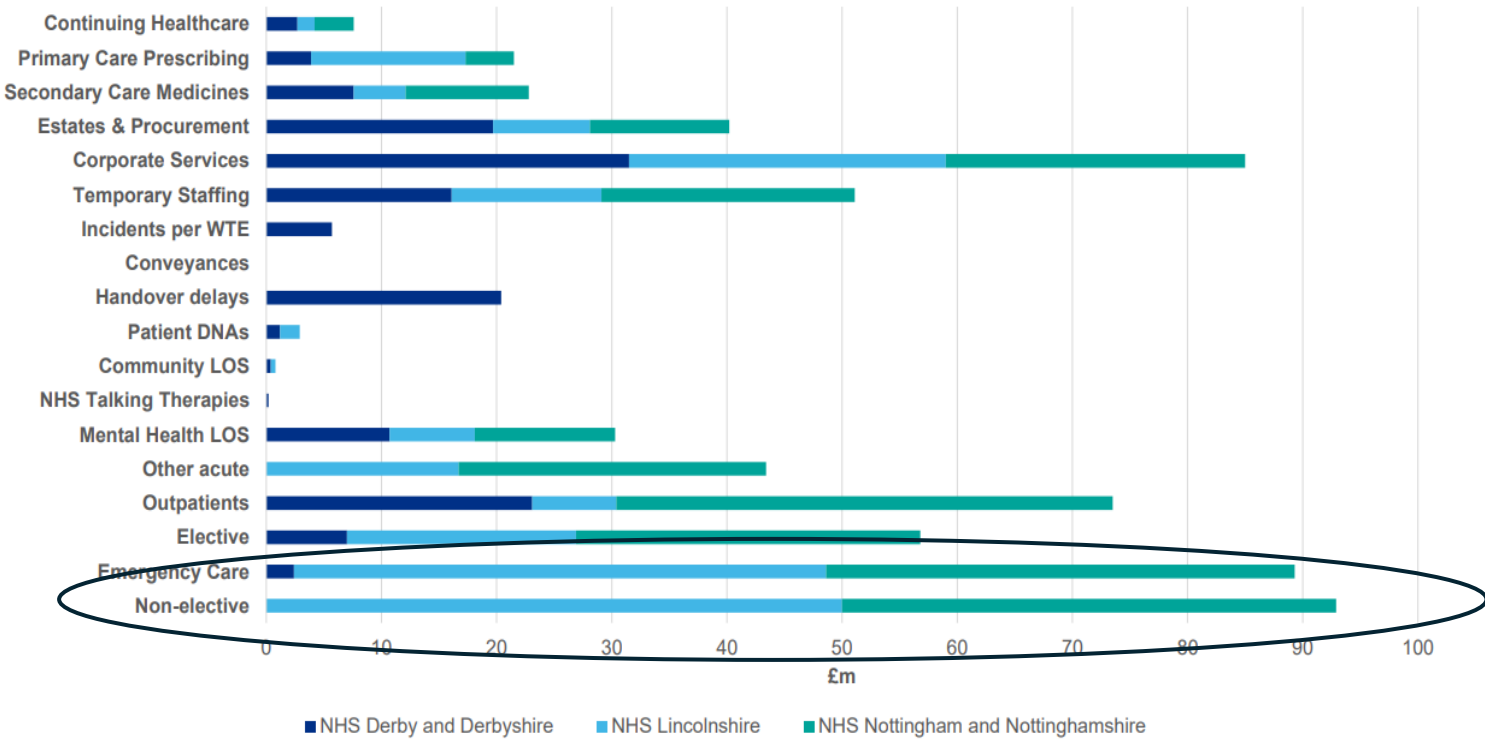
As a strategic commissioner we will continue to demonstrate disciplined stewardship of public resources, ensuring that every pound delivers maximum value and return. There is clear and well-evidenced opportunity to release additional capacity and productivity from resources already committed. Provider efficiency plans and national productivity data highlight where smarter use of investment can strengthen sustainability and create headroom for transformation into new models of care. Realising these opportunities is essential. Without this, the scope to invest in transformation will remain constrained, particularly in a context of continued reliance on system recovery and cost control measures. NHS England Productivity Packs identify opportunities for efficiencies in non-elective and emergency care, together with corporate services, as key areas where targeted action can deliver both efficiency and improved system performance.

Summary of delivery against plan for provider efficiency plans 2025/6 (Month 7)

M7	In Month			YTD		
	Plan (£m)	Actual (£m)	Variance (£m)	Plan (£m)	Actual (£m)	Variance (£m)
D&D	0.6	-6.9	-7.5	-21.0	-29.9	-8.9
Lincs	0.7	0.0	-0.7	-15.5	-24.9	-9.4
N&N	0.6	-15.1	-15.7	0.4	-47.5	-47.9
Cluster	1.9	-22.0	-23.9	-36.1	-102.3	-66.1

M7	In Month			YTD		
	Plan (£m)	Actual (£m)	Variance (£m)	Plan (£m)	Actual (£m)	Variance (£m)
UHDB	0.0	-5.3	-5.4	-13.8	-19.8	-6.0
CRH	0.6	-1.3	-1.9	-6.7	-9.6	-2.9
Lincs ICB	-1.3	-1.0	0.4	-0.9	-9.3	-8.4
ULTH	2.1	0.4	-1.7	-9.9	-11.6	-1.7
NUH	0.0	-8.6	-8.6	0.0	-24.8	-24.8
SFH	0.6	-2.4	-3.0	0.4	-5.7	-6.0
NHT	0.0	-4.1	-4.1	0.0	-17.0	-17.0
High risk orgs	1.9	-22.3	-24.3	-31.0	-97.8	-66.9

Productivity Opportunities Packs | DLN Cluster Overview



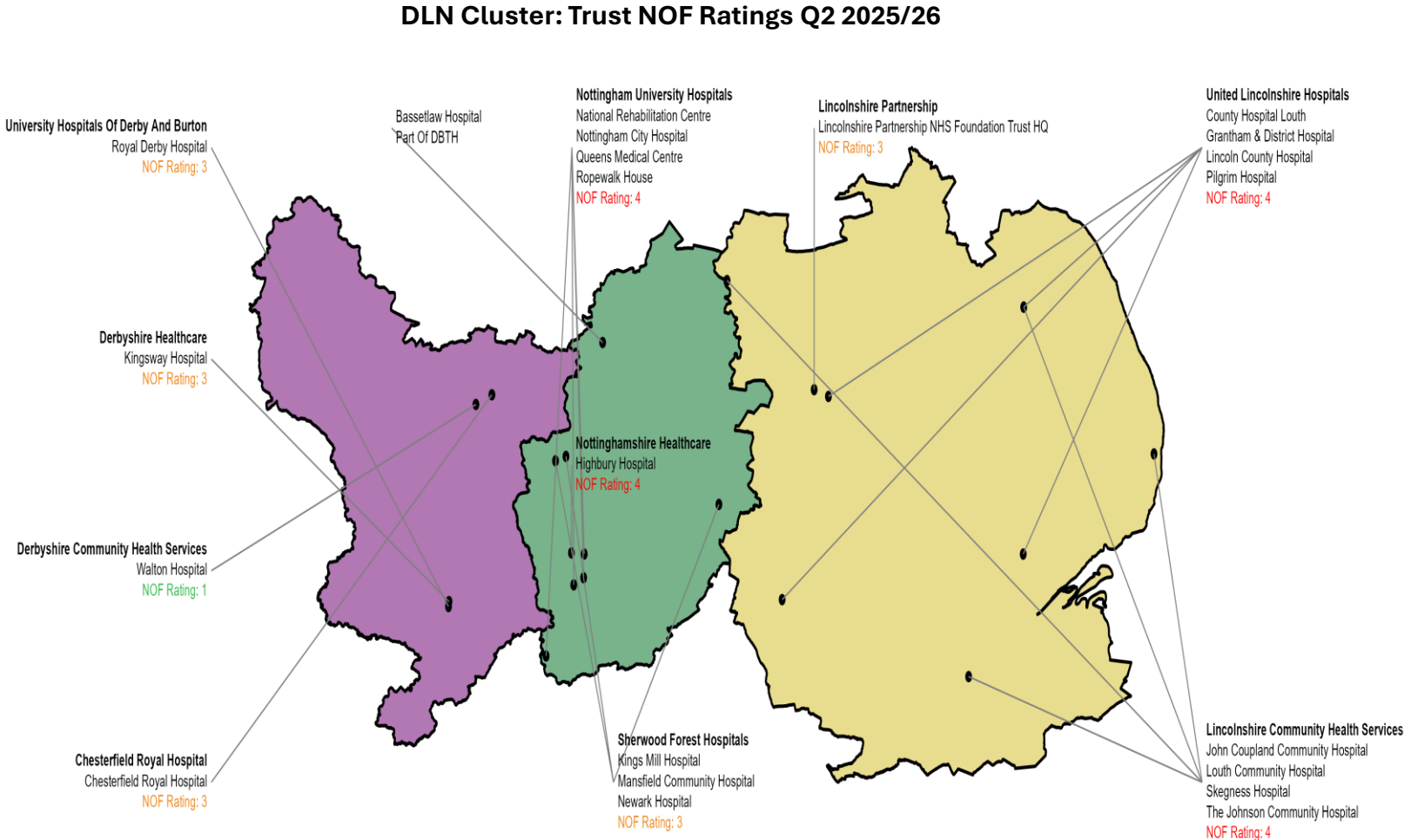
Appendix 2 provides further detail in respect to the opportunities for efficiencies across our Cluster

Strategic Context: Our Performance Challenges

We aim to better align our resources to deliver greater impact from existing investment, while creating the space to innovate and transform local services in support of our strategic ambitions. This will be achieved in close partnership with our providers, recognising current system pressures, including challenges in meeting some local and national standards and the need for focused support where providers are subject to NHS England’s tiered performance oversight.

Domain	Derby & Derbyshire	Lincolnshire	Nottingham & Nottinghamshire
Elective Care			
Cancer – 28-day Dx			
Cancer – 62-day Tx			
Diagnostics – 6-week waits			
ED 4-hour waits			
NHSE Tiering			
GP Access			
Dental UDAs			
Pharmacy First			
Community Services			
Mental Health & LD&A			
Vaccinations			
NHSE Oversight (Q1)			

November 2025



Strategic Context: Summary System Challenges and Opportunities

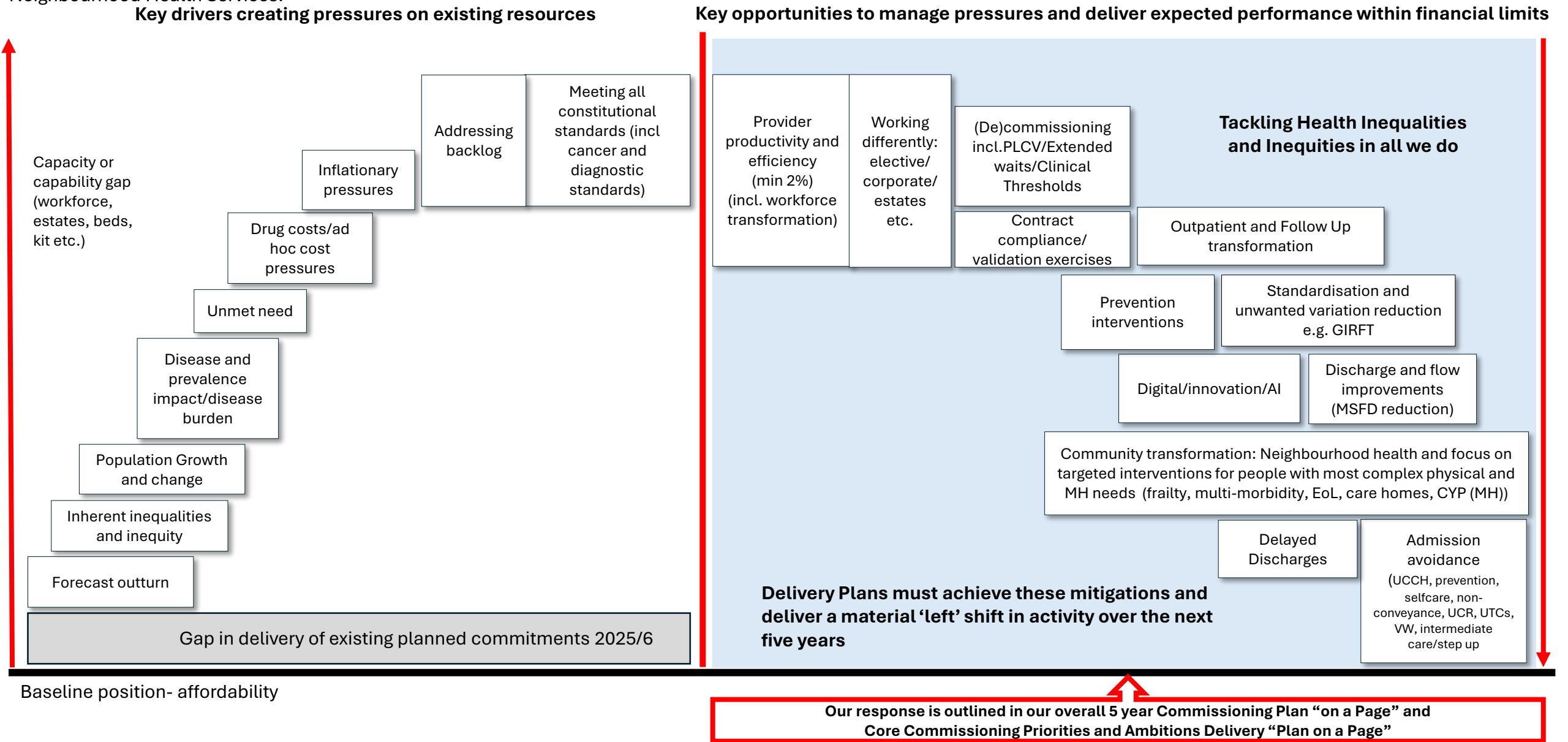
Against a backdrop of population need, performance pressures and financial constraint, we have identified clear opportunities to take a different and more effective commissioning approach. These opportunities will shape our future commissioning intentions and demonstrate strong leadership in delivering meaningful, sustainable change.

Our commissioning opportunities at a DLN level to improve population outcomes
Use shared population health intelligence to consistently prioritise the most deprived communities across DLN, focusing investment and service redesign where avoidable demand and outcome gaps are greatest.
Shift earlier into prevention by strengthening cluster-wide approaches to smoking in pregnancy, childhood vaccination, oral health and school readiness, reducing long-term demand and intergenerational inequality.
Scale proven approaches to smoking cessation, obesity and alcohol harm reduction across the cluster, reducing duplication and variation while targeting communities with the highest risk and lowest engagement.
Redesign care around people with multiple conditions rather than single pathways, strengthening proactive primary and community management to reduce avoidable admissions and outpatient activity.
Improve uptake of screening, health checks and early cancer diagnosis in deprived populations, addressing inverse care patterns that currently drive late presentation and higher cost.
Strengthen cluster-wide focus on physical health for people with SMI and learning disabilities, improving access to prevention and reducing premature mortality through integrated care models.
Proactively identify and support people living with frailty across DLN, reducing emergency demand, delayed discharge and avoidable bed days through earlier intervention and rehabilitation.
Reduce unwarranted variation in NEL bed utilisation by aligning admission avoidance, discharge pathways and community capacity across the cluster.
Improve flow by strengthening step-down, community and reablement capacity, reducing length of stay and releasing acute capacity without additional beds.
Standardise high-volume, high-cost pathways across DLN to reduce variation, improve outcomes and ensure spend is proportionate to benefit.
Shift resource and effort upstream into prevention, primary and community care, addressing unmet need that currently presents late through UEC.
Bend the demand curve by investing earlier in prevention, frailty management and long-term condition optimisation, avoiding a “do nothing” increase in bed days by 2030.

Maximising these opportunities requires us to develop new models of integrated health and care

Strategic Context: Summary System Challenges and Opportunity

We recognise the cumulative impact of challenges on our ability to meet population need, maintain constitutional standards and deliver financial sustainability. Our Five Year Commissioning Plan sets out the actions we will take, including the mitigating measures below, to address these pressures. A key delivery vehicle is the development of Neighbourhood Health Services.



DLN Opportunities: Delivering new models of integrated care

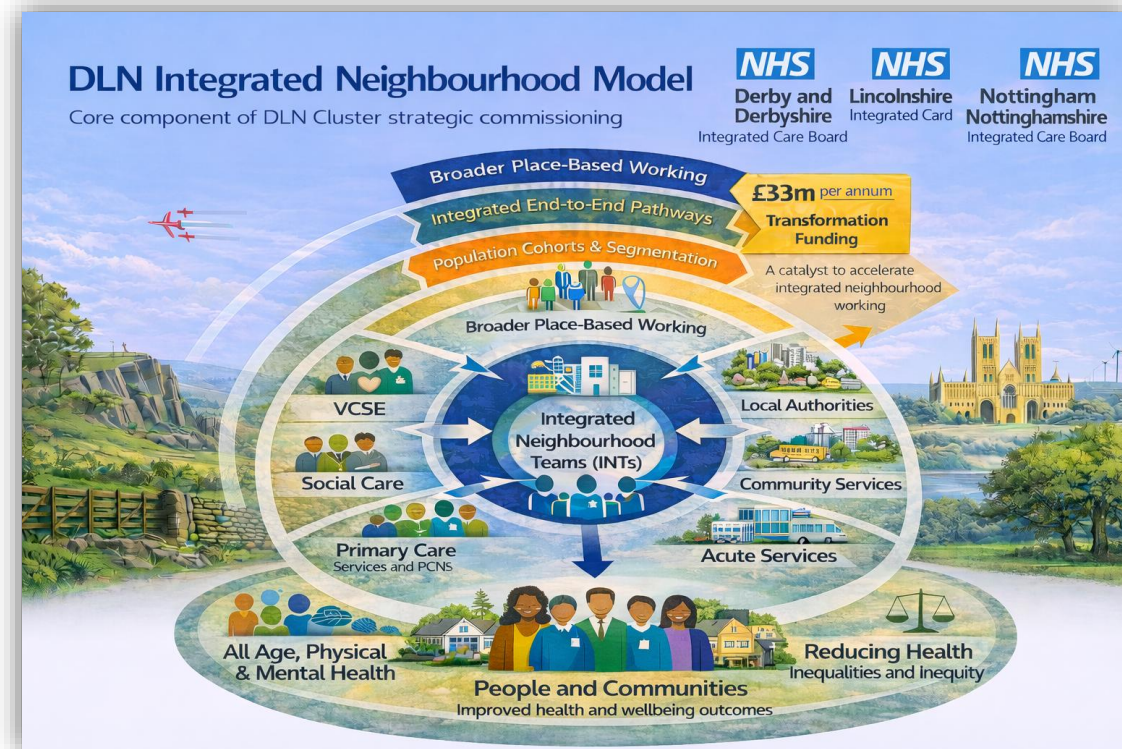
A major transformational opportunity is in the development of new models of care and the delivery of the three shifts towards prevention, digital modes of access and support, and integrated neighbourhood health and wellbeing. While co-design with key stakeholders will shape final models, the consistent core features of integrated neighbourhood health we will seek to commission over the next five years are outlined below. We will make use of new contracting mechanisms to accelerate our achievement of this transformation from 2026/7 onwards. **We have good foundations for this work across our three ICBs – we now need to accelerate implementation for consistency and impact.**

Core Expectations

- Neighbourhood Health Services will typically operate at a population scale of 30,000–50,000, with flexibility to aggregate delivery across multi-neighbourhood footprints (up to c.250,000) where this improves resilience, access and value.
- Strong primary care foundation; embedded VCSE engagement
- Integrated leadership and joint accountability
- Providing coordinated, all-age, physical and MH, relationship-based care
- Support organised around people and communities, not organisations
- A simple, consistent front door to ease navigate, reduce duplication
- A single, integrated health and care team
- Working with communities, carers and people with lived experience to co-design priorities and solutions promoting patient choice, activation and self management.

Core Functions

- Same-day community response to prevent deterioration and avoid unnecessary urgent and emergency care. Services will offer timely clinical assessment, treatment and escalation as required, operating as the default response for people whose needs can be safely met outside hospital.
- Personalised care and activation, including care planning, shared decision making and proportionate use of PHBs for people with complex needs – promoting independence, reduced reliance on reactive services and improving outcomes
- Neighbourhood coordination for priority population groups, including people with moderate and severe frailty, 3+ LTCs, adults and children and young people with mental health needs, and people at the end of life. Complex needs more generally will include SMI, LD/A, High Intensity users – all having a standardised care plan at neighbourhood level with shared metrics
- Proactive, planned and preventative care, informed by population health management and risk stratification.
- Integrated MDTs delivering personalised, continuous and coordinated care across primary, community, acute and wider primary care professions.
- Integrated intermediate care to support recovery, independence and care closer to home.
- Strong links to community assets, including the VCSE, housing, employment and wider public-sector support.



Underpinned by modernising Digital and Technology capability and promoting the three shifts

- Remote monitoring and virtual care options
- Strong use of population health data and local insight to target support where most impactful
- Using joined up information across partners to support seamless care
- Modern digital access routes e.g. online consultations, NHS App, digital telephony to increase efficiency and patient experience

DLN Opportunities: Delivering new models of integrated care

Impact and Outcomes

- Address wider determinants, or building blocks, of health as well as prevention of illness and demand. Early stages of development NHS providers expected to focus on tertiary/secondary prevention to support demand management.
- Interventions culturally sensitive, co-designed by the communities served and individuals
- A focus on improving outcomes where need and opportunity is greatest using a PHM approach
- Outcomes closely monitored, clear targets aligned to strategic priorities
- Improved uptake of prevention opportunities such as vaccinations, screening, early detection, metabolic risk markers

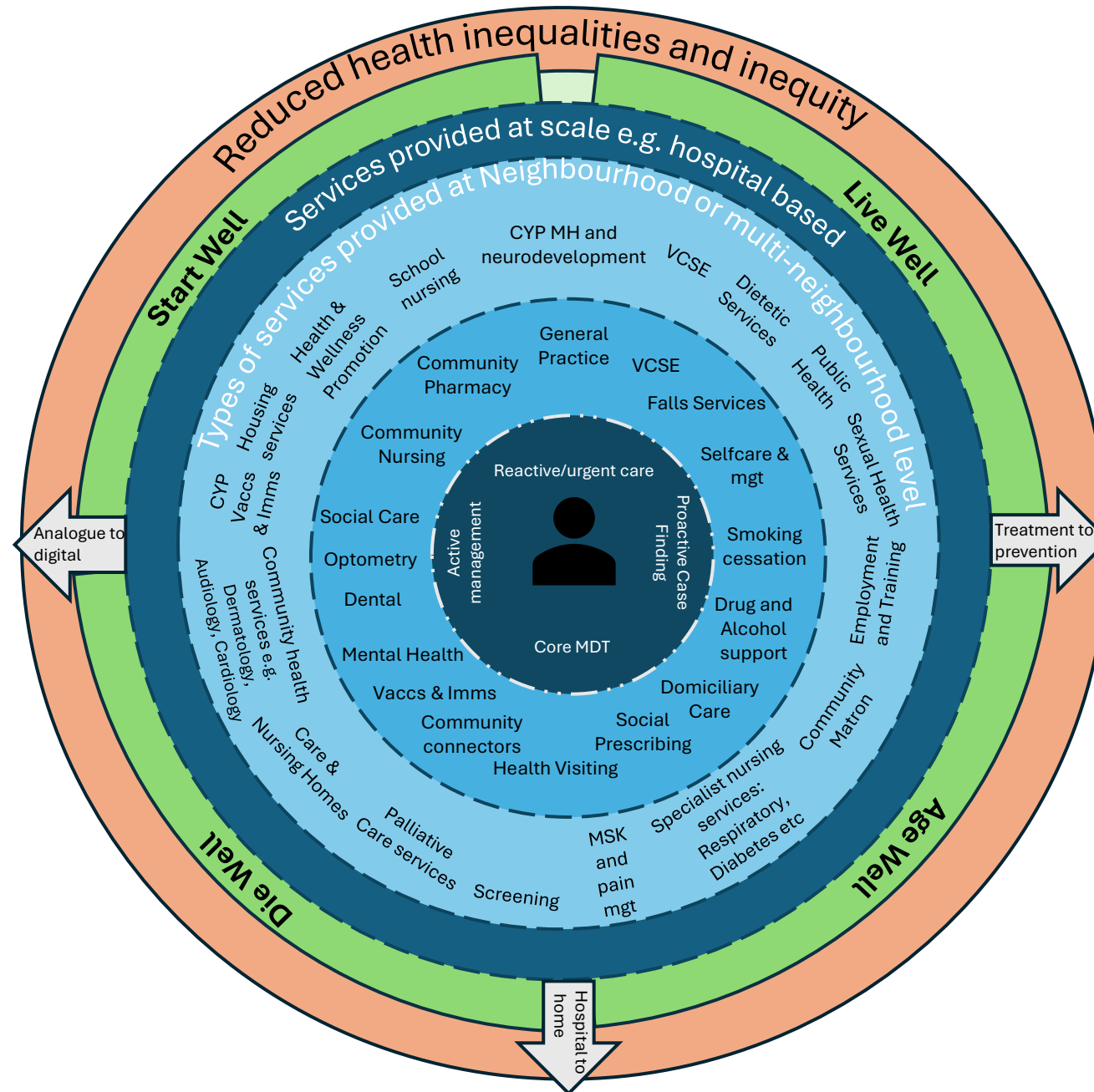
Workforce and Estates

- Integrated and multi-disciplinary, with joint accountability for outcomes and impact
- Ensuring coordinated care for all age, physical and mental health needs of a neighbourhood population, maintaining specific focus on prioritized cohorts
- Working intimately, consistently, with communities and individuals with lived experience to identify, co-design and deliver local interventions that address local priorities
- Consolidation of estates is expected to be a core feature of Neighbourhood Health Centres (NHCs) – providing expanded scope access hubs including local community diagnostic and pharmacy services.

Governance

- Local Neighbourhood Boards/Partnerships with multi-agency and community representation champion neighbourhood health and wellbeing through local voices/insight/intelligence
- Clear decision-making, escalation and joint problem-solving routes at Neighbourhood level
- Proportionate assurance reflecting local need, inequalities, quality and risk
- Health and Wellbeing Boards responsible for oversight of delivery plans/priorities aligned with annual Neighbourhood Health Needs Assessments and overall population health outcomes - “what matters”
- Strategic commissioners retain accountability for commissioning delivery responses to neighbourhood needs and priorities – “how it is delivered”

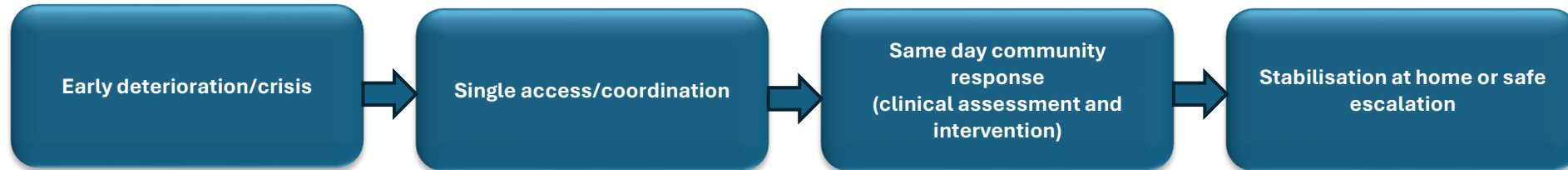
Developing our Neighbourhood Target Operating Model



Our target operating model will continue to be co-designed with our strategic partners and Health and Wellbeing Boards. Services that could emerge as part of new models of integrated neighbourhood working, aligned to our life course approach and at different delivery scales are illustrated here. The specific scale, form and function of services will be dependent upon the priorities of each Neighbourhood.

Developing our Neighbourhood Target Operating Model

Same day, reactive, community response to Neighbourhood Population Need

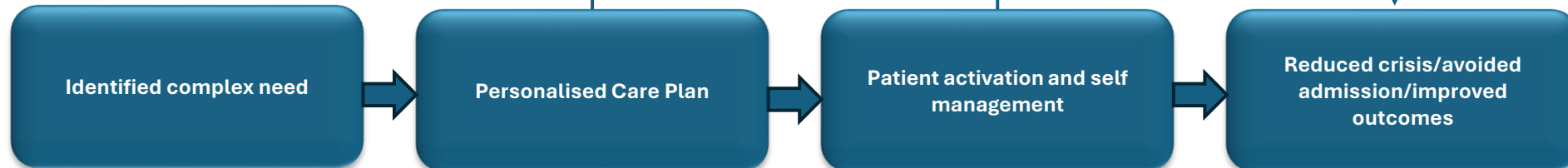


Single access point

Rapid clinical decision making

Alternatives to ED

Time limited intervention(s)



Active case finding

Supported care planning, single care plan

Empowered decision making; earlier recognition of deterioration

Proportionate use of personal health budgets

Proactive and planned community response to Neighbourhood Population Need

DLN Opportunities: Delivering new models of integrated care

2026/7

Prioritise and Learn

Establish the conditions for sustainable transformation



What changes for Providers

- Move from single-organisation planning to joint neighbourhood design.
- Participate collaboratively in co-design of integrated pathways and MDT models.
- Accelerate testing of new roles, skill mix, MDT working and shared governance.
- Early adopter providers supported with Transformation Fund allocations to de-risk change.

What changes for Commissioners

- Shift from activity management to outcomes-led commissioning intent.
- Define neighbourhood footprints (with HWBs), priority cohorts and investment focus (aligned to NHSE Guidance).
- Introduce enabling transformation funding and early contractual flexibilities/risk share/gain share options.
- Establish clear success measures and ROI expectations.
- Establish robust governance and oversight of delivery.
- Establish data capture/mapping of performance variation.

What changes for Neighbourhood Teams

- Formation of Integrated Neighbourhood Teams (INTs).
- Initial MDT working focused on 'core' priority cohorts.
- Clear neighbourhood leadership and clinical ownership. PCNs play critical role as does VCSE.
- Early use of population health insights to target need.

2027/8

Scale and Optimise

Achieve system level impact, realise early benefits



What changes for Providers

- Scale consistent neighbourhood delivery beyond initial priority PCNs to core service lines as a minimum.
- Work across organisational boundaries with shared accountability.
- Accelerate shift of capacity from reactive care towards proactive, preventative interventions.
- Begin operating under shared outcomes and aligned incentives.

What changes for Commissioners

- Move from funding initial tranche of priority PCNs/neighbourhoods to strategic investment at scale where evidence of impact and ROI is assured.
- Use transformation funding to incentivise ongoing collaboration and delivery where still warranted.
- Introduce contract 'wrappers' or aligned contractual mechanisms with shared outcomes. Review options of new national contracting forms.
- Actively manage variation and support under-performing INTs/neighbourhoods.

What changes for Neighbourhood Teams

- MDTs become routine, regular and decision-making.
- Stronger links to urgent care, community services and social care.
- Expanded scope of practice and clearer escalation/de-escalation pathways.
- Growing confidence, capability and shared ownership of outcomes across provider community.

2028/9+

Normalise and Reinvest

Make neighbourhood working business as usual



What changes for Providers

- Neighbourhood delivery becomes core business, not an add-on.
- Duplicative functions, waste and inefficiency identified and removed.
- Providers operate within integrated pathways, not isolated services.
- Increased focus on population outcomes, quality and productivity.
- Reduced reliance on acute and reactive models where avoidable.

What changes for Commissioners

- Neighbourhoods embedded as a core unit of commissioning and delivery.
- Resources and contracts aligned to long-term outcomes and value.
- Reduced emphasis on activity-based management.
- Ability to reinvest released capacity into prevention and innovation.

What changes for Neighbourhood Teams

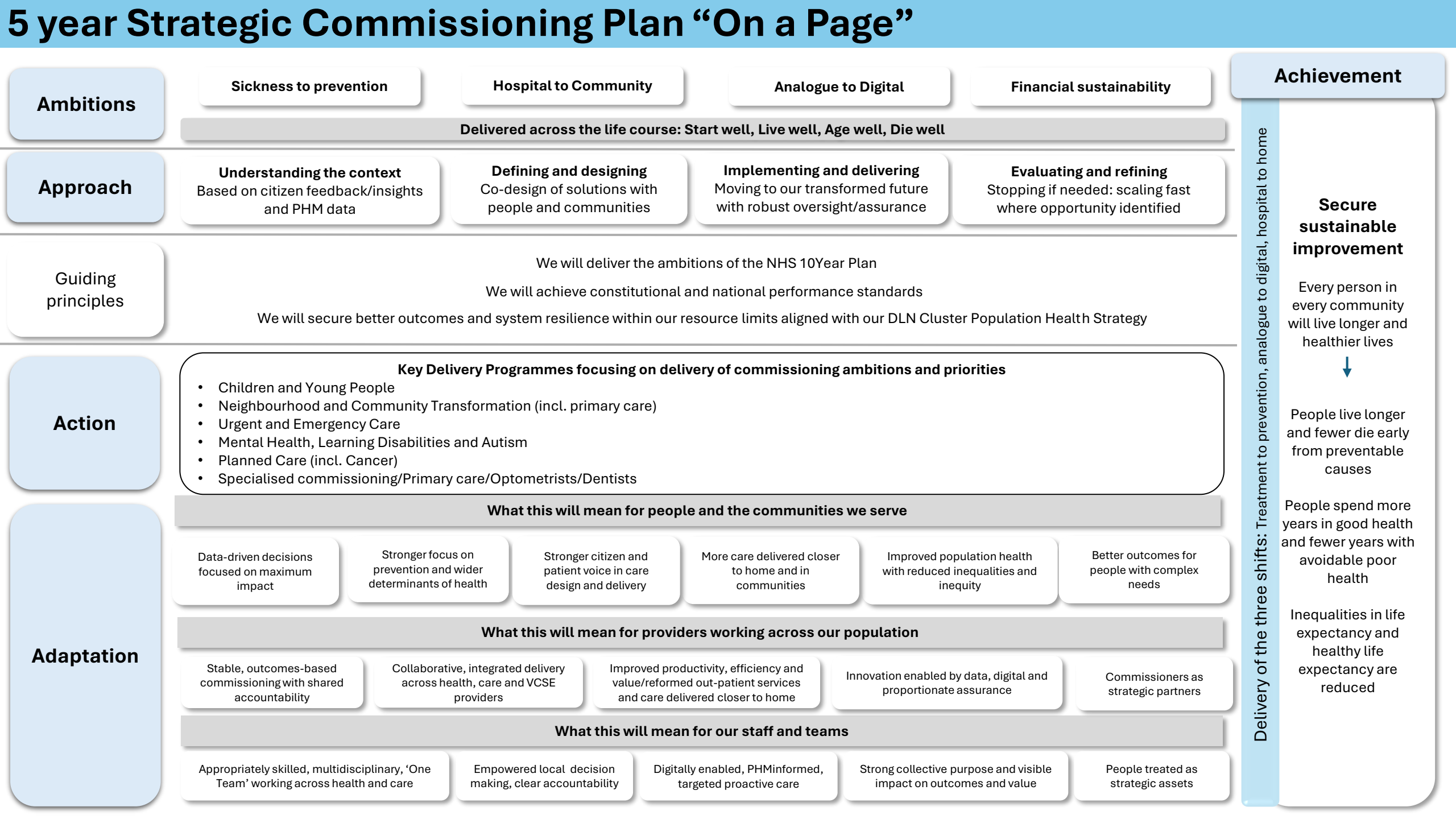
- INTs fully embedded with clear authority, stable workforce, shared records and use of PHM data to target/refine activity.
- Strong relationships with VCSE, local authority and community partners.
- Focus shifts from managing demand to improving population health.
- Neighbourhood teams recognised as a permanent and valued delivery model.

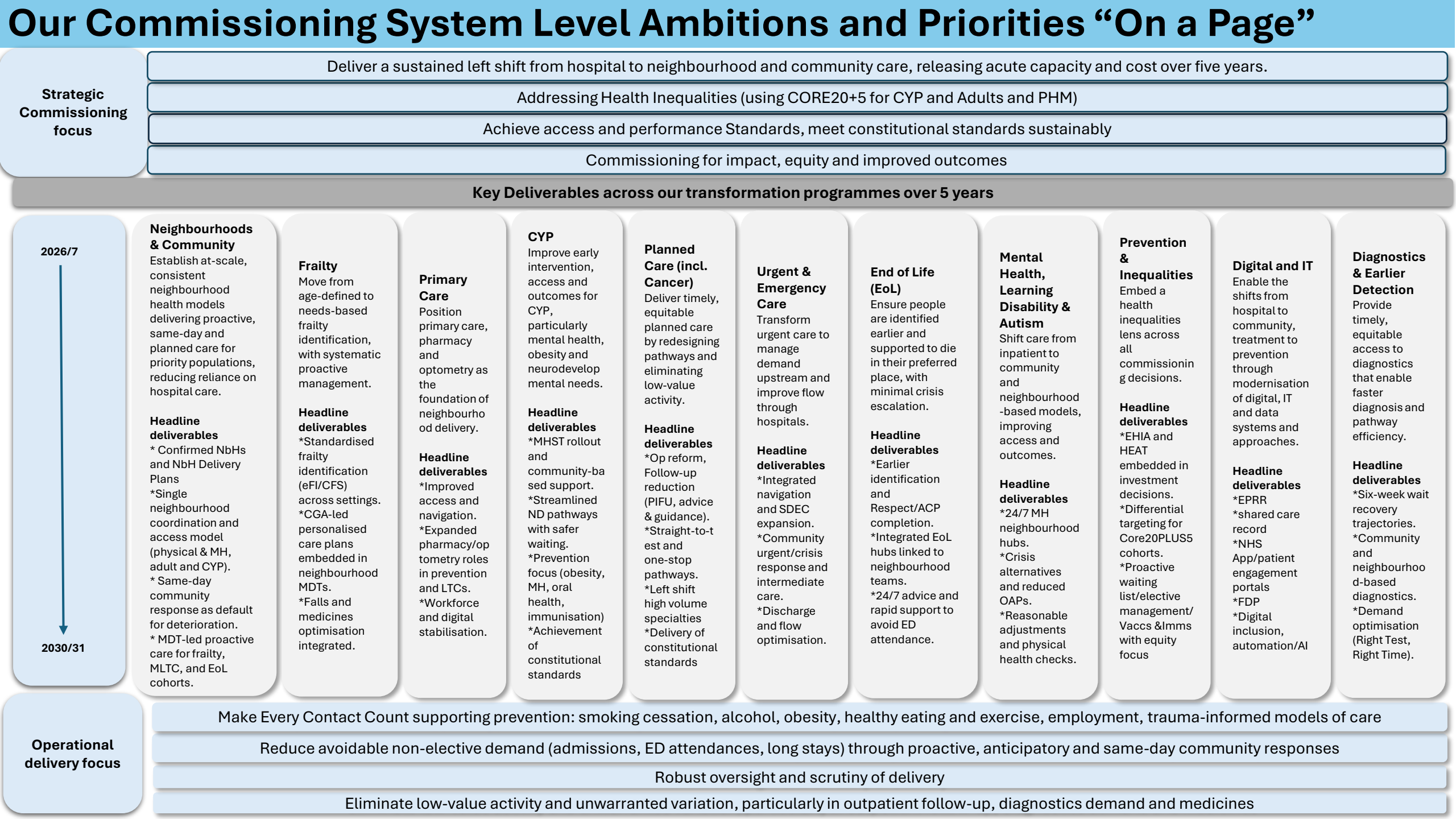
2. Core commissioning ambitions and priorities

This section describes the commissioning approach that will drive delivery over the next five years within this challenging context. It outlines in more detail how we will convert strategic ambition into tangible change on the ground through coordinated action by commissioning leads working collaboratively with providers and system partners. It sets out the level of ambition through clear delivery expectations and measurable population outcomes.

Our commissioning approach follows NHS England's strategic commissioning expectations: using population need and insight to set priorities; co-designing service and pathway changes with partners and communities; contracting and incentivising delivery around outcomes and value; and continuously evaluating impact to scale what works and stop what does not. This ensures our role as a strategic commissioner is consistently applied across all programmes and population scales. Choice and personalisation will be actively enabled through commissioning, including pathway design, contracting and digital access so that people can choose how, where and by whom they receive care wherever clinically appropriate.

The “Plan on a Page” (Slide 19) provides a single, high-level view of our strategic commissioning direction—linking population priorities, transformation programmes, neighbourhood delivery and system enablers—while the sections that follow set out the commissioning approach, outcomes and delivery expectations in more detail, supported by programme-level plans and operational trajectories.





Commissioning System Headline Delivery Targets: 2026/7-2030/31

These headline targets represent the **GROSS system impact** we will deliver over five years. Delivery will be mainly achieved through (1) pathway redesign (including outpatient and follow-up transformation), (2) neighbourhood health models providing proactive and same-day community response, (3) demand management and prevention, and (4) stronger contracting, productivity and variation reduction. Detailed baselines, phasing, programme contributions, and dependencies (workforce, digital, estates and provider capacity) will be set out in programme delivery plans and tracked through benefits realisation and governance. Delivery trajectories assume timely availability of workforce, digital enablement, estates capacity and provider readiness, alongside sustained collaboration across system partners*. These risks, dependencies or external constraints which we recognise may materially affect delivery pace, will be robustly reviewed and managed through transformation programme and wider system governance arrangements to ensure continued affordability, safety and system stability.

Headline delivery targets

Total 1st Outpatient
Acute Activity
reduced by 25%

Total Acute Follow Ups
reduced by 25%
(baseline 2019/20)

<90 day Emergency
Readmissions (adults)
(excluding cancer pts)
reduced by 25%

Non-Elective
Admissions reduced by
36%

Occupied bed days
(non-elective acute and
community beds)
reduced by 10%

Emergency department
attendance reduction
33%**

Phasing

-5% by Q4 2026/7
-10% by Q4 2027/8
-15% by Q4 2028/9
-20% by Q4 2029/30
-25% by Q4 2030/31

-25% by Q4 2030/31

-5% by Q4 2026/7
-15% by Q4 2027/8
-25% by Q4 2028/9

-min 5% by Q4 2026/7
-min 10% by Q4 2028/9
-min 20% by Q4 2029/30
-min 36% by Q4 2030/31

-2% by Q4 2026/7
-4% by Q4 2027/8
-6% by Q4 2028/9
-8% by Q4 2030/31
-10% by Q4 2029/30

-5% by Q4 2026/7
-10% by Q4 2027/8
-15% by Q4 2028/9
-25% by Q4 2029/30
-33% by Q4 2030/31

Supporting interventions/initiatives

Transformation of outpatients. This is activity out but will be supported by wider initiatives to also offer alternative modes of advice and guidance, digital and self help/PIFUs. Stronger grip and control and appropriate use of A&G and triage will be critical.

Primary mechanism via contract activity amendments i.e. reduction in acute follow up activity/F:FU ratios, and expected increase in virtual appointments. Strong correlation with patient empowerment/self care/PIFU.

Supported through the development of UCCH, EoL, care home patient management and support via Neighbourhood Health Services including reactive/same day care. Expected that Transformation Funding applications will focus on this as a key deliverable. Also supported by improved primary care access, diagnostics.

Likely to impact on our strategic priority cohorts

Supported through promotion of weekend discharge back into community or 'at home' based care. Also supported by Neighbourhood Health Service development of proactive, planned and reactive care for frail/MLTC/care home/EoL patients. Expected that Transformation Funding applications will focus on this as a key deliverable.

(*Default baseline position 2025/6 unless otherwise stated)

(** see Appendix 6 for further detail)

Commissioning System Headline Delivery Targets: 2026/7-2030/31

Headline delivery targets

Left Shift in high volume specialties

(e.g. Ophthalmology, Dermatology, MSK, Gynae, ENT, urology, metabolic risk)

Full population coverage of Neighbourhood Health Services

(to minimum specification)

National Access Standards Delivered

Min 90% same day GP appointments for all clinically urgent patients

Reduce CYP long waits for MH services

MH UEC Hubs across all ICBs for adults and CYP

Phasing

Trajectories to be agreed at Place and specialty level from 2026/7

100% by Q4 2026/7

Includes:
RTT, Cancer, Diagnostics
ED Flow, 52 ww, MH
(adults and CYP)

by Q4 2028/9

zero 52ww by Q4 2030/31
zero 104ww by Q4 2028/9

by Q4 2028/9

Supporting interventions/initiatives

Delivery of the left shift requires moving activity from acute to community settings, with primary care—general practice, dentistry, optometry and community pharmacy—playing a central role through reformed contracts, improved access and productivity, reduced variation, and integrated neighbourhood health models. We will explicitly manage the transition to avoid destabilising services, including agreed approaches to double-running, activity risk, and gainshare where appropriate, so that resources can move safely from acute to neighbourhood delivery.

Development of Neighbourhood Health Services is a key priority of the Commissioning Plan – with significant interdependency for delivery of key delivery targets. Commissioning support for Neighbourhood new models of care has remained substantial and will continue over the next five years to support the model's maturity. This includes the development of a Transformation Fund £33m per annum which will identify development of Neighbourhoods as an area of priority investment support.

Providers are expected to commit to delivery of standards or as minimum demonstrate aggressive plans to work towards as part of planning and activity profiles.

Establishment of performance oversight mechanisms for GP practices, identification of variation, routine reporting of benchmarked data to practices, support/contract oversight arrangements consistently applied across the Cluster.

Supported through the ongoing programme of work in collaboration with providers to review pathways of care in areas of greatest challenge. Includes the creation of MH Hubs, community teams and graduated support pathways reducing exacerbation as well as supporting crisis management support.

As part of extended provision of urgent mental health crisis facilities and ensuing 24/7 accessible crisis pathways. Requirement to be integrated into broader urgent care pathways including community crisis teams and NHS 111 MH response.

Commissioning System Delivery : Addressing barriers to achievement

As a strategic commissioner, we have explicitly designed this Plan to overcome the delivery barriers that have historically prevented ambition from translating into impact. It sets out how we commission, govern and assure delivery, ensuring measurable improvements in outcomes, reduced inequalities and sustainable use of resources. Below is a summary of key themes about what will be different this time, building on our knowledge of what has gone before, in order to improve our chances of success over the next five years.

Stronger commissioning grip on delivery of provider productivity, efficiency and cost improvement plans, aligned to system financial trajectories.



Rigorous, data-driven and evidence-based commissioning, linking population need, outcomes and financial impact



Stronger emphasis on market development and management supporting new models of care



Stronger scrutiny of variation, offering support and constructive challenge where unwanted or unwarranted; eradication of low value activity



Cultural shift: Clinical leadership and stewardship emphasising 'value add' decision making



More sophisticated, outcomes-based commissioning with defined success measures, milestones and benefits realisation



Well defined system governance with clarity of accountabilities and responsibilities as well as delivery of outcomes and underpinning trajectories



Intentful shift in commissioning resource allocation towards upstream interventions (prevention and neighbourhood health services)



Increased appetite for financial, digital, analytical and contracting innovation to secure delivery of outcomes, performance standards, financial balance



Clarity of commitment to a five year set of strategic commissioning ambitions



Realigned relationships with partner organisations: retaining role as an active partner and system enabler, empowering providers to take responsibility for delivery



More effective contract management and commercial oversight, accelerating delivery of "should cost" models and outcome-based incentives



Systematic benefits realisation and financial impact tracking, ensuring commissioning decisions deliver measurable value and deliver MTFP



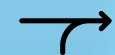
Population Health Management approach embedded into service delivery and changes: population segmentation supporting more targeted/prioritised resource allocation where need and inequality greatest



Maximising the benefits of scale through standardisation, aggregation and strategic investment across a larger commissioning footprint: working cross-system on shared challenges e.g. estates, workforce, digital



Increased emphasis on demand management, pathway simplification and standardisation/consistency shifting care from acute into community at scale



3. Commissioning Delivery 2026/7-2030/1

This section brings clarity to the outcomes we will deliver across our priority transformation themes and population groups, setting out what success looks like over the next five years. It establishes clear priorities to ensure our limited resources are applied deliberately and decisively, focusing on the interventions that will deliver the greatest population impact. This disciplined approach recognises the need to make choices, to pace delivery, and to continually review how capacity is deployed as circumstances evolve and our strategic commissioning operating model matures. The delivery horizon extends across the full five-year period to 2030/31, providing a clear and credible trajectory for transformation.

In response to this delivery commitment, far more granular programme and project plans will be developed over the immediate period across our five key transformational programmes: Neighbourhood and Community Transformation (including primary care), Planned Care (including Cancer), Children and Young People, Mental Health (including LD and Autism), and Urgent and Emergency Care. Initial outline Delivery plans providing more granular detail in respect to deliverables, milestones, timescales and impact are provided in Appendix 11.

The Executive Director for Commissioning will hold system-wide responsibility for delivery of the Plan.

Core Commissioning Outcomes - Delivery

The following section sets out the high-level priorities that we will focus on that will deliver meaningful, system-wide change over the next five years (2026/27–2030/31). They are intentional outcome-focused, providing a clear line of sight between ambition and impact, while avoiding unnecessary operational detail.

More detailed delivery plans with milestones, deliverables and dependencies sit within **Appendix 11**. This approach ensures the main document remains clear and strategic, while retaining the necessary depth to support delivery, assurance and performance management.

Together, these priorities demonstrate the core enablers and interventions required to deliver change and directly address the challenges and system pressures identified in the Strategic Context section above.

Delivery of these priorities will be further refined, phased and planned across the five-year period, recognising the need for sequencing, system readiness and sustained improvement rather than short-term fixes.

KEY:

Delivery status indicators - Each priority is shown against an annual trajectory using the following status symbols:

-  **Blue square** – *Planning / design phase*
-  **Orange circle** – *In progress / implementation underway*
-  **Green circle** – *Delivered / embedded*

In recognition of the capacity limitations on commissioning resources prioritisation of delivery is also identified using a score of 1-3 where
1 = MUST DO,
2 = SHOULD DO,
3 = NICE to DO

These indicators provide a clear, visual representation of maturity over time, supporting oversight, accountability and transparency as delivery progresses.

Access Priorities 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Unnecessary outpatient activity reduced by 25% in total, through pathway redesign, advice & guidance and virtual delivery	1					
Patient-initiated follow-up and advice & guidance embedded, reducing first-to-follow-up ratios by 40% in total. PIFU standard approach for all clinically appropriate pathways by end 2026.	1					
25% of outpatient consultations delivered virtually where clinically appropriate	2					
Missed appointments reduced, with no more than 6.6% not attended or cancelled late	2					
All referrals made using standardised digital referral systems, reducing paper referrals by 25% by 2031	2					
Long waiters eliminated, achieving sustained elimination of >65-week and >52-week waits	1					
Elective access restored, with at least 92% of patients waiting 18 weeks or less	1					
A&E 4 hour, 12 hour performance standards consistently met, supported by reduced avoidable attendances and improved flow	1					

Neighbourhoods and Community Priorities - 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Population coverage of Integrated Neighbourhood Teams reaches 100% using standardised specification by end 2026/7	1					
ED attendances reduce by 15% in total by end of Qt 4 2029/30	1					
Left Shift Dermatology, MSK, Gynae and Pain (2026) followed by Paeds, Gastro and ENT (2027) into community neighbourhood model	2					
Crisis mental health presentations reduced through neighbourhood-based alternatives and integrated support	2					
Identification and support of unpaid carers improved, reducing carer breakdown and avoidable admissions	3					
100% of Referrals for Left shift referred and triaged through RSS	3					
People supported to live independently at home for longer, with a 5% reduced care home admissions by 2031	2					
People discharged from acutes are received to their usual place of residence increased by at least 3%	3					
Proactive approach to LTC reducing non-elective admissions year-on-year to achieve overall 36% reduction over five years (supported by strong focus on same day care)	1					

Frailty Priorities - 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Frailty consistently identified and coded in primary care, with a minimum 20% increase in frailty coding	1					
At least 80% of people living with moderate or severe frailty receive an annual holistic frailty review (PCSP, Respect, falls assessment)	2					
At least 80% of people at high risk of fall living with frailty receive an annual falls risk assessment	3					
Emergency admissions for people with frailty or 3+ LTCs reduced by at least 20% by 2028/29	1					
Ambulatory Care Sensitive Condition admissions reduced by at least 30% for frail or 3+LTCs populations by 2030/31	2					
90-day emergency readmissions for people aged 55+yrs reduced by at least 20% by 2030/31	1					
Minimum 1% year-on-year increase (26/7-30/1) in discharge for people with frailty or 3+LTCs to usual place of residence	3					
Intermediate care and virtual ward capacity embedded, supporting step-up and step-down care for frailty	2					
Carers of people living with frailty identified and supported, with personalised support plans in place	3					
Frailty pathways embedded within neighbourhood operating models, reducing unwarranted variation between places	1					
Structured medication reviews embedded for priority cohorts, reaching ≥60% of people with frailty, care home residents and complex LTCs	1					

End of Life Priorities- 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
At least 85% of people in their last year of life identified and recorded, with a documented advance care plan – visible across urgent, community and acute settings	1					
Personalised end-of-life care plans shared and visible across urgent, community and acute settings	1					
ReSPECT plans in place for those on EoL register increased by 12%, reducing avoidable conveyance and admissions and visible across urgent, community and acute settings	1					
Reduction in non-beneficial hospital admissions in the last 90 days of life	3					
People dying in their preferred place of death increased by at least 2% by 2028/29	2					
Consistent access to 24/7 palliative and end-of-life advice and support, including community and hospice services	2					
Improved coordination between EoL services, UEC, ambulance and out-of-hours providers	2					
Reduction in inappropriate emergency department attendance in the last year of life	3					
Improved patient and carer experience measures for end-of-life care, including feeling supported and listened to	3					
Improve the recognition of people in their last year of life – with the aim of achieving the 1% of population on the GSF register for between 6 and 12 months before death	1					

Primary Care Priorities - 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Ensure timely access to assessment (GP in-hours) with 90% of ‘clinically urgent’ cases seen same day’ (face to face, phone or on-line)	1					
Improve access to NHS dentistry – deliver ICB shares of additional urgent dental appointments (tbc); increase number of patients accessing routine NHS dental care by X% (tbc)	1					
Maximise use of pharmacies and deliver the Community Pharmacy Strategy :X% (tbc) increase in pharmacy first consultations (5.6% in 26/27) including emergency contraception & roll out of new services (e.g. emergency contraceptives and HPV)	1					
Reduce unwarranted negative variation across General Practice (overall reduction in negative indicators)	2					
Improve patient experience of access to General Practice focusing on those factors that the ICB cluster can most influence (year on year improvement measured through HIS , national and friends and family surveys)	2					
Ensure effective referrals from General Practice to support outpatient and elective transformation. Increase use of advice & guidance to ?min 20% per 1000 OPFA)	2					
Optimise primary care providers use of digital technology (e.g. digital triage and ambient voice technologies)	2					
Working within neighbourhoods manage the needs of high priority cohorts to improve their care and reduce avoidable admissions (working to targets within community/ frailty plans)	2					

Primary Care Priorities - 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Deliver the Oral Health Needs Strategy, implementing locally driven quality improvement approaches for dentistry to support high needs and complex patients	2					
Ensure consistent GP & POD input into neighbourhood multi-disciplinary teams, and neighbourhood leadership and governance	2					
Develop and optimise community optometry services in line with the eye health needs assessment, shifting services from acute to community to reduce avoidable acute demand and strengthen community optometry	2					
Support the development of ‘at scale’ GP organisations to support GP resilience & provide architecture for large scale ‘left shift’ of resources	2					
Deliver ~3% annual growth in community health services (CHS) capacity to meet rising demand. Align with NbH Health Delivery Plans and workforce needs analysis to support growth and avoid ‘right-drift’ to acute care.	1					

Meds Optimisation Priorities - 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Pharmacy professional stewardship: strengthen pharmacy professional stewardship with a skilled, agile and resilient pharmacy workforce with opportunities for career development	2					
Digital: advance the adoption of innovation to support meds optimisation	2					
Prevention: Improve health outcomes and reduce morbidity, mortality and hospital admissions through appropriate evidence-based management and optimisation including community pharmacy (e.g. biosimilars, cost effective switching etc.	2					
Community Pharmacy: expand the development and commissioning of community pharmacy independent prescribers, with year-on-year growth in BP checks, reviews and preventative interventions	1					
Community Pharmacy: strengthen the role of community pharmacy by integrating services as a core neighbourhood partner	1					
Neighbourhoods: embed medicines optimisation priorities within neighbourhood teams to reduce HI and improve population health e.g. promoting high quality SMRs	1					
Reduce the risk of preventable harm from medicines and inappropriate microbial use in line with national requirements	1					
Medicines optimisation fully embedded in neighbourhood population health strategies, supporting prevention and long-term condition management	1					

Children & Young People Priorities - 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Emotional wellbeing support accessed earlier, waiting times reduced by 20% by 2031	2					
CYP with long-term conditions receiving coordinated care plans increased by 25%	3					
Emergency admissions for asthma, epilepsy and diabetes in CYP reduced by 20% in total	2					
Neurodevelopmental assessment waiting times achieving a minimum 20% total reduction (c.5% per year from 2027)	2					
Children and young people with SEND or learning disabilities receiving annual health checks increased to at least 75%	2					
CYP with SEND or learning disabilities receiving MDT intervention increased to 100%	2					
Out-of-area mental health placements reduced with zero placements by 2030/31	2					
Improved transition support from children’s to adult services, with 80% having a documented transition plan by age 18	2					
Vaccination and immunisation uptake increased	1					
Avoidable urgent and emergency demand for children and young people reduced year-on-year, by 1% contributing to a 5% sustained reduction in acute reliance	2					
Achievement of RTT, and 104 week waits in community and mental health services (CAHMS, SLT and ND Assessment) and ED 4 hr waits for CYP. Ringfence CYP elective capacity (inc Paed Hubs). Use GIRFT and CYP ER tools Expand access and capacity of Paed Clinical Assessment Service (PCAS)	1					
Reduced reliance on acute Tier3 services for CYP with long term conditions	1					
Fulfil our partnership statutory duties and address (potential) gaps in CYP pathways currently identified as Obesity (CEW clinic pilot), Oral Health, Speech and Language Communication Needs, Continence etc.	1					
Strengthening CYP crisis support pathways as part of Neighbourhood MDT working to reduce reliance on Tier 4 admissions across the DLN cluster	1					
Delivery of Start Well / School Readiness and Neighbourhood Teams with alignment to Family Hubs and Best Start in Life in Local Authorities.	2					
Implement a shared DLN approach for complex health needs in educational settings	2					
Promote active support at neighbourhood level for pregnancy and early years prevention: tobacco dependency, healthy eating, physical activity advice in pregnancy, targeted support for women with high BMI	1					
Complete inpatient PEWS implementation by April 2027. Launch and implement ED PEWS by April 2028	1					

Planned Care Priorities - 2026/7-2030/31

Outcome & Target (Total Impact) Must Do	Priority Status	26/27	27/28	28/29	29/30	30/31
Outpatient first activity reduced by 25% total by Q4 2030/31	1					
Patient follow-ups reduced by 25% total by Q4 30/31	1					
Deliver national access standards across all three ICBs (52 weeks, 18 week RTT, TWL) including Community Health Services waiting times targets ≥78% within 18 weeks (2026/27), ≥79% (2027/28), ≥80% (2028/29); elimination of all 52 ww with particular focus on CYP services.	1					
Increase pre-referral Advice & Guidance diversion rate to 45% by Q4 26/27	1					
Reduce DNA/WNB to 6.6% across all IMD cohorts by Q4 27/28	1					
Increase Patient Initiated Follow Up appt to 5% by Q4 26/27	1					
Left Shift of services e.g. Dermatology, MSK, Gynae, Paeds, Pain, ENT into community model – neighbourhood models/community MDTs across all ICBs – specific target activity profiles TBC	1					
Cost per pathway identified, intention to reduce/improve value with recurrent productivity gains embedded in contracts in 2029/30 at latest	1					
All referrals to go through a referral triage function either in acute or community by Q4 27/28	1					
Aligned Prior Approval and PLCV Policies including EBI across the cluster	2					
Women’s Health App implemented across the cluster	2					
Patient experience improved, with year-on-year improvement in elective PREMs	3					

Diagnostics & Earlier Detection 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Min 3% improvement in performance (or performance of 20%+) so that no more than 14% of patients wait over 6 weeks for a test	1					
By 28/9 achievement of standard that no more than 1% of patients are waiting 6weeks+	1					
Min 11-15% improvement in proportion of patients waiting less than 6 weeks for diagnostic tests by 2028/9 (Derbys to 85%, Lincs to 80%, Notts to 97%)	1					
Community Diagnostic Centres operating at scale, achieving ≥80% utilisation by 2030/31	2					
Faster Diagnosis Standard (28-day) consistently met, with sustained performance across all cancer pathways	2					
Six-week diagnostic waiting time standard consistently achieved, with overall diagnostic waits reduced year-on-year.	3					
At least 75% of cancers diagnosed at stage 1 or 2, supporting improved survival and reduced treatment intensity	2					
Straight-to-test and one-stop diagnostic pathways expanded, with measurable reductions in pathway length and appointments per pathway	3					
Cancer waiting time standards consistently met (including 62-day referral-to-treatment), with sustained delivery	2					
Holistic Needs Assessments and treatment summaries embedded, reaching ≥90% coverage for people diagnosed with cancer	3					
Unwarranted variation in diagnostic access and outcomes reduced, including across deprivation groups	2					
Earlier detection embedded as routine practice, contributing to improved cancer survival and reduced emergency cancer presentations	2					

UEC Priorities - 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Admission Avoidance - Category 1 and 2 ambulance response times improved, achieving sustained delivery against national standards	1					
Avoidable emergency department attendances reduced by 15%, through improved navigation, UTC, SDEC and crisis pathways	1					
Same Day Emergency Care (SDEC) utilisation increased (0 day LOS), with at least 35–40% of medical emergency admissions managed via SDEC	1					
Emergency admissions reduced by 10% for 1+day LoS, through robust clinical triage, senior decision-making and community alternatives	1					
Flow – Improvement in Average length of stay for emergency admissions reduced, supporting improved flow and timely discharge achieving min 3% reduction in overall bed days by 28/29	1					
Increase the number of weekend discharges through introducing and embedding criteria led discharges	1					
Increase the number of P0 discharges before 12pm	1					
Discharge/Readmission - Reduction in overall 28 days emergency readmissions	1					
Emergency 90-day readmissions for people aged 65+ reduced by at least 20%, through improved discharge planning and follow-up	1					
Overall emergency hospital admissions reduced by at least 36% in total by 2030/31, driven by neighbourhood urgent care and prevention	1					
Alignment to end of life provision to track a reduction in conveyance to ED by 10%	2					
Non-elective admissions for people aged 65+ with multi-morbidity reduced by 25% through frailty pathways and intermediate care	2					

Mental Health Priorities - 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
94% coverage of mental health support teams in schools and colleges, reaching 100% by 2029.	1					
Reduction in number of inappropriate out of area placements	1					
10% year on year reduction in mental health inpatient care for people with LDA	1					
Development of MH 24/7 Hubs,Crisis response and Home Treatment teams in each ICB	1					
Same-day access to crisis assessment and urgent mental health support reducing MH related A&E attendance by 10% by 2030/31 and reducing crisis home treatment waits	1					
Annual health checks for people with LD, SMI and Autism increased to min 75% coverage	3					
Reasonable adjustments consistently recorded and shared, reaching ≥90% coverage across relevant pathways	3					
Patient experience and reported outcomes improved, with measurable year-on-year improvement in PREMs and PROMs	3					
People supported to live well in the community, with reduced repeat crisis episodes and re-admissions for high intensity MH patients	2					
Average length of stay for all inpatients (Incl LD/A, PICU) reduced by at least 10% in total	1					
Improved access to community mental health services;waiting times reduced by at least 15%	2					
Improved access to assessment, diagnosis, treatment, support for LD,ADHD, ASD	1					
Minimum maintenance of talking therapies performance, improving access to integrated psychological services at neighbourhood level and access to work	2					
Mental Health Digital Strategy to support flow, service productivity	2					
Market development/management to support step down CSL placements for females with complex mixed diagnoses including EUPD.	1					
Procurement of DLN Neuro-developmental Neuro Hub	2					
Review of LD S75 arrangements with local authorities	2					

Digital, Data & System Priorities - 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Digital maturity and resilience improved system-wide, enabling sustainable transformation, fit for purpose infrastructure and reduced reliance on manual workarounds. Includes Cluster wide development of EPRR, shared care record, NHS App, FDP (implementation and utilisation at Neighbourhood level), digital inclusion, automation, AI	1					
Interoperable digital health and care records/shared care records embedded, with ≥90% of GP practices sharing records with neighbourhood teams	1					
Record sharing extended across health, local government and VCSE, with ≥75% of organisations connected by 2030/31	2					
Population health data routinely used to inform commissioning and operational decisions, embedded across all programmes	2					
NHS App single front door for digital patient interactions with at least 70% of repeat prescriptions processed digitally, reducing administrative burden and unwarranted variation	1					
Digital referral, triage and advice systems embedded, reducing paper-based processes and improving pathway efficiency	1					
Clinically meaningful dashboards and performance intelligence routinely used by leaders and frontline teams	2					
Data quality, assurance and information governance strengthened, enabling safe sharing and trusted decision-making	2					
Digital capability embedded in neighbourhood and place-based working, supporting integrated care delivery and proactive population management	1					
80% of Neighbourhood’s have credible delivery plans for how digital inclusion will be addressed with specific milestones and responsible owners for each element of the plan.	2					

Prevention & Inequality Priorities 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Smoking prevalence reduced by at least 5%, with smoking in pregnancy below 10% and reducing gap in CORE20+ groups	1					
At least 5% increase in uptake of integrated weight mgt pathway (T2/3) and behavioural support for overall population and gap reduction in healthy weight programme uptake by CORE20+ cohort	1					
BMI/Obesity prevalence reduced by at least 5% and reduce the obesity gap between most deprived quintile and least deprived who are obese	1					
Inclusive Elective Recovery Indicators: Reduction in RTT pathways treated within 18week overall and gap between least and most deprived quintiles reduced. Track share of >52>62 and >78 week waits by group. Supports equitable return to elective recovery 92% by March 2029.	1					
Inclusive Elective Recovery Indicators: Monitor % patients waiting >6weeks for diagnostics, overall and stratified (IMD and ethnicity)	1					
Inclusive Elective Recovery Indicators: Monitor FDS - % urgent suspected cancer referrals with diagnosis or exclusion within 28 days and equity gap	1					
Inclusive Elective Recovery Indicators: DNA/WNB rates by IMD quintile, ethnicity, disability	1					
Inclusive Elective Recovery Indicators: Monitor % eligible surgical pts on waiting list completing prehab prior to elective by IMD and CORE20+ cohort	1					
Inclusive Elective Recovery Indicators: >10% reduction in emergency cancer presentations (CORE20 vs rest of population)	1					
Inclusive Elective Recovery Indicators: >10% reduction in asthma and COPD emergency admissions Adult and CYP (CORE20+ v's rest of population)	1					
Inclusive Elective Recovery Indicators: 10% reduction in CYP epilepsy related emergency admissions	1					

Prevention & Inequality Priorities 2026/7-2030/31

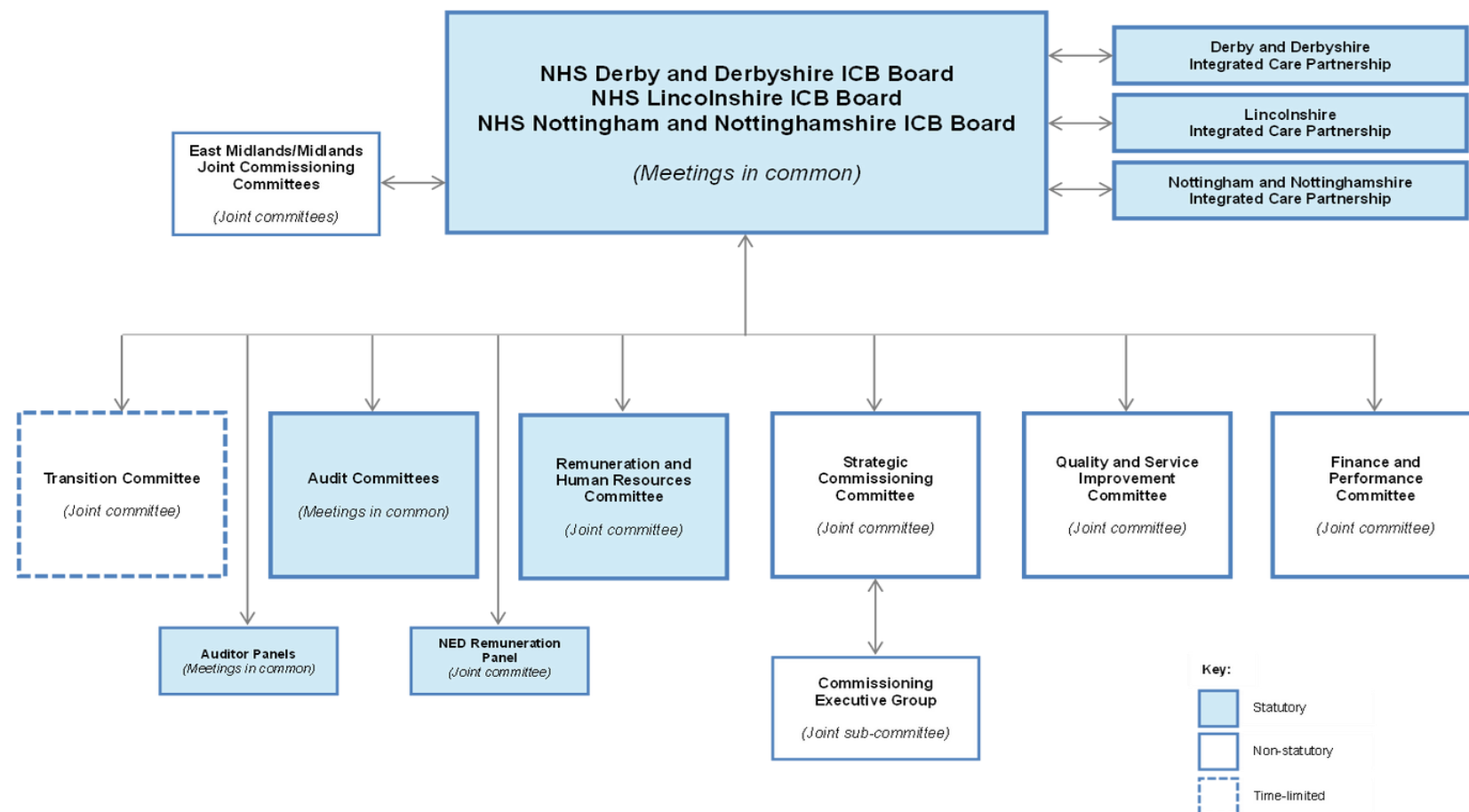
Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Admissions related to alcohol harm reduced by at least 10% through early identification and community-based support	2					
Multi-morbidity – improvement in metabolic risk markers (HbA1c, Lipid, Liver function, BMI Obesity) and optimised management for all and reduce the gap between most deprived quintile and least deprived	2					
>5% reduction in premature CVD mortality gap (CORE20 v's rest of population)	2					
Admissions related to obesity reduced by at least 5%, supported by integrated weight management pathways	2					
Vaccination and screening programmes work towards meeting national standards, with the inequality gap reduced by at least 10%	2					
Late-stage cancer diagnoses reduced by at least 1% year-on-year, with sustained shift to earlier diagnosis	2					
Cardiovascular disease case-finding improved, with measurable year-on-year increases in hypertension and AF detection	1					
Preventative interventions embedded in neighbourhood pathways (MECC, smoking cessation, weight, alcohol, physical activity)	1					
Health inequalities reduced across national priority conditions, delivering a minimum 2% improvement in outcomes by 2030/31	2					
Unwarranted variation between places reduced, with statistically significant convergence in access and outcomes	3					
Population health intelligence routinely and consistently used to target prevention, focusing on CORE20PLUS5 and highest-need cohorts	1					

Delivery oversight and governance arrangements

Effective delivery and robust oversight arrangements are fundamental to the successful implementation of the DLN Cluster five-year commissioning plan and are a core requirement of strategic commissioning as set out in the NHSE Commissioning Framework. Clear governance, accountability and assurance mechanisms will ensure that commissioning intentions translate into sustained service change, measurable improvements in outcomes and delivery of constitutional standards. Consistent with the NHS 10-Year Health Plan and MTFP, oversight of delivery will provide the necessary grip on performance, quality, finance and transformation, enabling timely intervention where delivery is off-track and ensuring that resources are deployed to greatest effect. Strong system-level oversight across the DLN Cluster will support alignment between neighbourhood, place and system priorities, ensure value for money and affordability, and maintain collective accountability for reducing avoidable acute demand, strengthening prevention and securing long-term financial and operational sustainability.

A single Decision-Making Framework will be in place from 2025/6 to:

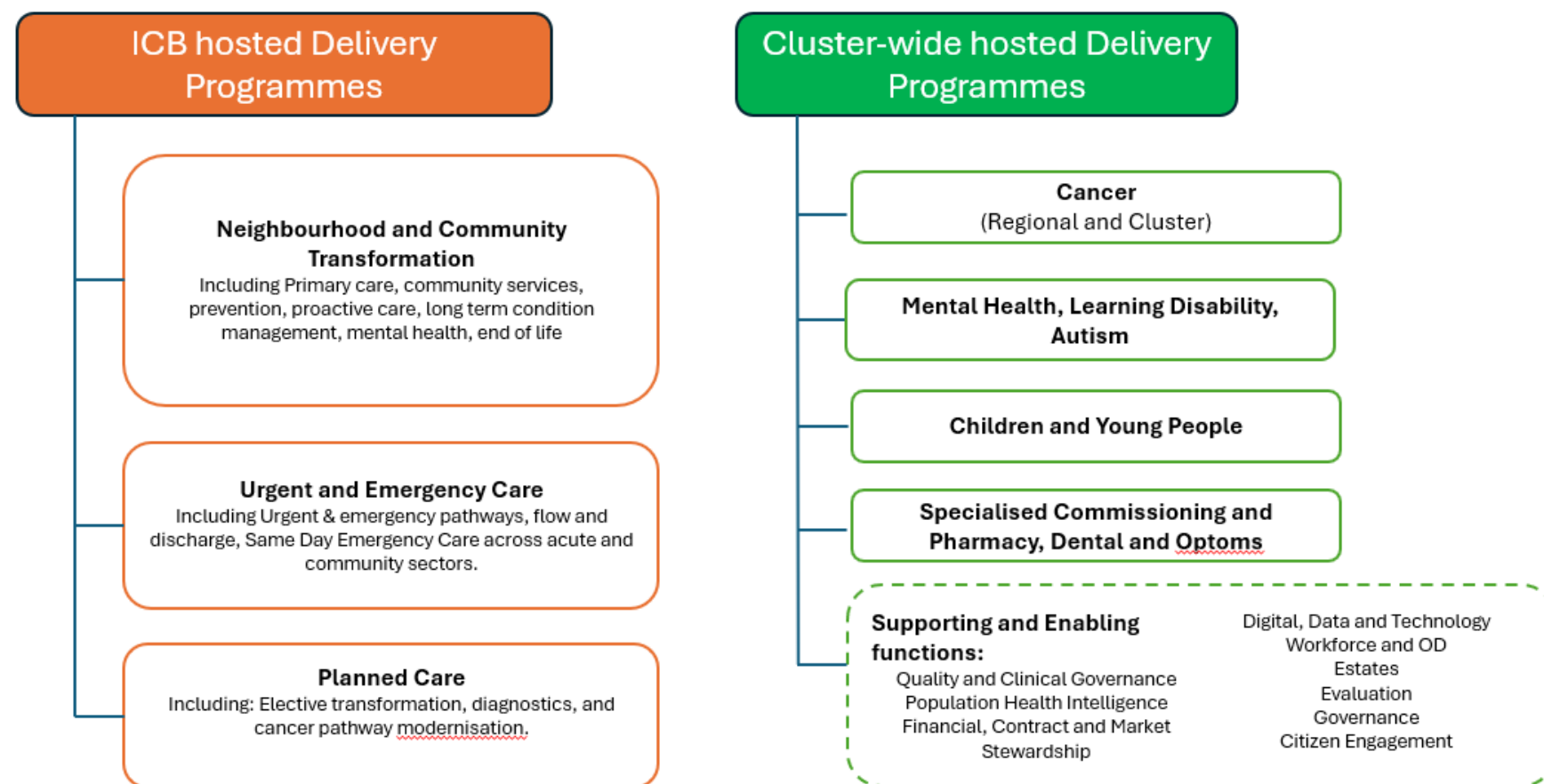
- Support commissioning decision making in respect to investment/disinvestment decisions in line with statutory responsibilities, and strategic and operational priorities.
- Establish a single process to ensure consistency in approach across the Cluster ICB arrangements.
- Ensure the Board has assurance of decision-making in line with the Cluster governance framework.



Delivery oversight and governance arrangements

The Commissioning Executive Team and Strategic Commissioning Committee will provide routine assurance to the ICB Boards on delivery of the Commissioning Plan. The Executive Director for Commissioning, supported by delivery teams, will hold system-wide responsibility for programme leadership, performance management and benefits realisation. Ultimate accountability for delivery of the Five-Year Commissioning Plan sits with the ICB Boards, supported by the Strategic Commissioning Committee, with clear escalation routes where delivery, quality, financial or inequality risks threaten achievement of agreed outcomes.

Delivery will be managed through a consistent and disciplined programme management approach, providing clear governance, transparent reporting, effective issue and risk escalation, and robust benefits tracking. All programmes will be defined by SMART, outcomes-focused measures, with constituent projects setting clear milestones, delivery timescales and success criteria to evidence progress and impact. For each priority we will track a small set of Board-level outcome and access metrics with equity drilldowns (e.g., deprivation, ethnicity and other protected characteristics where relevant) and neighbourhood/PCN-level views, enabling proportionate universalism: a universal core offer for all, with targeted intensification in ‘core neighbourhoods’ where need and inequality impact are greatest.



This programme framework will be applied consistently across the Cluster footprint to support:

- A common understanding of delivery expectations
- Cross-system benchmarking and shared learning
- Clear identification of support needs
- Strengthened assurance, grip and control
- Timely escalation where delivery risk emerges
- This diagram is not exhaustive of all programmes for oversight of delivery. For example the Immunisation Delivery Board and a future Screening Delivery Board will provide added detailed scrutiny and oversight of delivery of strategic priorities.

Delivery oversight and governance arrangements

Commissioning Oversight and Governance

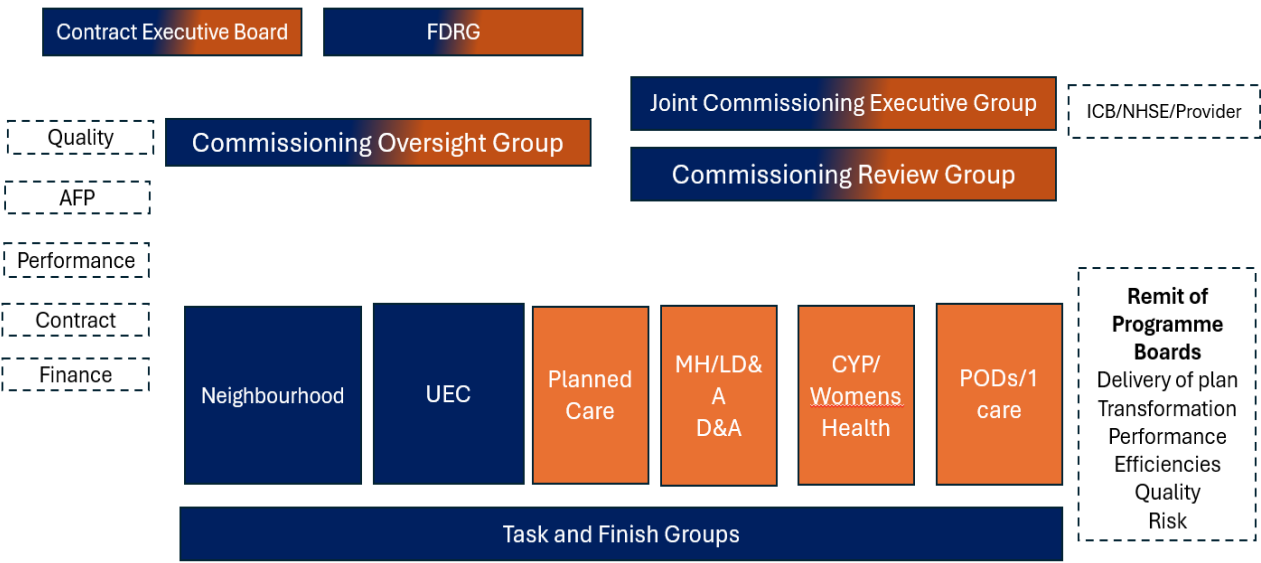
The commissioning arrangements set out above describe how priorities are governed, assured and delivered across the system. Oversight operates at multiple levels to ensure that commissioning decisions translate into improved outcomes, value for money and sustainable delivery.

At system level, the Contract Executive Boards and FRG provide strategic leadership, financial control and executive accountability, ensuring commissioning intentions remain aligned to system priorities, financial envelopes and national requirements.

Delivery and performance oversight is coordinated through a Commissioning Oversight Group at Local and/or Cluster level, providing a clear line of sight between system priorities and place-based implementation. This enables consistent decision-making while allowing flexibility to respond to local need. All decisions in respect to commissioning/de-commissioning will continue to flow through established governance arrangements via the Joint Commissioning Executive Group or Strategic Commissioning Committee. Subject to approval, initial multi-professional consideration of proposals will come through a proposed single Cluster Commissioning Review Group (est. March/April 2026).

Operational commissioning is organised across six core portfolios: Neighbourhoods and Community, Urgent and Emergency Care (UEC), Planned Care/Cancer, Mental Health, Learning Disability and Autism, Children and Young People and Specialised Commissioning/Primary care, Optometrists and Dentists. Each portfolio is accountable for transformation delivery, performance improvement, efficiency and quality, supported by task-and-finish groups where focused action or time-limited interventions are required.

All major commissioning decisions will be subject to proportionate Equality Impact Assessment at key gateways, including business case approval, procurement and contracting, mobilisation, and post-implementation review. Identified risks and mitigations will be tracked through programme governance and reported through commissioning oversight groups.



(Orange is cluster level/blue is place level)

Cross-cutting assurance functions — including quality, intelligence, performance, finance, contracts and AFP — provide horizontal oversight across all portfolios. This ensures that risks are identified early, delivery is evidence-led, and performance is managed consistently.

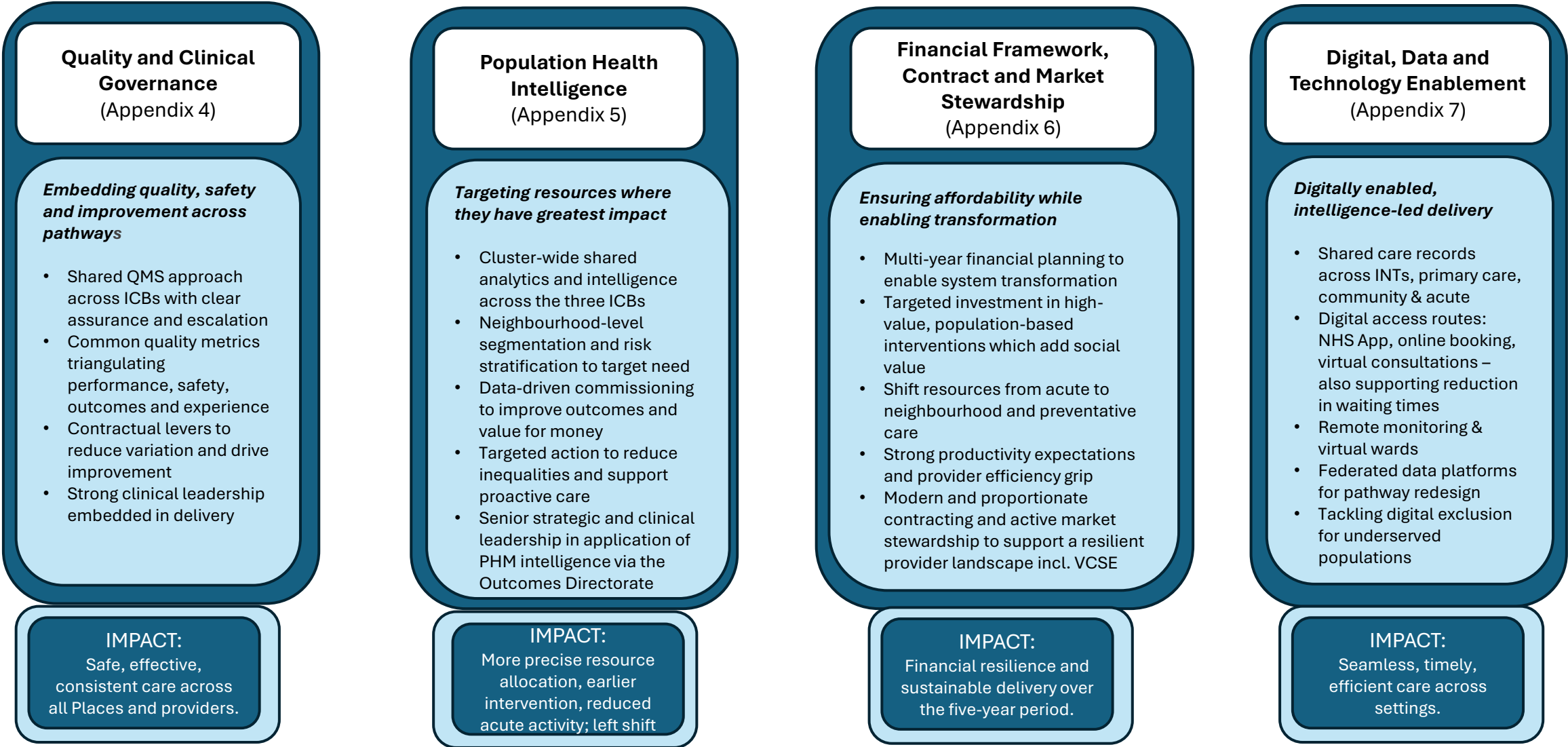
Together, this model ensures strong grip across transformation, delivery, performance, efficiency, quality and risk, while maintaining clear accountability between the ICB, NHS England and providers. It supports a balance between system coherence and local delivery, enabling commissioning to drive measurable improvement over the life of the plan.

4. Creating the conditions for success

Delivering our commissioning intentions depends on a robust and coherent commissioning infrastructure that creates the conditions for success and brings together the full range of strategic commissioning functions, skills and capabilities required to operate effectively. As the Cluster continues to mature, we will further shape and strengthen these enabling functions to ensure they remain fit for purpose and responsive to evolving system needs. The section below sets out the contribution each enabling function makes, the value it adds, and the breadth of capability required to sustain delivery of our strategic ambitions. Together, these capabilities provide the foundation for confident, outcomes-focused commissioning at scale.

Creating and enabling the conditions for success

To deliver our five major programmes over the next five years the DLN Cluster will operate through a set of mature, consistent and high-impact enabling functions that will continue to evolve over the next five years. These create the conditions for system-wide progress, disciplined delivery, and measurable outcomes. Further detail on the contribution of each enabler is provided in Appendices 4-11. Key activities expected over the next five years are summarised below:



Creating and enabling the conditions for success

Workforce and Organisational Development (Appendix 8)

Building the workforce needed for modern care models

- Cluster-wide workforce planning for community, MH, neighbourhoods
- New skill-mix and multidisciplinary roles
- Anchor workforce strategy supporting recruitment from deprived communities
- Capability building: commissioning, digital, PHM, quality improvement
- Workforce transition from acute to community over time

IMPACT:

A capable, flexible workforce aligned to neighbourhood and prevention models.

One Public Sector Estates Approach (Appendix 8)

Using Collective Assets to Enable Neighbourhood-Centred Care

- Rationalise underused estate to release capital and revenue
- Develop integrated neighbourhood health centres/hubs providing extended scope access to community based services
- Align health, care and community estate through shared planning
- Refurbish before building new to maximise asset use
- Leverage joint capital funding opportunities

IMPACT:

Neighbourhood hubs deliver affordable, integrated care by improving access and reducing duplication.

Evaluation Framework (Appendix 9)

Ensuring Strategic Decisions Translate Into Measurable Outcomes

- Robust pre-decision analysis of clinical value, inequalities, cost and opportunity impact
- Embedded equality and quality assessments to reduce variation and avoid harm
- Clear benefits realisation aligned to programme KPIs
- Routine post-implementation evaluation and course correction
- Continuous feedback to support adaptive commissioning

IMPACT:

Assures impact and enables evidence-led improvement

Citizen Engagement (Appendix 10)

Meaningful Engagement and Co-Production

- Embed inclusive listening in commissioning and delivery
- Shape decisions with citizens, staff and partners
- Improve equity, relevance and legitimacy
- Build trust and support effective implementation of co-designed interventions
- Adopt multi-method approaches using best practice techniques to ensure all voices are appropriately heard.

IMPACT:

Shapes services through community insight, improving relevance and deliverability.

Creating and enabling the conditions for success

Leadership and Culture

Providing a focus for strategic leadership for transformation

- Set direction: Provide clear system leadership by setting long-term priorities based on evidence focused on population outcomes, value and equity.
- Enable change: Create the conditions for transformation by aligning investment, incentives and governance across system, place and neighbourhood levels.
- Drive impact: Hold the system to account for delivering measurable outcomes, scaling what works and addressing inequality.
- Create positive cultural context: Support change in behaviours aligned to strategic commissioning responsibilities across stakeholder community

IMPACT:

Enable the system to work collectively, accelerating transformation that improves population outcomes, reduces inequalities and inequity and delivers sustainable value.

Partnership and Collaboration

Joined-up partnerships for system impact and better population outcomes

- Lead in partnership: Foster a positive transformation culture through collaboration, co-design and responsible innovation with partners and communities.
- Build shared purpose: Bring partners together around shared outcomes and priorities.
- Enable collaboration: Align governance, resources and accountability for joint delivery.
- Amplify voices: Embed co-production with people, patients and communities.
- Extend impact: Work with VCSE, health and care, local authority and wider public sector as well as business partners to address the building blocks of health

IMPACT:

Strong partnership working enables coordinated action across the system, improving outcomes, reducing inequalities and delivering lasting benefits for local communities.

Supporting social and economic development

Building stronger, healthier communities in partnership with people. Promoting the NHS as an anchor institution.

- As an ICB Cluster and anchor organisation, we will use commissioning to drive inclusive growth, add social value and improve access to employment, skills and opportunity, in line with the NHS Long Term Plan and national anchor institution guidance.
- By strengthening communities and addressing wider determinants of health, we will deliver impact far beyond healthcare alone.

IMPACT:

Investing in social and economic development reduces inequalities, improves health outcomes and delivers lasting value for our places and populations.

Creating and enabling the conditions for success

Research

Converting evidence into impact, maintaining a learning and research – driven commissioning culture under pinned by effective academic partnerships

- Embed research at the heart of commissioning, ensuring services are research-active, evidence-led and continuously improving.
- Promote participation in applied and population health research, we will accelerate learning, innovation and the translation of evidence into everyday practice.

IMPACT:

Research-driven commissioning delivers better outcomes faster and ensures public funding is invested where it makes the greatest difference.

Supporting Innovation

Accelerating transformation through innovation, converting insight into scale and opportunity

- We will be a confident, enabling commissioner that actively supports innovation, creating the conditions for new models of care, digital solutions and transformational approaches to be tested, scaled and sustained, consistent with NHSE's expectations of ICBs as system leaders.
- We will balance ambition with assurance, enabling innovation that delivers measurable impact.

IMPACT:

Enabling innovation unlocks faster transformation, improved productivity and more responsive services for our communities.

Sustainability

Creating sustainable health futures and through climate smart commissioning

- We will embed environmental sustainability as a core commissioning principle, aligning with NHS Net Zero commitments by prioritising models of care that reduce carbon emissions, minimise waste and strengthen system resilience.
- Sustainable commissioning will be integral to improving population health and long-term affordability.

IMPACT:

Environmentally sustainable commissioning protects health, reduces future demand and secures a resilient NHS for generations to come.

5. Risk and Mitigations

This ambitious change programme will be supported by robust oversight at both programme and system level. Strong programme management discipline will ensure delivery remains on track, with risks identified, escalated and addressed promptly to maintain pace and momentum towards achieving our intended outcomes.

Risk and Mitigations

Effective risk management is integral to the successful delivery of the five-year commissioning plan and to meeting the statutory duties of the Integrated Care Boards. A single Cluster Risk Management Policy has been formally agreed and adopted across NHS Derby and Derbyshire, NHS Lincolnshire, and NHS Nottingham and Nottinghamshire ICBs, providing a consistent and systematic approach to the identification, assessment, mitigation and escalation of risks associated with delivery of strategic commissioning priorities.

The ICB Boards recognise that achieving long-term financial sustainability, improving population health outcomes and delivering transformation in line with NHSE expectations requires a balanced and mature approach to risk. The ICBs therefore operate within a clearly articulated risk appetite that supports proportionate and managed risk-taking where this enables innovation, service transformation and long-term benefit, subject to the implementation of robust and effective controls.

Risks that may adversely impact patient safety, quality of care, health outcomes, statutory and regulatory compliance, or standards of probity and accountability are actively minimised and closely monitored. Where risks are accepted in pursuit of strategic objectives, including transformation of care models, these decisions are taken transparently, with clear ownership, defined mitigations and appropriate Board-level oversight. Reputational risk is managed cautiously, with a focus on delivery approaches that are evidence-based, affordable and most likely to achieve sustainable improvement.

The Cluster risk appetite and associated controls are reviewed regularly to ensure continued alignment with the external operating environment, NHSE guidance and the strategic objectives of the ICBs. This framework provides assurance of consistent, transparent and accountable decision-making and effective risk management across the DLN Cluster.

Risk and Mitigations

Risk Type	Risk Descriptor	ICB Committee Oversight	Mitigating Actions	Residual Risk		
				Impact	Likelihood	Score
Financial	Failure to achieve efficiency/productivity or VFM expectations leading to failure to achieve control total	Joint Finance and Performance Committee	Delivery of Operational and Financial Plan and Joint Medium Term Financial Plan. Oversight of delivery by transformational programmes.	4	4	High
Quality	Failure to systematically or consistently improve the quality of services	Joint Quality and Service Improvement Committee	Delivery of Quality Strategy and quality priorities	4	4	High
Transformation	Confirmation/reconciliation of target activity/commissioning requirement with planning/activity expectations (commissioning and provider) within a new planning regime and at an early stage in the formation of the strategic commissioner. This could lead to failure to adequately identify and develop operational bridging plans to achieve targets and supporting transformation programme deliverables leading to poor performance, failure to meet constitutional standards and achieve financial balance.	Strategic Commissioning Committee	Routine oversight and reporting of SCP delivery progress into Programme Boards and Commissioning Executive Group. Reporting into HWBs re Neighbourhood Health Services	4	2	Medium
Workforce	Commissioning workforce and associated capacity/capability to deliver the Strategic Commissioning Plan is currently subject to management of change processes leading to temporary uncertainty in the assignment of delivery responsibilities and roles.	Cluster ICB Board	Joint Commissioning Executive Committee oversight of transition. Workforce support packages.	4	3	Medium
Partnerships	Potential for new models of care and outcomes commissioning approach disrupting established funding routes/payment methods/driving transformation at a scale and pace that cannot be matched by the local provider market impacting on relationships.	Cluster ICB Board	Strategic Commissioning Committee oversight of partnership impact as part of decision making processes. Maintenance of constructive engagement with stakeholders by Executive team. Ongoing communications and engagement workshops.	4	2	Medium
PHM Data intelligence and infrastructure	It is imperative that PHM data and intelligence continue to inform commissioning decision making and prioritisation of resources; current arrangements are inconsistent across DLN hindering system analytics.	Cluster ICB Board	Business Care (Q1 2026/7) to mature digital and analytics capability and infrastructure across DLN (including centralised data warehouse).	4	1	Medium

Appendices

1.	Health inequality, inequity, population growth and change Challenges
2.	Current resource utilisation: Opportunities to reduce unwanted variation and improve efficiency
3.	Productivity and Opportunity Pack data: Acute and Community
4.	Creating and enabling the conditions for success: Our Quality Framework
5.	Creating and enabling the conditions for success: Population Health Data and Intelligence
6.	Creating and enabling the conditions for success: Our Financial Framework, Contract and Market Stewardship
7.	Creating and enabling the conditions for success: The Shift from Analogue to Digital
8.	Creating and enabling the conditions for success: Workforce and OD and Estates
9.	Creating and enabling the conditions for success: Our Evaluation Framework
10.	Creating and enabling the conditions for success: Citizen Engagement
11.	Summary Delivery Plans for transformational Delivery Programmes: Neighbourhood and Community Transformation Children and Young People Mental Health, Learning Disability and Autism Planned Care Urgent and Emergency Care
12.	Summary of our commissioning ambitions
13.	Cluster Outcomes Framework
14.	Equality Impact Assessment Compliance Summary

Strategic Context: Health inequality, inequity, population growth and change challenges

Appendix 1

Inherent inequality and inequity, combined with population growth and change, is driving considerable variation in health outcomes and use of resources across Derbyshire, Lincolnshire and Nottinghamshire.

Care isn't as integrated or proactive as it should be

Diabetes patients that have not achieved the NICE-recommended treatment target

Type 1: 69%
Type 2: 57%

Asthma patients that don't have an action plan

34%

At risk population (including COPD and Asthma) have not had a flu vaccination

40%

Over 65s who suffer a fall

2%

Emergency admissions for COPD, stroke, heart failure, asthma, diabetes, heart attacks, angina & hypertension

9%

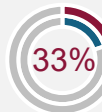
Hospital admissions for 65+/75+ that are medicines related



No of falls related ambulance call out-outs to homes for 65+



Children from most deprived quintile have higher rate of emergency admission.



We have become overly reliant on bed-based care

Mental health patients admitted to an 'out of area' unit

6%

Emergency admissions with mental health comorbidities

5%

Over 75s: make up of population; emergency admissions; emergency bed days



Over 65s: make up of population; emergency admissions; emergency bed days



7+ day hospital stays



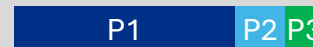
21+ day hospital stays



Proportion of acute hospital bed base classified as discharge ready

18%

Discharge pathway distribution:

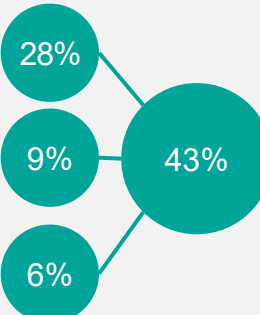


Deaths that occur in hospital

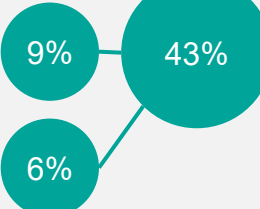
42%

Our planned specialist care services aren't as efficient or equitable as they should be

Outpatient appointments that result in a decision not to treat.



Outpatient appointments cancelled by patients



Outpatient appointments not attended by patients.



Proportion of clinics that provide an alternative to face-to-face follow-ups

48%

Proportion of Patient-Initiated Follow-Up (PIFU) and digital triage-first PIFU

5%

Patients in most deprived areas experience longer waits

No significant difference

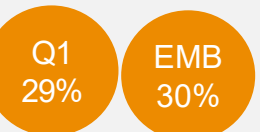
People from ethnic minority backgrounds (EMB) experience longer waits

>18 Weeks: EMB: 39% v White British: 38%

Elective backlog in most deprived areas reducing slower



People from most deprived areas & ethnic minority backgrounds more likely to have appts cancelled/ marked as DNA



Patients from the most deprived areas use more A&E or urgent care whilst waiting for elective treatment



Strategic Context: Health inequality, inequity, population growth and change challenges

Current resource utilisation

Appendix 2

Projected population growth of around 3% over the next five years—driven largely by an ageing population with increasingly complex needs—will place sustained pressure on local health and care services. In line with NHS England guidance, maintaining and improving outcomes while securing financial sustainability will require timely, scalable and transformational change, underpinned by a strong population health management approach.

High-quality population health data enables a system-wide understanding of need, variation and risk across pathways, helping to identify where demand pressures arise and where targeted intervention will have greatest impact. By bringing together data from multiple sources, we can proactively identify people at highest risk of deterioration or high service use, predict future demand, and target integrated, preventative support. This supports more coordinated care, reduces avoidable exacerbations, enables timely redirection to alternative pathways, and promotes more efficient and cost-effective use of system resources.

Population Segment	% Patients	Total Cost	% Total Cost	% Outpatient Att.	% Day Cases	% Elective Adm.	% Ambulance Calls	% Emerg. Adm.	% Emerg Bed Days
Segment 1 - End or Life	2%	£302,766,148	16%	9%	11%	9%	25%	25%	34%
Segment 2 - Frailty or Dementia	1%	£131,196,439	7%	3%	3%	4%	13%	11%	17%
Segment 3 - LTC 3 or more	4%	£261,687,333	14%	16%	18%	18%	15%	15%	16%
Segment 4 - LTC 2	6%	£223,182,866	12%	14%	16%	15%	10%	10%	9%
Segment 5 - LTC 1	15%	£332,433,700	18%	21%	24%	25%	13%	13%	9%
Segment 6 - Common MH	9%	£140,185,381	7%	7%	5%	6%	7%	5%	2%
Segment 7 - Risk Factors	16%	£124,803,822	7%	9%	7%	6%	5%	5%	3%
Segment 8 - Healthy	35%	£191,836,384	10%	13%	7%	8%	4%	9%	3%
Unknown Segment	12%	£189,238,109	10%	10%	10%	9%	8%	8%	8%
ALL SEGMENTS	100%	£1,897,330,182	100%	100%	100%	100%	100%	100%	100%

3 Segments account for c.7% of the total population, but around:

- 35% of healthcare costs
- 30% of elective activity
- 50% of ambulance calls
- 50% emergency admissions
- 65% emergency bed days

Segment 1 End of Life	Segment 2 Frailty or Dementia	Segment 3 LTC 3 or more	Segment 4 LTC 2	Segment 5 LTC 1	Segment 6 Common MH	Segment 7 Risk Factors	Segment 8 Healthy
• End of life register • GSF stage • Organ failure • Palliative care	• CFS 6-8 (patients aged 65+) • Dementia	• 3 or more LTC from: • Cancers (diagnosed in last 10 years) • Long-term physical conditions • Learning disabilities • Serious mental illness	• 2 LTC from: • Cancers (diagnosed in last 10 years) • Long-term physical conditions • Learning disabilities • Serious mental illness	• 1 LTC from: • Cancers (diagnosed in last 10 years) • Long-term physical conditions • Learning disabilities • Serious mental illness	• Depression or Anxiety (with medication in last 5 years) • Eating disorders • Neurodivergence • Stress reactions	• Alcohol or substance misuse • Cancers (diagnosed over 10 years ago) • Depression or Anxiety (without medication in last 5 years) • Hypercholesterol • Hypertension • Obesity • Pre-diabetes • Smoking	• Patients not appearing in any of the above segments

Current resource utilisation: Opportunities to reduce unwanted variation and improve efficiency

DLN Challenge	Scale of opportunity to reduce variation and improve overall outcomes across our Cluster
Care isn't as integrated or proactive as it should be	
Diabetes patients that have achieved the NICE recommended treatment target	Type 1: 29.2% – 33.4% Type 2: 42.0% – 44.1%
Asthma patients that don't have an action plan	18.64% to 35.3%
At risk population (including COPD and Asthma) have not had a flu vaccination	34.4% to 48.7%
Emergency admissions for COPD, stroke, heart failure, asthma, diabetes, heart attacks, angina and hypertension	8.75%
Hospital admissions for 65+/75+ that are medicines related	22.3%
Over 65s/75s who suffer a fall	1.5% - 1.9%
No of falls related ambulance call out-outs to homes for 65+/75	2%
Children from most deprived quintile have higher rate of emergency admission.	D&D: No, 40% less; In Notts & Lincs: yes, most deprived quintile = 31%

Current resource utilisation: Opportunities to reduce unwanted variation and improve efficiency

DLN Challenge	Scale of opportunity to reduce variation and improve overall outcomes across our Cluster
Have become overly reliant on bed-based care	
Mental health patients admitted to an ‘out of area’ unit	5 - 8%
Admissions with mental health comorbidities	5 – 25%
Over 75s: - Make up of population - emergency admissions - emergency bed days	9.0% - 12.3% 28.8% - 37.9% 49.5% - 52.6%
Over 65s: - Make up of population - emergency admissions - emergency bed days	18.2% - 24.1% 43.9% - 53.2% 68.0% – 71.0%
Admitted spells > 7 days. Total bed related to 7+ day part of this.	7.3% - 23.5% 66.66 – 88.8%
Admitted spells > 21 days. Total bed related to 21+ day part of this.	1.5% - 5.9% 31.0% - 68.8%
Proportion of acute hospital bed base classified as discharge ready	18%
Discharge pathway proportions/distributions: - Pathway 1 - Pathway 2 - Pathway 3	7% – 59% 1.6% - 29% 1.0% - 11%
Deaths that occur in hospital	1.3%, 43.0% & 44.6%

Current resource utilisation: Opportunities to reduce unwanted variation and improve efficiency

DLN Challenge	Scale of opportunity to reduce variation and improve overall outcomes across our Cluster
Our planned specialist care services aren’t as effective or productive as they should be	
Outpatient appointments that result in a decision not to treat.	22.2% - 33.0%
Outpatient appointments cancelled by patients	8.1% - 9.4%
Outpatient appointments not attended by patients.	5.1% - 7.6%
Proportion of clinics that provide an alternative to face-to-face follow-up appointments	31.2% – 70.1%
Proportion of Patient-Initiated Follow-Up (PIFU) and digital triage-first PIFU	2.6% - 6.7%
Planned care specialist services are not always delivered equitably	
Patients in most deprived areas wait longer for elective care (seen within 18 and 52 weeks target) compared to least deprived areas	No significant difference: Q1 seen marginally quicker in Lincs and marginally slower in Notts
People from ethnic minority backgrounds (EMB) are more likely to experience longer waits compared to White British patients, even after adjusting for age and need	>18 Weeks: EMB: 39.1% v White British: 38.0%
Most deprived areas have a higher elective backlog growth rate compared to least deprived areas	Q1: Growth rate -9.4% v Q5: Growth rate -12.1%
People from most deprived areas and ethnic minority backgrounds are more likely to have appointments cancelled or marked as DNA	Deprivation: Q1: 29.1% v Q5: 25.5% Ethnicity: EMB: 29.6% v White British: 26.6%
Patients from the most deprived areas use more A&E or urgent care whilst waiting for elective treatment compared to least deprived areas	Q1: 323 v Q5: 200

Productivity Opportunities Packs | Acute Sector

	Non-Electives			Emergency Care			Electives			Outpatients			Other Acute			Temp. Staffing			Corp. Services			Estates & Proc.			Medicines			Total £m
	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	
CRH	0	1	Low	2.4	54	Med	7	73	Med	8.7	90	High	0	1	Low	4.6	81	High	5.4	30	High	2.1	50	Med	2.1	84	High	32.3
NUH	13.4	42	Med	38.7	97	High	27.7	68	Med	29	77	Med	26.7	68	Med	9.2	18	Low	1.8	9	Low	9.3	60	Med	7.4	64	Med	163.2
SFH	29.5	106	High	2	47	Med	2.2	42	Med	14.1	100	High	0	1	Low	5.3	67	Med	4.7	72	Med	2.1	31	Low	3.3	107	High	63.2
ULTH	50	117	High	46.2	115	High	19.9	90	High	7.3	55	Med	16.7	84	High	10.4	89	High	17.3	109	High	5.6	86	High	4.5	89	High	177.9
UHDB	0	1	Low	0	1	Low	0	1	Low	14.4	66	Med	0	1	Low	8.2	30	Low	3.1	24	Low	11	103	High	5.5	65	Med	42.2

Summary of high opportunities	
CRH	- Outpatients: OP appointments/consultant 94.1 v median of 109.4; Change in OP appointments/consultant (vs 2023) 0.6% v median of 11.3% - Temp. staffing: Sickness absence rates 5.5% v median of 4.6%; Consultant job planning sign-off rates 0%? v median of 72.3% - Corporate services: Digital & technology and Governance & Risk functions form the bulk of the opportunity - Medicines: Aflibercept molecule forms bulk of biosimilar opportunity
NUH	Emergency Care: A&E attendance EM consultant 647.9 v median of 513.8; Change in A&E attendances/EM 14.7% v median of 3.6%
SFH	- Non-electives: Bed occupancy, clinically ready for discharge 26.3% v median of 25.7%; Change in NEL 1+ LOS 14.8% v median of 10.0% - Outpatients: 2.9% opportunity v median of 1.0% - Medicines: Aflibercept molecule forms bulk of biosimilar opportunity
ULTH	- Non-electives: Bed occupancy, clinically ready for discharge 27.7% v median of 25.7%; Change in NEL 1+ LOS 19.7% v median of 10.0% - Emergency care: A&E attendance EM consultant 647.9 v median of 513.8; Change in A&E attendances/EM 14.7% v median of 3.6% - Electives: Capped elective theatre utilisation 77.9% v median of 80.6%; BADS day case rate of 82.6% v median of 85.0% - Outpatients: OP appointments/consultant 86.7 v median of 109.4; Change in OP appointments/consultant 5.7% v median of 11.3% - Other acute: 2.0% opportunity v median of 1.3% - Temp.staffing: 1.2% opportunity v median of 0.9% - Corporate services: : Digital & technology, HR, Procurement Governance & Risk functions form the bulk of the opportunity - Medicines: Aflibercept and Eltrombopag molecules forms bulk of biosimilar opportunity
UHDB	Estates & Procurement: % of non-clinical estate 34.6% v median of 31.8%; Change in general supplies spend vs 2023/24 of 4.7% v median of - 0.5%

Productivity change 2024/25 (vs 2019/20)			
	Cost weighted activity growth	Resource growth	Estimated productivity
CRH	9.2	33.5	-18.2
NUH	17.9	28.1	-8
SFH	14.1	24	-8
ULTH	10.4	28.1	-13.8
UHDB	10	22.6	-10.2

Appendix 3

	Community LOS			Patient DNAs			Temp. Staffing			Corp. Services			Estate & Proc.			Total £m	Productivity change 2024/25 (vs 2019/20)			
	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank			Cost weighted activity growth	Resource growth	Estimated productivity
DCHS	0.4	2	Low	1.2	2	Low	0.9	2	Low	7.8	12	High	1.4	8	Med	11.7	DCHS	-3.7	1.3	-4.9
LCHS	0.4	3	Low	1.7	7	Med	0.7	4	Low	1.8	2	Med	1.4	13	High	6	LCHS	21.6	1.9	19.3

Summary of high opportunities

DCHS	- Clinical contacts per day in community nursing: 4.6 v median of 5.3 - Corporate costs: change in corporate service costs since 2020/21 of 47.1% v median: of 22.2%; HR and Governance & Risk functions form the bulk of the opportunity
LCHS	Estates & Procurement: Change in general supplies spend vs 2023/24 of 12.6% v median of - 4.5%

	MH LOS			NHS TT			Temp. Staffing			Corp. Services			Estate & Proc.			Total £m	Productivity change 2024/25 (vs 2019/20)			
	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank			Cost weighted activity growth	Resource growth	Estimated productivity
DHC	10.1	41	High	0.6	8	Low	1.8	6	Low	6.3	29	High	0.2	9	Low	19.0	DHC	11.7	6.4	5.0
LPFT	7.4	30	High	0.3	4	Low	1.9	14	Low	8.4	43	High	1.4	42	High	19.4	LPFT	2.7	7.4	-4.4
NHC	12.2	10	High	0.5	1	Low	7.5	16	Med	19.5	31	High	0.7	12	Low	40.4	NHC	2.4	1.3	1.1

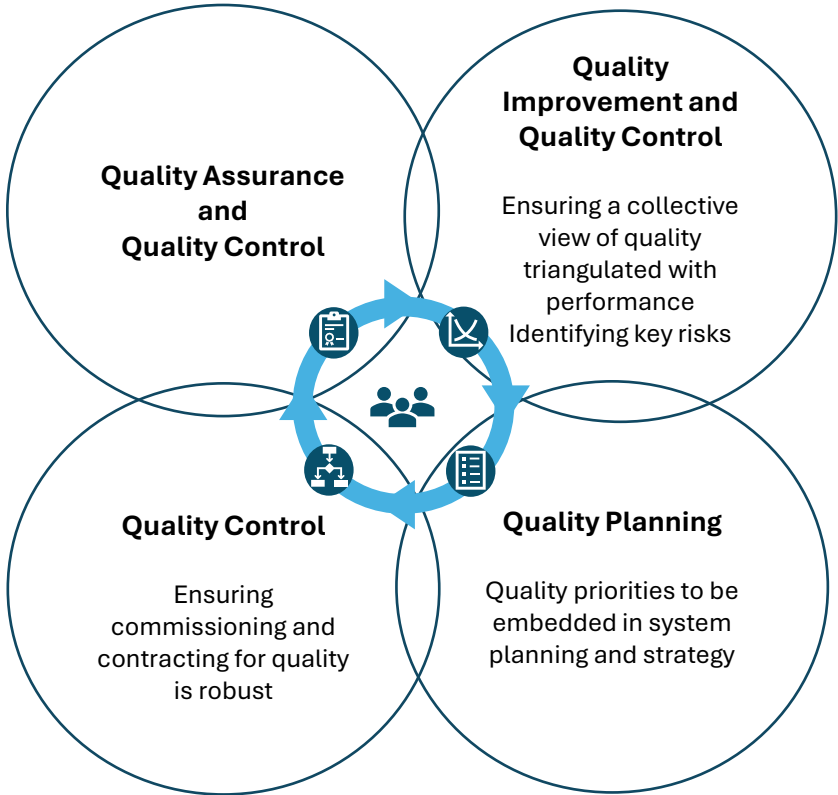
Summary of high opportunities

DHC	• Inappropriate OAP bed days as % of total : 1.9% v median of 0.6% • Length of stay: Mental health length of stay opportunity (% of operating expenditure) 4.8% v median of 3.7% • Corporate services: change in corporate service costs since 2020/21 of 41.0% v median: of 38.1%; HR and Governance & Risk functions form the bulk of the opportunity
LPFT	• Length of stay: Mental health length of stay opportunity (% of operating expenditure) 3.9% v median of 3.7% • Corporate services: change in corporate service costs since 2020/21 of 54.4% v median: of 28.1%; Digital & Technology, HR and Governance & Risk functions form the bulk of the opportunity • Estates & Procurement: 0.8% opportunity v median of 0.4%
NHC	• Inappropriate OAP bed days as % of total : 1.6% v median of 0.6% • Length of stay: £12.2m opportunity • Corporate services: 2.8% opportunity v median of 1.9%; Digital & Technology, HR and Governance & Risk and Legal functions form the bulk of the opportunity

We have a unique opportunity to bring the best of each ICB to create optimal conditions for successful delivery of our Delivery Plans. We will continue to explore these opportunities as we evolve into our new Cluster form. There are three supportive frameworks that will be critical to this success - Quality, Financial and Population Health Intelligence and Management – that will continue to evolve over the next five years.

Quality will be core to everything that we do. We remain committed to the definition of *High quality is care that is safe and effective; experience that is as positive as possible*. In alignment with the NQB Quality Strategy and Strategic Commissioning Framework we regard quality as a key function of strategic commissioning and delivery of our statutory responsibilities. Over the next five years we will fully implement the NHSE Quality Strategy and a Quality Management Systems (QMS) approach incorporating the four key functions of Quality Planning, Quality Control, Quality Improvement and Quality Assurance. This will ensure we continue to meet, if not excel, in our quality agenda including safeguarding for both adults and children.

Quality Management System Approach



Summary of Quality oversight of commissioning delivery

Quality Planning:

- Setting strategic commissioning plans for high-quality, cost-effective care, reducing inequalities and improving population health
- Undertaking Quality and Equality Impact Assessments
- Commissioning high-quality care, designed with service users, unpaid carers, staff, volunteers and local communities, including Neighbourhood Health Services
- Overseeing provider patient safety incident response planning and identifying shared priorities to inform strategic planning

Quality Control:

- Monitoring quality through contract management
- Triangulating quality metrics with feedback and qualitative data to identify areas for improvement and inequalities

Quality Improvement:

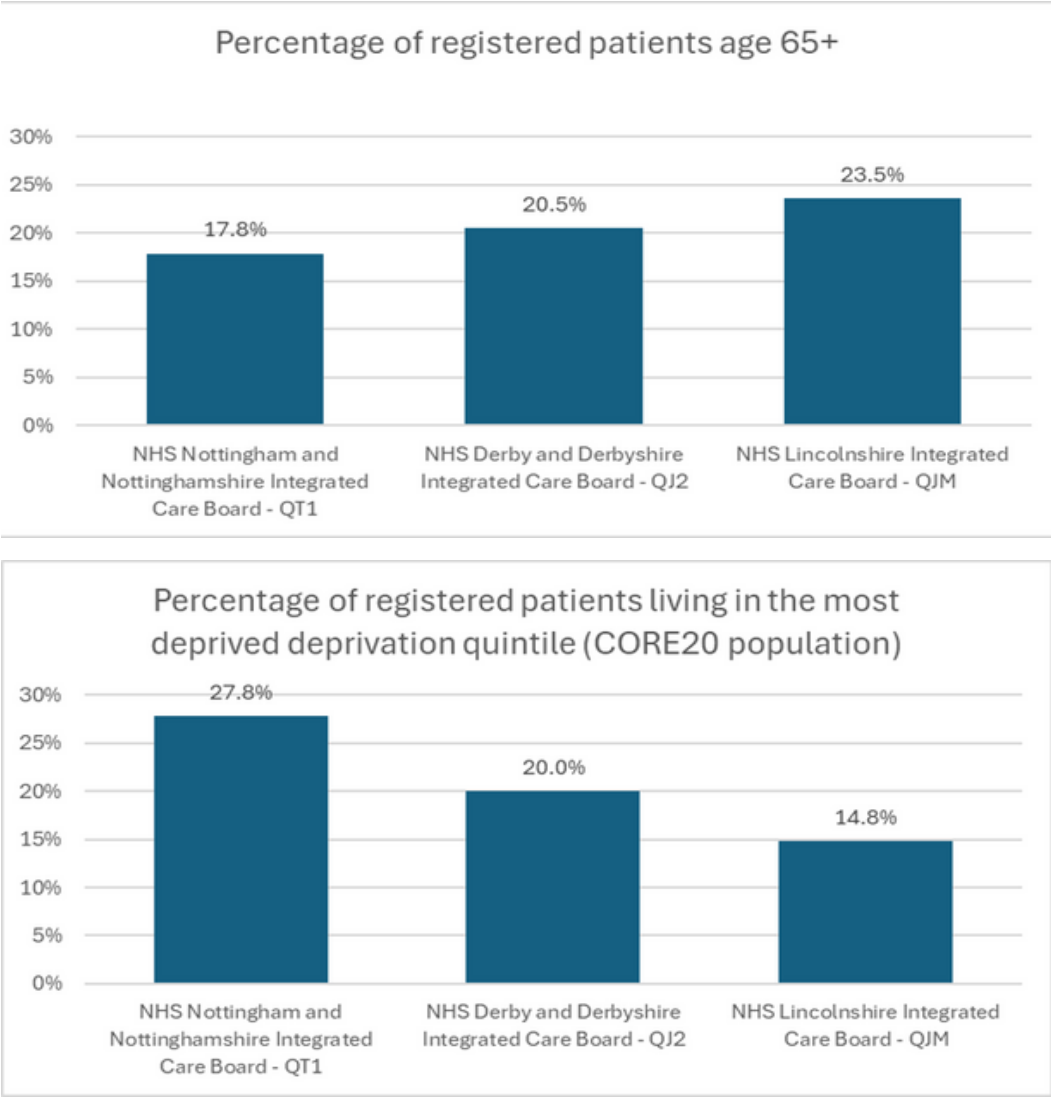
- Using contractual levers to drive quality improvement and address variation
- Working with regions to support providers to implement national standards
- Supporting providers to proactively manage and escalate risks in accordance with NQB guidance
- Using System Quality Groups to share intelligence to inform improvement and risk management
- Commissioning and managing Patient Safety Incident Investigations where escalated from providers, ensuring actions and learning are implemented
- Supporting coordination of cross system learning responses including Patient Safety Incident Investigations where escalated from providers, ensuring actions and learning are implemented
- Delivering ICB statutory quality functions

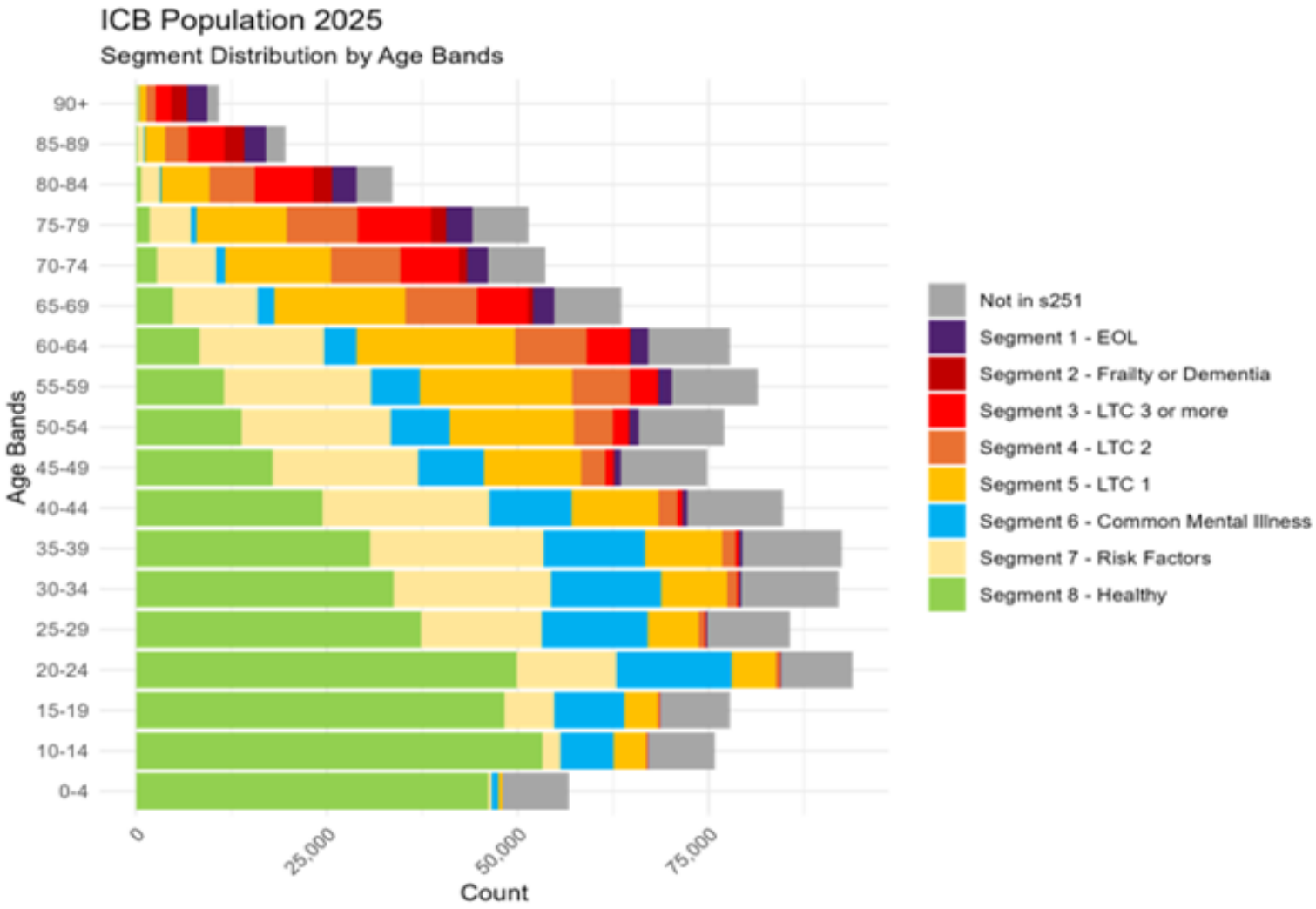
Quality Assurance:

- Operating effective governance to ensure visibility of quality, including strong clinical leadership, effective use of data, audits and risk reporting
- Specifying and assessing quality in procurement activities under the Provider Selection Regime
- Complying with minimum practice standards, oversight and regulatory frameworks (including NHS Oversight Framework and ICB Annual Assessment)

Population health management (PHM) is central to the DLN Cluster’s role as a strategic commissioner and to delivering the ambitions of the NHS Commissioning Framework and ICB Model Blueprint. By using data, insight and local intelligence, PHM enables a shift from reactive, activity-led commissioning to proactive, preventative and outcomes-focused approaches, targeting resources where they have greatest impact and reducing unwarranted variation and inequality.

PHM also provides the foundation for effective system leadership and partnership working, aligning NHS organisations, local authorities, the VCSE sector and communities around shared population outcomes. Building on work led by local authorities to address the wider determinants of health—such as housing, education, employment, transport and healthy behaviours—we will work closely with partners through ICBs and Health and Wellbeing Boards. Leadership will be most evident through programme delivery alongside providers, supporting improved outcomes, sustainable demand management and long-term system resilience in line with national expectations.





Projected population growth of around 3% over the next five years—driven largely by an ageing population with increasingly complex needs—will place sustained pressure on local health and care services. In line with NHS England guidance, maintaining and improving outcomes while securing financial sustainability will require timely, scalable and transformational change, underpinned by a strong population health management approach.

High-quality population health data enables a system-wide understanding of need, variation and risk across pathways, helping to identify where demand pressures arise and where targeted intervention will have greatest impact. By bringing together data from multiple sources, we can proactively identify people at highest risk of deterioration or high service use, predict future demand, and target integrated, preventative support. This supports more coordinated care, reduces avoidable exacerbations, enables timely redirection to alternative pathways, and promotes more efficient and cost-effective use of system resources.

The DLN Cluster will adopt common Equality Data Standards across all commissioned services, requiring the routine collection and quality assurance of protected characteristic data (including ethnicity, disability, language need, sexual orientation, gender identity, religion/belief and maternity). The Accessible Information Standard will be mandated contractually across all access points, including GP practices, neighbourhood hubs, SPOA/telephony, UTCs and digital routes.

Creating and enabling the conditions for success: Our Financial Framework

Appendix 6

The Derbyshire, Lincolnshire and Nottinghamshire (DLN) health system clearly faces a challenging financial starting position, reflecting sustained operational pressures, legacy deficits, growing demand, workforce constraints and structural cost pressures across our three ICBs. These challenges are particularly acute within acute and urgent care pathways, and they limit our immediate capacity to invest in transformation and prevention. However, they also reinforce the urgency of adopting a clear, disciplined and system-wide financial strategy that enables a sustainable return to balance over the next five years while improving outcomes for our population and delivering performance standards. Our financial framework is summarized below.

Context and Ambition	Planning Principles	Shifting Investment to Deliver Value	Promoting Efficiency and Productivity	Contract and Market Levers	Strategic Market Stewardship
Significant system pressures limit short-term financial head room	Multi-year budgets to support planning and delivery	Deliberate left shift away from hospital based care towards neighbourhood based care	Productivity and efficiency are critical to financial recovery – minimum expectations must be delivered which includes agreed plans	NHS Standard Contract as default in 2026/7 using provision to ensure contract compliance	Active stewardship of a pluralistic provider market using flexibilities of the NHS Provider Selection Regime
We need to stabilise run-rates, recognising that financial sustainability underpins resilience and transformation	Clear affordability and prioritisation framework	Increased investment in prevention and community services	Tackling unwarranted and unwanted variation	Multi-neighbourhood contracts implemented from 2026/7	Maximising NHS capacity where best value
Clear expectation of trajectory to financial balance over 5 years	>3% annual spend reserved for recurrent transformation	Scaled neighbourhood models of care to deliver ‘at scale’ transformation	Improved pathway efficiency and workforce productivity	Deconstruction of block contracts	Targeted use of independent sector where this supports delivery of strategic intentions
Strong financial grip, governance and delivery assurance	VCSE partner resilience baked into commissioning expectations	Relentless focus on outcomes and reducing health inequalities and inequity	Focus on structural change rather than short-term cost control	Outcomes-based, alliance and lead provider models promoted	Development of Neighbourhood provider models. Primary care and VCSE are critical delivery partners
Alignment of finance, performance, commissioning delivery and quality	Allocative Framework used to support investment/disinvestment decisions		Benefits are embedded and recurrent	Implementation of financial levers linked to quality and outcomes	
Embedded Board level oversight of delivery and risk supported by robust programme management approach	Minimum productivity expectation of 2% for all providers				
	Understanding and exploiting opportunities for added social value				

Transforming our models of care today to meet the challenges of tomorrow

This medium-term financial approach is grounded in affordability, prioritization and sustainability. From 2026/7 we will stabilize system run-rates and create financial headroom to enable targeted investment in service transformation, prevention and reducing health inequalities and inequity. This will be supported by our intention to commission multi-year contracts and provide multi-year budget expectations for providers – including our VCSE sector. This will support increased market resilience, providing greater certainty and enabling longer-term planning and delivery of transformation. Our ambition is high. We recognize that financial recovery will not rely on short-term cost controls but on structural change that improves quality, outcomes and sustainability. We need to transform and we need to do this at scale and pace. We also acknowledge that workforce transition will be paced alongside service redesign and capacity development, recognising the need for training, role expansion and system support to ensure safe, sustainable movement of capacity from acute to community and neighbourhood settings.

To maintain momentum for transformational change, from 2026/7 we will:

- Continue to meet our obligations for minimum NHSE anticipated spend (e.g. inflation, MHIS)
- Reserve at least 0.5% (£33m) of annual system spend for recurrent, one-off investments in transformation, enabling providers to accelerate the adoption of innovation and convert improvement into routine practice. This will be increased by 0.5% per year over the five year period.
- Apply a consistent Cluster activity growth assumption based on performance requirements and our outcomes framework and expected levels of productivity. Our initial assumption is that growth will be offset by the impact of deconstructing block contract arrangements commencing 2026/7.
- Invest where needed to achieve constitutional standards i.e. 18weekRTT and reduction of waiting lists
- Continue to deconstruct block contracts to support stimulation of investment needed for transformational change – without destabilising our provider market.
- Further to deconstruction of blocks, progress with the transition of reduced acute funding value by 2.5% every year until achieve a ‘should pay’ baseline which is the efficient level of care.
- Work towards a more coherent phasing of transfer/re-profiling of commissioning resources to shift commissioning investment into community based services. 2026/7 will prioritise our understanding of efficient use of existing resources and consolidation of intelligence in respect to ‘should pay’ baseline positions. This will enable us to rebalance where and how we pay for health care services in the future.

Our future investment decisions will be guided by an allocative framework that will be established in 2026/7. This will offer a credible prioritisation approach to ensure that commissioning decisions deliver the greatest possible value for the populations we serve

Our allocative framework will be formulated on the principles of:

- prioritising interventions that deliver the greatest population health benefit and value for money expressed as ROI
- shifting investment towards prevention, proactive care and community-based models with primary care and VCSE regarded as integral delivery partners
- protecting core services, quality and safety while enabling innovation and transformation
- addressing health inequalities, ensuring equity and consistency across the DLN footprint
- commissioning for performance and outcome not activity

Allocation will follow a rigorous business case submission process aligned to these principles. All transformation initiatives will be delivered in partnership with providers, with transparent engagement, phased implementation and shared ownership of risk and benefit to maintain service stability and workforce confidence.

Doing better with what we have to meet the challenges of today

Ongoing system-wide productivity and efficiency programmes will continue to be central to our route to balance. These will focus on tackling unwarranted and unwanted variation, improving pathway efficiency, reducing duplication, and maximising the use of digital and workforce innovation. Transformation of outpatient and follow-up activity will be significant in the demonstration of provider commitment to this agenda.

As part of this work in 2026/7 we will continue to explore options to increase the value proposition of joint and pooled budget arrangements with strategic partners including Better Care Fund arrangements.

We will also support/learn from national trialling of new financial flows and incentives to promote save-to-invest options. This will include working with providers to develop gainshare principles, activity risk management during ‘left shift’ transformation, and a joint commitment to prevent double running costs.



We recognise that achieving sustainable transformational change requires close collaboration with our provider partners to translate commissioning ambition into deliverable and affordable models of care. We will operate transparently in setting out our financial principles, enabling providers to design delivery responses that are financially sustainable, value-driven and aligned to system priorities.

Summary of Agreed Modelling Assumptions

Outcomes listed on slide 21 have been modelled for impacts in 2026/27 based on a number of assumptions. These will be used for activity and finance modelling in cluster ICBs plans. Key assumptions used in that modelling are:

1. First Outpatient Acute Activity

Overall 25% reduction over 5 years, implemented in 2026/7 through the following phasing: 0% Q1-Q2, 2.5% Q3, 5.0% Q4
Year 1 specialties focus including (from shared tables / agreement):
Ophthalmology, Trauma & Orthopaedics, MSK, Dermatology, then Urology, Gynae, ENT in year 2. These are high-impact areas for RTT and activity reduction.

2. Acute Face-to-Face Follow-Ups

Overall 25% reduction over 5 years, implemented in 2026/7 by mitigation of growth, and reductions on 2025/6 FOT in Q3 and Q4.
Year 1 specialties focus including (from shared tables / agreement):
Ophthalmology, Trauma & Orthopaedics, MSK, Dermatology, then Urology, Gynae, ENT in year 2. These are high-impact areas for RTT and activity reduction.

3. Emergency Readmissions – 90 Day

Treated as the actionable component feeding into wider non-elective reduction.
Apply same Q3 (2.5%) / Q4 (5%) phasing, with focus on Geriatric Medicine, Respiratory, Frailty cohorts where mitigable readmissions are identified. In modelling, treat 90-day readmissions as a priority subset of non-elective shifts.

4. Emergency Department Attendances

33% reduction, assumed to relate only to low-acuity / “BB11Z” HRG attendances (no treatment, no significant investigations). Same phasing as other metrics: 2.5% Q3, 5% Q4.
Apply to in-area Acute Emergency Departments, with the additions of NLAG, and Peterborough

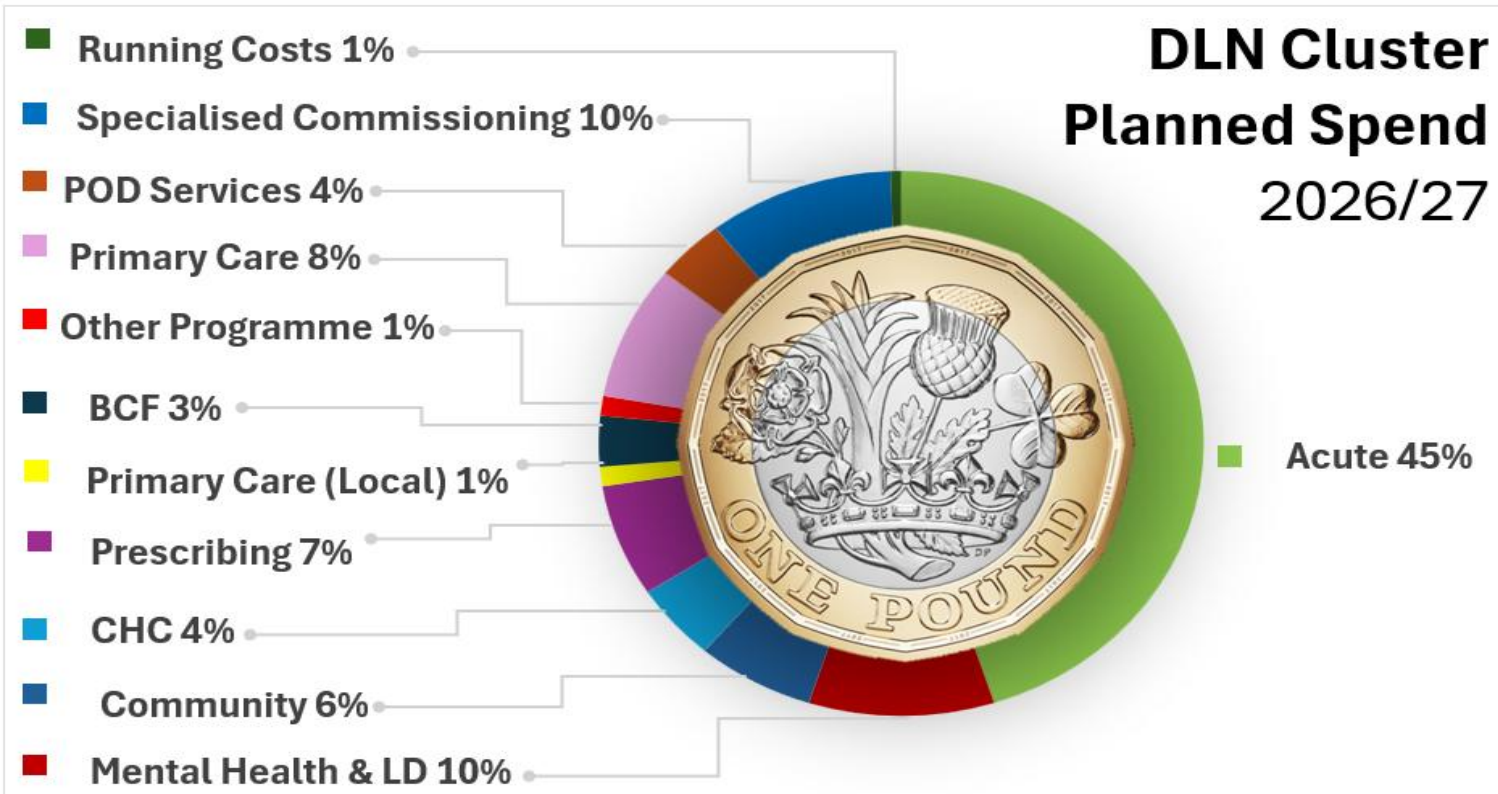
5. Occupied Bed Days (Non-Elective Community Beds)

10% reduction – recognised as internal provider efficiency, not an activity modelling adjustment. Aligned to agreed bed capacity plans.

6. Left Shift, Community Access, Hubs, CYP Long Waits

Treated as enablers/support mechanisms, not directly modelled as reductions.

DLN Cluster Utilisation of Resource



DLN Pound - Key Messages

- Total DLN ICB’s spend - £8.8 billion of which:
 - £6.8bn core services
 - £1.9bn primary care/POD/spec comm
 - £50m running costs
- Within the DLN Cluster 57% of Programme allocation, is planned to be spent with Cluster Providers.
- Within DLN ICB’s 45% of total allocations and 58% of Programme allocations is planned to be spent on Acute Services.

Transformation impact

- The ICBs have identified £33m of transformation investment funds in 2026/27.
- This is expected to grow to £150m over the 5-year horizon.
- The investment is prioritised to support the left shift agenda, and invest in neighbourhood health.
- A minimum ROI of 2:1 is required from this investment – reducing ICB spend with acute providers and supporting those providers with removing unaffordable capacity and cost

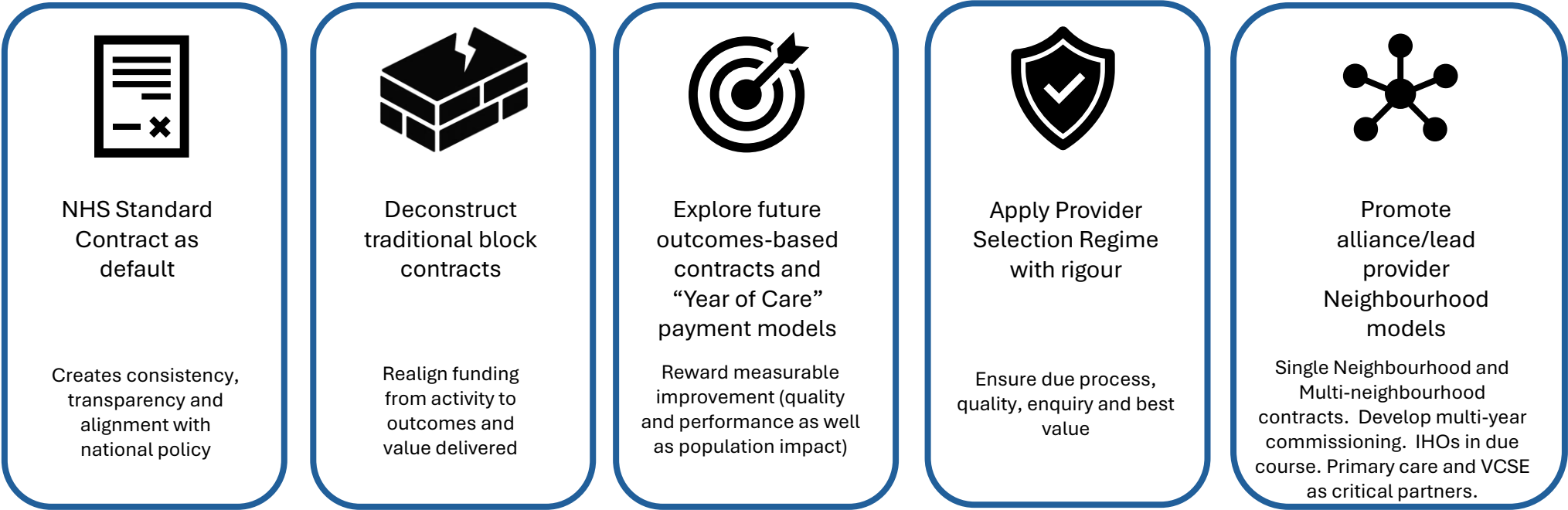
Expected change in shape of spend over 5-year period	£m
Transformation/Neighbourhood Investment - Primary Care (1/3)	50
Transformation/Neighbourhood Investment - Community (2/3)	100
Total investment in primary and community care	150

Expected ROI from investment (min. 2:1) of which:	300
Reduction in ICB acute expenditure to return ICBs to sustainable positon (1% surplus)	140
Reduction in acute provider expenditure position (improvement to provider bottom line)	160

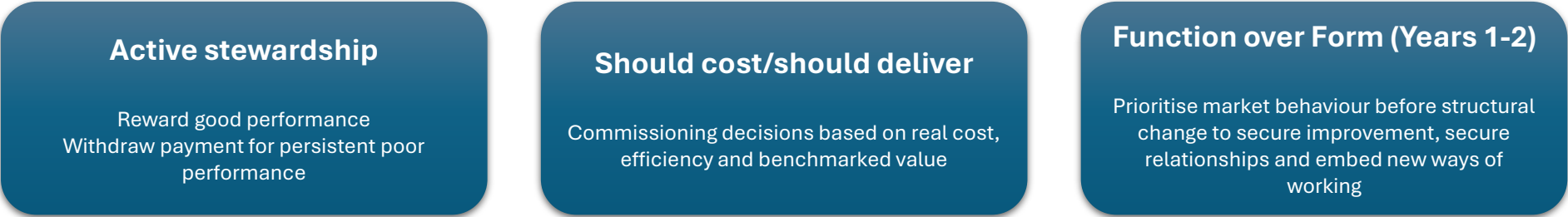
Impact on ICB Spend	£m	
Primary Care	50	↑
Community	100	↑
Acute	-140	↓

Creating and enabling the conditions for success: Contract and Market Stewardship

We will be an outcomes focused, value-driven strategic commissioning Cluster. Our approach to contract management is aligned with our financial framework.



Our Market Management Principles



Creating and enabling the conditions for success: Contract and Market Stewardship

Appendix 6

In translating our intentions into operational delivery we will commission at every population scale, with responsibility for delivery of contracted services at population scale that makes most sense in terms of improving population outcomes and achieving cost effective use of resources.

Population scale for contracting and delivery of commissioning priorities*

Cluster level	e.g. Commission specialised , ambulance and cross-system services to benefit from scale (including analytical and intelligence services, strategic digital, procurement, transactional contracting, finance etc).	3.25m population
ICB level	Commission acute, community and mental health services: embedding primary care within system priorities and aligning incentives, workforce and digital infrastructure at ICB and Place level	0.8-1.3m population
Place level	Provide strategic leadership in bringing providers, local authority, voluntary and community and wider public sector partners together at a level commensurate with Health and Wellbeing Board footprints. This will include a joint focus on physical and mental health, all age, as well as the building blocks of health to create vibrant communities building on local strengths. We will develop stronger pooled budget and joint strategic commissioning arrangements with upper tier local authorities in order to achieve this. This includes the use of the Better Care Fund to address local needs and reduce inequalities and inequity.	Aligned with HWBs Derby (274k) Derbyshire (811k) Nottingham (324k) Nottinghamshire (825k) Lincolnshire (770k)
Multi-neighbourhood level	Delivery of services might be aggregated at a multi-neighbourhood level. This will support supply chain resilience and cost effectiveness for populations that have similar/same needs.	<250k population
Neighbourhood level	Neighbourhoods will be the engine rooms of delivery for proactive, person-centred care led by PCNs to coordinate care and support prevention for people with complex or long term needs. Initial focus in 2026/7 will be people identified as moderate or severely frail, housebound, living in care homes, on the End of Life register.	50k population

*Population scales are indicative and applied flexibly to maximise outcomes, value and resilience, with neighbourhoods (30–50k) as the core delivery unit and aggregation to multi-neighbourhood or place level where this improves effectiveness.

Creating and enabling the conditions for success: Shift from Analogue to Digital

Theme	Priority Area	Cluster level targets to achieve mitigatable benefits	Lead Delivery Team
Promoting the Shift from Analogue to Digital	Digital transformation leading to digital-first patient care. Characterised by universal digital access, fully digital providers, real-time data access, improved population health. Digital access will be delivered on a ‘digital by choice’ basis. Non-digital routes will be available and equivalent in timeliness and quality, supported by assisted-digital offers, interpreter-enabled telephony and face-to-face access where required. Performance against digital inclusion metrics will be monitored at neighbourhood and place level.	Digital and Social Inclusion: Develop and implement a Digital Inclusion Strategic Plan in 2026/7. Run digital literacy workshops across Cluster Years 1-5 to boost inclusion/expand reach of impact.	Finance: Digital Transformation Team
		Provider Digitisation: Achieve 100% electronic patient record coverage; enable e-prescribing in all GP practices across the Cluster. Ongoing maintenance of and upgrade to systems; min 70% repeat prescriptions digital by end 2027/8	
		Interoperability & Data Integration: Onboard City Council, EMAS, PCNs to Notts Care Record by end Q1 2026/7; decommission legacy systems by end Q2 2026/7. Ensure all data feeds integrated, monitor and expand to include VCSE/patient level data across Cluster by end 2027/8.	
		Intelligent Decision Making: Deploy consistent federated data platform dashboards for all clinicians and managers 2027/8; comprehensive staff training programme developed (2026/7) and deployed on analytics tools (2026/7 onwards). Monitoring/reporting of utilisation established 2026/7.	
		Public-Facing Digital Services: Launch campaign to increase NHS App registrations and enable GP record access via NHS App. Min 95% population coverage by 2030/31 consistently across all three ICBs.	
		Embed reasonable adjustments for LDA populations, including digital flag systems and toolkits implemented within core clinical systems (EPRs, PAS, GP systems).	Digital Transformation Team/Mental Health
		Expansion of digital self monitoring, self management, remote monitoring including vision/oral health	Digital Transformation Team/Neighbourhood and Community Transformation

Creating and enabling the conditions for success: Workforce and OD

In order to meet the challenge of the scale and pace of transformation and efficiency/productivity we have we must accelerate the pace of workforce development to respond accordingly. We recognise the need to support NHS and care staff to adapt to new models of care as part of our transformation journey. This requires new ways of working, underpinned by integration and collaboration, agility and flexibility, and strong digital confidence and capability across health and care teams. Strengthening strategic commissioning capability will be an essential element of this workforce development to ensure delivery of our Five Year Plan. In 2026/7 will develop key organisational and individual skills and competencies over the immediate to medium term as part of our Organisational Development Plan, supported by the national Strategic Commissioning Development Programme. This investment in our staff will equip them to act as system leaders, population-health strategists, and intelligent stewards of public resources—combining analytical rigour, collaborative leadership, commercial skill, and a relentless focus on outcomes, equity, and value.

Building Strategic Commissioning Skills & Capabilities

1. Population Health & Intelligence



- Advanced population health management and segmentation
- Use of data, analytics, and insight to target need and reduce inequalities
- Strong understanding of prevention, early intervention, and wider determinants of health

2. Strategic Leadership & System Stewardship (including Clinical)



- Clear vision-setting aligned to national priorities and local need
- Ability to lead place-based and system-wide change
- Stewardship of resources across pathways, not organisations

3. Outcomes-Focused Commissioning



- Designing services around outcomes, not activity
- Value-based and outcomes-based contracting
- Robust performance management and benefits realisation

4. Integrated & Person-Centred Care Design



- Commissioning end-to-end pathways across health, care, and VCSE
- Co-ordinating across primary, community, mental health, social care, and acute sectors
- Embedding personalised care and lived-experience perspectives

5. Partnership, Co-Production & Collaboration



- Deep collaboration with providers, local authorities, VCSE, and communities
- Effective co-design with people and communities
- Cluster and place-based commissioning capability

6. Commercial, Contracting & Market Shaping Expertise



- Strong commercial and negotiation skills
- Provider development, market shaping, and sustainability planning
- Managing provider relationships within system incentives

7. Financial Management & Value for Money



- Medium- and long-term financial planning
- Resource prioritisation and investment shifting (including disinvestment)
- Productivity, efficiency, and sustainability expertise

8. Quality, Safety & Improvement



- Commissioning for quality, safety, and continuous improvement
- Understanding clinical standards, assurance, and governance
- Using improvement science and learning systems

9. Governance, Accountability & Risk Management



- Strong governance, assurance, and decision-making frameworks
- Managing risk, complexity, and regulatory requirements
- Transparency and accountability to populations and partners

10. Workforce & Capability Development



- Commissioning to support workforce transformation and new roles
- Understanding workforce supply, skill mix, and sustainability
- Developing commissioning capability within ICBs and partners

11. Digital & Innovation Enablement



- Commissioning digitally enabled pathways and services
- Supporting data sharing, interoperability, and digital access
- Enabling innovation, scaling what works

12. Adaptive & Learning Commissioning Culture



- Agile, evidence-led/informed and responsive commissioning
- Ability to operate in uncertainty and manage change at pace
- Continuous learning, reflection, and improvement mindset

Developing our approach to One Integrated Workforce

Alongside our Strategic Commissioning workforce development agenda we will work with our wider system partners to promote a strategic shift in our workforce capability to meet the demands of our transforming system.

Workforce Transformation: Empowering staff and promoting integrated working

Ambition	Deliverables
Enable neighbourhood health and commissioning ambitions through a whole-system workforce view	2026/7 - Working with health and care partners, VCSE and LA, map existing and future workforce identifying capacity and capability needs for neighbourhood working. This will build on work already completed within each ICB. - Work with Integrated Neighbourhood Teams and partners to identify new workforce models to deliver future models of care 2027/8 - Promote workforce shift from acute to community - Work with HEIs and FEIs to design new professional training programmes to deliver new workforce capabilities - Publish a Cluster “People Plan” to deliver ICB strategic priorities
Establish a cluster-wide Anchor approach to attract, develop and retain talent to deliver the 10-Year Health Plan and commissioning priorities	2026/7 - Map existing anchor and talent initiatives across the three ICBs - Identify hard to recruit posts and develop targeted supply pipelines. - Use PHM data to identify work cold spots and under represented local communities to develop targeted campaign widening participation and talent supply chain programme. Supporting employment in areas of highest need/deprivation aligned with Community Transformation and Mental Health Programme deliverables. 2027/8 - Launch Cluster Anchor Brans and targeted participation activities to reduce health inequalities

Developing our approach to One Public Estates

Estates Transformation: Enabling Neighbourhood Health Hubs

Across Nottinghamshire, Derbyshire and Lincolnshire, we are transforming the NHS estate to enable neighbourhood health delivery, shifting care closer to home, improving access and outcomes, and making better use of public sector assets.

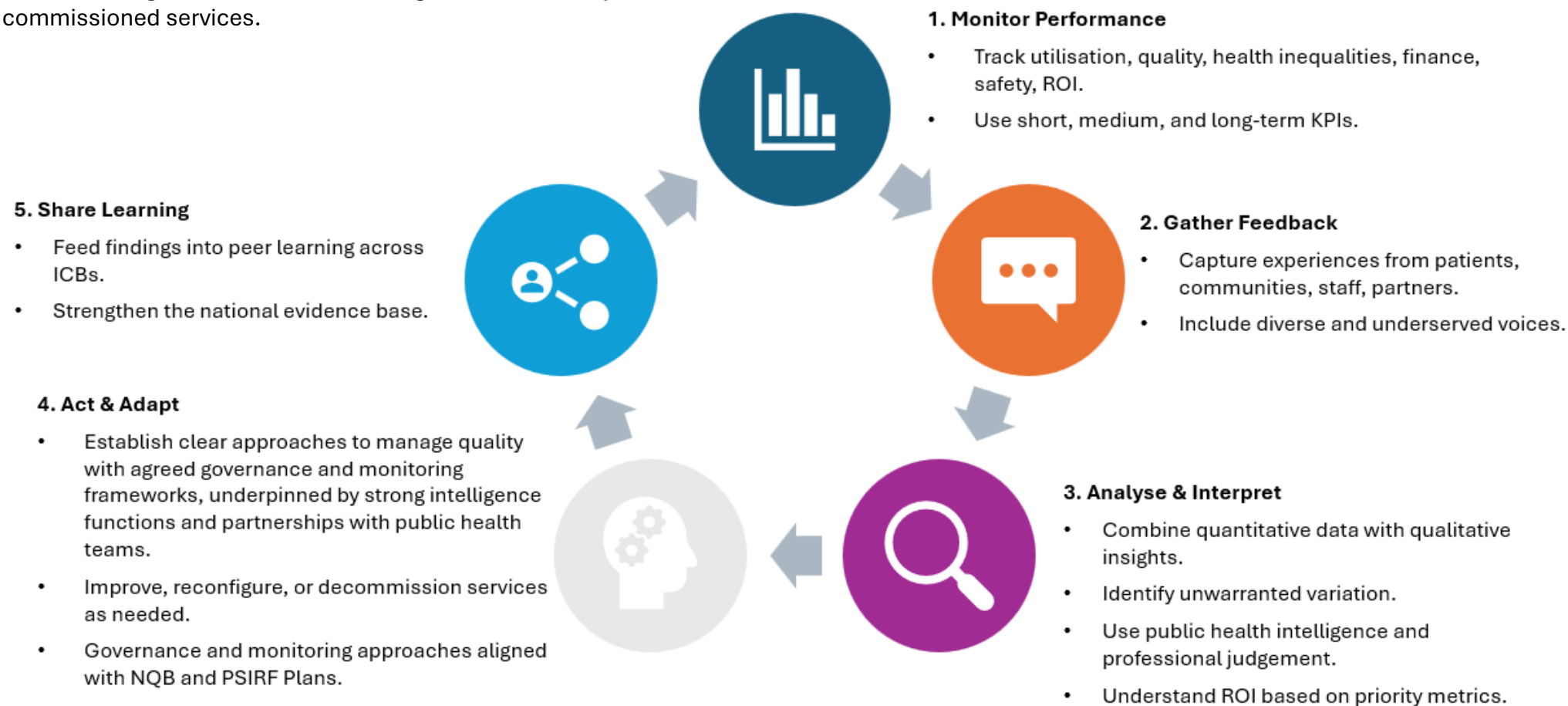
Our Cluster approach prioritises optimisation of core estate—including LIFT buildings, community hospitals and diagnostic centres—to create integrated Neighbourhood Health Hubs aligned to population and place-based need.

Equality and access are embedded in estates decision-making, including travel time, step-free access, blue-badge provisions, signage in priority languages, hearing loops and personal safety to ensure accessible facilities. Options appraisal will support inclusive design and engagement with people with lived experience and seldom-heard groups.

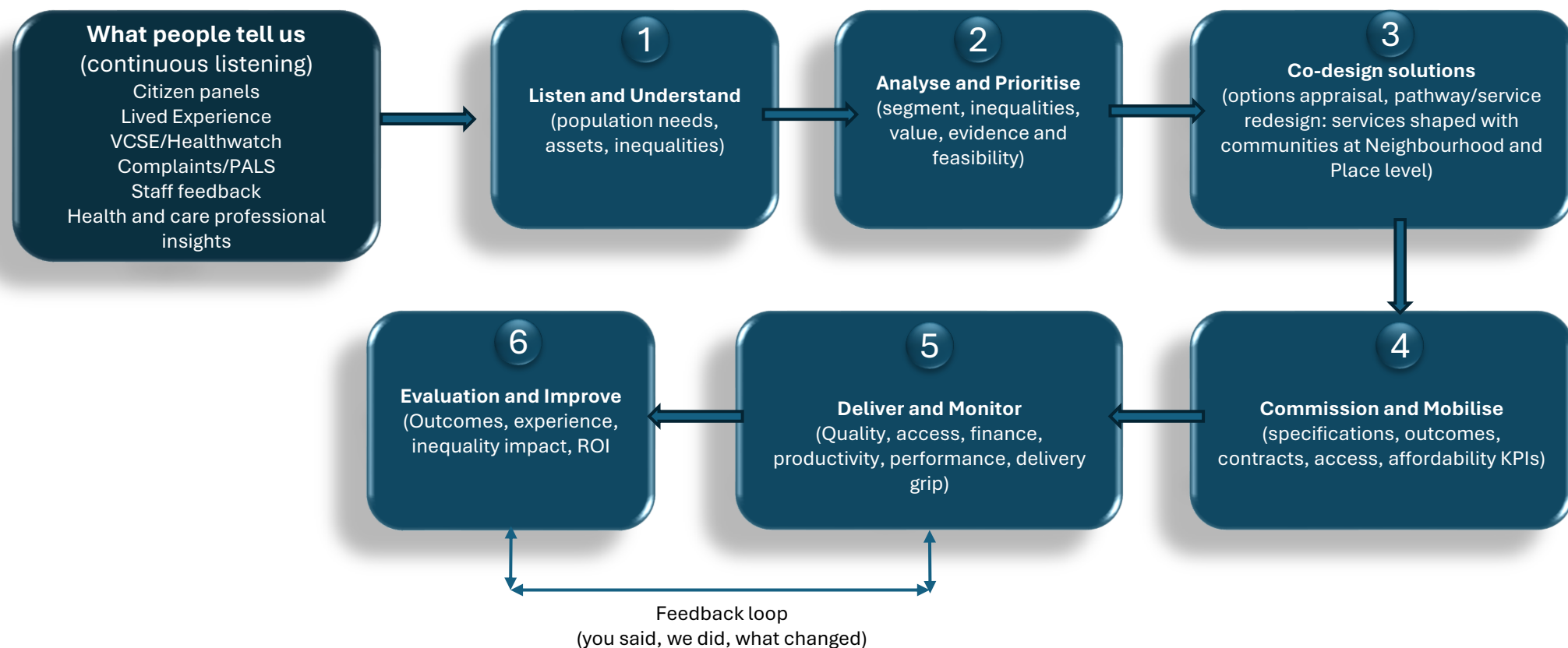
As LIFT concessions end and utilisation patterns change, there is a clear opportunity to rationalise underused space, repurpose high-quality assets and align investment with clinical strategy.

Through system-wide planning, partnership working and our One Public Estate approach, we will continue to seek to maximise collective assets, supporting integrated, prevention-focused care and minimising avoidable estate costs. NHS capital investment will support this, targeted to improve quality, productivity and environmental sustainability, ensuring care is delivered in the right place, at the right scale, and within affordable, sustainable envelopes.

As a strategic commissioner we will adopt a structured, evidence-led approach to measuring outcomes, act on findings, and continually improve commissioned services.



Strategic commissioning requires a systematic “listen–design–deliver–learn” approach, with people and communities’ voice embedded throughout the commissioning cycle to improve outcomes, reduce inequalities and support sustainable use of resources. Engagement is not a one-off consultation: it combines neighbourhood intelligence, lived experience and co-production to shape service models, then uses ongoing feedback and performance data to refine delivery and demonstrate impact and value for money. In line with NHSE expectations for strategic commissioners, this approach strengthens allocative decisions (investing where need and impact are greatest), improves service quality and access, and provides Board-level assurance that transformation plans remain deliverable and affordable over the medium term. In bringing our three ICBs together we have the opportunity to strengthen our approach to citizen engagement over 2026/7. Targeted engagement will prioritise older adults (frailty), disabled and neurodivergent people, carers, racially minoritised communities, Gypsy, Roma and Traveller communities, refugees and people experiencing severe multiple disadvantage. We will also strengthen/embed CYP, parent and carer voice e.g. through Youth Forums, Young Board Members, co-production approaches. Feedback and ‘you said, we did’ actions will be visible at neighbourhood, place and Cluster level.



“Nothing about us without us”: participation and co-production embedded at every stage of commissioning

Our listening and engagement approaches across the three ICBs are already providing a rich source of intelligence that have shaped our five year Commissioning Plan. There is a great deal of consistency in what people have told us in relation to the health services they want to receive. Analysis of their feedback has identified three key strategic themes i) Patient Empowerment ii) Access To Services iii) Communication. We believe our Plan responds to these expressed preferences.

Patient Empowerment	Access To Services	Communication with Services
Shared Decision-Making & Personalised Care - Citizens want more control and decision-making in their care, including being fully informed about what to expect and support available, and expect to see others taking responsibility for their own health - Carers should be actively involved in decision-making - People value community-based specialist clinics (e.g. diabetes, respiratory) to avoid unnecessary hospital visits	Timely & Flexible Access - Ongoing frustration with long waits for GP appointments, elective procedures, and diagnostics, often pushing patients to A&E - Citizens want same-day or next-day access for urgent needs, better triage systems, and extended hours - Calls for streamlined referral processes and co-located services to reduce delays and improve safety	Clear & Accessible Information - Citizens want timely and transparent communication that meets their need, waiting times, and discharge plans Information should be available in multiple formats (Easy Read, BSL, translated) and repeated as needed for accessibility - People continually stress the importance of plain language and culturally appropriate communication to build trust
Health Literacy & Self-Management - Citizens stressed the need for clear, jargon-free information about conditions, treatments, and self-care options - Strong support for proactive prevention, including health checks, lifestyle support, and early intervention for long-term condition - People want education and awareness campaigns to improve NHS literacy and reduce misinformation	Localised & Integrated Care - People want care closer to home, including community hubs offering multiple services under one roof, and more use of lower acuity appointments - Strong support for joined-up care pathways between hospitals, GPs, and social care to reduce duplication and improve continuity - Positive experiences with providers outside of the NHS are broad, with lots of citizens advocating better use of the VSFSE sector	Joined-Up Care & Interoperability - Citizens are frustrated as having to repeat ‘their story’ multiple times repeating medical history and poor information sharing between providers - Citizens want consistent digital systems across practices to avoid confusion and improve care coordination - Better integration between health and social care is seen as critical to reducing delays and improving patient experience
Digital Inclusion & Choice - Citizens support digital tools (NHS App, AskMyGP, virtual consultations) but want user-friendly systems and consistency Concerns about digital exclusion for older adults, rural communities, those with low digital literacy; and mis-diagnosis - People want choice between digital and face-to-face appointments, ensuring inclusivity for all preferences	Equity & Transport Solutions Rural and coastal communities face transport barriers, requesting improved public transport links or mobile health units - Citizens call for interpreters and culturally sensitive care to overcome language and cultural barriers - Digital inclusion initiatives are needed to ensure online services do not widen inequalities, especially for older and disabled people	Continuous Engagement & Feedback Loops - Citizens want ongoing engagement opportunities, not one-off consultations, and visible action on feedback - Calls for simplified feedback routes (QR codes, SMS) and public reporting of changes made based on feedback - People value co-production of services with local communities and seldom-heard groups to ensure inclusivity

Summary Operational Delivery Plans for transformation

Appendix 11

Delivery Plan for Neighbourhoods and Community Transformation

Executive Director: Maria Principe
Senior Responsible Officer: XXXXXX

Neighbourhood Health



Summary

Ambition (2026–2031)

Establish at-scale, consistent neighbourhood health models delivering proactive, same-day and planned care for priority populations, reducing reliance on hospital care.

Headline deliverables

- Single neighbourhood coordination and access model (physical & MH).
- Same-day community response as default for deterioration.
- MDT-led proactive care for frailty, MLTC, SMI and EoL cohorts.

Impact

- Reduced ED attendances and NEL admissions.
- Improved experience and continuity of care.
- Clear attribution of left-shift benefits.

Context

National Policy and System Context alignment

NHS 10 Year Health Plan Expectations

- Shift care closer to home and into neighbourhoods
- Prioritise prevention and population health management
- Reduce reliance on hospitals through integrated community services
- Address inequalities through place-based delivery

NHS Commissioning Framework

- Focuses on outcomes rather than activity
- Uses system leadership to reduce unwarranted variation
- Commissioning for value, productivity and sustainability
- Supports provider collaboration and integration

Mid-Term Financial Planning

The left shift is a core financial sustainability strategy:

- Reducing growth in non-elective admissions
- Releasing acute capacity and cost over time
- Reinvesting savings into community and neighbourhood services
- Delivering recurrent efficiencies rather than short-term mitigations

Neighbourhood Health Guidance

The plan reflects current national expectations for neighbourhood health by:

- Building multidisciplinary neighbourhood teams
- Aligning health, social care and voluntary sector provision
- Using proactive, anticipatory care for high-risk populations
- Operating at a scale of 30–50k population

Local Strategic Alignment (across the three ICBs)

Derbyshire ICB

- Prevention and early intervention
- Integrated place-based care
- Reducing avoidable hospital use

Lincolnshire ICB

- Addresses rurality and access challenges
- Community-first models of care
- Reducing dependency on hospital services

Nottinghamshire ICB

- Tackling inequalities
- Redesigning urgent and same day care
- Scaling neighbourhood and place-based delivery models

Delivery Plan for Neighbourhoods and Community Transformation



Neighbourhood Health

Ambitions

- Create an at scale, comprehensive and consistent Neighbourhood Health and Wellbeing model across the DLN Cluster delivering the three shifts
- Promote prevention and proactive care, including self care, to support people to remain independent for longer in their own homes and communities.
- Mature a truly integrated approach to delivery of health and care pathways that deliver the ‘left shift’ of resources, bridging support for people across planned, urgent and reactive care
- Secure a resilient provider market that can respond to this new model of care
- Reduce health inequalities and inequity as a fundamental prerequisite of all transformational change
- Enable communities and individuals to shape and co-design solutions that meet their needs
- Ensure strong partnerships across our Cluster and within each ICB to maximise collaborative ways of working to achieve value and improved outcomes for people

Headline Deliverables

2026/7 – Establish and Stabilise Neighbourhood Delivery

- Develop a consistent Neighbourhood Health Target Operating Model (TOM) across the Cluster aligned with emergent national guidance. This will be a comprehensive, all-age clinical and wellbeing NbH model focused on prevention and multi-sector, multi-disciplinary support. Prevention initially focussing on secondary/tertiary opportunities as the model embeds.
- Confirm neighbourhood footprints (50,000 population) across the Cluster with HWBs.
- Complete Integrated Neighbourhood Health Needs Assessments/Neighbourhood Health Delivery Plans for all NbHs
 - Reduces unwarranted variation in GP access.
 - Reduces non-elective admissions and bed days for high-priority cohorts (frailty, care homes, housebound, EoL).
 - Shifts appropriate planned care closer to home
- Based on above, revise Cluster level Population Health Improvement Plan demonstrating commissioning response
- 100% Cluster population coverage of Integrated Neighbourhood Teams (INTs)
 - for people with complex needs (frailty, multiple morbidity, care home, EoL patients, CYP (complexity/MH))
 - Min specification incorporating care coordination, proactive case management/case finding, planned and reactive/same day care; MDTs for CYP (primary, secondary paed, MH +professionals)
 - Uses segmented PHM data to identify cohorts
- NbH Health Delivery Plans also require
 - targeted improvement in GP patient experience, 14day GP appointment and same day access
 - improvement in data quality/completeness (CHC SitRep, CYP data sets)
 - Regular reporting of neighbourhood level utilisation, cost and outcomes reporting

Impact

Short Term

- Providers and partners recognise agreed neighbourhood footprints
- Targeted reduction at Neighbourhood level in ACSC non-elective admissions (contribute to escalating 5yr 50% reduction)
- Targeted reduction at Neighbourhood level in LoS for people identified as frail/complex needs (contributing to 5yr min 10% reduction)
- 30% reduction in pts frail/complex needs as ED attendances
- Improved access to high-quality general practice (virtual and face to face) – achievement of NHSE standards
- Reduction in unwarranted variation in patient outcomes.
- Min 1% reduction in people discharged to care homes
- Increase in people receiving home based technology support to maintain independent living
- Capacity in virtual wards and intermediate care min 85%
- Demand growth slowed or stopped
- Increase in people with mental health needs staying in work

Delivery Plan for Neighbourhoods and Community Transformation



Neighbourhood Health

Ambitions	Headline Deliverables	Impact
• Create an at scale, comprehensive and consistent Neighbourhood Health and Wellbeing model across the DLN Cluster delivering the three shifts • Promote prevention and proactive care, including self care, to support people to remain independent for longer in their own homes and communities. • Mature a truly integrated approach to delivery of health and care pathways that deliver the ‘left shift’ of resources, bridging support for people across planned, urgent and reactive care • Secure a resilient provider market that can respond to this new model of care • Reduce health inequalities and inequity as a fundamental prerequisite of all transformational change • Enable communities and individuals to shape and co-design solutions that meet their needs • Ensure strong partnerships across our Cluster and within each ICB to maximise collaborative ways of working to achieve value and improved outcomes for people	2026/7 – Establish and Stabilise Neighbourhood Delivery • Undertake workforce/skills development assessment within each ICB to support ongoing maturity of INT/Neighbourhood development. • Publish 5 yr workforce development plans at ICB and Cluster level supporting left shift activity increase • Publish Market Management Strategy outlining future market development ambitions as a strategic commissioner. Market development to include NHS providers and VCSE. • 100% roll out of Individual Placement Support across the Cluster CORE20+ population • Establish single GP coordinating forum in each ICB to support collective engagement in transformation agenda – delivery and oversight • Establish Cluster primary care performance support process • Publish practice level data packs including benchmarked outcomes as well as process measures (use of A&G, virtual consultations etc). • Board approval of Neighbourhood delivery oversight arrangements within each HWB footprint aligned with national guidance (incl. Community Programme monitoring and reporting) • Comms and Engagement Neighbourhood Plan published. Includes mechanisms for hyper local citizen and public feedback supporting co-design of transformation proposals as well as ongoing comms • Commission Phase 1 multi-neighbourhood contract(s) in respect to management of frailty/complex cases using TOM. Focus on neighbourhoods of highest need/opportunity.	Short Term • Providers and partners recognise agreed neighbourhood footprints • Targeted reduction at Neighbourhood level in ACSC non-elective admissions (contribute to escalating 5yr 50% reduction) • Targeted reduction at Neighbourhood level in LoS for people identified as frail/complex needs (contributing to 5yr min 10% reduction) • 30% reduction in pts frail/complex needs as ED attendances • Improved access to high-quality general practice (virtual and face to face) – achievement of NHSE standards • Reduction in unwarranted variation in patient outcomes. • Min 1% reduction in people discharged to care homes • Increase in people receiving home based technology support to maintain independent living • Capacity in virtual wards and intermediate care min 85% • Demand growth slowed or stopped • Increase in people with mental health needs staying in work

Delivery Plan for Neighbourhoods and Community Transformation



Neighbourhood Health

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• Create an at scale, comprehensive and consistent Neighbourhood Health and Wellbeing model across the DLN Cluster delivering the three shifts • Promote prevention and proactive care, including self care, to support people to remain independent for longer in their own homes and communities. • Mature a truly integrated approach to delivery of health and care pathways that deliver the ‘left shift’ of resources, bridging support for people across planned, urgent and reactive care • Secure a resilient provider market that can respond to this new model of care • Reduce health inequalities and inequity as a fundamental prerequisite of all transformational change • Enable communities and individuals to shape and co-design solutions that meet their needs • Ensure strong partnerships across our Cluster and within each ICB to maximise collaborative ways of working to achieve value and improved outcomes for people	2026/7 – Establish and Stabilise Neighbourhood Delivery • Publish commissioning intentions for Phase 2 of MNP rollout. Define scope/geographical spread. Scope to include broader modality of service provision (e.g. community geriatrics, falls, fracture liaison, enhanced care in care homes, dementia outreach). Spread to continue to focus on areas of highest deprivation. • Publish a One Public Sector Estates Plan across each ICB to confirm opportunities for rationalisation/efficiency in use of estates and support integrated working over medium to long term. • Produce Estates Plan for development of Neighbourhood Health Centre development across the Cluster. Plan to outline the NHC commissioning proposition including core service menu, access model, workforce assumptions, options to re-purpose estates • Review of pooled budget arrangements (e.g. BCF) with upper tier local authorities to identify opportunities for • Implementation of shared care record consistently accessed across all INTs including PODs. • 100% roll out of Individual Placement Support across the Cluster CORE20+ population • Extend Start for Life dental services from conception to age 5yrs as integral to neighbourhood health service offer. • Dental services reform/transformation explicitly designed for delivery at neighbourhood level – considered as part of Neighbourhood Delivery Plan.	Short Term • Providers and partners recognise agreed neighbourhood footprints • Targeted reduction at Neighbourhood level in ACSC non-elective admissions (contribute to escalating 5yr 50% reduction) • Targeted reduction at Neighbourhood level in LoS for people identified as frail/complex needs (contributing to 5yr min 10% reduction) • 30% reduction in pts frail/complex needs as ED attendances • Improved access to high-quality general practice (virtual and face to face) – achievement of NHSE standards • Reduction in unwarranted variation in patient outcomes. • Min 1% reduction in people discharged to care homes • Increase in people receiving home based technology support to maintain independent living • Capacity in virtual wards and intermediate care min 85% • Demand growth slowed or stopped

Delivery Plan for Neighbourhoods and Community Transformation



Neighbourhood Health

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• Create an at scale, comprehensive and consistent Neighbourhood Health and Wellbeing model across the DLN Cluster delivering the three shifts • Promote prevention and proactive care, including self care, to support people to remain independent for longer in their own homes and communities. • Mature a truly integrated approach to delivery of health and care pathways that deliver the ‘left shift’ of resources, bridging support for people across planned, urgent and reactive care • Secure a resilient provider market that can respond to this new model of care • Reduce health inequalities and inequity as a fundamental prerequisite of all transformational change • Enable communities and individuals to shape and co-design solutions that meet their needs • Ensure strong partnerships across our Cluster and within each ICB to maximise collaborative ways of working to achieve value and improved outcomes for people	2027/8 – Scale, integrate and optimise • Complete maturity assessment/matrix review of all INTs across Cluster population. • Neighbourhood Development Programme launched in response to assessed maturity and gap to full maturity. Programme meets maturity gap within each ICB (estates, workforce, digital elements as well as outcome/delivery improvements). • Establish formal acute/GP interface forums across each acute provider where not already. Confirm annual agendas based on priority transformation needs per provider. • Review workforce development plan in line with capacity requirements at Neighbourhood level (e.g. urgent, acute, rehabilitation, step-up/down care, planned care etc.) • Evaluation from MNP contracts expand MNP approach across Cluster with Phase 1 extended scope. • For initial MNPs extend scope into Phase 2 (to include continence, wound care, self management, community nursing (palliative care, cardiovascular, heart failure, respiratory). Ensure ongoing interdependency with same day/urgent care pathway maintained. • Develop proposals for scope of MNPs in Phase 3 (possible considerations therapists and reablement). • Implementation of shared digital record for EoL care plans • Further to completion of the Management of Change process develop plans for the transfer of transformational capability	Medium Term • Consistent high quality citizen engagement and co-production in service delivery and transformation at all delivery scales • Reduction in overall emergency admissions (frail/complex needs pts) • Min 30% reduction in ED attendances (frail/complex needs) • Escalating reduction in emergency admissions from 25/6 baseline for people with complex needs • INTs fully matured (Phase 1) • Reduced workforce attrition rates • Increase in staff reported satisfaction and working well within INTs • Maximise use of public sector estate • Improved digital interoperability for personalised care • Increase in contracted activity from VCSE sector in relation to neighbourhood delivery models • Recurrent/ embedded acute reduction in utilisation

Delivery Plan for Neighbourhoods and Community Transformation



Neighbourhood Health

Ambitions	Headline Deliverables	Impact
• Create an at scale, comprehensive and consistent Neighbourhood Health and Wellbeing model across the DLN Cluster delivering the three shifts • Promote prevention and proactive care, including self care, to support people to remain independent for longer in their own homes and communities. • Mature a truly integrated approach to delivery of health and care pathways that deliver the ‘left shift’ of resources, bridging support for people across planned, urgent and reactive care • Secure a resilient provider market that can respond to this new model of care • Reduce health inequalities and inequity as a fundamental prerequisite of all transformational change • Enable communities and individuals to shape and co-design solutions that meet their needs • Ensure strong partnerships across our Cluster and within each ICB to maximise collaborative ways of working to achieve value and improved outcomes for people	2028/9-2030/1 – Embed and sustain system impact • Minimum consistent INT landscape across the Cluster of Phase 1 and Phase 2 scope of service delivery. • Phase 3 expansion confirmed (scope and geography) based on evaluation of performance and impact of Phase 1 and 2. • Formal delegation of responsibilities to providers for identified areas of delivery outside MNP contractual commitments • Review of opportunities for IHO development within the Cluster. • Fully integrated record sharing across primary care (Incl PODs), VCSE as well as acute and community and social care.	Long Term • Improved healthy life expectancy in areas of highest deprivation (CORE 20+ cohorts) • Reduction in acute resource utilisation overall • Highest level of reduction in acute resource utilisation in people identified as frail/complex needs and living in CORE20+ areas • More vibrant communities with improved rates of employment, smoking, exercise, vaccination and immunisations • Increase in eligible people accessing benefits support • Increase in upstream investment in prevention and neighbourhood models. • Integrated public sector estates operating at neighbourhood, ICB and Cluster level releasing financial and non-financial benefits. • Reduced duplication across services generating process efficiencies • More productive use of community workforce • Shorter average length of stay in acute beds (elective) • Reduced non-elective admissions and bed days • Vibrant VCSE sector supporting delivery of neighbourhood based services • Sustainable system balance

Delivery Plan for Neighbourhoods and Community Transformation

Executive Director: Maria Principe
Senior Responsible Officer: XXXXXX

Primary Care and Community



Summary

Across Derbyshire, Lincolnshire and Nottinghamshire, the DLN Cluster will transform primary care over the next five years into the cornerstone of neighbourhood health—accessible, resilient and fully integrated around people and communities. General practice, community pharmacy and community optometry will operate as equal, connected partners within neighbourhood teams, working in alliance with community, acute, VCSE and social care to deliver coordinated, proactive and preventative care tailored to local need. People will experience faster, simpler access to the right professional first time, with pharmacy and optometry playing an expanded and standardised role in early diagnosis, prevention and long-term condition management, reducing avoidable demand on hospitals and improving outcomes. This transformation will be enabled through strong strategic commissioning, with clear expectations for access, quality and equity, robust contract and performance management, and disciplined multi-year investment and productivity planning. Together, these changes will reduce unwarranted variation, target resources to the highest-value interventions and ensure national standards are consistently met while delivering sustainable, affordable primary care for the future.

Context

Primary care access (NHS Constitution / national access expectations)

- Improved patient ability to contact GP practices
- increased same-day/appropriate appointments
- improved GP Patient Survey access and experience scores.

Delivery of national primary care service standards

- Consistent delivery of GP contractual requirements
- Community Pharmacy services (e.g. CPCS, Pharmacy First) and Community Optometry enhanced services with improved utilisation and coverage.

Neighbourhood health and integration

- Increased participation of GP practices, pharmacies and optometrists in neighbourhood MDTs
- Measurable growth in activity delivered outside hospital settings

Prevention and inequalities (Core20PLUS5)

- Improved uptake of prevention activity in primary care (e.g. vaccinations, case-finding, medicines optimisation)
- Reduced variation in access and outcomes across deprivation groups.

Quality, safety and patient experience

- Improved patient-reported experience
- Reduced medicines-related harm
- Improved compliance with quality and safety requirements across primary care contracts.

Productivity, value and sustainability (MTFP)

- Increased activity delivered in primary care and community pharmacy/optometry
- Reduced avoidable urgent and acute demand
- Delivery within agreed prescribing and primary care investment envelopes.

Workforce resilience

- Improved workforce stability indicators (vacancy, turnover, agency use)
- Increased uptake of extended roles and skills supporting neighbourhood delivery.

Delivery Plan for Neighbourhoods and Community Transformation



Primary Care and Community

Ambitions

- By 2030/31 people living in DLN will experience consistently timely access to integrated primary and community care, receiving the right care first time, close to home, with reduced reliance on acute services.
- Within five years, personalised, proactive and coordinated care will be delivered at scale across all neighbourhoods, measurably improving outcomes and experience for the whole population.
- Prevention and early intervention, driven by population health management (Core20PLUS5) will deliver sustained reductions in inequalities and improved long-term health outcomes.
- Within five years, responsive community urgent care and home-based services will significantly reduce avoidable admissions and enable timely, supported discharge from hospital.
- People will experience interoperable digital infrastructure and shared data fully embedded in their care pathway, enabling seamless care, informed clinical decision-making and demonstrable improvements in quality and productivity.
- By 2030/31, a skilled, flexible and resilient primary care workforce will be fully aligned to neighbourhood models of care, providing sustainable capacity and capability to meet population needs.

Headline Deliverables

2026/7 – Establish and standardise

- Establish single GP coordinating forum in each ICB to support collective engagement in transformation agenda and market management
- Implement single digital front door to primary care incl. urgent dental triage
- Direct access to Community Urgent Eye Care Service (CUES) go live
- Routine reports at POD level for all PCNs across the Cluster launched (Notts early adopter)
- Business Case for expansion of self monitoring/remote monitoring for PODs demonstrating ROI
- Review of care pathways for extension of peer support networks for self management, initial focus in CORE20+ areas
- Business Case for expansion of home IV therapy and step up-down capacity across Cluster
- Implement Cluster wide pharmacy home delivery for urgent medicines
- Review domiciliary optometry for housebound to ensure consistent minimum standard across Cluster
- Establish mobile central units for urgent care
- FDP supported Record sharing capability established for PODs and GP practices.
- Undertake review of ambient technologies for use in primary care
- Oral health promotion undertaken in all schools across the Cluster
- Risk stratification reports updated routinely for GP practices to identify proactive case finding opportunities. Mobilisation in Notts.
- Implementation of new models of integrated home visiting services across all ICBs
- Digital booking for all PODs go live
- Dental workforce plan mobilised
- Complete review of AI for primary care
- Develop and implement CHS Waits Action Plan including:
 - Targeting high volume service lines
 - Productivity implements (MDT working, high impact appts)
 - Support for patients while waiting
- Produce a 5 year Primary Care Action Plan incl GP, POD. Sign-off Q1 26/7

Impact

Short Term

- Improved access to GP services: achievement of 14 day access target
- Improve GP access including increasing same-day urgent care capacity
- Improved patient experience of GP access and care
- Improve access to routine and urgent dental care services
- Increase in Pharmacy First activity (incl. smoking cessation/vaccination/oral contraception)
- Increase in routine vision screening in optometry
- Increase in oral health promotion in schools/care homes
- Increase in social prescribing into primary care
- Increase in personalised care plans for most complex patients
- Achievement of 2hr UCR standard
- Improved patient experience
- Reduction in avoidable urgent and emergency demand
- Improved grip on performance, quality and unwanted variation

Medium Term

- Increase in use of pharmacy and optometry for diagnosis, prevention and treatment
- Increase in patient expressed confidence in primary care
- Increase in shared decision making training across primary care and INTs
- Min 70% repeat prescriptions digital
- Sustained improvement in access, continuity and outcomes across neighbourhoods
- Expansion of self monitoring, self management, remote monitoring including vision/oral health
- Digital self management tools for PODs
- More consistent delivery of national access and quality standards
- Improved management of long term conditions and prevention for priority populations
- Increased workforce resilience through INTs
- Reduced locum reliance incl. dental

Delivery Plan for Neighbourhoods and Community Transformation



Primary Care and Community

Ambitions

- By 2030/31 people living in DLN will experience consistently timely access to integrated primary and community care, receiving the right care first time, close to home, with reduced reliance on acute services.
- Within five years, personalised, proactive and coordinated care will be delivered at scale across all neighbourhoods, measurably improving outcomes and experience for the whole population.
- Prevention and early intervention, driven by population health management (Core20PLUS5) will deliver sustained reductions in inequalities and improved long-term health outcomes.
- Within five years, responsive community urgent care and home-based services will significantly reduce avoidable admissions and enable timely, supported discharge from hospital.
- People will experience interoperable digital infrastructure and shared data fully embedded in their care pathway, enabling seamless care, informed clinical decision-making and demonstrable improvements in quality and productivity.
- By 2030/31, a skilled, flexible and resilient primary care workforce will be fully aligned to neighbourhood models of care, providing sustainable capacity and capability to meet population needs.

Headline Deliverables

2026/7 – Establish and standardise

- Segment practices and PCNs by performance and need
- Provide targeted support for practices with negative variance
 - Use Modern General Practice assessment tools and peer support

2027/8 – Scale and integrate

- Subject to approval, progress with implementation of remote monitoring – established in 2027/8
- Subject to approval, progress with implementation of home IV/step-up/down capacity
- Subject to approval, progress with roll-out of AI, RPA and AVT across primary care
- Fully interoperable shared records across PODs and GP practices embedded as part of INT working across all ICBs
- Routine reporting of digital referral/feedback for eye/dental care
- Electronic dental records provided in NHS App
- Risk stratification reports updated routinely for GP practices to identify proactive case finding opportunities. Mobilisation across Derbys and Lincs.

2028/9 onwards – Embed and optimise

- Fully established digital recall/appointment booking for dental services

Impact

Long Term

- A resilient, integrated primary care system embedded as the foundation of neighbourhood health
- Improved population health outcomes and reduced health inequalities
- Lower reliance on hospital-based care and reduced avoidable admissions
- Sustainable primary care delivery within medium-term financial envelopes
- Better value for money through targeted investment in high-impact, preventative care
- Interoperability standards met
- Increase in community alternatives to acute care
- Demand growth addressed
- Increase in Cluster relative investment in primary care

Delivery Plan for Children and Young People



Executive Director: Maria Principe
Senior Responsible Officer: XXXXXX

Summary

This five-year delivery plan sets out how the Derbyshire, Lincolnshire and Nottinghamshire Integrated Care Boards (ICBs) will work individually and collectively to improve outcomes for children and young people (CYP), deliver constitutional standards and maximise efficiency opportunities. The plan aligns with the NHS 10 Year Health Plan, the NHS Commissioning Framework and NHS mid-term financial planning guidance.

The plan is informed by a review of published Joint Strategic Needs Assessments (JSNAs) for Derby, Derbyshire, Lincolnshire, Nottingham and Nottinghamshire, alongside common productivity and pathway opportunities identified through NHS provider opportunity packs. It is intended as a system-level delivery framework, with detailed local implementation plans developed by each ICB under the responsibility of the Commissioning Directorate Children and Young People Programme.

Context

Population Need and Shared Challenges (all three ICBs)

Across the JSNAs for Derby, Derbyshire, Lincolnshire, Nottingham and Nottinghamshire, common pressures affecting children and young people include:

- Rising mental health needs, particularly anxiety, depression and emotional wellbeing issues in adolescents
- Increasing demand for neurodevelopmental assessments, including autism and ADHD
- High rates of childhood obesity and poor oral health, especially in deprived communities
- Widening inequalities affecting children in deprivation, those with SEND, children in care and marginalised groups
- Ongoing pressure on urgent and emergency care, including avoidable paediatric attendances and admissions
- Workforce shortages across community, mental health and specialist services

Collectively, these challenges are impacting the ability to meet constitutional standards, maintain quality and ensure financial sustainability.

Commissioning and Delivery Principles

- Population health management for CYP
- System leadership and collaboration across ICBs
- Commissioning for value and outcomes
- Digital enablement and workforce transformation
- Co-production with children, young people and families

National Alignment

The plan is underpinned by:

- Prevention and early intervention across the life course
- Integrated, place-based models of care
- Reducing health inequalities and unwarranted variation
- Improving access, experience and outcomes
- Financial sustainability and productivity

Delivery Plan for Children and Young People

Ambitions	Headline Deliverables	Impact
- Shift Cluster focus towards early years, school readiness and early intervention/prevention (including vaccs/immunisation uptake, socialisation and SALT skills) and addressing health inequalities - Improve access to integrated MDTs within a community setting for CYP with mental health needs, particularly anxiety, depression and emotional wellbeing in adolescents - Redesign/streamline neurodevelopmental assessment and pathways (including autism and ADHD) - Reduce prevalence of childhood obesity to at least the national average - Reduce poor oral health for children with emphasis of children living in deprived communities - Reduce widening inequalities for children living in deprivation, children with SEND, in care and from marginalised communities - Reduce urgent and emergency care attendances and admissions: address specific needs of CYP with asthma, LTCs and MH needs - Support skill development and capacity gaps in community, mental health and specialist services - System wide compliance with national guidance on CYP service offers - Ensure appropriate levels of paediatric critical care	2026/7 – Stabilise and Standardise - LD/A T4 oversight meetings established, and assurance secured. No more than 3 CYP inpatients at one time. - Review of cluster wide CYP Mental Health Service Pathways.Phased review over 2026/7: data analysis, co-design/engagement, decision making, mobilisation. Purpose to improve access to MH services in the community via a quality MDT approach and consistency of outcomes across all pathways across the Cluster addressing inequity. - Delivery in full of Lincolnshire’s CYPMH Commissioning and Transformation Plan. - CYP LTP Transformation delivery plans reviewed for consistency across Cluster. Plans mobilised/implementation progress (comprising 4 Clinical Priorities, Transitions, Elective and Continuing Care). - Review of digital and group-based interventions for CYPMH support offer providing graduated support response. Consideration of prevention and early years support in rural and coastal communities. - Review of SEND partnerships across the Cluster, ensuring partnership working at ICB level is regarded as effective by partners. - Review of safeguarding arrangements for consistency/opportunity across Cluster/LA arrangements ensuring continuation of meeting statutory duties - Delivery in full of the Derbyshire & Lincolnshire SEND Recovery Impact Plan - Neighbourhood delivery of dental access/prevention support for CYP in CORE20 areas – implementation of A Start for Life (0-5yrs) connecting health visiting/FS services, perinatal care to neighbourhood integrated teams and their outcomes. 2027/8 - Transform and Integrate - Develop workforce plans, including collaborative specialist children’s Placements, to support Cluster wide provision of ICB level teams with additional skills in de-escalation, trauma and dysregulation management support across health and care - Standardise service specifications for community paediatrics and therapies - CYP LTP Transformation delivery plan delivery completed. - Digital and group-based interventions confirmed and implemented - Specialist Children’s Placements with additional skills in de-escalation, trauma and dysregulation in place within each ICB 2028/9 onwards – Optimise and Sustain - Mental Health in Schools Team Rollout 100% coverage achieved by 29/30.	Short Term - Achievement of 4 week waiting time standard across Cluster by 2027/8 - Min 5% increase of help based clock stops recorded in 4 weeks across all CYP Mental Health Services - CYP who access MHSTS consistently demonstrate improved clinical paired outcomes - Min 5% reduction in the number of Category 0 and 1 presentations in A&E - Min 80% children are moved out of ED and discharged or admitted into appropriate care setting in under 4 hours. - CYP feedback of improved coordination in system support to meet their needs - Improvement in health outcomes for CYP with LDA (health checks completed, referral into prevention interventions key indicator) - Min 10% reduction in LoS for under 18yrs with LDA in MH inpatient beds - SEND partnership arrangements reported as effective by partners - Reduction in waiting times for access to neurodevelopmental assessment to min national average Medium Term - Increase in childhood vaccs and imms to at least national average - All children with LD/A crisis needs offered intervention by MDT - Min 20% reduction in ED attends for CYP 50% increase in GP registration for vulnerable cohorts. - Min 10% improved patient-reported outcomes and experience (PROMS/PREMS). - Min 10% reduction in FYE emergency admissions for CYP into MH inpatient beds (baseline 2025/6) - Min 10% reduction in Cat 0-1 presentations in A&E - Annual health checks for 75%+ of CYP with LD/A. - Reduction in breakdown of Placement breakdown - Zero out of area placements for CYP (incl. MH) - Compliance with national guidance Long Term - Consistent digital CYP MH support across Cluster as part of graduated offer - Improvement in premature mortality and morbidity. - Reduction in unwarranted variation in access and outcomes - Reduction in individuals reaching crisis point - Reduced overall demand on acute and urgent CYP services - Improved utilisation of community capacity - Reduced duplication in assessment and FU for CYPs services - Improved provider productivity through pathway standardisation

Delivery Plan for Mental Health, Learning Disability and Autism

Executive Director: Maria Principe
Senior Responsible Officer: XXXXXX



Summary

Across Derbyshire, Nottinghamshire and Lincolnshire, mental health services face sustained pressures that reflect well-recognised challenges across parts of the local provider landscape. These include variable access and waiting times across community and specialist pathways, continued reliance on inpatient care for some cohorts, unwarranted variation in quality and outcomes, workforce capacity and stability challenges, and increasing financial and operational constraints. Together, these issues limit the system’s ability to respond effectively to rising and increasingly complex demand, particularly for vulnerable populations. National policy and guidance are clear that these challenges require a step change rather than incremental improvement. The NHS Long Term Plan, emerging 10-Year Health Plan, NHSE Commissioning Framework and Mid-Term Financial Plan set a clear expectation for the transformation of mental health services towards integrated, neighbourhood-based models, stronger prevention and early intervention, reduced reliance on inpatient care, and commissioning approaches that deliver improved outcomes, reduced inequalities and sustainable use of resources. Transforming mental health services across the DLN Cluster is therefore a core strategic priority, essential to improving quality and access, supporting system sustainability and meeting NHSE expectations over the next five years.

Context

National Alignment

The Plan is consistent with national expectations in respect to its delivery of:

- **Neighbourhood-based integrated care**
 - Shift delivery from inpatient and acute settings to proactive, community and neighbourhood mental health, LD and autism services.
- **Early intervention and equitable access**
 - Improve timeliness, reduce variation and address inequalities through standardised pathways and targeted support for priority cohorts.
- **Improved inpatient quality and flow**
 - Reduce avoidable admissions and length of stay, strengthen discharge and community alternatives, and improve safety and experience.
- **Accessible, person-centred care**
 - Embed reasonable adjustments, accessible information and co-production for people with learning disabilities and autistic people.
- **Sustainable workforce and infrastructure**
 - Align workforce, estates, digital and data capability to transformed models of care
- **Outcomes-led commissioning and delivery grip**
 - Commission for outcomes and value, supported by strong governance, programme management and assurance.

Delivery Plan for Mental Health, Learning Disability and Autism



Ambitions	Headline Deliverables	Impact
- Secure community mental health transformation through integrated neighbourhood/community models for adults and older adults with severe mental illness, including improved access to psychological therapies, physical health support, and personalised care. - Ensure people are supported to live well in their local community, with early intervention to reduce crisis and urgent care needs. This includes NHS Talking Therapies (IAPT) in line with the national service model/manual (including pathway standards, outcomes focus and equity of access). - Deliver a responsive early support and crisis offer to avoid unnecessary hospital admissions. - Provide services that are reasonably adjusted to meet the needs of people with learning disabilities, autism, and ADHD. - Deliver inpatient quality transformation to ensure continuity, valued therapeutic relationships, safety and quality improvements in line with high performing peer ICB communities. - Be a national exemplar in developing cross-agency commitment to reduce reliance on inpatient care for people with learning disability and autistic people, strengthening community alternatives and discharge pathways	2026/7 - Approved Business Case (with implementation plan) for Mental Health & Wellbeing Hubs serving the population of DLN. Plan commencing with supporting CORE20 population/those neighbourhoods with highest MH need (September 2026) - Implementation Plan mobilised (October 2026) 24/7 Neighbourhood Mental Health Centres established across the Cluster (by March 2027) - Approved Plan for mandatory training on learning disability, autism and reasonable adjustments across Cluster providers (September 2026) - Training implemented across all provider sectors on Reasonable Adjustments Toolkit, Digital Flag Guidance, Learning Disability Improvement Standards, Annual health check frameworks (December 2026) - Implement/expand reasonable adjustment recording and sharing as part of core clinical workflows across each ICB (by March 2027) 2027/8 - Implement Crisis Assessment Centres and Mental Health Emergency Departments, co-located with Type 1 Eds across the Cluster (by March 2028) - Develop new Autism and Learning Disability Strategy with ICB level implementation plans. Strategy approved (by June 2027). - Expand access to NHS Talking Therapies and Individual Placement and Support (IPS) to meet minimum wait targets across Cluster. - Embed reasonable adjustments for LDA populations; digital flag systems and toolkits implemented within all core clinical systems (EPRs, PAS, GP systems) across the Cluster (by Dec 2027). - Achieve min 60% and sustain higher uptake of annual health checks for people with learning disabilities (from April 2027). - Strengthen community-based support and alternatives to hospital admission based on citizen feedback and PHM intelligence.	Short Term - Increased access to mental health and LDA services. - Reduced crisis presentations and A&E attendances. - Improved patient experience and timely support. - Higher uptake of annual health checks and health action plans. Medium Term - Reduction in inpatient admissions and readmissions. - Shorter lengths of stay in hospital. - Improved flow and coordination across services. - Greater use of community-based alternatives to hospital. Long Term - Sustained reduction in avoidable deaths and improved mortality rates for people with LDA and autism. - People supported to live well in their communities, with fewer escalations to crisis or hospital care. - System-wide embedding of reasonable adjustments and personalised support.

Delivery Plan for Mental Health, Learning Disability and Autism



Ambitions

- Secure community mental health transformation through integrated neighbourhood/community models for adults and older adults with severe mental illness, including improved access to psychological therapies, physical health support, and personalised care.
- Ensure people are supported to live well in their local community, with early intervention to reduce crisis and urgent care needs. This includes NHS Talking Therapies (IAPT) in line with the national service model/manual (including pathway standards, outcomes focus and equity of access).
- Deliver a responsive early support and crisis offer to avoid unnecessary hospital admissions.
- Provide services that are reasonably adjusted to meet the needs of people with learning disabilities, autism, and ADHD.
- Deliver inpatient quality transformation to ensure continuity, valued therapeutic relationships, safety and quality improvements in line with high performing peer ICB communities.
- Be a national exemplar in developing cross-agency commitment to reduce reliance on inpatient care for people with learning disability and autistic people, strengthening community alternatives and discharge pathways

Headline Deliverables

2028/9

- Evaluate use of Digital Reasonable Adjustment Flag (RAF) for routine use across primary, community, acute, mental health (March 2029). Evidence to include recorded adjustments to inform future learning and commissioning adjustments.

2029/30 – 2030/31

- Embedding community transformation to support sustainable improvements in outcomes for people with severe mental illness, learning disabilities and autism

Impact

Short Term

- Increased access to mental health and LDA services.
- Reduced crisis presentations and A&E attendances.
- Improved patient experience and timely support.
- Higher uptake of annual health checks and health action plans.

Medium Term

- Reduction in inpatient admissions and readmissions.
- Shorter lengths of stay in hospital.
- Improved flow and coordination across services.
- Greater use of community-based alternatives to hospital.

Long Term

- Sustained reduction in avoidable deaths and improved mortality rates for people with LDA and autism.
- People supported to live well in their communities, with fewer escalations to crisis or hospital care.
- System-wide embedding of reasonable adjustments and personalised support.

Delivery Plan for Planned Care

Executive Director: Maria Principe
Senior Responsible Officer: XXXXXX



Summary

Planned care transformation is critical to improving access, reducing waiting times and delivering a sustainable elective system across Derbyshire, Lincolnshire and Nottinghamshire. Rising demand, limited capacity and unwarranted variation across pathways require a step change in how planned care is commissioned and delivered, moving beyond incremental improvement. Transformation will focus on redesigned elective pathways that reduce unnecessary outpatient activity, expand timely access to diagnostics, standardise care and make better use of community and primary care capacity. This will improve flow, patient experience and outcomes while increasing productivity and releasing capacity for those with the greatest need. This approach aligns with established commissioning priorities across the three ICBs, supporting elective recovery, improved performance, reduced variation and long-term financial sustainability through robust commissioning, contract management and delivery oversight. Planned care and follow-up reduction programmes will include explicit safety-netting for people with severe mental illness, learning disability and autism, sensory or cognitive impairment and low health literacy. This will include personalised recall thresholds, non-digital follow-up options and proactive outreach, with outcomes monitored by protected characteristic and deprivation.

Context

National Alignment

The Plan is consistent with national expectations in respect to its delivery of:

- Commission for outcomes and value and reducing unwarranted variation
- Supporting provider collaboration including NHS and VCSE providers
- Strengthening our approach to allocative efficiency (right mix of activity across settings) and technical efficiency (delivering activity more efficiently).
- Multi-year planning, recurrent efficiency focus, and transparent demand/capacity assumptions.
- Contracting and incentives to enable reform (including shifting activity, reducing low-value follow-ups and better use of diagnostics).
- Development of new integrated delivery models at neighbourhood level
- Single coordination and proactive care for those most at risk
- Reform of outpatient care (reducing unnecessary follow-ups, increasing patient initiated follow-up, increase advice and guidance and straight-to-test).
- Meeting the elective access standard (at least 92% of patients waiting 18-week or less) by March 2029 and interim targets as outlined in national planning guidance (min 7% improvement in 18week performance or min 65% March 2026).
- Meeting cancer constitutional standards (28/31/62days)
- Meeting diagnostic 6week wait standard

Cluster Alignment

Derbyshire ICB Planned Care focus:

- Improve outcomes
- Reduce Inequalities
- Enhance Productivity

Lincolnshire ICB Planned Care focus:

- Improve access
- Improve productivity
- Deliver care closer to home

Nottinghamshire ICB Planned Care focus:

- Reduce health inequalities
- Improve access
- Achievement of constitutional standards

Delivery Plan for Planned Care



Ambitions

Elective Activity and Demand Management

- Reimagine outpatient and follow up activity, transforming care by reducing the number of routine and clinically low value follow-up appointments, promoting the use of remote or digitally enabled review to improve the patient experience and add value. These approaches will expand patient choice by enabling people to initiate follow-up when they need it, access advice without unnecessary appointments, and select the most appropriate mode of review, supported by robust safety-netting and personalised recall.
- Improve earlier access to the right care at the right time by expanding straight to test pathways and one-stop clinics including use of CDCs.
- Expand the use of Advice and Guidance and Referral Triage to allow patients to be treated in the most clinically appropriate setting to meet their needs.
- Promote health equity and reduce health inequalities by adopting a proactive approach to waiting list management (also including waiting list validation, patient compliance with access rules, referral to treatment guidance etc.)
- Accelerate the left shift through ‘triage first’ and community based delivery for lower complexity cohorts (MSK, dermatology, ophthalmology, ENT etc.)

Promoting effective and efficient use of resources:

- Drive down the cost and improve value of planned care through accelerated progress on transformational initiatives including digital-be-default, compliance with EBI Guidance, increase in day case rates etc.
- Support reduced use of back/agency staff, promoting ongoing benchmarking of performance

Headline Deliverables

2026/7

- Publish outpatient transformation plan for high-volume specialties (gynae, MSK, ENT, ophthalmology, dermatology, pain, pre-op optimisation, diagnostics). Plan aligned with aggregate activity ambitions with ICB specific target/stretch delivery levels. Plan has clear delivery timescales for implementation and benefits realisation. Confirm location of community based services in line with Estates Plan for Neighbourhood Health Centres across DLN.
- Single PLCV Policy approved across DLN
- Complete pathway reviews and implementations for specific specialties at ICB level where Productivity Packs/local intelligence suggests significant opportunity. Min of 2 specialty reviews per ICB completed. These are in addition to high volume specs. Confirm location of community based services in line with Estates Plan for Neighbourhood Health Centres across DLN.
- Routine contracting oversight in relation to internal provider efficiency expectations e.g. A&G rate of 45%.
- Review cross Cluster integrated cancer pathways to identify opportunities for efficiencies.
- Review cross Cluster diagnostic pathways, top 3 most challenged. Implementation plan initiated to assure best-practice delivery and Increased capacity where identified.
- Fragile services reviews undertaken (min 2 pathways/care function). Implementation plan initiated.
- Cluster Women’s Health Strategy developed incorporating ICB level sensitivities. Implementation plan initiated.
- Commission additional Independent Sector Provision identified to meet RTT requirements.
- Review Cluster contract oversight arrangements. Implement single approach including establishment of single contracting database.
- Publish Implementation plan to standardise contracts/align contracts. Implementation initiated.

Impact

Short Term

- Improved elective access and flow
- Reduction in RTT >52-week and >65-week waits
- Improved compliance with the 6-week diagnostic standard
- Outpatient productivity gains
- Reduction in unnecessary follow-ups and first-to-follow-up ratios
- Increased use of advice & guidance and straight-to-test pathways
- Increased utilisation of community diagnostics and alternative providers
- Stabilisation of elective performance against agreed trajectories

Medium Term

- Expanded implementation of personalised care and stratified follow-up.
- Increase diagnostic and treatment capacity across the system.
- Embedded digital tools for pathway management and patient engagement.
- Reductions in waiting times and variation in care.
- Sustained RTT improvement
- Delivery and maintenance of the 18-week RTT standard
- Reduced unwarranted variation in waits and outcomes across Places
- Measurable reductions in cost per pathway and outpatient activity growth
- Recurrent productivity improvements embedded in contracts
- Improved patient experience
- Fewer appointments per pathway
- Improved patient-reported experience measures (PREMs)

Delivery Plan for Planned Care



Ambitions	Headline Deliverables	Impact
Cancer Improve cancer management and outcomes by implementing system-wide changes that enhance early diagnosis, streamline pathways, and optimise treatment capacity and efficiency. Stabilise services Fully exploit the opportunities of Cluster scale and regional partnership to secure delivery of services that are identified as fragile Women’s and Men’s Health Improve access, equity and outcomes for women and men across the Cluster, ensuring local services meet their specific needs and are truly person centred, addressing health inequity and ensuring prevention is at the core of delivery responses. Promote market resilience Creating the conditions for our NHS, independent and VCSE providers to respond with agility and flexibility to changing population needs whilst driving up value. Prevention and integration Ensure every opportunity is taken to embed prevention into the DNA of delivery of all providers. This includes increasing the rate of screening and early diagnosis, uptake of holistic needs assessments and treatment summaries.	2026/7 • Achieve constitutional standards – Meet NHS targets (e.g., RTT, cancer, diagnostics). • Develop and deliver Men’s Health Strategy – Improve prevention and early diagnosis for men. • Increase services within neighbourhoods and community – Shift care closer to home. • Roll out targeted screening programmes and outreach campaigns. • Expand community diagnostic centres and mobile units. • Embed holistic needs assessments and treatment summaries in cancer care pathways. • Commission and integrate psychological support services into cancer pathways. • Monitor and meet NHS constitutional standards (e.g., waiting times, cancer targets). • Confirm Plan for ‘left shift’ of high volume activity specialities into Neighbourhood Health Centres across DLN	Long Term • Sustained screening and early diagnosis rates at or above 75% • Fully embedded community diagnostics as standard practice. • Holistic needs assessments and treatment summaries are universal. • Maintain psychological support as a core part of cancer care. • Consistently meet all constitutional standards and improve survival rates. • Demand and capacity aligned to population need • Reduced reliance on acute hospital outpatient models • Narrowed inequalities in elective access and outcomes across the three ICBs • Earlier diagnosis and intervention for priority conditions • Planned care delivered within medium-term financial envelopes • Resources released to support prevention and neighbourhood care

Delivery Plan for Outcomes: Planned Care (Medicines Optimisation)



Ambitions

- Optimise medicines use to improve population health outcomes, through preventative, evidence-based and data-driven prescribing that reduces avoidable morbidity, mortality and hospital admissions.
- Embed safe and responsible prescribing, strengthening antimicrobial stewardship, reducing inappropriate polypharmacy and fostering a culture of medicines safety, learning and continuous improvement.
- Ensure equitable, value-based access to medicines, including high-cost drugs, new medicines and technologies, within agreed financial envelopes.

Contd....

Headline Deliverables

2026/27 – Q1

- Medicines safety framework in place
System-wide framework for incident review, learning and national safety alert implementation.
- Antimicrobial stewardship improvement plan implemented
Coordinated AMS programme across primary and secondary care.
- ICB-wide pharmacy leadership model established
Clear leadership and accountability across primary, community and secondary care.
- Shared prescribing dashboards operational
Agreed metrics and interoperable data to support targeting and variation reduction.
- Prescribing efficiency programme mobilised
Biosimilars, switches and demand management aligned to MTFP trajectories. Cardiometabolic, respiratory and pain/opioid pathways standardised and implemented
- Future prescribing budget-setting approach agreed reflecting shifts from secondary to primary/community care and prevention

2026/27 – Q2

- Targeted polypharmacy reviews embedded
Frailty, care homes and complex LTC cohorts prioritised.
- High-cost drugs and new medicines framework agreed
Consistent, equitable and affordable decision-making across the three ICBs.
- Green prescribing actions embedded
Inhaler optimisation, waste reduction and greener formulary choices.

Impact

Short Term

- Harmonised antimicrobial stewardship initiatives and reduce inappropriate antibiotic use.
- Increase in structured medication reviews and reduce overprescribing.
- Expanded community pharmacy services (e.g., BP checks, virtual wards).
- Strengthened care coordination, advice services, and medicines safety reporting.
- Achievement of prescribing savings
- Increase pharmacy workforce placements and training opportunities.
- Implement new digital tools and data systems.
- Optimised prescribing pathways delivered

Medium Term

- Embed medicines optimisation in neighbourhood population health strategies.
- Integrate pharmacy services across care pathways and focus on high-need areas.
- Deliver ongoing education, patient engagement, and workforce development.
- Maintain cost-effective prescribing and adapt to new guidelines.
- Consistently reduce emissions and medicines waste.
- Shared innovations and best practice across the system
- Reduced antibiotics and broad-spectrum use and medicine related harm
- Reduced high-risk polypharmacy and medicines-related admissions
- Improved disease control and reduced unplanned admissions
- Recurrent prescribing cost avoidance delivered
- Improved equity of access to medicines

Delivery Plan for Outcomes: Planned Care (Medicines Optimisation)



Ambitions	Headline Deliverables	Impact
• Deliver long-term financial sustainability in prescribing, achieving improved value for money and future-focused budget setting that reflects shifts to prevention and community-based care. • Strengthen integrated pharmacy leadership and workforce capability, developing a skilled, agile and resilient pharmacy workforce across all care settings • Harness digital innovation to enable sustainable medicines use, using interoperable data to improve outcomes, reduce waste and minimise the environmental impact of medicines.	2026/27 – Q3 • Pharmacy workforce development plan implemented Focused on independent prescribing, neighbourhood delivery and resilience. 2026/27 – Q4 • Optimised prescribing pathways delivered Cardiometabolic, respiratory and pain/opioid pathways standardised and implemented. • Future prescribing budget-setting approach agreed Reflecting shifts from secondary to primary/community care and prevention.	Long Term • Sustained reductions in antimicrobial resistance, medicine-related harm, and hospital admissions. • Achieve full integration of medicines optimisation into neighbourhood and system strategies. • Maintain financial resilience and equitable access to medicines and technologies. • Embed environmentally sustainable prescribing as routine practice. • Realise a skilled, adaptable pharmacy workforce and a culture of innovation and continuous improvement. • Improve population health outcomes and reduce health inequalities. • Lower medicines-related carbon emissions and waste • Improved financial alignment between commissioning, prevention and prescribing growth • Improved disease control and reduced unplanned admissions

Delivery Plan for Urgent and Emergency Care

Executive Director: Maria Principe
Senior Responsible Officer: XXXXXX



Summary

Urgent and Emergency Care transformation across Derbyshire, Lincolnshire and Nottinghamshire is essential to address sustained system pressures, improve patient flow and ensure safe, timely access to care. Across the three systems, demand for urgent care continues to outstrip capacity, contributing to pressures on ambulance response times, emergency department crowding, prolonged waits, and delayed discharges. These challenges are compounded by variation in access to same-day and urgent community services, workforce constraints, and insufficient alternatives to hospital-based care, particularly for frail older people and those with complex needs. Transforming UEC will require a whole-system approach that strengthens neighbourhood and place-based urgent care, improves front-door streaming and clinical decision-making, and ensures consistent access to urgent primary, community and mental health services seven days a week. A particular focus is required on improving flow through acute sites by reducing avoidable attendances and admissions, accelerating discharge, and expanding intermediate care and community capacity. This aligns with the expectation for systems to shift from reactive, hospital-centric models towards proactive, integrated urgent care pathways that manage demand more effectively and improve patient experience. This transformation agenda aligns with established priorities across the three ICBs, including improving ambulance handover performance, reducing emergency department waits, supporting same-day emergency care, and strengthening discharge and community alternatives. Delivery will be underpinned by robust commissioning, system-wide performance oversight and partnership working to ensure improvements in access, quality, outcomes and financial sustainability are achieved and sustained.

Context

National Alignment

The Plan is consistent with national expectations in respect to its delivery of:

- Deliver the 4-hour standard, eliminate 12-hour waits from decision to admit and reduce long waits.
- Achieve Category 1 and 2 response standards and eliminate excessive ambulance handover delays.
- Increase the proportion of emergency attendances managed via SDEC, reducing avoidable admissions.
- Improve flow through acute sites, reduce length of stay and minimise delayed discharges through effective intermediate care.
- Reduce avoidable ED attendances through urgent primary care, community services and mental health crisis pathways.
- Improve productivity and patient experience within financial envelopes, supported by strong system governance and oversight.

Cluster Alignment

Derbyshire ICB UEC focus:

- Strengthen SDEC and front-door streaming to reduce ED pressure
- Improve ambulance handovers and patient flow
- Expand community alternatives to avoidable admission
- Improve discharge and intermediate care capacity

Lincolnshire ICB UEC focus:

- Improve urgent access across a large rural geography
- Strengthen community and urgent primary care alternatives
- Improve flow and discharge performance
- Reduce variation in UEC performance across sites

Nottinghamshire ICB UEC focus:

- Reduce emergency demand through neighbourhood urgent care
- Improve ED performance and long waits
- Strengthen mental health crisis pathways
- Improve discharge, reablement and intermediate care

Delivery Plan for Urgent and Emergency Care



Ambitions

- Ensure patients receive the right care, in the right setting, first time.
- Deliver right care first time while reducing urgent care demand.
- Establish a 24/7 central navigation hub for integrated access and advice.
- Maintain an accurate Directory of Services to enable effective patient navigation.
- Strengthen care coordination and advice services to reduce acute demand and improve integration.
- Optimise hospital front door processes to improve emergency performance
- Improve access to expert consultant advice—including paediatrics—for system healthcare professionals, supporting the shift of care from hospital to community settings and enhancing clinical decision-making in the community
- Build an integrated, sustainable community urgent care system.
- Align community urgent care with neighbourhood and primary care strategies.
- Ensure consistent delivery across all urgent treatment centres.
- Provide rapid, integrated community response to prevent avoidable admissions.

Contd....

Headline Deliverables

2026/7

- Implement a 24/7 Central Navigation Hub (SPOA) for integrated access and advice.
- Maintain and regularly update the Directory of Services (DoS) for accurate patient navigation.
- Strengthen Care Coordination and Advice Services (CAS) to improve integration and reduce acute demand.
- Develop protocols to ensure right care, right place, first time across all pathways.
- Develop a business case for an Integrated Community Urgent Care System across the ICB footprint.
- Align community urgent care development with Neighbourhoods, Community Transformation Plan, and Primary Care Strategy.
- Standardise Urgent Treatment Centre (UTC) delivery across all sites.
- Deploy Rapid, Integrated Community Response Teams to prevent avoidable admissions.
- Expand Intermediate Care Services to support timely discharge, rehabilitation, and recovery.
- Implement demand management strategies for ED and UTC attendance.
- Undertake a review of hospital discharge processes across acute providers to understand opportunities for shared learning

2027/8

- Implement a Cluster Integrated Community Urgent Care System
- Introduce alternatives to ambulance conveyance for 999 calls.
- Develop targeted high-intensity user intervention programmes.
- Implement recommendations from review to optimise acute hospital discharge processes to reduce length of stay.

Impact

Short Term

- Reduction in ambulance handover delays (30- and 60-minute breaches)
- Fewer 12-hour waits and reduced ED crowding
- Increased SDEC utilisation and reduced conversion to non-elective admission
- Improved same-day access to urgent primary and mental health crisis services

Medium Term

- Sustained improvement in A&E 4-hour performance
- Achievement of Category 1 and 2 ambulance response standards
- Reduced emergency length of stay and improved patient flow
- Lower rate of avoidable ED attendances and emergency admissions
- Expanded virtual care capacity.
- Sustainable community urgent care system aligned with neighbourhood and primary care strategies.
- Expanded Virtual Wards to maximise home-based care and provide step-up/step-down alternatives to hospital admission.
- Enhanced intermediate care provision to support timely discharge, rehabilitation, and recovery.
- Consistent frailty and falls prevention pathways to reduce admissions, improve patient safety, reduce duplication.

Delivery Plan for Urgent and Emergency Care



Ambitions

- Enhance intermediate care to support timely discharge, rehabilitation, and recovery.
- Reduce avoidable demand on UEC
- Shorten hospital stays through efficient care pathways
- Expand virtual wards to maximise home-based care and reduce hospital admissions
- Improve frailty care to reduce admissions and enhance quality of life
- Deliver reliable patient transport to support timely care and efficient discharge.
- Integrate emergency and patient transport services to reduce delays and improve flow.
- Optimise hospital front door processes to improve emergency performance and patient flow.
-

Headline Deliverables

- Expand Virtual Ward capacity for step-up and step-down care.
- Integrate virtual ward services within local navigation hubs.
- Develop falls prevention and management programmes to reduce admissions.
- Enhance urgent care pathways for frailty patients.
- Deliver a resilient patient transport service for timely care and discharge.
- Integrate emergency (999) and patient transport services for efficiency.
- Optimise hospital front door processes to improve ED performance.
- Guarantee same-day GP appointments for clinically urgent needs.

Impact

Long Term

- A more resilient and sustainable UEC system with demand aligned to capacity
- Consistently safer care and improved patient experience during peak pressure
- Reduced reliance on acute hospital settings through strengthened community alternatives
- Improved productivity and financial sustainability across UEC pathways
- Optimised hospital front door processes to sustain improvements in emergency performance targets.
- Fully integrated emergency and patient transport services to improve flow and reduce delays.
- Embedded frailty care models and community-based interventions to enhance quality of life and reduce long-term demand.
- Digitally enabled, cohesive urgent care system that meets future population needs and delivers seamless care across all settings.
- Min 30% reduction in non-elective admissions for people 65yrs+ with multi-morbidity
- Min 50% reduction in ACSC emergency admissions
- Min 36% reduction in overall non-elective admissions and attendances
- Min 1% improvement in people discharged to usual place of residence
- Reduction in MSFD rates
- Min 2% improvement in people dying in preferred place of death
- 100% CHC patients reviewed and discharged with packages of care in place
- Min 20% reduction readmissions for 65rs+ with multi-morbidity
- Min 85% people on EoL register have a personalised care plan

Commissioning Ambitions and Outcomes: Addressing the challenge

In maximising our opportunities and achieving our delivery ambitions we will build on existing work across our three ICBs. To support this we will develop a more robust programme approach across the five transformation programmes of Children and Young People, Mental Health (including Learning Disabilities and Autism), Planned Care (including cancer), Neighbourhood and Community Transformation (including primary care), Urgent and Emergency Care. Our escalating trajectory for maximising our opportunities and realising benefits from the work of these programmes over the next five years is illustrated below.

Core commissioning priorities for how we will do this that are threaded throughout our Delivery Plans:

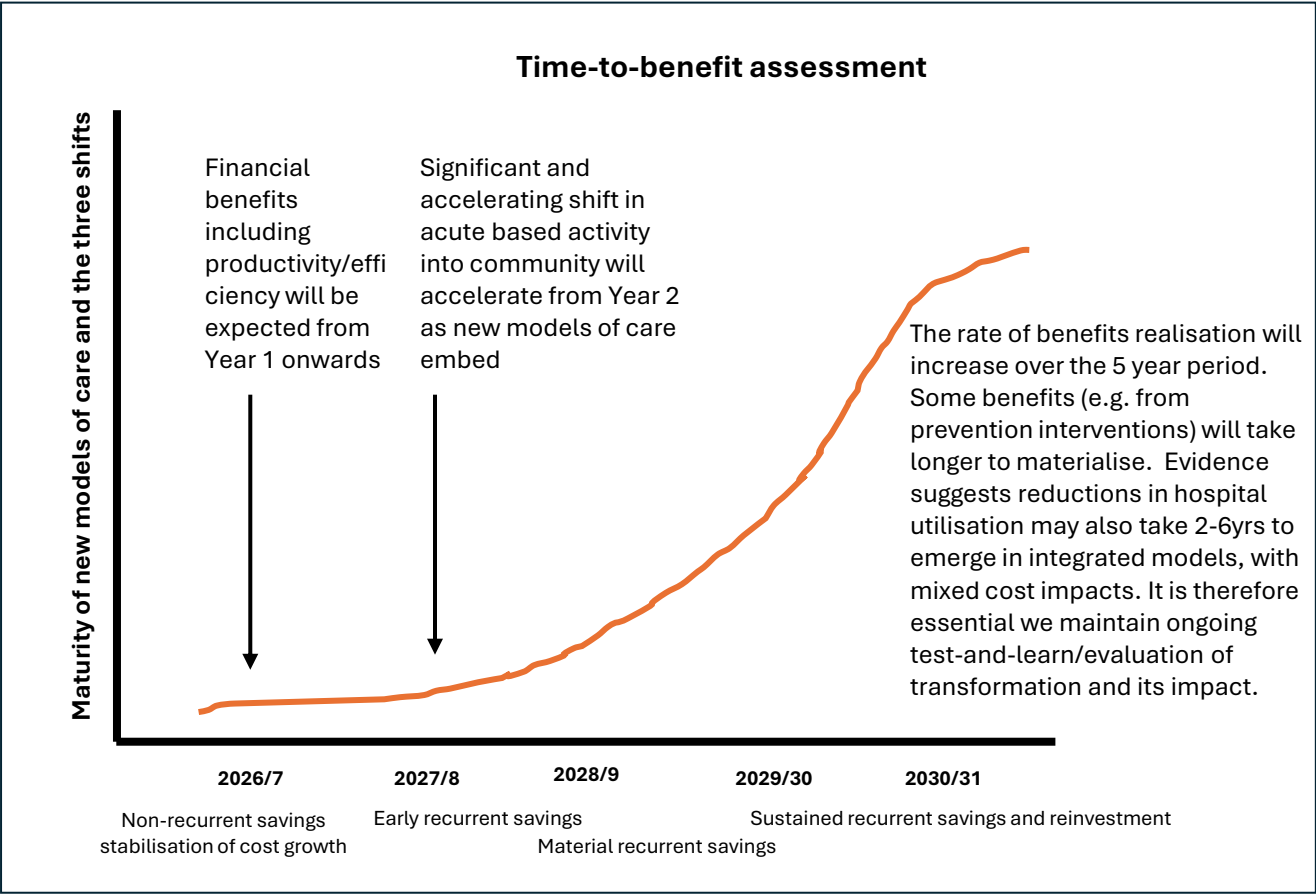
Doing better with what we have to meet the challenges of today

- Eliminating low value activity
- Reducing unwanted variation
- Strengthening clinical stewardship
- Making better use of shared resources
- Maintaining robust oversight of delivery

Transforming our models of care to meet the challenges of tomorrow

- Shared vision for neighbourhood health and wellbeing
- Consistent implementation of proactive, responsive/planned, reactive (same day) care in neighbourhoods
- Co-developing and implementing local neighbourhood transformation plans to meet hyper local needs

Whilst recognising that some benefits will materialise over time we will build on work already started and accelerate our momentum towards delivery within the next five years



We are shaping a Cluster Outcomes Framework that looks beyond today’s measures and sets a bold direction for the future of health and wellbeing across our three ICBs. As it evolves, this Framework will become the unifying compass for our system — aligning with national expectations while driving us toward a future where every commissioning decision measurably improves population health, closes inequality gaps, and delivers consistently excellent care. It embodies our ambition to create a healthier, fairer system, where outcomes are not only met but continually lifted through intelligence-led, community-focused, and equity-driven transformation. A Cluster-wide Equality Outcomes Dashboard will also be developed and reported quarterly, triangulating access, outcomes and experience by deprivation and protected characteristic. This will inform targeted commissioning action, engagement and course-correction through Commissioning Oversight Groups.

DLN ICB Cluster Population Health Strategy Outcomes Framework: Overview

Whole Population		
People live longer and healthier lives		
People live longer and fewer die early from preventable causes	People spend more years in good health and fewer years with avoidable poor health	Inequalities in life expectancy and healthy life expectancy are reduced

Start Well			Live Well				Age Well			Die Well		
Children enjoy good health so they can grow, learn and develop to their full potential			Adults stay healthier for longer, with well managed conditions so they can work, care and take part in life without their health holding them back				Older people stay as well, active and independent as possible, spending more time living in their own homes and communities			People approaching the end of life are cared for with comfort and dignity, spending as much time as possible in their usual place of residence		
Babies and children have a good start to life	Children develop well that sets up future good-health and well-being	Children & young people are supported to be as well as they can be	Adults maintain good health, with risks picked up early	Adults with long-term conditions have their health well managed and remain stable	People with a learning disability or severe mental illness have good physical health	People with care needs and their carers are supported to stay independent and well	Older people with long-term conditions have their health well managed and remain stable	People living with frailty are supported to stay active and independent at home	When older people have a crisis, they get home quickly to stay independent	People likely in their last year of life are identified early and supported in a planned, proactive way	People at the end of life have clear plans that protect their comfort and independence	People at the end of life are supported to spend more time in their usual place of residence

Equality and health inequality considerations are integral to the design, delivery and oversight of the Five-Year Commissioning Plan, with robust governance in place to meet statutory duties and national expectations. Specific assurance is provided in respect to the following:

Statutory Compliance

- The Five-Year Commissioning Plan complies with the Public Sector Equality Duty (Equality Act 2010), embedding equality, health inequality reduction and human rights considerations throughout commissioning decisions.

Equality by Design

- Equality considerations are embedded at all stages of the commissioning cycle, including strategy development, options appraisal, procurement, mobilisation and evaluation.
- Proportionate EQIAs will be completed at key decision gateways, with risks and mitigations tracked through programme governance.

Targeted Focus on Inequalities

- Commissioning priorities explicitly address inequalities by deprivation, ethnicity, disability and inclusion health groups, aligned to Core20PLUS5.
- Neighbourhood and place-based models enable tailored responses to local need and differential access.

Access, Inclusion and Reasonable Adjustments

- The Accessible Information Standard and reasonable adjustments are mandated across all access routes (digital, telephone and face-to-face).
- Estates and service redesign incorporate inclusive access criteria (travel, step-free access, safety, language and sensory needs).

Data, Monitoring and Assurance

- Equality data standards will be applied consistently, with outcomes and experience monitored by protected characteristic.
- A Cluster-wide Equality Outcomes Dashboard will provide ongoing assurance and support corrective action where inequity is identified.

Engagement and Co-production

- Targeted engagement with seldom-heard groups (including disabled people, older adults, racially minoritised communities, carers and people experiencing severe multiple disadvantage) informs service design and improvement.

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	19/03/2026
Paper title:	Dental Services: Strategic Overview and System Strategy
Paper reference:	ICB CIC 25 046
Paper author:	Vanessa Hails, Head of Primary Care Services and Liz Gundel, Deputy Head of Primary Care Services, NHS Nottingham and Nottinghamshire ICB Caroline Goulding, Director of Strategic and Specialised Commissioning
Paper sponsor:	Maria Principe Executive Director of Commissioning
Presenter:	Maria Principe Executive Director of Commissioning Caroline Goulding, Director of Strategic and Specialised Commissioning

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

Report summary:
The paper sets out the strategic context for NHS dental services across Derbyshire, Lincolnshire and Nottinghamshire, highlighting that oral health is a core component of overall health and wellbeing, yet outcomes continue to reflect significant social and geographical inequalities. The paper describes how the current commissioning landscape is shaped by the national dental contract introduced in 2006, which is based on Units of Dental Activity and historic contract distribution. This limits commissioner flexibility to reallocate activity in line with changing population need. Looking forward, the paper sets out a shared Derbyshire, Lincolnshire and Nottinghamshire ambition to improve access to NHS dental services so that all residents experience access levels comparable with the best-performing areas in the East Midlands. This will be underpinned by a coordinated Derbyshire, Lincolnshire and Nottinghamshire-wide commissioning approach, a stronger focus on prevention and targeted action to reduce inequalities. The forthcoming national dental contract reforms from April 2026 are identified as a key opportunity to move away from a purely activity-driven model towards one that better supports urgent care, prevention and patients with complex needs. By aligning local commissioning with national reform and maintaining system collaboration, the ICBs aim to improve access, strengthen workforce sustainability and deliver more equitable oral health outcomes over the longer term.

Recommendation(s):
The Boards are asked to receive the paper for assurance regarding the current dental provision and future commissioning plans to improve access.

Relevant statutory duties:
☒ Quality improvement ☐ Public involvement and consultation
☒ Reducing inequalities ☒ Equality and diversity
☐ Financial limits/ breakeven ☒ Effectiveness, efficiency and economy

Relevant statutory duties:

☐ Integration of services	☐ Wider effect of decisions (triple aim)
☐ Promoting innovation	☐ Promoting research
☐ Patient choice	☐ Obtaining appropriate advice
☐ Promoting education/training	☐ Climate change

Appendices

Not applicable.

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Dental Services: Strategic Overview and System Strategy

Introduction

1. Oral health is a fundamental component of overall health and wellbeing. It affects people's ability to eat, speak, socialise and maintain confidence throughout their lives. Poor oral health can lead to pain, infection, reduced quality of life and wider health complications, while also placing avoidable pressure on health services. Although oral diseases are largely preventable, they remain among the most common chronic conditions and continue to represent a significant public health challenge.
2. Across Derbyshire, Lincolnshire and Nottinghamshire, oral health outcomes reflect the wider inequalities experienced across communities. Tooth decay, gum disease and tooth loss disproportionately affect people living in areas of higher deprivation, as well as vulnerable groups including children, older adults and those with complex health or social needs.
3. Nationally, tooth decay remains the leading cause of hospital admission for children aged five to nine, with over 19,000 hospital admissions in England in 2023/24 for dental extractions due to preventable disease. Similar patterns are observed across the Derbyshire, Lincolnshire and Nottinghamshire footprint, where variation in oral health outcomes closely mirrors broader inequalities in income, housing, access to services and health behaviours.
4. While oral diseases have historically been associated with individual behaviours such as diet, oral hygiene and dental attendance, there is now clear evidence that these behaviours are strongly shaped by wider social, economic and environmental factors.
5. The conditions in which people are born, grow, live and work influence their ability to maintain good oral health. Improving oral health across Derbyshire, Lincolnshire and Nottinghamshire therefore requires a population health management approach, addressing these wider determinants alongside improving access to prevention and treatment.

Current delivery of dental services across Derbyshire, Lincolnshire and Nottinghamshire

6. NHS dental services across Derbyshire, Lincolnshire and Nottinghamshire are delivered through a combination of:
 - a) General Dental Services
 - b) Personal Dental Services
 - c) Community Dental Services

- d) Specialist secondary care pathways
- 7. Together, these services support a population of approximately 3.2 million people across a geographically diverse area that includes major urban centres alongside rural and coastal communities.
- 8. Unlike many other areas of healthcare, there is no single reliable measure of the number of dentists working within the system. Workforce capacity is therefore monitored through commissioned activity rather than practitioner headcount. Activity is measured using Units of Dental Activity. Each course of treatment is assigned a band attracting a defined number of Units of Dental Activity depending on the complexity of care provided. Dental providers are contracted to deliver a specific number of Units of Dental Activity each year.
- 9. Performance is monitored against these targets, and where providers underperform, commissioners may recover funding through a reconciliation process commonly referred to as clawback. Nationally, delivery of NHS dental contracts has remained below pre-pandemic levels since 2020. Some providers have also handed back NHS contracts.
- 10. Factors influencing this include:
 - a) Dissatisfaction with the current contract model
 - b) Workforce recruitment challenges
 - c) Movement toward private practice
 - d) Increasing interest in aesthetic dentistry
 - e) Desire for improved work–life balance
 - f) Geographic workforce preferences
- 11. Across the Derbyshire, Lincolnshire and Nottinghamshire ICBs there are approximately 335 NHS dental contracts, including:
 - a) 139 in Derby and Derbyshire
 - b) 134 in Nottingham and Nottinghamshire
 - c) 62 in Lincolnshire
- 12. These figures represent commissioned contracts rather than individual dentists, as multiple practitioners may work under a single contract.
- 13. The majority of NHS dental services are delivered through primary care practices operating under the national dental contract introduced in 2006. Because these contracts were largely based on historic activity levels, current service capacity reflects previous commissioning arrangements rather than current population demand. This limits the ability of commissioners to redistribute activity to areas experiencing higher need.

14. Provision therefore varies across the Derbyshire, Lincolnshire and Nottinghamshire geography. Lincolnshire continues to experience the greatest access challenges due to rurality, workforce recruitment difficulties and historically lower levels of commissioned activity.
15. Derbyshire and Nottinghamshire generally demonstrate higher provider coverage but continue to face pressures maintaining consistent delivery of contracted activity.

Dental services and inequalities

16. Oral health outcomes are shaped by a range of wider social and economic factors rather than individual behaviour alone. National policies, economic conditions and social structures influence a person's socioeconomic position, including factors such as income, education, occupation, gender and ethnicity. These factors then affect people's day-to-day circumstances, including their living and working conditions, access to healthy food, levels of stress, social support and access to healthcare services. Together, these influences shape health behaviours and biological risks, which ultimately determine oral health outcomes. Because these conditions are not evenly distributed across society, people living in more deprived communities are significantly more likely to experience tooth decay, gum disease and tooth loss.
17. Understanding this is important for the Derbyshire, Lincolnshire and Nottinghamshire systems because it highlights that improving oral health cannot be achieved through dental services alone. A narrow focus on treatment or individual behaviour change will not address the underlying drivers of poor oral health. Instead, improving outcomes requires a broader population health management approach that focuses on prevention, tackling health inequalities and addressing the wider determinants of health. This includes strengthening early prevention, improving access to dental services, supporting healthier environments and working with partners across health, local government and communities. Recognising the wider drivers of oral health inequalities enables the system to target interventions more effectively and deliver sustainable improvements in population health.
18. Although oral health has improved significantly over the past 50 years, inequalities in outcomes remain a major concern. Across England, people living in the most deprived communities continue to experience a much greater burden of oral disease and are less likely to access routine dental care. National data shows that around one in five five-year-old children (approximately 22%) has visible tooth decay, with children living in the most deprived areas experiencing levels of decay more than twice as high as those in the least deprived areas. Tooth decay also remains the leading cause of hospital admission for children aged five to nine, with over 19,000 admissions

in England in 2023/24 for dental extractions due to preventable disease. More broadly, dental attendance has not fully recovered since the pandemic, and millions of adults report difficulty accessing NHS dental services.

Oral Health Needs Assessments

19. Oral Health Needs Assessments completed across Derbyshire, Lincolnshire and Nottinghamshire in 2024 provide a shared evidence base to inform commissioning priorities and identify areas where services should be targeted to address inequalities in oral health and access to NHS dentistry. Across the Derbyshire, Lincolnshire and Nottinghamshire footprint, the assessments highlight how oral health outcomes are closely linked to deprivation, population demographics, workforce availability and the distribution of dental services.
20. In Derby and Derbyshire, the most deprived communities are concentrated in Derby, Chesterfield, Bolsover and North East Derbyshire, with projected population growth and an ageing population expected to increase future demand for dental services.
21. In Nottingham and Nottinghamshire, most residents live within four miles of a dental practice, suggesting reasonable geographical coverage; however, this does not necessarily translate into access where practices are not accepting NHS patients, and some rural areas, particularly in the north-east of the county and parts of Bassetlaw, have more limited provision.
22. In Lincolnshire, challenges are more pronounced due to the county's large rural and coastal geography, higher levels of deprivation in some coastal communities, and longstanding workforce recruitment and retention difficulties. Lincolnshire also has historically fewer NHS dental contracts relative to population size, contributing to lower access rates compared with neighbouring systems.
23. Together, these findings demonstrate that variation in access across Derbyshire, Lincolnshire and Nottinghamshire is influenced by a combination of geography, workforce capacity, contract distribution and wider social determinants of health, reinforcing the need for targeted commissioning and prevention initiatives to address inequalities and improve access to NHS dental services. These patterns reflect a clear social gradient in oral health, where poorer outcomes are closely linked to deprivation, access to services, and wider social determinants of health. Certain population groups are particularly vulnerable, including young children, older adults, people living in deprived communities, those with long-term conditions or disabilities, and individuals who face barriers to accessing dental care.

Current context

24. The current commissioning environment for NHS dentistry is heavily shaped by historic policy and contractual arrangements that continue to influence how services are distributed and delivered across Derbyshire, Lincolnshire and Nottinghamshire.
25. From the creation of the NHS in 1948 until 2006, dentistry operated under an 'Items of Service' model, where dentists were paid for each treatment provided. Dentists were able to establish practices in locations of their choosing and there were no limits on the amount of activity they could undertake. While this model supported the growth of NHS dentistry, it also led to steadily increasing costs for government as activity levels expanded.
26. In response to these national cost pressures, the 2006 national dental contract introduced a new commissioning framework based on Units of Dental Activity and fixed funding envelopes. Under this system, dental providers were contracted to deliver a defined level of activity each year for an agreed annual value. While this provided greater financial control nationally, it also created structural features that continue to shape dental commissioning today.
27. When the contract was introduced, commissioners inherited the existing distribution of dental practices because all providers delivering NHS care at the time were offered contracts that effectively continued indefinitely. Many practices had originally been established in locations that were commercially viable for providers rather than aligned with areas of greatest population need. As a result, the current distribution of NHS dental services continues to reflect historic patterns of provision rather than contemporary demand.
28. Funding allocations and Units of Dental Activity values were also set using historic activity levels during the contract reference period. This created variation in contract values between practices that persists today. In addition, some providers chose not to adopt the new contractual arrangements and moved entirely into private dentistry, which reduced NHS capacity.
29. A significant proportion of NHS dental funding therefore remains tied to long-standing contracts with no fixed end date. This limits the ability of commissioners to redistribute activity, reshape services or increase capacity in areas experiencing higher demand or poorer access. Across the Derbyshire, Lincolnshire and Nottinghamshire footprint, access challenges are not evenly distributed. Lincolnshire in particular experiences greater pressures, influenced by rural geography, workforce recruitment and retention difficulties, and historically lower levels of commissioned activity.
30. These historic contractual arrangements mean that commissioners have limited flexibility to rapidly reconfigure services. As a result, improvements in access often rely on incremental measures such as reinvesting under-delivered

funding, supporting recovery of contract activity, commissioning urgent dental care services, and working with providers to maximise the use of existing capacity.

Clinical support/development

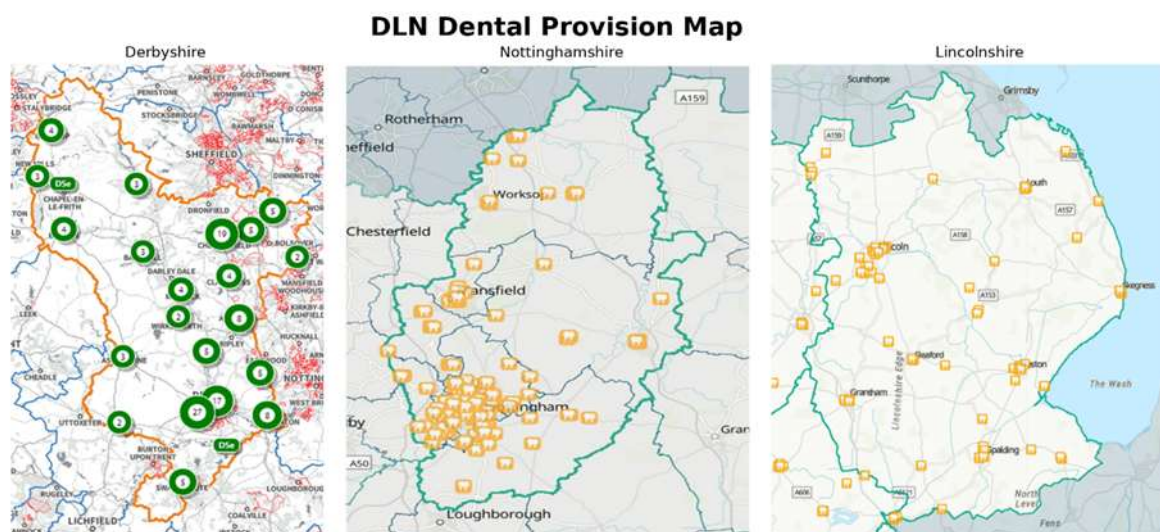
31. Local Dental Networks play an important role in providing clinical leadership and supporting the development of NHS dental services. Nationally, Local Dental Networks bring together commissioners, clinicians and providers to support service improvement, workforce development, and pathway transformation, ensuring that dental services respond effectively to patient needs and system priorities.
32. Across Derbyshire, Lincolnshire and Nottinghamshire, Local Dental Networks provide multidisciplinary clinical leadership across both commissioning and provider organisations. They support the development of clinically informed commissioning decisions, promote collaboration across the dental system and help improve outcomes for patients by bringing together clinical expertise, service insight and local intelligence.
33. Within the Derbyshire, Lincolnshire and Nottinghamshire footprint there are three Dental Network Chairs, aligned to the three ICB areas, providing leadership at a place level. This structure enables strong links with local providers, commissioners and system partners, ensuring that local priorities and population needs are reflected in service planning and delivery.
34. To support wider service transformation and pathway development, Managed Clinical Networks operate across the broader East Midlands footprint. These networks bring together specialists, primary care clinicians and system leaders to support the development of consistent clinical pathways, improve access to specialist services and strengthen integration between primary care, community services and hospital-based care.
35. Together, Local Dental Networks and Managed Clinical Networks provide an important mechanism for clinical engagement, system leadership and service improvement, helping to align local commissioning priorities with national policy direction and supporting the development of more sustainable and integrated dental services across the Derbyshire, Lincolnshire and Nottinghamshire system.

Dental services provision and utilisation

36. Derbyshire, Lincolnshire and Nottinghamshire commission NHS dental services for a population of approximately 3.2 million people across three ICB areas,

with 335 NHS dental contracts in operation, including 139 in Derby and Derbyshire, 134 in Nottingham and Nottinghamshire, and 62 in Lincolnshire.

37. The Derbyshire, Lincolnshire and Nottinghamshire footprint covers a large and geographically diverse area, ranging from densely populated urban centres such as Nottingham and Derby to more remote rural and coastal communities, including areas of the Peak District in Derbyshire and the extensive rural and coastal geography of Lincolnshire. This diversity presents different challenges in terms of workforce availability, access to services, and population need.



38. Provision and utilisation of NHS dental services across Derbyshire, Lincolnshire and Nottinghamshire demonstrate variation in both access and delivery of commissioned activity across the three Integrated Care Boards. While access levels in Derbyshire and Nottinghamshire are broadly higher than the national average, Lincolnshire consistently reports lower levels of population access and greater delivery challenges.
39. Analysis of NHS dental access data shows that 32.1% of the population in Derbyshire accessed NHS dental services, including 27.3% of adults and 51.5% of children aged 0–17. Nottinghamshire demonstrates a similar pattern, with 30.8% of the population accessing NHS dentistry, including 25.2% of adults and 51.7% of children. In contrast, Lincolnshire reports lower access across all population groups, with 25.8% of the population accessing NHS dental care, including 21.6% of adults and 44.4% of children. Across the Derbyshire, Lincolnshire and Nottinghamshire footprint, children consistently demonstrate higher access rates than adults, reflecting national commissioning priorities to improve access for younger populations.
40. Delivery of commissioned dental activity also varies across the ICBs. Units of Dental Activity delivered as a proportion of contracted activity remain below full delivery across all three systems. As of December 2025, Derbyshire delivered

65.1% of contracted activity, Nottinghamshire 62.2%, and Lincolnshire 55.2%, indicating continued pressures on workforce capacity and service delivery.

41. The most recent full-year data for 2024/25 demonstrates improved performance but continued variation across the systems. Derbyshire delivered 91% of commissioned activity, with 1,365,742 Units of Dental Activity delivered against 1,495,425 commissioned. Nottinghamshire delivered 83% of commissioned activity, with 1,578,055 Units of Dental Activity delivered from 1,908,703 commissioned. Lincolnshire delivered 76% of commissioned activity, with 814,092 Units of Dental Activity delivered from 1,065,332 commissioned, representing the largest gap between commissioned and delivered activity across the cluster.
42. Population access patterns broadly reflect these activity levels. In Derbyshire and Nottinghamshire, 47% of adults accessed NHS dental services, while child access rates were 65% and 69%, respectively. In Lincolnshire, access is lower, with 39% of adults and 55% of children accessing NHS dental care.
43. Across the wider Midlands region, no ICB is currently delivering 100% of its commissioned dental activity, highlighting the scale of workforce pressures and structural challenges affecting NHS dentistry nationally.
44. To support improved access and increase utilisation of commissioned activity, a number of commissioning initiatives have been implemented across the Derbyshire, Lincolnshire and Nottinghamshire areas. A 110% activity scheme has been introduced to allow high-performing practices to deliver additional NHS dental activity where capacity exists. Within Derby and Derbyshire, 14 providers are participating, delivering an additional 22,700 Units of Dental Activity. In Nottingham and Nottinghamshire, nine providers are delivering an additional 30,554 Units of Dental Activity, while in Lincolnshire six providers have been approved to deliver additional activity through a £33 per Units of Dental Activity uplift scheme, reflecting the specific workforce and access challenges within the county.
45. Additional workforce initiatives have also been implemented to support recruitment and retention. This includes a £30,000 'Golden Hello' incentive scheme aimed at attracting dentists to underserved areas. To date, one dentist has been recruited through this scheme in Derbyshire. Further work is underway to assess whether enhanced incentives may be required to address workforce shortages in areas experiencing the greatest challenges, particularly Lincolnshire.
46. Urgent dental care provision has also been expanded following the national initiative announced in February 2025 to deliver 700,000 additional urgent dental appointments across England. Additional capacity has been commissioned across the East Midlands; however, utilisation has been lower than anticipated. Year-to-date performance shows under-delivery of urgent care

appointments across all Derbyshire, Lincolnshire and Nottinghamshire systems, with underperformance of 16.2% in Derbyshire, 26.7% in Lincolnshire and 19.6% in Nottinghamshire.

47. To support improved utilisation, the Derbyshire, Lincolnshire and Nottinghamshire systems have implemented joint public awareness campaigns, including targeted social media activity, local radio promotion and engagement with primary care partners to improve awareness of urgent dental services. An Urgent Dental Care Incentive Scheme, currently in place until March 2026, also provides financial incentives to encourage additional urgent care activity from participating providers.
48. Alongside primary care provision, a range of specialist dental services support the wider oral healthcare pathway across Derbyshire, Lincolnshire and Nottinghamshire. Secondary care dental services provide treatment for patients with complex clinical needs that cannot be managed in general dental practice, including advanced oral surgery, treatment of severe infections, facial trauma and care for patients with complex medical conditions. These services are delivered across five acute trusts within the Derbyshire, Lincolnshire and Nottinghamshire footprint.
49. Demand for specialist care continues to place pressure on secondary care pathways. The combined oral surgery waiting list across the Derbyshire, Lincolnshire and Nottinghamshire systems currently stands at 20,724 patients, with 12,974 patients waiting longer than 18 weeks and 1,102 patients waiting longer than 52 weeks. Orthodontic services show comparatively stronger performance, although waiting list pressures remain, with 1,923 patients currently waiting for treatment across the three systems.
50. Intermediate Minor Oral Surgery services provide Level 2 care for procedures that are too complex for general practice but do not require hospital-based treatment. As of January 2026, 3,951 patients were within the Intermediate Minor Oral Surgery treatment pathway, with 26% waiting longer than six weeks. Performance has improved in recent months, with the number of patients waiting longer than six weeks reducing by 62.7% compared with the previous month. A live procurement process is currently underway to secure long-term Intermediate Minor Oral Surgery provision across the Derbyshire, Lincolnshire and Nottinghamshire footprint.
51. Overall, the provision and utilisation of Derbyshire, Lincolnshire and Nottinghamshire dental services across the geographies reflects a combination of historic contract distribution, workforce capacity challenges and geographical variation. While access and delivery are stronger in Derbyshire and Nottinghamshire, Lincolnshire continues to experience greater pressures due to rural geography, workforce recruitment challenges and historically lower levels of commissioned activity. Addressing these variations will require continued

system collaboration, targeted workforce initiatives and investment in service capacity to improve access and utilisation across the Derbyshire, Lincolnshire and Nottinghamshire footprint.

Strategic ambition and commissioning principles

52. The shared ambition across the Derbyshire, Lincolnshire and Nottinghamshire cluster is to improve access to NHS dental services so that residents across the region experience levels of access comparable with the best-performing areas within the East Midlands. Achieving this ambition will require continued collaboration between commissioners, providers and system partners to improve access, strengthen the dental workforce and address inequalities in oral health outcomes.
53. To support this ambition, the system is developing long-term access objectives aligned with the forthcoming five-year dental commissioning plan. This work reflects a shared commitment across the Derbyshire, Lincolnshire and Nottinghamshire footprint to increase access to NHS dental services for both adults and children, while reducing variation between local areas and ensuring that services are targeted towards communities with the greatest need. Embedding these ambitions within a coordinated cluster-wide commissioning framework will enable the system to take a more strategic and population-focused approach to improving access, strengthening prevention and supporting sustainable dental services across the region.
54. To underpin this approach, seven shared commissioning principles have been agreed. These principles align with the Strategic Commissioning Framework for ICBs and support delivery of the NHS Medium Term Planning Framework. Together, they provide a consistent framework for commissioning decisions across the Derbyshire, Lincolnshire and Nottinghamshire footprint and are intended to support improvements in access to NHS dental services while reducing inequalities in oral health outcomes.



55. The commissioning principles focus on establishing minimum standards for dental access across each ICB, while setting higher expectations in areas where population need is greatest. This targeted approach supports the reduction of health inequalities and ensures that resources are directed to communities experiencing the greatest challenges in accessing dental care. The principles also encourage innovation through engagement with local communities, ensuring that services are designed around the needs of the populations they serve, while recognising the importance of workforce engagement to support innovation, service improvement and long-term sustainability.
56. These principles will inform commissioning delivery plans from 2026/27 onwards, providing a framework for consistent performance monitoring and improvement. As part of this approach, a regional commissioning standard has been established across the East Midlands footprint, which sets a baseline expectation that each ICB will commission NHS dental services with the aim of achieving, as a minimum, the England average level of access to NHS dentistry. As of March 2025, this equates to 40% of adults and 57% of children accessing NHS dental care within the reporting period. This standard provides a baseline benchmark for access across the region. Longer-term ambitions will include stretch targets beyond the national average, supporting sustained improvements in access and helping to reduce variation in access.

Contract reform

57. In December 2025, the Government confirmed that it would proceed with a package of reforms to the national NHS dental contract, due to take effect from 1 April 2026. These reforms aim to move away from a purely activity-based model historically driven by the Units of Dental Activity system and introduce a more balanced approach that places greater emphasis on improving patient access, prevention, and the management of patients with more complex oral health needs.
58. The reforms form part of a wider national ambition to improve access to NHS dental services, address longstanding limitations within the current contract model, and support a more sustainable dental workforce. Key elements of the proposed changes include increased remuneration for urgent and unscheduled care, recognising the growing demand for urgent dental treatment and the need to improve timely access to care. Practices will also be required to deliver a minimum level of urgent and unscheduled care activity as part of their contracts.
59. Implementation planning is currently underway, with detailed contractual and clinical guidance expected from NHS England by the end of March 2026. From April 2026, dental contractors will be required to deliver 8.2% of their contract

value as urgent or unscheduled care activity, supporting more consistent geographical access to urgent care and a more equitable distribution of urgent dental capacity across practices.

60. For systems across Derbyshire, Lincolnshire and Nottinghamshire, these reforms present an opportunity to align local commissioning approaches with national policy changes, strengthen urgent care pathways and support practices in prioritising patients with the greatest clinical need. Local implementation planning is therefore underway to ensure contractual, operational, and communication arrangements are in place ahead of the April 2026 implementation date.
61. Although commissioning responsibility for dental services has been delegated to ICBs, NHS England retains overall accountability for dental commissioning. To ensure that delegated responsibilities are delivered effectively, NHS England operates the Primary Care Assurance Framework. This framework requires ICBs to demonstrate that contracts are managed safely, effectively and in line with national standards, providing assurance that services are delivered in accordance with the terms of delegation.

Finance and contracting

62. NHS dental practices operating under General Dental Services or Personal Dental Services contracts are funded through annual contractual values agreed with the ICBs. These contracts specify the number of Units of Dental Activity that providers are expected to deliver each financial year. Practices receive monthly payments equivalent to one-twelfth of their annual contract value, with delivery monitored throughout the year using activity data submitted to the NHS Business Services Authority. At year end, performance is reconciled against the contracted Units of Dental Activity target. Where providers deliver below the agreed level of activity, commissioners may recover a proportion of the contract value through clawback, while additional activity may be remunerated where funding is available. Contract reconciliation also accounts for patient charge revenue, which is collected by practices and offset against contract payments.
63. Following the 2023/24 delegation of Pharmacy, Optometry and Dental services, NHS England confirmed that dental budgets must remain ringfenced, ensuring that the entirety of dental funding is used to deliver and improve NHS dental services. This policy was introduced to safeguard investment in dentistry at a time when access challenges and oral health inequalities were increasing. The ringfence has now been confirmed to remain in place until at least 2028/29.
64. For Derbyshire, Lincolnshire and Nottinghamshire, the delegated dental allocation is confirmed at £209.0 million in 2026/27, rising to £213.2 million in 2027/28, and £217.4 million in 2028/29. Three-year financial plans have been

developed to assess expected expenditure against the ringfence requirements. Current modelling indicates a gap between anticipated spend and the ringfenced allocation, although these projections do not yet include the financial impact of the national dental contract reforms expected from April 2026, in line with national guidance.

65. Underspends within the dental allocation arise primarily from two factors. The first is handed-back contracts, where providers cease delivering NHS dentistry and services are not immediately recommissioned, reducing available NHS capacity. The second is underperformance clawback, where funding is recovered from contracts delivering less than 96% of their contracted activity. In 2024/25, £21.9 million was recovered across Derbyshire, Lincolnshire and Nottinghamshire from Category 1 and 2 Units of Dental Activity contracts, representing approximately 16% of the total contract value for those services.
66. Managing these underspends is challenging within the constraints of the dental ringfence, as any unspent funding must be returned to NHS England. In 2024/25, £14.7 million across Derbyshire, Lincolnshire and Nottinghamshire was reallocated into dental budgets from other ICB areas, where indirect dental expenditure, such as NHS111 activity, accident and emergency attendances, prescribing and other primary care services, was identified. Despite this, £0.25 million was still ultimately returned to NHS England as an underspend at year end.
67. To mitigate this risk in future years, early approval and timely implementation of dental investment plans will be critical to maximising the use of the dental allocation and avoiding further clawback. This will need to be managed alongside the forthcoming national dental contract reforms from April 2026. While these reforms aim to improve access, increase flexibility and support workforce retention, the financial implications are not yet fully known. Potential changes to activity requirements, remuneration models, banding structures and contract management approaches may affect baseline contract values, levels of clawback and provider behaviour. Until the detailed national funding framework is confirmed, it remains difficult to fully assess how these reforms will influence utilisation of the dental allocation or the scale of future reserves across the Derbyshire, Lincolnshire and Nottinghamshire systems.

ICB	24/25 % UDA Delivered	24/25 Underperformance Clawback Recovery	25/26 Total Contracted UDA	25/26 Average UDA Rate
Derby and Derbyshire ICB	84%	£7,335,288	£49,709,061	£36.39
Lincolnshire ICB	73%	£6,242,338	£30,598,826	£32.92
Nottingham and Nottinghamshire ICB	79%	£8,371,257	£56,979,124	£35.46
Cluster Total	79%	£21,948,883	£137,287,012	£35.18

Conclusion

68. Over the past two years, progress has been made to stabilise NHS dental services across Derbyshire, Lincolnshire and Nottinghamshire through targeted commissioning initiatives and stronger collaboration between commissioners, providers and system partners. Activity uplift schemes, urgent care commissioning, workforce incentives and focused investment have helped to improve utilisation of commissioned capacity and maintain access to care during a period of sustained national pressure on NHS dentistry.
69. Despite these efforts, challenges remain. Workforce availability, historic contract distribution and variation in access continue to influence how services are experienced across the region. Lincolnshire in particular faces greater pressures due to rural geography, workforce recruitment and historically lower levels of commissioned activity. At the same time, demand for services continues to grow as the population increases, ages and presents with more complex health needs.
70. The forthcoming national dental contract reforms present an important opportunity to reshape how services are delivered and commissioned. These reforms, alongside the development of a coordinated Derbyshire, Lincolnshire and Nottinghamshire commissioning approach, provide a platform to strengthen pathways, increase flexibility within the system and improve the targeting of services to areas with the greatest need.
71. By working collaboratively across Derbyshire, Lincolnshire and Nottinghamshire there is an opportunity to move towards a more strategic and population-focused approach to dental commissioning. This will support improved access to NHS dental services, better utilisation of commissioned activity, and greater alignment between prevention, primary care and specialist dental services.
72. Ultimately, improving oral health across Derbyshire, Lincolnshire and Nottinghamshire will require sustained focus on prevention, workforce sustainability and equitable access to care. Through continued collaboration and alignment with national reform, the Derbyshire, Lincolnshire and Nottinghamshire systems is well positioned to make meaningful progress in improving oral health outcomes and reducing inequalities for the population it serves.

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	19/03/2026
Paper title:	Finance Report
Paper reference:	ICB CIC 25 047
Paper author:	Rebecca McCauley, NHS Lincolnshire ICB Donna Johnson, Craig West, NHS Derby and Derbyshire ICB Clare Hopewell, Ian Livsey, NHS Nottingham and Nottinghamshire ICB
Paper sponsor:	Bill Shields, Executive Director of Finance
Presenter:	Bill Shields, Executive Director of Finance

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

Report summary:

The report outlines the financial position of the three ICBs' and NHS providers' financial positions, for the ten-month period April 2025 to January 2026. The overall year to date (YTD) financial position is a £165.3 million adverse variance to plan, and an actual deficit of £190.3 million against a deficit plan of £25.0 million. In month, the position is £47.6 million adverse to plan.

For the full year, the forecast has moved from an on-plan position in month nine to a £220.7 million adverse position. This recognises the large net risk reported in month nine being now reported in the Income and Expenditure position. In addition, and as a result, deficit support funding of £42 million will now not be received from NHS England out of the total £115 million originally expected and planned. This year end forecast position has been agreed with NHS England.

Nottingham and Nottinghamshire providers remain the key driver of the YTD position at £117.5 million adverse to plan (£36.6 million adverse to plan in month) mainly due to staffing cost pressures. Derby and Derbyshire providers are £33.5 million adverse to plan. Lincolnshire ICB (LICB) is £7.7 million adverse to plan YTD, due to pressures arising in year. Nottingham and Nottinghamshire ICB (NNICB) is £4.2 million adverse to plan wholly attributable to deficit support funding being withheld.

Efficiency delivery across the three systems is £54.3 million behind the YTD target of £481.4 million. The full year target is £623.8 million, with delivery forecast below at £537.1 million. Delivery of this target remains a significant risk.

Capital expenditure is forecast to be delivered within allocation, once all anticipated in year allocations are received.

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

Report summary:

The ICB specific position is a YTD adverse variance to plan of £11.8 million, with LICB the main driver as above. NNICB has a YTD adverse variance of £4.2 million, representing the deficit support funding that has been withheld by NHS England for quarter three.

The forecast for the ICBs is now £6.2 million adverse to plan, recognising the deficit support funding that will not be received in NNICB. Derby and Derbyshire ICB (DDICB) and LICB are both forecasting on plan outturns. Common pressure areas remain across the three ICBs, notably independent sector acute activity, prescribing charges and mental health costs. Delivery of the full year efficiency plan is key to the delivery of the on-plan forecast.

ICBs opening budget statements for 2026/27

Under the ICBs' Schemes of Reservation and Delegation, approval of the ICBs' opening budget statements is a matter reserved for the Boards. As the scheduling of the Boards does not align to the deadline for their submission to NHS England, the Boards are requested to delegate approval of the opening budgets to the Joint Finance and Performance Committee to take the decision at their meeting on 1 April 2026.

Recommendation(s):

The Boards are asked to:

- **Receive** the paper for assurance in relation to the financial position of the ICBs and NHS providers.
- **Delegate** approval of the ICBs' 2026/27 opening budgets to the Joint Finance and Performance Committee.

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.

Finance Report - Month 10

Contents

Overview of Financial Position – slides 1-2

ICB Financial Positions – slides 4-6

Provider Financial Positions – slides 7-10

Appendix – Summary Income and Expenditure – slide 11

Overview of Financial Position

Key Finance Metrics by System at Month 10

Key Finance Metric – Year To Date (YTD) Position	Derby and Derbyshire ICS Year to Date Variance £'m	Derby and Derbyshire ICS Year to Date RAG Rating	Lincolnshire ICS Year to Date Variance £'m	Lincolnshire ICS Year to Date RAG Rating	Nottingham and Nottinghamshire ICS Year to Date Variance £'m	Nottingham and Nottinghamshire ICS Year to Date RAG Rating	Total Year to Date Variance £'m	Total Year to Date RAG Rating
Financial Performance (Note 1)	(33.4)	Red	(10.3)	Red	(121.6)	Red	(165.3)	Red
Efficiency	(12.8)	Red	(7.1)	Red	(34.4)	Red	(54.3)	Red
Capital - Charge Against Original Plan	1.5	Green	7.8	Green	6.3	Green	15.5	Green
Pay Costs (Provider)	(0.2)	Red	(3.1)	Red	(68.4)	Red	(71.8)	Red

Key Finance Metric - Forecast Position	Derby and Derbyshire ICS Full Year Variance £'m	Derby and Derbyshire ICS Full Year RAG Rating	Lincolnshire ICS Full Year Variance £'m	Lincolnshire ICS Full Year RAG Rating	Nottingham and Nottinghamshire ICS Full Year Variance £'m	Nottingham and Nottinghamshire ICS Full Year RAG Rating	Total Full Year Variance £'m	Total Full Year RAG Rating
Financial Performance (Note 1)	(51.1)	Red	0.0	Green	(169.6)	Red	(220.7)	Red
Efficiency	(18.4)	Red	(10.3)	Red	(58.1)	Red	(86.7)	Red
Capital - Charge Against Original Plan	(9.2)	Red	(10.4)	Red	(10.1)	Red	(29.8)	Red
Pay Costs (Provider)	0.7	Green	1.4	Green	(84.1)	Red	(82.0)	Red
Mental Health Investment Standard (MHIS)	0.0	Green	0.0	Green	0.0	Green	0.0	Green
Risk (Net Position)	(12.8)	Red	(15.0)	Red	(1.5)	Red	(29.3)	Red
Underlying Position	(181.1)	Red	(121.5)	Red	(228.7)	Red	(531.3)	Red

Note 1. Financial Performance is inclusive of non-recurrent Deficit Support Funding (Derby and Derbyshire ICS £33.7m month 1-9 only and Nottingham and Nottinghamshire ICS £39.3m month 1-6 only). Of the £115m planned DSF £42.0m is being held back by NHS England (NHSE) due to provider financial performance.

See next slide for overview narrative

Overview of Financial Position (continued)

Overview of the Derbyshire, Lincolnshire, Nottinghamshire systems

The Month 10 year-to-date (YTD) position shows an adverse variance of £165.3 million (Month 9 £117.7 million). The position has deteriorated in month for all systems indicating ongoing financial pressures. The total in-month adverse movement is £47.6 million, with Nottingham and Nottinghamshire (N&N) ICS making up 79% or £37.6 million of this movement, Derby and Derbyshire (D&D) ICS accounting for 19% or £9.2 million of the movement, and a movement of £0.8 million for Lincolnshire (L) ICS. Appendix 1 shows the consolidated income and expenditure position of the systems.

The full year forecast is now a £220.7 million deficit, a position that has moved from the Month 9 'on plan' forecast and a position that has been agreed with NHS England, recognising the systems' financial pressures. This position includes the withholding of £41.9 million of the original total £112 million deficit support funding (DSF). All providers with deficit positions have written to NHS England to explain the movement in forecast.

Efficiency delivery of £427.1 million achieved YTD is resulting in a £54.4 million adverse variance against target, an adverse movement of £5 million from Month 9. Efficiency plans for 2025/26 total £623.8 million and all systems are now forecasting an adverse variance to plan with a total variance of £86.7 million. Efficiency delivery remains the most significant financial risk this year, with the current NHS England calculated risk-adjusted assessment at 96% of the reduced forecast, a gap of £21.1 million.

Pay costs are a major driver of the YTD position, with a £71.8 million adverse variance at Month 10 (£62.7 million at Month 9), almost entirely within the N&N system. This pressure is experienced across both substantive and temporary staffing, with bank pay being the main contributor due to efficiencies not delivering as expected.

Cash is constrained in some providers due to under-delivery of cash-releasing efficiencies, with both Nottingham University Hospitals NHS Trust (NUH) and Chesterfield Royal Hospital NHS Foundation Trust (CRH) having requested quarter 4 cash support and further cash escalations from acute providers are likely.

ICB Financial Positions (1 of 3)

Key Finance Metrics for Integrated Care Boards (ICBs) at M10

ICB Key Metrics - Year to Date	Derby & Derbyshire ICB Year to Date Variance £'m	Derby & Derbyshire ICB Year to Date RAG Rating	Lincolnshire ICB Year to Date Variance £'m	Lincolnshire ICB Year to Date RAG Rating	Nottingham & Nottinghamshire ICB Year to Date Variance £'m	Nottingham & Nottinghamshire ICB Year to Date RAG Rating	Total Cluster Year to Date Variance £'m	Total Cluster Year to Date RAG Rating
Financial Performance	0.1	Green	(7.7)	Red	(4.2)	Red	(11.8)	Red
Efficiency	0.0	Green	(2.9)	Red	16.9	Green	14.0	Green
Spend of Capital Resource	0.0	Green	1.0	Green	0.0	Green	1.0	Green
Spend of Running Cost Allocation	0.9	Green	(0.1)	Red	0.2	Green	1.0	Green
Better Payment Practice Code	>95%	Green	>95%	Green	>95%	Green	>95%	Green

ICB Key Metrics - Forecast Outturn	Derby & Derbyshire ICB Full Year Variance £'m	Derby & Derbyshire ICB Full Year RAG Rating	Lincolnshire ICB Full Year Variance £'m	Lincolnshire ICB Full Year RAG Rating	Nottingham & Nottinghamshire ICB Full Year Variance £'m	Nottingham & Nottinghamshire ICB Full Year RAG Rating	Total Cluster Full Year Variance £'m	Total Cluster Full Year RAG Rating
Financial Performance	0.0	Green	0.0	Green	(6.2)	Red	(6.2)	Red
Efficiency	0.0	Green	(10.3)	Red	0.0	Green	(10.3)	Red
Spend of Capital Resource	0.0	Green	0.0	Green	0.0	Green	0.0	Green
Spend of Running Cost Allocation	3.5	Green	1.4	Green	3.8	Green	8.7	Green
Mental Health Investment Standard	0.0	Green	0.0	Green	0.0	Green	0.0	Green
Risk (Net Position)	0.0	Green	0.0	Green	0.0	Green	0.0	Green
Underlying Position	8.1	Green	(57.6)	Red	(26.5)	Red	(76.0)	Red
Better Payment Practice Code	>95%	Green	>95%	Green	>95%	Green	>95%	Green

Financial Performance and Key Drivers of the Position

The ICBs are forecasting delivery of their full-year plans, with the exception of Nottingham and Nottinghamshire ICB (NNICB), which is not expecting to receive quarters 3 and 4 Deficit Support Funding (DSF). This results in Derby and Derbyshire ICB (DDICB) reporting breakeven, Lincolnshire ICB (LICB) a £3.7 million surplus, and NNICB a £6.2 million due to deficit supported only by quarters 1 and 2 DSF. Financial pressures remain, evidenced by LICB and NNICB's YTD adverse variances of £7.7 million and £4.2 million respectively. Risks will need active management over the final two months of the year to deliver the reported outturn positions.

ICB Financial Positions (2 of 3)

Financial pressures persist, notably:

- The loss of deficit support funding for NNICB has been shown as a year to date (£4.2 million) and forecast (£6.2 million) pressure.
- Acute activity is expected to be £41.9 million adverse to plan by the financial year-end. This is mainly due to higher than planned elective activity in the Independent Sector, and operational constraints and increasing activity pressures within NHS providers.
- Mental health and learning disabilities shows a £12.3 million adverse forecast, driven by continued increased demand for ADHD/ASD assessments in the private sector, section 117 activity, and costs and pressure in acute out of area bed costs.
- Prescribing, services are under pressure mainly in LICB and, to a lesser extent, at NNICB, due to diabetes medicines and price/volume trends.
- Community services are under pressure from delayed efficiency schemes, particularly in DDICB and NNICB.

Efficiency:

At Month 10, the ICBs are £14.0 million ahead of the YTD efficiency plan, but this is due to non-recurrent efficiencies. Recurrent efficiencies are behind plan, which will impact the underlying position. The ICBs' ability to deliver the efficiency target is a key risk, with £8.5 million of schemes assessed as high or medium risk (£16.7 million at Month 9). Additional efficiency schemes are being sought, and further efficiency governance is being developed to support intel into the Financial Recovery Meeting.

Other Areas to Note:

The ICBs are anticipating to remain within the capital and running cost allocations, as per national directions and are on track to achieve the Mental Health Investment Standard (MHIS).

The Better Payment Practices Code (BPPC) target is consistently achieved across the ICBs to Month 10. Nationally, ICBs went live with a new financial ledger on 1 October 2025. There have been several challenges following implementation of the new ledger; however, BPPC and month end cash targets have been achieved.

ICB Financial Positions (3 of 3)

Recovery Actions

The key action is the implementation of the LICB Recovery Plan to address the key driver of the ICB collective net risk of £12.8 million. This is currently in place and being monitored/overseen by the Financial Recovery Meeting (FRM).

Linked to the above, a key risk is the delivery of original efficiency plans across all three ICBs. Focus in FRM and Financial Recovery Delivery Group (FRDG) continues to push scheme leads to maximise efficiency opportunities and maximise delivery of schemes in place.

A key mitigating action is leveraging non-recurrent efficiency solutions. These include review of in-year and year-end accruals (e.g. continuing healthcare, GP quality and outcomes framework), slippage on allocations (e.g. digital, additional roles), slippage on reserve commitments (e.g. mental health reserves, prior year reprovision reserves, health inequality) and secondary care dental care expenditure.

The other key actions relate to putting in controls, or enhancing controls, where expenditure pressures are being observed. These include:

Acute Independent Sector – pressures across all three ICBs, commissioning colleagues raised Activity Query Notices (AQNs) with providers and negotiating revised activity plans, also understanding the levels of sub-contracted activity from NHS providers with a view to looking at contract levers to control this.

Acute NHS provider pressures – similarly, AQNs issued regarding elective and diagnostic activity levels. In addition, discussions with NHS providers have been instigated to agree year end issues and ensure all items are resolved for month 12 reporting. Triangulation issues with providers across the cluster have now been resolved for this financial year.

Mental Health ADHD services – DDICB implementing a Single Point of Access (SPA), with the aim to reduce activity by 30%. NNICB are looking at a similar SPA being implemented in 2026/27. Additionally, a dedicated adult ADHD assessment service is being commissioned in DDICB.

Mental Health section117 services – Additional external support in place to maximise the reviews taking place, with funding panels established. However, impact per case is not as great as original modelling.

Prescribing – Overspend in LICB, with medicines management teams continuing to review all opportunities for cost reduction, e.g. switches to cheaper generics and regular visits to practices to discuss details with GPs and other practice staff. NNICB has come back to budget in Month 10, and the actions implemented will continue to be pushed to ensure costs remain as low as possible. Risk shares agreed on secondary care drugs, where the approach is being shared across all ICBs.

Community non-NHS contract pressures – NNICB has established a Community Contracts Board with the aim to review pressures areas e.g. Termination of Pregnancy and instigate appropriate action plans.

Provider Financial Positions (1 of 4)

Provider	Financial Performance Year to Date Variance £'m	Financial Performance Year to Date RAG Rating	Efficiency Year to Date Variance £'m	Efficiency Year to Date RAG Rating	Revised Capital Envelope Forecast Variance £'m	Revised Capital Envelope Forecast Variance RAG Rating	Underlying Position Full Year Forecast £'m	Underlying Position Full Year RAG Rating
Chesterfield Royal Hospital NHS Foundation Trust (Note 1)	(13.1)	Red	(1.2)	Red	0.1	Green	(33.6)	Red
Derbyshire Community Health Services NHS Foundation Trust	0.0	Green	0.0	Green	(2.8)	Red	(8.1)	Red
Derbyshire Healthcare NHS Foundation Trust	0.5	Green	0.0	Green	1.1	Green	(9.3)	Red
East Midlands Ambulance Service NHS Trust	0.1	Green	0.0	Green	1.8	Green	(6.4)	Red
University Hospitals Of Derby And Burton NHS Foundation Trust (Note 1)	(20.9)	Red	(11.6)	Red	2.4	Green	(131.8)	Red
Total Derby & Derbyshire Providers	(33.5)	Red	(12.8)	Red	2.5	Green	(189.2)	Red
Lincolnshire Community Health Services NHS Trust	0.4	Green	0.8	Green	(0.1)	Red	(8.1)	Red
Lincolnshire Partnership NHS Foundation Trust	0.0	Green	0.0	Green	0.5	Green	(12.3)	Red
United Lincolnshire Teaching Hospitals NHS Trust	(3.0)	Red	(4.9)	Red	0.0	Green	(43.5)	Red
Total Lincolnshire Providers	(2.6)	Red	(4.2)	Red	0.4	Green	(63.9)	Red
Nottingham University Hospitals NHS Trust (Note 1)	(55.2)	Red	(23.5)	Red	1.1	Green	(96.4)	Red
Sherwood Forest Hospitals NHS Foundation Trust (Note 1)	(24.4)	Red	(11.5)	Red	(3.7)	Red	(38.6)	Red
Nottinghamshire Healthcare NHS Foundation Trust (Note 1)	(37.9)	Red	(15.3)	Red	0.0	Green	(67.2)	Red
Total Nottingham & Nottinghamshire Providers	(117.5)	Red	(50.4)	Red	(2.6)	Red	(202.3)	Red
Grand Total Cluster Providers	(153.5)	Red	(67.4)	Red	0.4	Green	(455.3)	Red

Key Drivers

Total YTD adverse variance to plan is £153.5 million, primarily due to pay overspends of £71.8 million and a shortfall in planned efficiencies of £67.4 million (of which a proportion is directly related to pay costs). Chesterfield Royal Hospital NHS Foundation Trust (CRH) and University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) in Derby and Derbyshire), and all providers in Nottingham and Nottinghamshire are forecasting that the planned financial position for the year will no longer be achieved, and this is reported in month 10 following agreement with NHS England. All other providers are forecasting to achieve their planned positions for the year. The revised total forecast for all providers is a deficit of £214.5 million.

Efficiencies are off plan by £67.4 million YTD (an adverse movement of £9.2 million from Month 9), especially in recurrent schemes, with stepped increases in the second half of the year. Non-recurrent schemes have mitigated some shortfalls, but further cash-releasing efficiencies are needed. Of the YTD reported efficiencies, 41% are non-recurrent against a plan of 27%. Efficiency delivery is forecast at a total of £354.7 million, which is £76.5 million below the full year target of £431.1 million.

Provider Financial Positions (2 of 4)

Key Drivers continued

Capital at N&N providers is showing £2.6 million over the revised envelope mainly due to awaited allocation changes for Sherwood Forest Hospitals NHS Foundation Trust emergency department £3.7 million and £1 million deduction re NUH's IT and medical equipment allocation. D&D is showing £2.5 million below envelope due to an additional allocation received in M10, which is planned to be spent but a split by organisation has not yet been agreed by the system.

Provider Pay Costs

A further risk to the delivery of the reported forecast position includes increased pay costs at £71.8 million over plan, particularly at N&N providers within Substantive Pay at £63.4 million over and Bank Staff at £7.3 million over. Other risks include delivery of elective activity, non-pay inflationary pressures and risks to provider income.

Provider	Total Pay Costs Year to Date Variance £'m	Total Pay Costs Year to Date RAG Rating	Substantive Pay Costs Year to Date Variance £'m	Substantive Pay Costs Year to Date RAG Rating	Bank Pay Costs Year to Date Variance £'m	Bank Pay Costs Year to Date RAG Rating	Agency Pay Costs Year to Date Variance £'m	Agency Pay Costs Year to Date RAG Rating
Chesterfield Royal Hospital NHS Foundation Trust	2.3	Green	13.6	Green	(8.0)	Red	(3.3)	Red
Derbyshire Community Health Services NHS Foundation Trust	2.9	Green	2.5	Green	0.4	Green	0.0	Green
Derbyshire Healthcare NHS Foundation Trust	4.1	Green	3.1	Green	0.3	Green	0.7	Green
East Midlands Ambulance Service NHS Trust	4.5	Green	4.4	Green	(0.1)	Red	0.2	Green
University Hospitals Of Derby And Burton NHS Foundation Trust	(14.0)	Red	(10.2)	Red	(1.9)	Red	(1.9)	Red
Total Derby & Derbyshire Providers	(0.2)	Red	13.3	Green	(9.3)	Red	(4.2)	Red
Lincolnshire Community Health Services NHS Trust	(1.5)	Red	(0.3)	Red	(2.0)	Red	0.8	Green
Lincolnshire Partnership NHS Foundation Trust	3.5	Green	2.7	Green	0.3	Green	0.5	Green
United Lincolnshire Teaching Hospitals NHS Trust	(5.2)	Red	(0.3)	Red	(3.4)	Red	(1.4)	Red
Total Lincolnshire Providers	(3.1)	Red	2.1	Green	(5.1)	Red	(0.2)	Red
Nottingham University Hospitals NHS Trust	(43.6)	Red	(40.7)	Red	(2.7)	Red	(0.2)	Red
Sherwood Forest Hospitals NHS Foundation Trust	(15.1)	Red	(19.4)	Red	3.5	Green	0.7	Green
Nottinghamshire Healthcare NHS Foundation Trust	(9.7)	Red	(3.3)	Red	(8.1)	Red	1.8	Green
Total Nottingham & Nottinghamshire Providers	(68.4)	Red	(63.4)	Red	(7.3)	Red	2.3	Green
Grand Total Cluster Providers	(71.8)	Red	(48.0)	Red	(21.6)	Red	(2.1)	Red

Provider Financial Positions (3 of 4)

Key Drivers continued.

Derby and Derbyshire

The month 10 year to date position is £33.5 million adverse to the planned deficit of £15.1 million, an adverse movement of £9.3 million in month. CRH is £13.1 million adverse to plan compared to £9.9 million adverse at Month 9. Key drivers include under delivery of efficiencies and operational cost pressures.

UHDB is £20.9 million adverse to plan compared to £14.4 million adverse at Month 9. Key drivers include increased variable pay costs due to providing care for increased number of emergency patients, and income shortfalls. UHDB is also reporting an underlying position of £131.8 million deficit. Further work is required to align the UHDB underlying position to the guidance shared by NHS England.

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

Lincolnshire

United Lincolnshire Teaching Hospitals (ULTH) is reporting £3.0 million adverse to plan year-to-date with a forecast in line with plan. The year-to-date position has been supported by technical efficiencies. There are risks to the delivery of full year plan (driven by capacity and cost pressures, and risks to income). The position is anticipated to be recovered through the impact of productivity work, and work is ongoing to close the gap in efficiency delivery.

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

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

Nottingham and Nottinghamshire

Month 10 year to date position is £117.5 million adverse variance to the planned deficit of £0.6 million, with an adverse in-month actual movement of £36.5 million. All providers have seen an in-month actual adverse impact – NUH £14.5 million, (SFH £13.6 million and Nottinghamshire Healthcare NHS Foundation Trust (NHT) £8.5 million. Key drivers of the in-month position are substantive and bank staffing, withheld deficit support funding (DSF) and under delivery of efficiencies.

The largest adverse variance year-to-date is NUH who are reporting a (£55.2 million) deficit variance, the main drivers are contract and income pressures (including months 7 to 10 DSF), shortfalls in efficiency delivery, substantive pay run rate deterioration and non-pay pressures.

For NHT (£37.9 million adverse variance to year-to-date plan), the main drivers are bank staffing, private sector beds, months 7 to 10 DSF, delivery of efficiency plans and income and cost pressures.

SFH is (£24.4 million) year-to-date adverse to plan which is driven by adverse efficiency performance, particularly in substantive pay, loss of months 7 to 10 DSF and pressures in emergency and urgent care.

Provider Financial Positions (4 of 4)

Financial recovery key actions include:

- Strengthened Financial Recovery Governance Arrangements implemented in November 2025, focussing on high-financial risk organisations across the Systems. This aimed to strengthen grip and control within organisations to support (2025/26) financial delivery, and to provide assurance to Boards, ICBs and NHS England.
- The fortnightly Financial Recovery Group (FRG) oversees financial recovery, with fortnightly Provider Recovery Assurance Groups reviewing progress in detail. This is underpinned by fortnightly organisational submission of lead indicators (workforce and pay) and FRP assurance packs.
- All high-financial risk organisations have enhanced their grip and control to support delivery of Financial Recovery Plans. Enhanced vacancy controls and mutually assured resignations schemes have resulted in a levelling and / or reduction in substantive whole time equivalent (WTE) staff. Enhanced temporary staffing controls has led to an overall reduction in bank and agency WTE and costs. Major interventions which address cost drivers at divisional / care group level are being progressed, with some underperforming divisions in “special measures” to drive recovery. Overall, the impact is positive, however it is still not at the scale or pace required for financial recovery.
- All Trusts are in the process of agreeing month 10 forecasts with NHSE, with an absolute expectation that Financial Recovery Plans to achieve agreed control targets are delivered.
- Organisations need to accelerate 2026/27 CIP and Transformation development, ensuring plans fully align with, and underpin, affordable workforce plans and budgets. Grip and control will need to be maintained in 2026/27. Importantly, large-scale transformation, aligned to the ambitions set out in the ICB 5-year strategic commissioning plan, will be required to meet efficiency requirements in 2026/27 and beyond.

Latest position of High Financial Risk Organisations is summarised below:

The **NUH** FRP is focussed on grip and control (pay/non-pay), CIP delivery and Care Optimisation. There is Board / Executive ownership, a Turnaround Director, weekly delivery assurance through Care Groups and assertive pay controls. As at month 10 the trust has indicated a “most likely” (£66.8 million) deficit at year end.

The **UHDB** FRP is focussed on improving run rate (CIP delivery), variable pay and enhanced pay/non-pay controls. Further assurance is required to illustrate clear action plans are in place at divisional level and that delivery is accelerating. UHDB has stepped up grip and control including a weekly executive financial recovery meeting with delivery leads and enhanced vacancy controls. At month 10 the trust has indicated a “most likely” (£20.4 million) deficit at year end.

The **NHT** FRP is focussed on pay, independent sector beds and discretionary spend. There is Board / Executive and Care Group ownership and a Director of Financial Recovery to oversee delivery. Workforce interventions include vacancy freeze and significant controls on bank and agency at Care Group level. The trust has reduced workforce, pay and beds however not at the pace and / or scale required. As at month 10 the trust has indicated a “most likely” (£47.9 million) deficit at year end.

CRH has approved £4.75 million of high impact actions focussing on divisional clinical major interventions, medical variable pay, corporate cost control and income. Enhanced workforce controls are in place with a focus on medical agency. Three divisions are in ‘special measures’ with weekly progress reviews with the CFO. Executive wide ownership is evidenced. As at month 10 the trust has indicated a “most likely” (£19.5 million) deficit at year end.

The **SFH** FRP focusses on enhanced grip and control across the Trust and six key work programmes within divisions. Robust pay / non-pay controls are in place and whilst pay costs are reducing, this is not at the required rate. There is strong Board, Executive and Divisional ownership. At month 10 the “most likely” position (£24.2 million) deficit at year end.

ULTH has a comprehensive FRP with major interventions including temporary pay (medical spend and bank nursing), executive led vacancy control (currently subject to a three month start date pause), discretionary spend controls, non-recurrent actions and elective sprint. There is Board / Executive and Care Group ownership with additional internal assurance to expand / expedite plan delivery. As at month 10 the trust has indicated a “most likely” balance at year end.

All these positions require continued delivery of challenging FRPs and also assume full receipt of deficit support funding which presents significant risk.

Appendix 1 – Summary Cluster System Income and Expenditure

Total Cluster	Year to Date Plan £'m	Year to Date Actual £'m	Year to Date Variance £'m	Year to Date Variance %	Full Year Plan £'m	Full Year Forecast £'m	Full Year Forecast Variance £'m	Full Year Forecast Variance %
System Revenue Resource Limit	(7,197.5)				(8,724.3)			
ICB Net Expenditure								
Acute Services	3,327.4	3,363.5	(36.1)	(1.1%)	3,989.2	4,031.0	(41.8)	(1.0%)
Mental Health Services	745.6	755.0	(9.4)	(1.3%)	901.7	914.0	(12.2)	(1.4%)
Community Health Services	568.3	566.4	1.9	0.3%	679.6	677.0	2.7	0.4%
Continuing Care Services	317.2	308.0	9.2	2.9%	383.7	370.1	13.6	3.5%
Primary Care Services	578.0	572.1	5.9	1.0%	685.9	679.1	6.8	1.0%
Memo: Prescribing	478.4	478.4	0.0	0.0%	566.5	566.8	(0.3)	(0.0%)
Other Commissioned Services	27.2	26.7	0.5	1.9%	33.4	32.9	0.5	1.4%
Other Programme Services	47.2	43.4	3.7	7.9%	55.7	70.3	(14.5)	(26.1%)
Reserves / Contingencies	40.1	44.1	(4.0)	(10.0%)	86.2	75.0	11.1	12.9%
Delegated Specialised Commissioning	657.3	651.0	6.3	1.0%	805.3	798.2	7.1	0.9%
Delegated Primary Care Commissioning	842.8	833.7	9.1	1.1%	1,022.0	1,010.2	11.8	1.2%
ICB Running Costs	46.8	45.9	0.9	2.0%	77.9	69.0	8.8	11.3%
Total ICB Net Expenditure	7,197.9	7,209.6	(11.8)	(0.2%)	8,720.6	8,726.8	(6.2)	(0.1%)
ICS Providers I&E - Adjusted Financial Performance								
Income	(5,723.5)	(5,741.3)	17.8	(0.3%)	(6,870.2)	(6,874.6)	4.4	(0.1%)
Pay	3,872.8	3,944.6	(71.8)	(1.9%)	4,633.2	4,715.2	(82.0)	(1.8%)
Non-Pay	1,766.9	1,871.0	(104.1)	(5.9%)	2,110.0	2,252.0	(142.0)	(6.7%)
Non Operating Items	108.6	104.0	4.5	4.2%	130.7	125.6	5.1	3.9%
TOTAL Provider Surplus/(Deficit)	(24.7)	(178.2)	(153.5)	2.7%	(3.7)	(218.2)	(214.5)	3.1%

Note - ICB position is shown gross, so includes intra system providers

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	19/03/2026
Paper title:	Quality Report
Paper reference:	ICB CIC 25 048
Paper author:	Quality Business Management Unit
Paper sponsor:	Rosa Waddingham, Executive Director of Quality (Nursing)
Presenter:	Rosa Waddingham, Executive Director of Quality (Nursing)

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

Report summary:

This report provides updates on quality and safety matters relating to the following NHS Trusts for which the ICBs have responsibility, and where there are escalations based on the NHS Oversight Framework:

- Derbyshire Healthcare NHS Foundation Trust
- University Hospitals of Derby and Burton NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust
- Nottinghamshire HealthCare NHS Foundation Trust
- Nottingham University Hospital NHS Trust
- Chesterfield Royal Hospital NHS Foundation Trust
- Lincolnshire Community Health Service NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- Sherwood Forest Hospital NHS Foundation Trust
- Urgent Emergency Care (All ICBs) (including use of temporary escalation spaces)

The report also provides exception reporting for areas of enhanced oversight, as per the ICBs' escalation framework (included for information at Appendix 1):

- Learning Disabilities and Autism
- Children and Young People
- Infection Prevention Control
- Primary Care
- Independent Sector
- Vaccinations
- Maternity (NHS Derby and Derbyshire and NHS Nottingham and Nottinghamshire ICBs)
- Special Educational Needs and Disabilities (NHS Derby and Derbyshire and NHS Nottingham and Nottinghamshire ICBs)

Recommendation(s):

The Board is asked to **receive** the paper for assurance in relation to areas of quality and safety.

Relevant statutory duties:

☒ Quality improvement	☐ Public involvement and consultation
☐ Reducing inequalities	☐ Equality and diversity

Relevant statutory duties:

☐ Integration of services	☐ Wider effect of decisions (triple aim)
☐ Promoting innovation	☐ Promoting research
☐ Patient choice	☐ Obtaining appropriate advice
☐ Promoting education/training	☐ Climate change

Appendices

Appendix 1: Current ICS Escalation Framework

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Quality Report

Derbyshire Healthcare NHS Foundation Trust – National Oversight Framework Three

1. Core Care Quality Commission (CQC) inspections started week commencing 19 January 2026 and updates and verbal feedback will be presented to the Clinical Quality Review Group.
2. Validated data for the end of November 2025 showed the number of inappropriate Out of Area Placement position at four, which was one above the agreed operational plan. Focused areas of improvement are underway.

University Hospitals of Derby and Burton NHS Foundation Trust – National Oversight Framework Three

3. The Trust received a CQC reinspection visit in December 2024, following the 'Inadequate' rating issued during the initial visit in November 2023. The report was published in November 2025 and as all the conditions had been met for the CQC's Section 29a warning notice, it was lifted. Evidence was submitted by the Trust for the CQC's Section 31 conditions and a notice of decision to remove them has been received from the CQC; however, due to a technical fault on the CQC website this has not yet been published.

United Lincolnshire Teaching Hospitals NHS Trust – National Oversight Framework Four

4. An outcome letter following the NHS England Midlands Regional Infection Prevention Control (IPC) visit was received in December 2025. This confirmed that the Trust remains on enhanced oversight for IPC. The ICB will continue to conduct planned site visits and monitor activities related to IPC through the Trust's monthly IPC Group meetings.
5. Following concern within the Ophthalmology service regarding potential patient harm caused due to delays in time critical follow up, a Task and Finish Group has commenced. Lincolnshire Community Hospitals NHS Group's Quality Committee has received a paper outlining the concerns. Assurances have been provided within the paper and corresponding action plan regarding approaches being taken to address the backlog and processes for reviewing and addressing identified harms.

Nottinghamshire HealthCare NHS Foundation Trust – National Oversight Framework Four

6. The CQC Well Led Review was published in January 2026 with an overall rating of 'Requires Improvement'. Regulatory breaches have been identified, requiring significant improvement actions.
7. Responses to both Preventing Future Deaths Reports issued in Quarter Three 2025/26 were submitted to the Coroner in January 2026. The Trust has worked collaboratively with several agencies to address the concerns raised in both cases and to improve joint working and outcomes.
8. There is ongoing monitoring and mitigation in Community Health services. Following a series of incidents in planned and proactive care, the leadership, safeguarding, and patient safety teams have confirmed that current oversight and mitigation measures remain appropriate, with continued assurance provided through the Improvement Oversight Assurance Group.
9. Challenges remain in accessing beds for people with mental health needs who have been placed at Lings Bar Hospital. Escalation is made to Mental Health Teams in a timely manner and advice is sought to manage the person's needs. Learning events are taking place with partners including discharge teams to identify improvement work.

Nottingham University Hospital NHS Trust – National Oversight Framework Four

10. There remains sustained winter pressure with repeated OPEL (Operational Pressures Escalation Levels) escalation; and overcrowding has driven corridor care usage and has created patient flow risks.
11. The CQC published its latest maternity report on 4 March 2026 following their inspection in May 2025. An overall 'Requires Improvement' rating was provided, which identified regulatory breaches relating to security, staffing and service management, with an associated requirement for the Trust to submit an action plan. NHS Nottingham and Nottinghamshire ICB will consider the findings and assurances through existing maternity quality oversight and governance processes.
12. A quality visit to the Emergency Department with IPC and System Coordination Centre colleagues observed sustained corridor care and elements of IPC non-compliance under very challenging operational conditions. The ICB Team fed back immediate actions for internal and external oversight.

Chesterfield Royal Hospital NHS Foundation Trust – National Oversight Framework Three

13. There are no new exceptions or escalations to report. Monitoring continues around the previously identified risk areas and mitigations. These will be reviewed in detail during the February Clinical Quality Review Group.

Lincolnshire Community Health Service NHS Trust – National Oversight Framework Four

14. The Trust has moved to National Oversight Framework Four from Three, relating primarily to performance issues.
15. There have been safeguarding concerns related to pressure ulcer damage highlighted through increases in Section 42 notices. The Trust's Quality Committee received a deep dive report, which identified learning and areas for improvement. An action plan has been developed with progress being monitored through Trust's Patient Safety Group and Quality Committee.

Lincolnshire Partnership NHS Foundation Trust – National Oversight Framework Three

16. The final CQC report for working age adult mental health rehabilitation wards was published January 2026 with an overall rating of 'Requires Improvement'. An Improvement Plan is being developed and will cover all areas identified in the report. A Notice of Proposal previously issued by the CQC did not proceed to enforcement after the Trust submitted sufficient evidence and assurance to address the concerns raised.

Sherwood Forest Hospital NHS Foundation Trust – National Oversight Framework Three

17. The Trust has moved to National Oversight Framework Three from Two, primarily relating to their financial deficit.
18. There are continued increased operational pressures experienced requiring the full capacity protocol to be enacted with an additional bed space added on each inpatient ward to create capacity. There is increased reporting of overcrowding in the emergency department, with ambulance handover times impacted. A Critical Incident was declared during this reporting period and lasted for four days in response to sustained demand for urgent and emergency care services. No harm or patient safety incidents relating to this have been reported.

Urgent Emergency Care (All ICBs)

19. Across all three ICBs, there continues to be sustained pressures within Urgent and Emergency Care (UEC) services. The winter period, combined with increased flu activity, industrial action, ambulance handover delays and challenges in achieving key UEC performance standards, has resulted in significant operational strain. Systems have reported the need for strengthened pathways that reduce avoidable attendance and admissions, improve patient flow, and minimise delays that may contribute to potential harm.
20. Lincolnshire Community and Hospitals NHS Group has revised their emergency department CQC improvement plan to reflect the recent CQC published reports. Oversight is provided through the Trust Executive-Led CQC assurance meeting and the Quality Committee. Quality improvement projects and real-time discharge monitoring is in place with review at the weekly UEC Clinical Reference Group and oversight at their UEC Programme Board.
21. The Coroner has issued two regulation 28 Preventing Future Deaths to Nottingham Emergency Medical Services (NEMS) and East Midlands Ambulance Service (EMAS) following inquests into the deaths of two young men presenting with abdominal pain transferred from EMAS to NEMS. A systemwide After Action Review was undertaken with a review of current actions in place to reduce risk of re-occurrence. A follow up is planned with providers, commissioners and the lead commissioner, NHS Derby and Derbyshire ICB.

Learning Disabilities and Autism – Enhanced Oversight

22. Across all three ICBs, the Learning Disabilities and Autism (LDA) agenda remains a significant priority, with continued focus on reducing reliance on inpatient care, strengthening community provision, and improving the quality, safety and experience of care for autistic people and people with learning disabilities. Systems continue to balance operational pressures, including inpatient flow challenges, the need for consistent admission criteria, and the importance of timely discharge supported by robust community pathways.
23. ICB Weekly senior leadership escalation meetings have been established and commenced in January 2026. These meetings provide ongoing oversight of Tier Four issues and support the early identification and escalation of emerging risks through the Daily Situation Report process. A comprehensive deep-dive review has been completed, with learning identified to inform ongoing improvement and system strengthening.

Children and Young People – Enhanced Oversight

24. Across all three ICBs, Children and Young People (CYP) services continue to focus on improving access, strengthening multi-agency collaboration, and ensuring safe, responsive support for children with increasingly complex needs. Key themes across the ICB areas include the development and stabilisation of specialist community services, strong partnership working with education and local authorities, safeguarding and statutory compliance, and the need to address workforce sustainability particularly within children's nursing and mental health services.
25. Lincolnshire ICB is currently reprocuring the CYP Tier Two Continence Service. The current provider, Lincolnshire County Council, has agreed to extend the provision of the service from their previous extension of 31 December 2025 until 30 June 2026. However, the Council is not able to support the service any longer with their generic CYP Nursing Team and have identified some gaps in provision during this time. The ICB is working with primary and secondary care providers during this time to mitigate risks.
26. There is challenge and media attention associated with two areas of disinvestment: Bassetlaw Learning Disability Nursing Service and the Complex Care Team in Oak Field School. There are transition plans in place and the delivery of ongoing care for eligible CYP is being led by the Children's Continuing Care Team.
27. There are concerns around the long-term workforce of children's nurses with the planned cessation of the Registered Children's Nursing course at the University of Nottingham. The Head of Nursing for CYP is working with Nottinghamshire Trusts to understand the impact. There is agreement with the University of Derby to increase their student numbers and for placements in Nottinghamshire Trusts to be offered. The CYP leads and education faculties will continue to meet to plan for the future. There will also be an impact for Child and Adolescent Mental Health Services, as the mental health nursing course is also planned to cease, but numbers are lower. Nottinghamshire Healthcare NHS Foundation Trust is progressing work around this.

Infection Prevention Control – Enhanced Oversight

28. Across all three ICBs, system pressures continue to drive challenges in IPC, with several acute providers operating above national trajectories for key Healthcare-Associated Infections. Whilst targeted improvement activity is underway, the overall position reflects a heightened level of risk, particularly in relation to environmental safety, antimicrobial stewardship, and the impact of operational crowding on IPC fundamentals.

Primary Care – Enhanced Oversight

29. The CQC has been focusing on assessing practices that were last inspected in 2015. The majority of these have now been completed and it is anticipated that the CQC will begin to prioritise those practices that are currently rated 'Requires Improvement' and those where the last inspected report was published in 2016.

Vaccinations – Enhanced Oversight

30. Across all three ICBs, vaccination programmes continue to focus on improving uptake, addressing service capacity challenges, and ensuring timely delivery of flu and RSV vaccines to priority cohorts. Key themes include managing staffing constraints in school-aged immunisation services, supporting maternity sites to improve RSV vaccination in pregnancy, and targeting communications to increase uptake in younger children. Systems are maintaining extended vaccination offers and implementing contractual or operational actions where needed to maximise coverage and protect vulnerable populations through to the end of the 2025/26 season.

Maternity (NHS Derby and Derbyshire and NHS Nottingham and Nottinghamshire ICBs) – Enhanced Oversight

31. Across both ICB areas maternity services continue to focus on strengthening safety, improving clinical outcomes, and embedding consistent oversight and assurance across providers. Key themes include responding to regulatory findings, reinforcing governance through targeted improvement programmes, and monitoring performance via Bellwether metrics and national frameworks such as the Maternity Incentive Scheme and Saving Babies' Lives Care Bundle. Systems are also prioritising workforce sustainability, enhancing education and competency-based training, refining pathways for antenatal and perinatal care, and supporting trusts to stabilise high-risk areas such as post-partum haemorrhage and perineal trauma. This collective approach aims to ensure safer, more responsive, and continually improving maternity and neonatal care across both systems.
32. University Hospitals of Derby and Burton NHS Foundation Trust received a CQC rating of 'Requires Improvement' following the reinspection visit in December 2024 and report publication in November 2025. A final notice of decision on removal of the section 31 conditions is awaited and due imminently (at the time of writing this report).
33. The introduction of Perinatal Pelvic Health Service to support management of injury with a revised pathway will be implemented. An action plan is in place for the Trust to meet the Perinatal Pelvic Health Service trajectory by March 2026

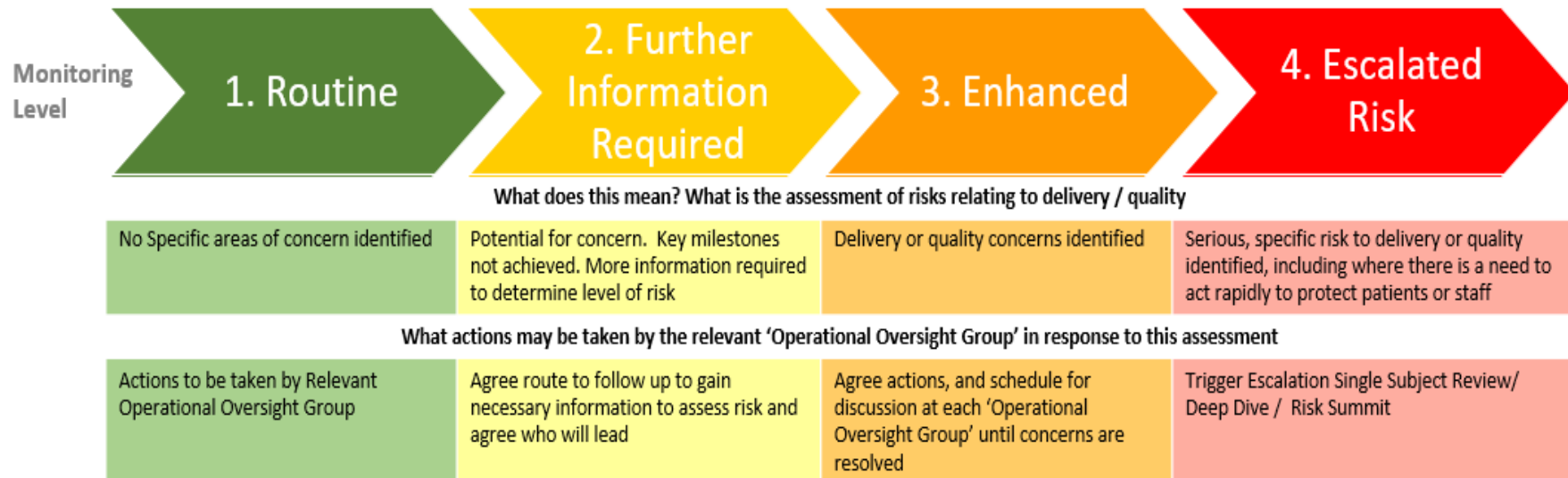
and monthly oversight meetings are in place to review progress. Local Maternity and Neonatal System support from Chesterfield Royal Hospital's Clinical Lead Physiotherapist is in place to improve patient education and self-assessment.

34. Both Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS Foundation Trust have quality improvement projects ongoing to support the reduction in rates of Postpartum Haemorrhage and 3rd and 4th degree Perineal Tears.

Special Educational Needs and Disabilities (NHS Derby and Derbyshire and NHS Nottingham and Nottinghamshire ICBs) – Enhanced Oversight

35. Across both ICB areas, Special Educational Needs and Disabilities (SEND) system priorities continue to centre on strengthening partnership working, improving statutory compliance, and ensuring children, young people and families experience more coordinated and timely support. Key themes include preparing for external inspections, embedding joint commissioning arrangements, stabilising leadership and workforce capacity within local authorities, and addressing ongoing pressures in high-demand pathways. This collective focus aims to build more consistent oversight, clearer accountability and better outcomes for children and young people with SEND across both ICB areas.

Appendix 1. Current ICS Escalation Framework



Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	19/03/2026
Paper title:	Commissioning Oversight Report
Paper reference:	ICB CIC 049
Paper author:	Sarah Bray, Associate Director of System Performance and Assurance, NHS Nottingham and Nottinghamshire ICB
Paper sponsor:	Maria Principe, Executive Director of Commissioning
Presenter:	Maria Principe, Executive Director of Commissioning

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

Report summary:

The report provides an overview of the national priority service delivery metrics against the operational plans submitted for 2025/26 for NHS Derby and Derbyshire, NHS Lincolnshire and NHS Nottingham and Nottinghamshire ICBs (the ICBs), as well as an update on the developing arrangements for commissioning leadership and oversight across the ICBs' areas, and the transitioning arrangements for provider oversight and delivery.

Commissioning oversight arrangements are progressing following the appointment of the Directors of Commissioning as part of the wave two management of change process, which will include management and delivery of the operational activity and performance plans and strategic transformational change delivery plans.

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

Whilst early progress has been made in strengthening commissioning governance and managing significant operational risks, performance remains materially off trajectory in several areas. The priority now is to translate strategic commissioning intentions into clear provider expectations, with measurable milestones and consistent escalation routes where delivery does not improve. There is an increasing need to tighten alignment between planning assumptions, commissioning activity, contractual levers and delivery expectations, which is being undertaken through working groups across directorates as the contract agreements are progressed through March 2026.

Recommendation(s):

The Boards are asked to **receive** the paper for assurance in relation to service delivery against the operational plans submitted for 2025/26, and development of strengthened commissioning arrangements.

Relevant statutory duties:	☒ Quality improvement ☐ Public involvement and consultation

Relevant statutory duties:

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

Appendices

Appendix 1 - Service Delivery Performance Report March 2026

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Commissioning Oversight Report – March 2026

Introduction

1. Areas of difficulty remain across the ICBs' areas in relation to urgent care, elective recovery, diagnostics, community services and areas of primary care services. The ICBs are undertaking a more evidence-based co-ordinated commissioning response to these areas of challenge, with some early benefits and indications of improvement from ICB-wide shared learning and solution development.
2. At the same time, there is evidence of a more co-ordinated commissioning response developing across the ICBs. The priority for the coming months will be to maintain grip on the areas of highest risk, continue strengthening alignment between planning and delivery, and ensure that commissioning programmes, particularly in planned care and neighbourhood services, translate into measurable improvement for patients and for the wider system.
3. An overview of ICB activity against the operational plans submitted is provided at Table 1 and an overview of ICB key priority system delivery metrics is provided in Table 2.

Commissioning oversight and governance

4. Appointments have now been made during the wave two management of change process to key commissioning roles, with the appointments of the Directors of Commissioning. Progress will commence at pace for the assignment of clear matrix leadership across the Commissioning Transformation Programmes and key provider contracts.
5. The development of the arrangements for commissioning oversight and internal governance and delivery accountability will be clarified during March, to enable oversight to be in place relevant for the strategic commissioner role of the ICB for 2026/27.
6. All Transformation Programmes will be expected to manage and deliver the operational performance requirements submitted as part of the NHS England operational planning process, as well as driving forward with pace the implementation plans underpinning the delivery of the Strategic Commissioning Plan.
7. Robust contract management, monitoring and analysis will be a key aspect of delivery of the aims and ambitions contained within the Strategic Commissioning Plan and the Operational Plan. This will be co-ordinated across finance, contracting, commissioning and performance teams within the ICBs.

8. A Commissioning Oversight Group will be established, which will triangulate and oversee progress against the transformational change and performance delivery across the programmes, as well as delivery of the contracted activity and performance expectations as the transacted delivery vehicles for the Strategic Commissioning Plan and Operational Plan.

Commissioning delivery

9. This month has been characterised by sustained operational pressure across urgent and emergency care, continued challenge against elective, cancer, diagnostics and community waiting time trajectories, and a growing need to ensure that commissioning activity is more tightly aligned to planning assumptions, contractual levers and delivery expectations. A strong focus through the month has been planning, specifically ensuring that the resources available are aligned with activity delivery, performance trajectories and the savings required across the system. Bringing those elements together in a coherent way has proved challenging and remains work in progress.
10. Alongside these pressures, there have been positive developments. Commissioning governance has continued to strengthen, work on neighbourhood commissioning is progressing, and teams have managed a number of significant operational risks effectively, particularly in relation to service continuity. A key theme emerging during February has been the need to strengthen alignment between planning assumptions, commissioning programmes and contractual delivery. In several areas where performance remains materially off trajectory, it is clear that planning ambitions, improvement programmes and contract management approaches need to be more closely connected. Our focus moving forward is therefore on ensuring that commissioning intentions translate clearly into provider expectations, supported by measurable milestones and clearer escalation routes where delivery remains off track.
11. **Urgent and emergency care** continues to experience sustained operational pressure across all three systems. The underlying challenge remains one of system flow: demand at the front door, ambulance handover delays, bed occupancy and discharge constraints all interact and continue to affect performance. Nottingham and Nottinghamshire remains particularly challenged, while Lincolnshire continues to see variation between sites and Derby and Derbyshire has maintained strong oversight through winter governance arrangements.
12. In response, the ICBs have maintained strong operational grip through daily and weekly oversight, ensuring winter initiatives are mobilised and monitoring their impact on flow. There has also been continued focus on discharge capacity and community alternatives to admission. From a commissioning

perspective, the priority is ensuring that winter initiatives are clearly aligned to system plans and deliver measurable impact. Looking ahead, a key focus will be bringing the Urgent and Emergency Care, System Coordination Centre and Emergency Preparedness Resilience and Response teams together into a single aligned function, which will allow a clearer operational plan to be developed around commissioning intentions in this area.

13. In **planned care**, the ICBs continue to face the challenge of reducing long waits and improving elective performance while managing workforce pressures and financial constraints. Demand remains high, and in some specialties, capacity remains limited, meaning progress can be uneven.
14. To address this, the ICBs have been working closely with providers on a series of planned care productivity 'sprints'. These sprints involve targeted use of non-recurrent funding to increase productivity and activity in key pathways as systems work towards year-end targets. The intention is to provide focused support to accelerate recovery where it is most needed, while maintaining oversight of sustainability and value for money. In parallel, work is underway to establish a planned care programme board across all three ICBs, which will bring providers and commissioners together around a shared work plan aligned to the commissioning strategy. This will help move the approach from a collection of individual recovery actions towards a more coordinated programme across the ICBs.
15. **Cancer and diagnostic services** remain closely linked to the elective challenge. Across the ICBs, capacity constraints in diagnostics and pressures within specific tumour pathways continue to affect delivery of national standards. Diagnostic delays, particularly in imaging and endoscopy, continue to influence both cancer pathways and broader elective recovery.
16. The response has focused on targeted pathway improvement, better use of available diagnostic capacity and strengthened oversight of the services where pressures are most acute. From a commissioning perspective, the key objective is ensuring that recovery work across diagnostics, cancer pathways and elective services is aligned and mutually reinforcing, rather than progressing in isolation.
17. Within **community services**, the challenge is twofold. In some areas, particularly within children and young people's services, waiting times remain longer than planned. At the same time, community services are central to the wider ambition to shift care closer to home and support neighbourhood-based delivery.
18. In response, the ICBs are working more closely with place teams to align commissioning expectations and delivery models. A key piece of work underway is the development of a core neighbourhood specification, which will outline the expected components of neighbourhood-based delivery across

community and primary care services. A draft of this specification will be shared with leads over the coming weeks for discussion and refinement, pending further national direction. The aim is to create greater clarity and consistency around neighbourhood models while still allowing flexibility for local delivery.

19. **Primary care** activity across the ICBs remains relatively strong, with GP appointment volumes meeting or exceeding planned levels across all three systems. However, there remains challenges in areas such as urgent dental access, digital uptake and ensuring that the wider urgent primary care offer is well understood by patients.
20. Work is therefore continuing to support practices with demand and capacity management, expand services such as Pharmacy First and strengthen communication with patients about the services available. The broader strategic aim is to ensure that primary care services are able to absorb demand effectively and support the wider system ambition to reduce avoidable hospital activity.
21. During the month, a significant commissioning issue arose in relation to Cliff Villages Medical Practice in Lincoln, which created a risk of service disruption. The practice subsequently closed temporarily before reopening under caretaker arrangements. The immediate challenge was protecting continuity of care for patients while managing a rapidly evolving situation. This required coordinated incident management, mobilisation of a caretaker provider, close operational coordination across teams and careful communication with stakeholders. While services have now stabilised, the situation highlights the fragility of some single-handed contractor arrangements and reinforces the need to strengthen resilience within primary care commissioning going forward.
22. Across **mental health, learning disability and autism services** there have been some encouraging developments, particularly in reducing certain out-of-area placements and strengthening community alternatives. However, pressures remain in areas such as inpatient flow, crisis demand and long waits for some assessments.
23. In response, work across the ICBs continues to focus on reducing reliance on inappropriate placements, improving inpatient flow and strengthening community-based support to prevent avoidable escalation into hospital care. There has also been positive collaboration across systems, including sharing learning from the Single Point of Access model in Lincolnshire with colleagues in Derbyshire. Commissioning teams are increasingly working together across the ICBs to develop a more aligned strategic direction for these services.

Provider oversight

24. NHS England has also been embedding enhanced oversight in relation to specific national priority metrics. This is determined through national

benchmarking of metrics for the delivery against the Operational Plan position, and assigning providers to tiering levels, with Tier 1 being the most intensive level of oversight. An overview of current tiering arrangements across the ICBs is provided in Table 3.

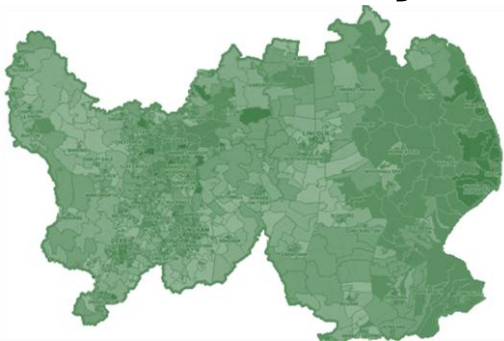
25. The ICBs have two providers under Tier One enhanced oversight, which are formal meetings led by the NHS England National team which include the provider and the ICB. Nottingham University Hospitals NHS Trust (NUH) is in Tier One for their four-hour wait target in the emergency department and for their cancer performance. United Lincolnshire Teaching Hospitals NHS Foundation Trust is in Tier One for four-hour, and twelve hour waits in Emergency Departments.
26. An overview of the NHS Oversight Framework and tiering levels across providers as at Quarter Three is outlined in Table 3. There are two providers that are under enhanced oversight arrangements and within the Recovery Support Programme arrangements, these are NUH and Nottinghamshire Healthcare NHS Foundation Trust. The ICB Executives are currently involved in the monitoring and improvement arrangements with NHS England.
27. As part of the changes relating to the new ICB and NHS England Operating Models, the primary monitoring, management and delivery approach by the ICBs with the providers will be through enhanced contractual oversight arrangements, which are being developed for 2026/27. Alignment of Strategic Commissioning transformation plans and expectations, as well as ICB activity and performance requirements into provider contracts, will be key to delivery in 2026/27.

Tables

28. Tables referenced through the report are provided at the end of the document as follows:
 1. Activity versus Operational Plan – December 2025
 2. Service Delivery Performance – February 2026 (Latest Position)
 3. NHS England National Oversight Framework (NOF) Ratings Overview – Q2 and Q3 Tiering

Table 1: Derby and Derbyshire, Lincolnshire, Nottingham and Nottinghamshire ICBs

NHS



Activity: December 2025 Year to Date (Apr-Dec 2025/26) & vs Last Year

December 2025 v Plan (YTD)

Above Plan ✓

Below Plan ✗

YTD Variance v Prior Month

Increased ↗

Decreased ↘

Current YTD v Last Year YTD

More Activity ↑

Less Activity ↓

Key

Outpatient 1st
(Specific Acute)

Outpatient F'Up
(Specific Acute)

Day Cases

Elective
(Ops)

Diagnostics
(9)

Derby and Derbyshire

Plan	Actual	YTD Var	vs LY
308,751	299,565	✗ -3.0% ↘	-1.9% ↓
692,937	677,023	✗ -2.3% ↘	-0.9% ↓
111,926	131,409	✓ 17.4% ↗	1.4% ↑
17,516	19,134	✓ 9.2% ↗	-0.5% ↓
381,407	388,156	✓ 1.8% ↘	12.5% ↑

Summary: Outpatients under plan, strong growth in Day Case and Diagnostics

Lincolnshire

Plan	Actual	YTD Var	vs LY
224,246	223,100	✗ -0.5% ↗	-2.5% ↓
375,511	389,463	✓ 3.7% ↗	-1.1% ↓
86,701	87,728	✓ 1.2% ↗	-2.1% ↓
13,567	13,503	✗ -0.5% ↗	-1.1% ↓
347,058	339,300	✗ -2.2% ↘	9.2% ↑

Summary: Outpatient Follow-ups over plan, all electives are lower than last year, strong growth in diagnostics

Nottingham and Nottinghamshire

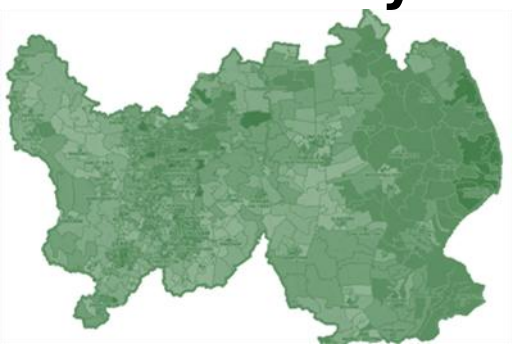
Plan	Actual	YTD Var	vs LY
302,212	265,981	✗ -12.0% ↘	-5.4% ↓
619,450	577,797	✗ -6.7% ↘	-3.6% ↓
136,834	134,323	✗ -1.8% ↗	-0.7% ↓
20,074	20,292	✓ 1.1% ↗	0.1% ↑
390,274	404,053	✓ 3.5% ↘	-0.6% ↓

Summary: Outpatients and Day case are under plan and lower than last year.

Key Messages:

Clear focus is needed on increasing outpatient 1st appointments and ensuring follow up activity is delivered in line with clinical best practice to enable capacity for the increased 1st appointments needed. Additional activity is needed to improve elective performance.

Table 2: Derby and Derbyshire, Lincolnshire, Nottingham and Nottinghamshire ICBs



NHS Operational Plan Delivery – Headline Overview

Actual v Plan (Latest Period)

Better than Plan Worse than Plan

Delivery

All Above Plan Areas Under Plan

Key

In Hospital Plan Delivery Headlines					
Programme Area	Period	DDICB	LICB	NNICB	DLN
Electives					
<18w waits RTT (%)	Dec-25	59.0%	56.3%	59.3%	✗
>52 week waits (%)	Dec-25	2.3%	1.2%	2.1%	✗
>65 week waits	Dec-25	35	19	45	✗
Waiting List	Dec-25	116,948	107,206	133,651	✗
Cancer					
<28-day Faster Diagnosis	Dec-25	78.1%	73.9%	69.8%	✗
<62-day RTT	Dec-25	65.1%	63.4%	62.1%	✗
Diagnostics					
>6 week waits (9)	Dec-25	25.5%	39.8%	24.7%	✗
Urgent Care					
<4 hour wait ED	Jan-26	66.2%	72.5%	64.0%	✗
>12 hour wait from arrival ED	Jan-26	18.8%	18.0%	16.5%	✗
>45m ambulance Handovers	Jan-26	21.5%	27.6%	26.5%	✗
Ambulance Cat 2 Response	Jan-26	00:49:34	01:05:35	00:44:07	✗
Summary: The ICB areas are worse than plan across all in-hospital performance measures.					

Key Plan Delivery Headlines					
Programme Area	Period	DDICB	LICB	NNICB	DLN
Primary Care					
GP Appointments	Dec-25	607,444	480,571	694,493	✓
Units of Dental Activity	Dec-25	58,712	65,142	123,383	✗
Pharmacy First Activity	Dec-25	8,375	7,746	7,032	✗
Community					
>52 week waits - Adult	Dec-25	0	0	2	✗
>52 week waits - CYP	Dec-25	2266	701	206	✗
Mental Health					
Inappropriate OAPs	Dec-25	4	0	10	✗
Inpatient Mean LOS	Dec-25	67	32	61	✗
Talking Therapy Reliable Recovery	Dec-25	48.0%	45.6%	43.0%	✗
Talking Therapy Reliable Improvement	Dec-25	70.0%	69.2%	67.0%	✗
CYP Access	Dec-25	14485	10705	21600	✗
CYP ED Routine	Dec-25	100.0%	71.0%	84.0%	✗
Learning Disability and Autism					
Adult Inpatients	Jan-26	31	33	36	✗
Summary: More GP appointments have been delivered than planned during December. Derby and Derbyshire are delivering to more plan areas than Lincolnshire and Nottingham and Nottinghamshire.					

Key Messages:

Focus is required across all in-hospital delivery, including understanding demand and commissioned capacity, as well as clear focus on increasing commissioned dental activity and patient uptake.

Table 3: Derby and Derbyshire, Lincolnshire, Nottingham and Nottinghamshire ICBs

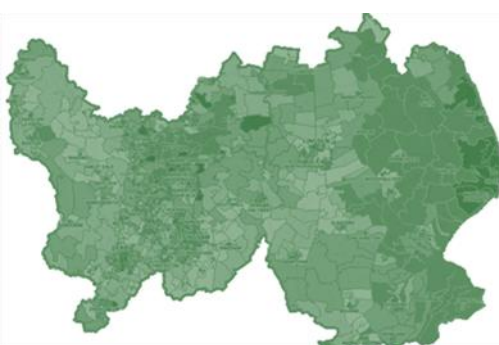
NHS

Provider Performance Overview

NHSE NOF Assessments Q2

NHSE Quarter 3 Programme Tiering

Organisation	Type	Q2 25-26 NOF Rating		Recovery Support		Elective	Diagnostics	Cancer	UEC
Nottinghamshire Healthcare (NHT)	MH & Comm	4*	↔	Y	↔	-	-	-	-
Nottingham University Hospitals (NUH)	Acute	4*	↓	Y	↔	2	2	1	2
United Lincolnshire Hospitals (ULTH)	Acute	4	↔	N	↔	2	2	2	1
Lincolnshire Community Health Services (LCHS)	Comm	4	↓	N	↔	-	-	-	-
University Hospitals of Derby and Burton (UHDB)	Acute	3	↑	N	↔	2	2	2	3
Chesterfield Royal Hospital (CRH)	Acute	3	↔	N	↔	2	2	2	3
Sherwood Forest Hospitals (SFH)	Acute	3	↔	N	↔	2	4	4	3
Lincolnshire Partnership (LPFT)	MH	3	↔	N	↔	-	-	-	-
Derbyshire Healthcare (DHcFT)	MH	3	↑	N	↔	-	-	-	-
Derbyshire Community Health Services (DCHS)	Comm	1	↑	N	↔	-	-	-	-
East Midlands Ambulance Service	Amb	1	↔	N	↔	-	-	-	-



Oversight Arrangements	Key: NOF Ratings	Key: Programme Tiering (distance from plan)
NHSE Led IOAG, ICB attend	NOF4* - National Conditions Applied	Significant failure - supports RSP 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

Service Delivery Performance Report

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

DLN Service Delivery Report - Contents

Item	Contents	Page Number
1.	Performance Headlines	3
2.	Service Delivery - Latest Performance	4
3.	Activity v Plan – Latest Performance	5
4.	Elective	6 - 9
5.	Cancer	10 - 12
6.	Diagnostics	13 - 14
7.	Urgent Care	15 - 16
8.	Primary Care	17
9.	Community	18
10.	Mental Health	19
11.	LD & A	20
12.	Seasonal Vaccinations	21 - 22
13.	Provider Oversight	23 - 24

1. 2025/26 Service Delivery – Performance Headlines

1. Elective Care & Waiting Times			
			• 18-Week RTT: All three ICBs are below plan in December 2025. Some providers (e.g. SFH) are below plan but have recovery plans in place
			• Long Waits (52+ Weeks): DDICB and NNICB are off plan for reducing long waits, with targeted actions underway. LICB are achieving the % of patients under 52 weeks. All ICBs are working to eradicate 65-week waits. NNICB risk due to PICS gynae patient transfers
			• PTL (Patient Tracking List): LICB and DDICB are better than plan , NNICB is above plan. Waiting lists in local NHS Providers remain challenging, with some providers seeing increases due to referral growth and reporting changes. Validation sprints and productivity programs are being implemented.
2. Cancer Pathways			
			• 28-Day Faster Diagnosis: Performance is below the plan target for LICB and NNICB. There is variation across the Cluster tumour sites, some increased capacity in key specialties.
			• 62-Day Treatment: Performance is below trajectory for all ICBs. Recovery plans focus on high-impact tumour sites, increased treatment capacity, and close monitoring by NHSE and ICBs. NUH is under Tier 1 NHS oversight.
3. Diagnostics			
			• 6-Week Waits (DM01): Performance is significantly off plan in LICB, and static under plan for DDICB and NNICB. Audiology, MRI, and endoscopy are particularly challenging. Improvement plans include increasing capacity, insourcing, and targeted support for underperforming specialties, although currently these do not all deliver back to ICB planned levels.
4. Urgent and Emergency Care			
			• 4-Hour ED Waits: System performance is below national plans for all three ICBs, with all acute trusts facing challenges, for ED performance and ambulance waits. Winter plans and targeted actions (e.g., flow improvements, handover protocols) are in place to support recovery. Providers submitted improvement plans to NHSE back to planned levels. NUH and ULTH are under Tier 1 NHSE oversight.
5. Primary, Community, and Mental Health Services			
			• Primary Care: ICBs are under plan for urgent dental appointments, with additional incentive schemes and public engagement being rolled out to improve appointment uptake . Pharmacy first appointments are performing well in DDICB and LICB, however risk to year end due to stepped increase required. GP appointments are higher than plan in December for all ICBs. All ICBs are under plan on dental UDAs, with actions to re-direct activity units in place.
			• Community Services: DDICB expect to deliver to March 2026 plan. LICB has a risk in relation to ULTH Community Paediatrician services, as ICB business case has not been taken forward. NNICB risks relate to NHT Community Paediatrics OT and SLT services, due to staffing issues and whole service pathway redesign required for SLT, extended waits are increasing.
			• Mental Health & LD&A: Access targets are being met in several areas, but challenges persist in out-of-area placements and acute bed utilisation. Recovery plans are in place for talking therapies and crisis services. LD&A inpatient numbers are above trajectory, but health checks are ahead of plan. Efforts focus on reducing inpatient reliance and improving neurodiversity assessment waits.
6. Vaccinations			
			• Seasonal Vaccinations: Flu uptake is strong in older and at-risk groups but below target in young children and pregnant women. Communication and outreach efforts are ongoing to address low uptake areas and support school-based programs.
7. NHS Oversight Framework Q2			
			• Q2 assessments have led to NUH and LCHS being down-rated to NOF 4. UHDB, DHFT and DCHS have had improved ratings. Recovery support remains for NUH and NHT.

2. DLN Service Delivery v Operational Plans – @ March 2026 report

DLN Cluster Service Delivery Dashboard v Plan					Derby and Derbyshire ICB			Lincolnshire ICB			Nottingham and Nottinghamshire ICB		
Acute	Metric	Pop / Provider	% / Value	Period	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Planned Care	<18 week wait for 1st OP	ICB Pop	%	Jan-26	69.3%	60.6%	-8.7% ✗	64.6%	59.5%	-5.1% ✗	72.9%	63.3%	-9.6% ✗
	<18w waits RTT	ICB Pop	%	Dec-25	61.9%	59.0%	-2.9% ✗	58.3%	56.3%	-2.1% ✗	62.3%	59.3%	-3.0% ✗
	>52 week waits	ICB Pop	%	Dec-25	1.4%	2.3%	0.9% ✗	1.4%	1.2%	-0.2% ✓	1.2%	2.1%	0.9% ✗
	>65 week wait	ICB Pop	Value	Dec-25	0	35	35 ✗	0	19	19 ✗	0	45	45 ✗
	PTL (Waiting List)	ICB Pop	Value	Dec-25	118,217	116,948	-1,269 ✓	112,551	107,206	-5,345 ✓	125,327	133,651	8,324 ✗
Cancer	<28 Day Faster Diagnosis	ICB Pop	%	Dec-25	77.7%	78.1%	0.4% ✓	79.5%	73.9%	-5.6% ✗	77.1%	69.8%	-7.3% ✗
	<31 day	ICB Pop	%	Dec-25	92.0%	90.7%	-1.3% ✗	94.4%	87.6%	-6.8% ✗	91.6%	92.9%	1.3% ✓
	<62 Day Referral to Treatment	ICB Pop	%	Dec-25	73.2%	65.1%	-8.1% ✗	72.9%	63.4%	-9.5% ✗	67.6%	62.1%	-5.5% ✗
	LGI Fit Test	ICB Pop	%	Dec-25	81.2%	82.3%	1.1% ✓	79.1%	87.9%	8.8% ✓	79.0%	78.3%	-0.7% ✗
Diagnostics	Planning 9 Modalities > 6ww	ICB Pop	%	Dec-25	18.9%	25.5%	6.6% ✗	11.7%	39.8%	28.0% ✗	8.4%	24.7%	16.3% ✗
Urgent Care	<4 hour wait ED	ICB Prov	%	Jan-26	77.8%	66.2%	-11.6% ✗	73.0%	72.5%	-0.5% ✗	70.9%	64.0%	-6.9% ✗
	>12 hour wait from arrival ED	ICB Prov	%	Jan-26	7.0%	18.8%	11.8% ✗	11.1%	18.0%	6.9% ✗	10.7%	16.5%	5.8% ✗
	>45m Ambulance Handovers	ICB Prov	%	Jan-26	0.0%	21.5%	21.5% ✗	0.0%	27.6%	27.6% ✗	0.0%	26.5%	26.5% ✗
	Cat 2 Mean Response Time	ICB Prov	Value	Jan-26	00:36:07	00:49:34	00:13:27 ✗	00:30:00	01:05:35	00:35:35 ✗	00:36:07	00:44:07	00:08:00 ✗
Primary Care	GP Appointments	ICB Pop	Value	Dec-25	586,582	607,444	20,862 ✓	442,507	480,571	38,064 ✓	620,105	694,493	74,388 ✓
	Units of Dental Activity (UDAs)	ICB Pop	Value	Dec-25	108,862	58,712	-50150 ✗	68,588	65,142	-3446 ✗	150,273	123,383	-26,890 ✗
	Urgent Dental Activity	ICB Pop	Value	Dec-25	6,371	5,848	-523 ✗	3,973	3,447	-526 ✗	8,022	6,738	-1,284 ✗
	Pharmacy First	ICB Pop	Value	Dec-25	7,891	8,375	484 ✓	5,886	7,746	1860 ✓	10,169	7,032	-3137 ✗
Community	>52ww - Adult	ICB Pop	Value	Dec-25	587	0	-587 ✓	59	0	-59 ✓	0	2	2 ✓
	>52ww - CYP	ICB Pop	Value	Dec-25	2,371	2,266	-105 ✓	23	701	678 ✗	12	206	194 ✗
Mental Health	Inappropriate Out of Area Inpatients	ICB Pop	Value	Dec-25	5	4	-1 ✓	2	0	-2 ✓	0	10	10 ✗
	Inpatient Mean Length Of Stay	ICB Pop	Value	Dec-25	44	67	23 ✗	56	32	-24 ✓	55	61	6 ✗
	Individual Placement Support	ICB Pop	Value	Dec-25	783	805	22 ✓	695	685	-10 ✗	1300	1420	120 ✓
	Early Intervention Psychosis	ICB Pop	%	Dec-25	60.0%	75.0%	15.0% ✓	60.0%	73.0%	13.0% ✓	60%	81.8%	21.8% ✓
	Talking Therapy Reliable Recovery	ICB Pop	%	Dec-25	47.2%	48.0%	0.8% ✓	47.1%	45.6%	-1.6% ✗	50%	43.0%	-7.0% ✗
	Talking Therapy Reliable Improvement	ICB Pop	%	Dec-25	68.0%	70.0%	2.0% ✓	70.0%	69.2%	-0.8% ✗	68%	67.0%	-1.0% ✗
	CYP Access	ICB Pop	Value	Dec-25	14,535	14,485	-50 ✗	11,277	10,705	-572 ✗	20475	21600	1125 ✓
	CYP ED Routine	ICB Pop	%	Dec-25	95%	100.0%	5.0% ✓	95%	71.0%	-24.0% ✗	95%	84%	-11.0% ✗
LD&A	Adult Inpatients	ICB Pop	Value	Jan-26	28	31	3 ✗	26	33	7 ✗	32	36	4 ✗
	CYP Inpatients	ICB Pop	Value	Jan-26	3	3	0 ✗	1	1	0 ✗	2	1	-1 ✓
	Annual Health Checks	ICB Pop	Value	Jan-26	661	621	-40 ✗	2,665	2,848	183 ✓	2,196	4,037	1,841 ✓
All data is taken from National Published Data Sources except for LD&A					Key: Orange = plan has not been achieved / Blue = plan has been achieved								

3. DLN Activity v Operational Plans – December 2025

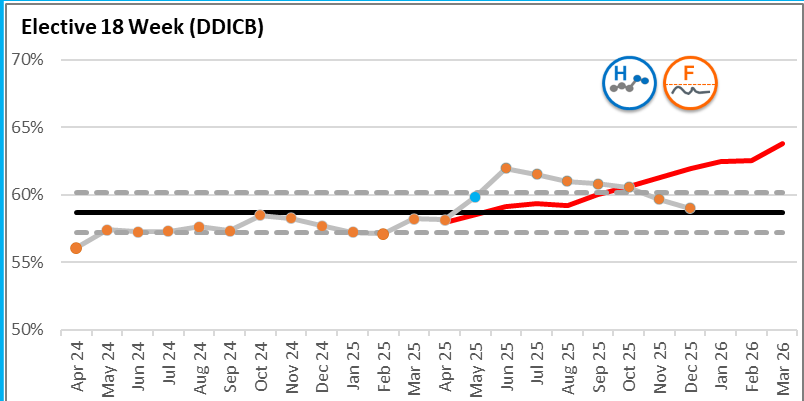
Derby and Derbyshire ICB Population Metric Full Name	December 2025 Only				Dec25 v Dec24		April 2025 - December 2025				YTD 25/26 v YTD 24/25	
	Plan	Actual	Variance	% Variance	Variance	% Variance	Plan	Actual	Variance	% Variance	Variance	% Variance
A&E Attendances (All types: UHDB, CRH, DCHS, DUCC)	49,547	52,022	2,475	5.0%	-4,097	-7.3%	440,182	504,377	64,195	14.6%	36,067	7.7%
Elective Ordinary	1,858	2,046	188	10.1%	132	6.9%	17,516	19,134	1,618	9.2%	-91	-0.5%
Day Cases	11,902	13,606	1,704	14.3%	376	2.8%	111,926	131,409	19,483	17.4%	1,811	1.4%
Diagnostics (9 key modalities)	41,783	41,649	-134	-0.3%	4,448	12.0%	381,407	388,156	6,749	1.8%	43,175	12.5%
Outpatients 1st (Spec Acute)	33,139	31,162	-1,977	-6.0%	327	1.1%	308,751	299,565	-9,186	-3.0%	-5,824	-1.9%
Outpatients Follow-ups (Spec Acute)	74,090	71,179	-2,911	-3.9%	1,788	2.6%	692,937	677,023	-15,914	-2.3%	-5,961	-0.9%

Lincolnshire ICB Population Metric Full Name	December 2025 Only				Dec25 v Dec24		April 2025 - December 2025				YTD 25/26 v YTD 24/25	
	Plan	Actual	Variance	% Variance	Variance	% Variance	Plan	Actual	Variance	% Variance	Variance	% Variance
A&E Attendances (All types: ULTH, LCHS, SMG)	30,820	29,950	-870	-2.8%	-552	-1.8%	273,404	268,655	-4,749	-1.7%	4,975	1.9%
Elective Ordinary	1,327	1,481	154	11.6%	177	13.6%	13,567	13,503	-64	-0.5%	-153	-1.1%
Day Cases	8,510	9,025	515	6.1%	-11	-0.1%	86,701	87,728	1,027	1.2%	-1,891	-2.1%
Diagnostics (9 key modalities)	35,608	35,146	-462	-1.3%	2,097	6.3%	347,058	339,300	-7,758	-2.2%	28,499	9.2%
Outpatients 1st (Spec Acute)	21,756	22,570	814	3.7%	-455	-2.0%	224,246	223,100	-1,146	-0.5%	-5,786	-2.5%
Outpatients Follow-ups (Spec Acute)	37,009	40,263	3,254	8.8%	200	0.5%	375,511	389,463	13,952	3.7%	-4,530	-1.1%

Nottingham and Nottinghamshire ICB Population Metric Full Name	December 2025 Only				Dec25 v Dec24		April 2025 - December 2025				YTD 25/26 v YTD 24/25	
	Plan	Actual	Variance	% Variance	Variance	% Variance	Plan	Actual	Variance	% Variance	Variance	% Variance
A&E Attendances (All types: NUH+SFH)	41,678	40,642	-1,036	-2.5%	-255	-0.6%	375,886	370,985	-4,901	-1.3%	6,319	1.7%
Elective Ordinary	1,980	2,174	194	9.8%	-56	-2.5%	20,074	20,292	218	1.1%	30	0.1%
Day Cases	13,674	13,811	137	1.0%	471	3.5%	136,834	134,323	-2,511	-1.8%	-963	-0.7%
Diagnostics (9 key modalities)	45,748	44,260	-1,488	-3.3%	1,535	3.6%	390,274	404,053	13,779	3.5%	-2,381	-0.6%
Outpatients 1st (Spec Acute)	30,374	26,782	-3,592	-11.8%	902	3.5%	302,212	265,981	-36,231	-12.0%	-15,069	-5.4%
Outpatients Follow-ups (Spec Acute)	62,984	59,535	-3,449	-5.5%	2,245	3.9%	619,450	577,797	-41,653	-6.7%	-21,886	-3.6%

4a. Elective – 18week RTT

Derby and Derbyshire ICB

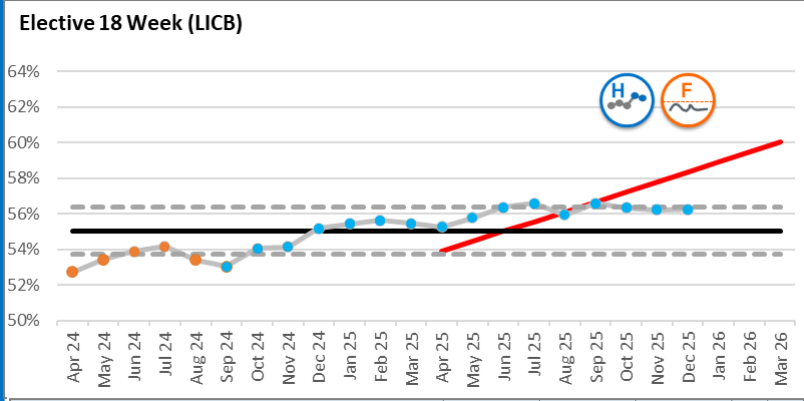


KPI	Latest month	Measure	Plan	Variation	Assurance
Elective 18 Week (DDICB)	Dec 25	59.0%	61.9%		
Elective 18 Week (CRH)	Dec 25	53.7%	60.0%		
Elective 18 Week (UHD)	Dec 25	58.1%	57.6%		

As an ICB the improvement in spring has been followed by a gradual deterioration over recent months, now landing just below plan at 59.0%.

CRH have followed the ICB trend, achieving 53.7% in December, which is below plan. UHDB had been seeing a gradual improvement, dropping to 58.1% in December, but this is still better than plan.

Lincolnshire ICB

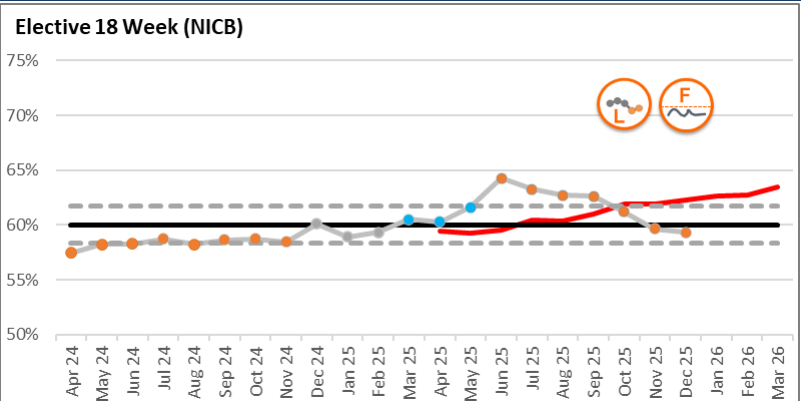


KPI	Latest month	Measure	Plan	Variation	Assurance
Elective 18 Week (LICB)	Dec 25	56.3%	58.3%		
Elective 18 Week (ULTH)	Dec 25	54.1%	58.3%		

At system level, at the end of December 56.3% of patients waiting to start treatment were under 18 weeks; which is 2% below plan.

Delivery of the ULTH RTT target for March 26 (60% of patients treated within 18 weeks) remains challenging. December actual for ULTH was 54.1% against plan of 58.3% (off-plan by 4.2%). This will however improve as long-waiters reduce and patients are moved over from the ASI list to the total waiting list, resulting in more patients sitting in the under (rather than over) 18 week wait cohort.

Nottingham and Nottinghamshire ICB



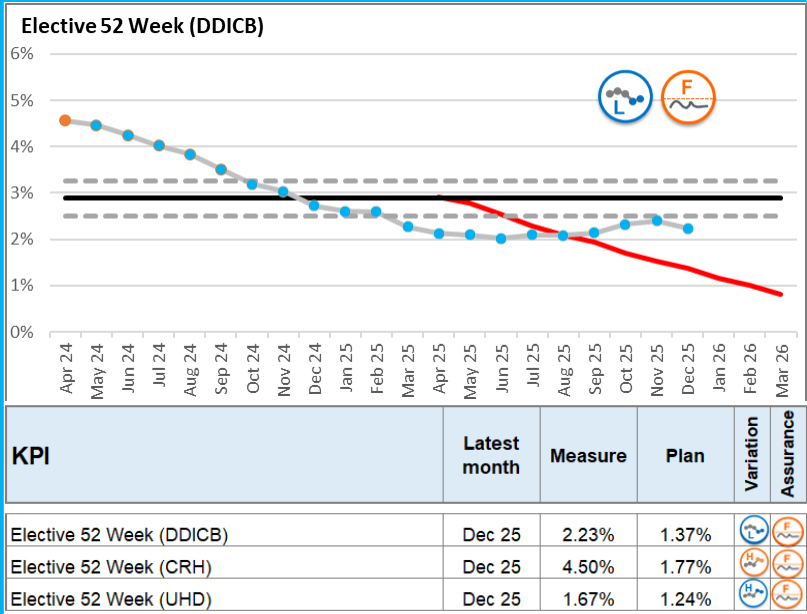
KPI	Latest month	Measure	Plan	Variation	Assurance
Elective 18 Week (NICB)	Dec 25	59.3%	62.3%		
Elective 18 Week (NUH)	Dec 25	57.2%	61.3%		
Elective 18 Week (SFH)	Dec 25	59.3%	66.2%		

In December 2025 NNICB failed to achieve the RTT 18ww % plan for the third consecutive period, 59.3% of pathways were below 18 weeks at the end of the month, which was 3.0% below the plan of 62.3%.

NUH and SFH also both did not achieve the planned performance at the end of December 2025. NUH had 57.2% of RTT pathways under 18 weeks at the end of the month, which is 4.1% below the plan of 61.3%. 59.3% of RTT pathways at SFH were waiting under 18 weeks at the end of the month, this is 6.9% under the plan of 66.2%.

4b. Elective- > 52 weeks

Derby and Derbyshire ICB

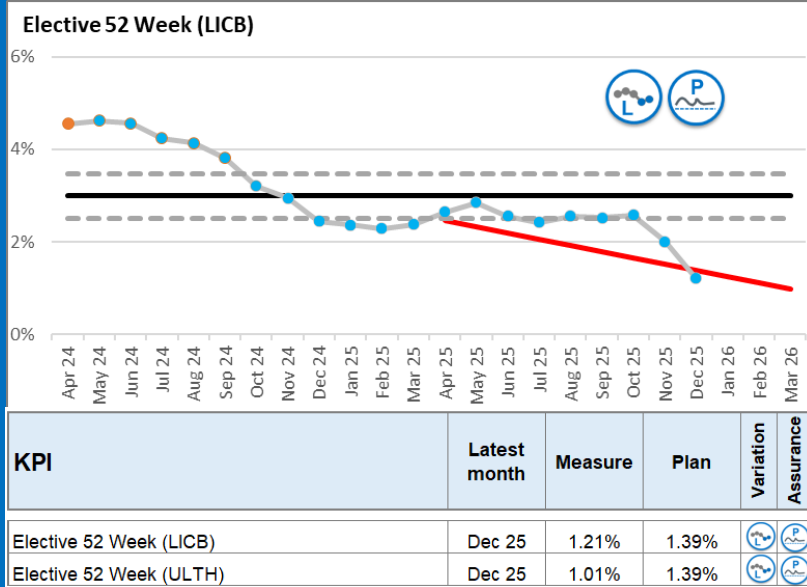


Proportions of 52 week waiters are fluctuating as a system.

At CRH the proportion of long waits (>52-weeks) has reduced to 4.5%, after a trend of gradual increases.
At UHDB the proportion of long waits (>52-weeks) remains at 1.7%.

Both trusts have numbers that are higher than planned, but they continue to validate the longest waiting patients and some patient treatments have been outsourced to Independent Sector providers.

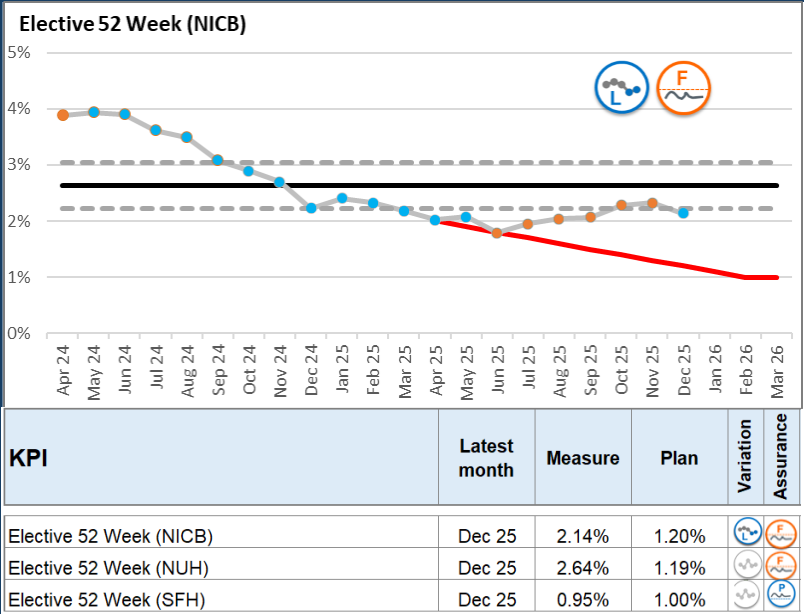
Lincolnshire ICB



52-week waits are now back on plan with a December validated position of 1.21% (0.18% below plan). Focus now is on sustainability (particularly out-patient improvements) combined with further short-term capacity increases via internal and outsourced clinics to achieve the March target of <1% of TWL.

ULTH concluded December with 1.01% of their total waiting list, which is 0.38% below plan. Plans to maintain this performance and achieve the 52-week performance target for March are currently being worked through.

Nottingham and Nottinghamshire ICB



At the end of December NNICB failed to achieve the plan of 1.20% of patients on the total waiting list waiting over 52 weeks with performance at 2.14%, which is 2,859 patients. Of the 2,859 waiting over 52 weeks, 2,083 were waiting at NUH, 301 waiting at Doncaster & Bassetlaw Hospitals (DBH) and 287 at SFH.

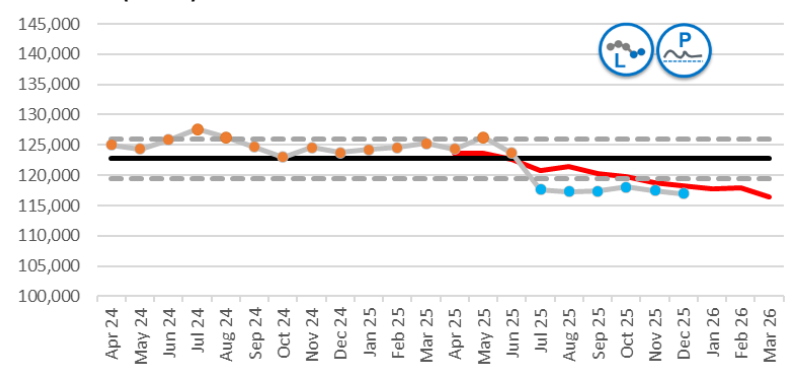
NUH performance is below the plan with 2.64%, which is 2,507 patients waiting over 52 weeks, against a plan of 1.19%. Of the 2,507 patients, 475 are waiting for Dermatology, 452 Gynaecology, 405 Other Medical Services, 279 ENT, 241 T&O. The remaining patients were waiting across a range of specialties.

SFH achieved the 1% plan with performance at 0.95%, which is 342 patients waiting beyond 52 weeks.

4c. Elective -> PTL

Derby and Derbyshire ICB

Elective PTL (DDICB)



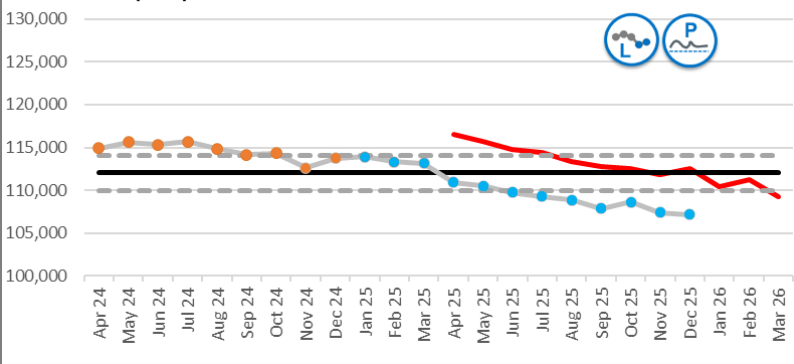
KPI	Latest month	Measure	Plan	Variation	Assurance
Elective PTL (DDICB)	Dec 25	116948	118217		
Elective PTL (CRH)	Dec 25	28841	25420		
Elective PTL (UHD)	Dec 25	96824	103666		

CRH's total incomplete waiting list is decreasing but is higher than the same period last year and higher than plan.

UHDB's total incomplete waiting list increased but is 10.8% lower than the same period last year, which is better than plan.

Lincolnshire ICB

Elective PTL (LICB)



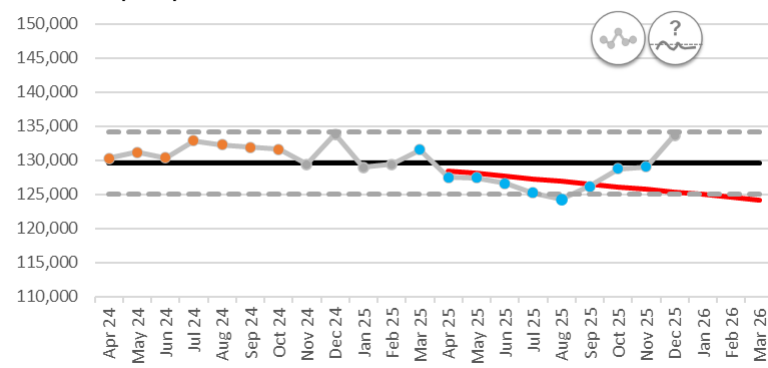
KPI	Latest month	Measure	Plan	Variation	Assurance
Elective PTL (LICB)	Dec 25	107206	112551		
Elective PTL (ULTH)	Dec 25	66860	69866		

December performance (107,206) improved on November position and is better than plan (112,551).

ULTH has around 5,000 patients on its Appointment Slot Issues (ASI) list, which are not included in the Total Waiting List (TWL) number above. However, some of these patients will not transfer to the TWL due to factors such as duplicate records or patients listed with multiple providers.

Nottingham and Nottinghamshire ICB

Elective PTL (NICB)



KPI	Latest month	Measure	Plan	Variation	Assurance
Elective PTL (NICB)	Dec 25	133651	125327		
Elective PTL (NUH)	Dec 25	95019	80001		
Elective PTL (SFH)	Dec 25	35975	32928		

The NNICB waiting list volume of 133,651 exceeded the planned level of 125,327 during December 2025, which is 8,324 pathways higher. More recent unvalidated local data shows that the waiting list has reduced to approximately 130,000 against a plan of 124,948 at the end of January 2025.

NUH and SFH are also not meeting the planned waiting list levels. With 95,019 pathways NUH are exceeding the plan of 80,001 by 15,018. SFH have a plan of 32,928 and are above this by 3,047, at 35,975 pathways.

4d. Elective – Actions and Recovery

Derby and Derbyshire

- At **CRH**, the incomplete waiting list in December is the same as December 2024 and December actual compared with Dec plan for 2025 is 12% above plan. The proportion of long waits (>52 weeks) remains above trajectory and performance against the 18-week standard remains below plan (6.3% lower than plan). CRH is forecast to report 5x 65-week breaches at the end of February, reducing to zero from March, supported by targeted capacity deployment and strengthened demand-management actions and Q4 sprint.
- At **UHDB**, the incomplete waiting list is 12% lower than in December 2024 and 7% below plan for Dec 2025. The proportion of long waits (>52 weeks) is slightly above trajectory, however the 18-week performance is better than plan. UHDB is forecasting 57x 65-week breaches at the end of February, with March projections awaited.
- System-wide, **DDICB** continues to report 65-week breaches into 2026, with weekly patient-level monitoring through NHS England . Both trusts are maximising Q4 elective sprint opportunities and accelerating demand-management initiatives - including enhanced Advice & Guidance - to stabilise long waits, improve patient flow and strengthen delivery trajectories.

Lincolnshire

- **ULTH** moved into Tier 2 for elective performance in Q3 based on RTT 18-week performance and 52 week waits. 52-week waits are now back on plan with a December validated position of 678 (293 below plan). Focus now is on sustainability (particularly out-patient improvements) combined with further short-term capacity increases via internal and outsourced clinics to achieve the March target of <1% of Total Waiting List. ULTH are also taking part in the Q4 elective sprint.
- **Delivery of the ULTH RTT target** for March 26 (60% of patients treated within 18 weeks) remains challenging. December actual for ULTH was 54.1% against plan of 58.3% (off-plan by 4.2%). This will however improve as long-waiters reduce and patients are moved over from the ASI list to the total waiting list, resulting in more patients sitting in the under (rather than over) 18 week wait cohort.
- **System level RTT** performance is also 2% under plan (56.3 % against 58.3%) but all main Providers have recovery plans in place.

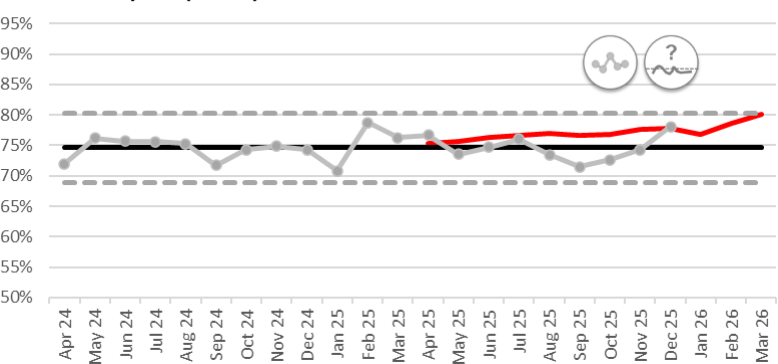
Nottingham and Nottinghamshire

- **ICB failed to deliver the December plan** for 18ww %, 52ww %, and PTL size. 65w reported 45 breaches, with 19 at D&B relating to T&O (11) and Audiology (8); and 16 at NUH relating to Gynaecology (10) (see detail below), T&O (3), Dermatology (2), and Urology (1)
- **PICS Gynaecology** Following the return of the community service contract previously managed by PICS, there is a backlog of gynaecology patients within the independent sector and local NHS. Patients have primarily chosen to be seen at Woodthorpe, Park and NUH. Regular weekly meetings are being conducted with independent sector providers, and patient-level tracking systems have been implemented to ensure timely treatment for all affected patients. Due to the transfer of patients, providers have inherited some lengthy waiting lists and are now working to offer treatment as quickly as possible.
- **NUH focus is on improving PTL data quality.** Full review of PTL for patients waiting 64 weeks and down (patients over 64 weeks are validated weekly) to take place late January and early February, 6-7000 patients to be validated per week. Expectation is that every patient waiting over 18 weeks to be validated by the end of March 2026. Recent unvalidated data shows the PTL has reduced to approximately 93,000 at the week ending 15/02/2026
- **SFHT have submitted plans to recover the 18ww % position.** Actions include increasing 1st seen activity, PTL cleansing programme filling of validation team staffing gaps

5a. Cancer – 28 Day Faster Diagnosis Standard

Derby and Derbyshire ICB

Cancer 28 Day FDS (DDICB)



KPI	Latest month	Measure	Plan	Variation	Assurance
Cancer 28 Day FDS (DDICB)	Dec 25	78.1%	77.7%		
Cancer 28 Day FDS (CRH)	Dec 25	76.1%	72.8%		
Cancer 28 Day FDS (UHD)	Dec 25	78.8%	79.1%		

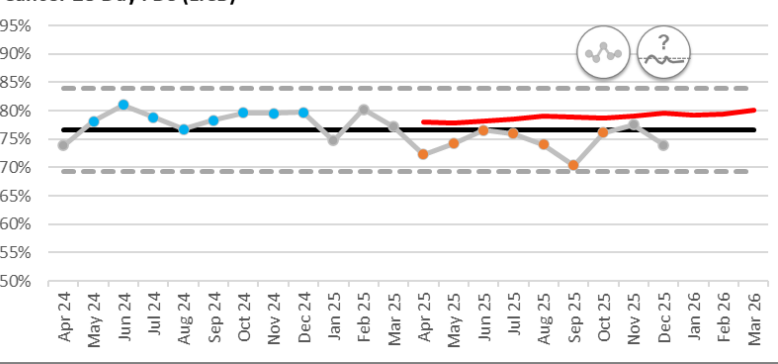
Earlier in the year, the CRH had been delivering 75% performance but dropped during Autumn. However, December saw improvement, achieving 76.1%, which is better than the 72.8% plan.

UHDB have also seen improvement, achieving 78.8% for December – however they have a higher plan of 79.1% that hasn't been reached.

The most challenging tumour sites across both Trusts are gynaecological, gastrointestinal and urological cancers.

Lincolnshire ICB

Cancer 28 Day FDS (LICB)



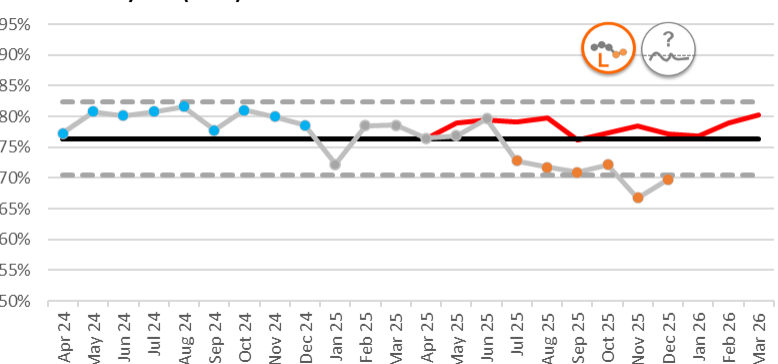
KPI	Latest month	Measure	Plan	Variation	Assurance
Cancer 28 Day FDS (LICB)	Dec 25	73.9%	79.5%		
Cancer 28 Day FDS (ULTH)	Dec 25	72.9%	79.5%		

28 Day FDS was off track in December; the validated position was 73.9% against a trajectory of 79.5%. Breast remains a current concern – rise in referrals, reduced workforce and mammogram machine failures have impacted multiple clinics.

Performance is expected to improve further in the next 4 weeks and further opportunities being identified in the diagnostics stage to improve performance.

Nottingham and Nottinghamshire ICB

Cancer 28 Day FDS (NICB)



KPI	Latest month	Measure	Plan	Variation	Assurance
Cancer 28 Day FDS (NICB)	Dec 25	69.8%	77.1%		
Cancer 28 Day FDS (NUH)	Dec 25	60.3%	76.5%		
Cancer 28 Day FDS (SFH)	Dec 25	81.7%	78.0%		

Performance in the 28-day Faster Diagnosis Standard (FDS) in December was 69.8% and did not achieve the 75% standard and the operational plan of 77.1%.

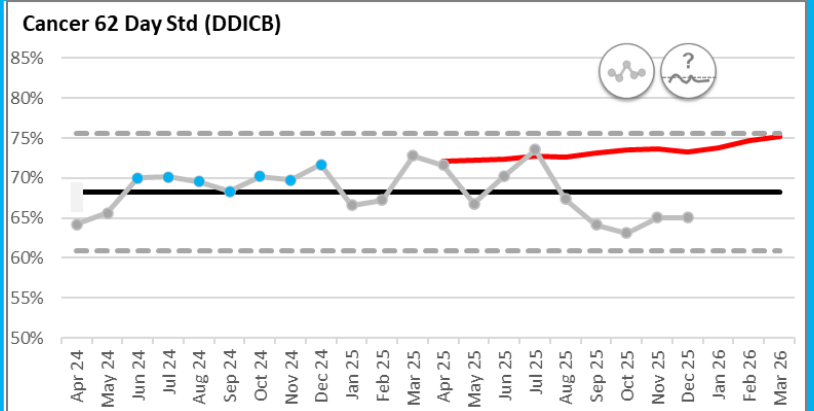
NUH January forecasting 55.4% v 75.7% plan and 72.5% revised local plan.

NUH remain in Tier 1 oversight with NHSE.

5b. Cancer – 62 Day Standard

Derby and Derbyshire ICB

Cancer 62 Day Std (DDICB)



KPI	Latest month	Measure	Plan	Variation	Assurance
Cancer 62 Day Std (DDICB)	Dec 25	65.1%	73.2%	⚡	⚡
Cancer 62 Day Std (CRH)	Dec 25	69.3%	70.6%	⚡	⚡
Cancer 62 Day Std (UHD)	Dec 25	63.1%	74.0%	⚡	⚡

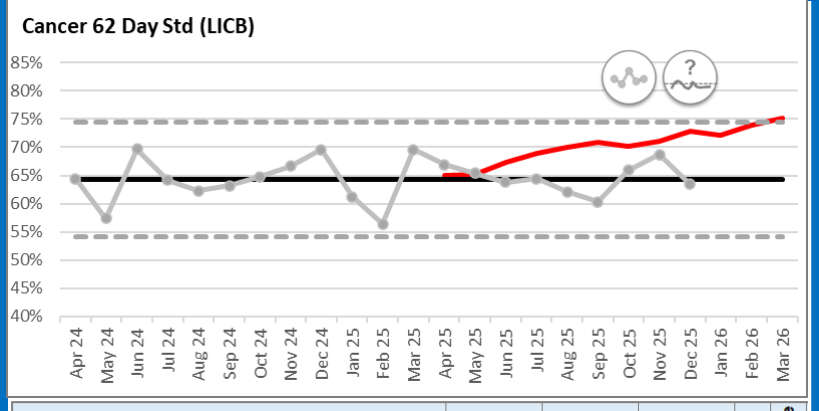
CRH saw an improvement during Quarter 3, achieving 69.5% in December. This remains below plan.

UHDB also remain below plan and have seen a gradual deterioration in performance, achieving 63.0% for December.

Variation persists in treatment times by tumour sites – where lower gastrointestinal, gynaecological and urological cancers are experiencing the longest treatment delays. This remains a priority for sustained improvement at both Trusts.

Lincolnshire ICB

Cancer 62 Day Std (LICB)



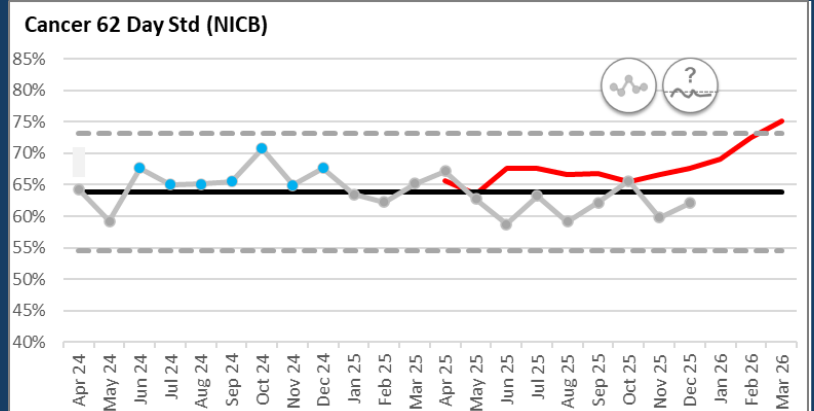
KPI	Latest month	Measure	Plan	Variation	Assurance
Cancer 62 Day Std (LICB)	Dec 25	63.4%	72.9%	⚡	⚡
Cancer 62 Day Std (ULTH)	Dec 25	64.0%	71.2%	⚡	⚡

62-day continues to perform below plan and be the most challenging of the standards, achieving 63.4% at system level against 72.9% plan. Colorectal pathways remain the area of greatest concern due to a high volume of patients over 62 days (125 patients)

United Lincolnshire Hospitals Trust performance remains off the planned trajectory with a significant impact following the festive break; the December validated position was 64% against 71.2% plan.

Nottingham and Nottinghamshire ICB

Cancer 62 Day Std (NICB)



KPI	Latest month	Measure	Plan	Variation	Assurance
Cancer 62 Day Std (NICB)	Dec 25	62.1%	67.6%	⚡	⚡
Cancer 62 Day Std (NUH)	Dec 25	60.8%	66.9%	⚡	⚡
Cancer 62 Day Std (SFH)	Dec 25	63.6%	69.7%	⚡	⚡

62-day performance did not achieve the operational plan in December with 62.1% against a plan of 67.6%. Challenges continue with Gynaecology, Breast and Urological at NUH.

The combined backlog for the system remains high at 620 patients against a plan of 425. Backlogs at NUH have started to reduce and at 15/02/2026 are 497 against a plan of 370, an improvement trajectory is being worked through as part of tiering discussions. SFH have 76 patients on the cancer backlog against a plan of 55 patients.

5c. Cancer – Actions and Recovery

Derby and Derbyshire

- **28-day Faster Diagnosis:** CRH's validated position up to November was 73.3%. Lower than October with breaches in LGI, Urology and skin, December's position shows improvement, although performance in January is expected to dip due to patient choice and Christmas NY. UHDB were just 0.2% below plan at 78.6% In December with improvements in LGI, skin and urology but similar to CRH expect a deterioration due to Christmas and are predicting 74.1% v's 78% in their plan.
- **62-day & 31 day standards:** December 62d performance at CRH was slightly below trajectory with constraints in IPS's diagnostic capacity and OPD delays; however, 31d was above plan at 91.3% and an improvement of 4.4% from November. UHDB saw a positive improvement in their 31d position in December at 93.9% v's 92.1% plan and forecast 91% in January. Unfortunately 62d performance was well below plan at 62.3% with poor performance in urology, breast, LGI and haematology.
- **System Actions:** The acute trusts continue to work with EMCA through Days Matter to accelerate recovery. CRH commenced some additional capacity with insourcing for breast, LGI, urology and skin as well as Trust-wide PTL governance cycle. UHDB has received additional funding via EMCA and NHSE to support increased capacity in gynae and improvement/transformation plans for histopathology, including outsourcing and project team to review pathways and to introduce transformation initiatives.

Lincolnshire

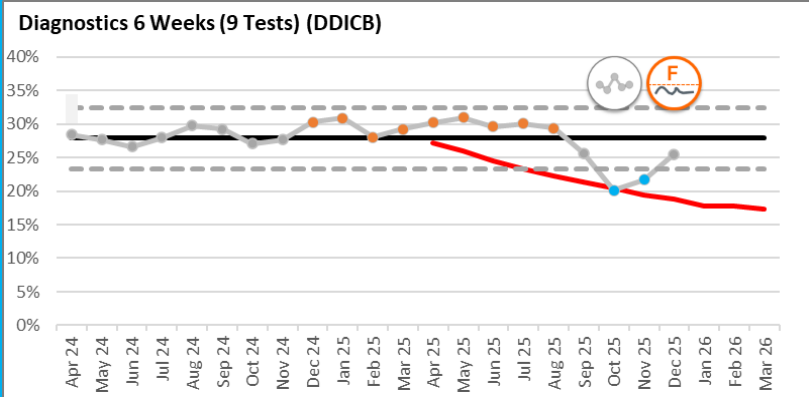
- **28-day Faster Diagnosis:** The greatest risk to 28 FDS is breast performance at present, they have lost a significant amount of in week capacity for a number of reasons; workforce, increased referrals and mammogram machine failure. Additional weekend clinics have been funded until March. Recovery trajectories get us back on track to meet 80% in March. Following the Colorectal CRG meetings, colorectal are showing an increased FDS performance, highlighting the positive changes made.
- **31-day Combined Treatment Standard:** The surgical specialities are bringing down performance. Urology Locum started early January, and interviews have taken place for 2 substantive surgeon, increasing by one. Colorectal are putting in place additional robotic list to improve their 31 day TAT. Working towards meeting 95% performance in March. Breast issues impacting performance, referral increases have also shown a cancer conversion rate increase to 13.6%, so more patients coming through for treatment. Theatres being reviewed.
- **62-day:** Due to breast performance it is unlikely that we will meet the original planned trajectory of 75%, current predictions are that we will meet 71.95% by March. If the expected improvements in 28 day and 31 day are achieved, 62 day performance should reach its trajectory.

Nottingham and Nottinghamshire

- **ICB** remains off track for FDS and 62-day and did not achieve plan in December. 31 day was above operational plan, but remains below standard, with Gynae, lung and urology remaining the most challenged tumour sites.
- **SFHT are achieving** both FDS and 31-day plan in December but were below plan for the 62-day target. SFHT have seen a deterioration in the Head & Neck pathway due to radiology capacity and an increase in the number of scans that are required to be repeated, additional theatre capacity has been obtained and a radiology consultant for Head & Neck and Lung is due to start in Q4.
- **NUH** remain under Tier 1 oversight arrangements for Cancer and have fortnightly meetings with NHSE to discuss recovery of the 62-day standard. In December NUH did not meet the FDS or 62-day standards but did achieve 31-day plan. A cancer improvement plan was developed by NUH to illustrate the steps to improve performance within the 62 standard and deliver 75% by March 2026. This is built upon increased delivery of treatments from 349 in September to 430 in March 2026. In December NUH delivered 401 treatments in total. NHSE are supporting NUH with a deep dive into the Urology pathway, focusing on capacity issues at the start of the pathway, diagnostic challenges and equipment issues

6a. Diagnostics – DM01 6 week waits

Derby and Derbyshire ICB



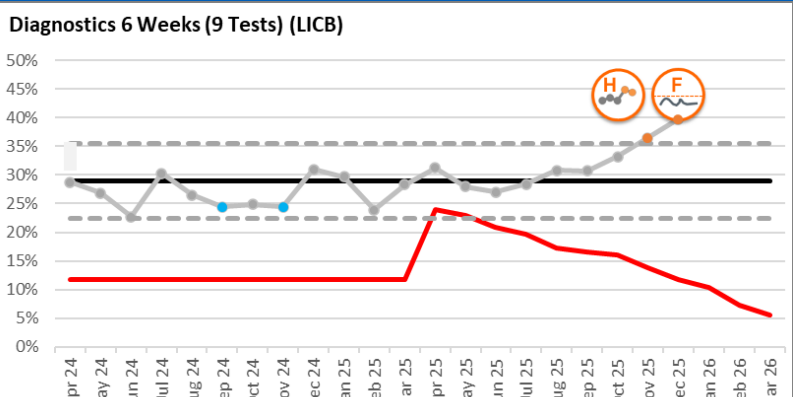
KPI	Latest month	Measure	Plan	Variation	Assurance
Diagnostics 6 Weeks (9 Tests) (DDICB)	Dec 25	25.5%	18.9%		

CRH had been performing better than plan but increased to 25.5% for December, which is worse than plan.

UHDB have not been achieving plan this year and seen a deterioration, achieving 26.7% for December.

There is continued development of Community Diagnostic Centres (CDCs) and targeted outsourcing for certain tests.

Lincolnshire ICB

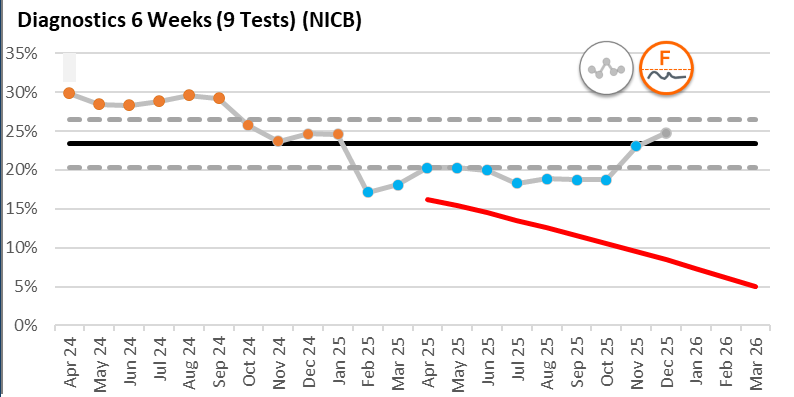


KPI	Latest month	Measure	Plan	Variation	Assurance
Diagnostics 6 Weeks (9 Tests) (LICB)	Dec 25	39.8%	11.7%		

The 6-week wait position continues to be significantly above plan, with the percentage of patients waiting longer than 6 weeks increasing by a further 3.3% in December and now sitting at 39.8%.

The main pressures this month are predominantly in audiology, MRI and also in NOUS due to the transfer of a significant number of patients from NWAFT who were already in breach of 6ww targets.

Nottingham and Nottinghamshire ICB



KPI	Latest month	Measure	Plan	Variation	Assurance
Diagnostics 6 Weeks (9 Tests) (NICB)	Dec 25	24.7%	8.4%		

In December, 24.7% of patients waited over 6 weeks for their diagnostic test, which was above the plan of 8.4% and the revised local plan of 12.0%. Granular performance monitoring continues at modality level, which highlights that the challenges are for MRI at NUH and CT Cardiac at SFH.

For the ICB population there were two modalities above the operational plans in December, which were DEXA and Echocardiography. DBHT have confirmed that all eight Adult Audiology staff are on track to complete their competencies by the end of February 2026. Approval has been given for insourcing; this will provide an additional 67 days of diagnostic activity and additional 60 days of hearing aid fittings which is planned to reduce the outstanding waiting list volume.

6b. Diagnostics – Actions and Recovery

Derby and Derbyshire

- **Diagnostic Waiting List:** The total Derbyshire diagnostic waiting list at the 2 acutes December 25 was 31,312 up by almost 300 from November 25. Total waiting list of patients waiting 6w+ stood at 8282 and 13w+ 2287. Total DMO1 performance was 73.6% (CRH 74.5% and 73.3% at UHDB).
- **6-week Performance & Challenged Modalities:** At UHDB Audiology, CT echo, CT, MRI and urodynamic have the highest PTL and the largest cohort of patients over 6w+ and 13w+. At CRH the most challenged modalities include audiology, colonoscopy, DEXA, MRI and NOUS.
- **Recovery Actions:** Vacancy freezes and reduction in WLI opportunities continues to impact performance and recovery, but we understand that there is some flexibility with recruitment now. Capital funding for circa £2m for both Trusts was confirmed this week, which will provide opportunities for improved service delivery in cardiology science, respiratory, audiology, vascular science and neurophysiology. Longer term capital funding bids for the system are just awaiting sign off from NHSE and include additional endoscopy space at CRH, ophthalmic diagnostic lanes and future plans for neighbourhood hub for the north of the county.

Lincolnshire

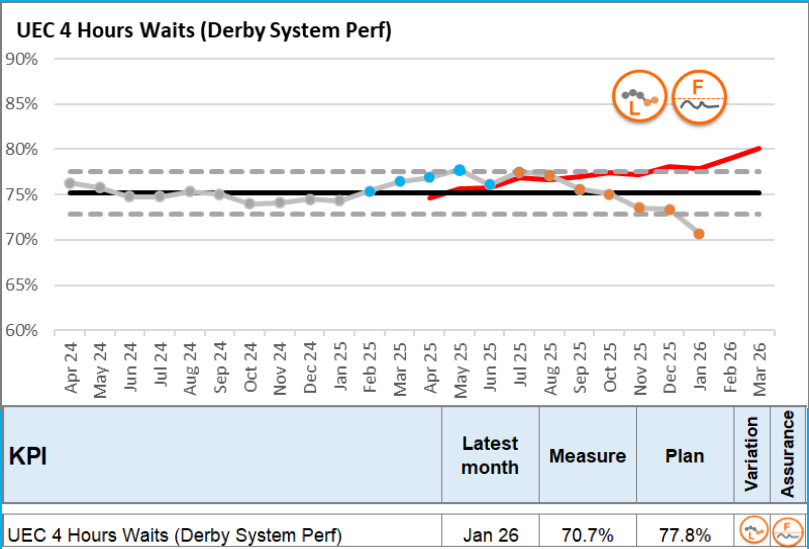
- **Diagnostics activity:** Main pressures are Endoscopy, NOUS & MRI. Endoscopy activity is being impacted by performance in our bordering systems, particularly NLAG and NWAFT – discussions & monitoring of these services is ongoing. NOUS & MRI - continues to be challenged by the availability of sonographers & the availability of booking team capacity. Additional activity is planned at ULTH through utilisation of a sub-contract with an ISP and increased use of CDC capacity; however these modalities will remain challenged until admin workforce pressures are resolved.
- **Diagnostics 6-ww's:** Main pressures are audiology, MRI and NOUS. Audiology improvement plans are being drafted between ULTH/Ernst and Young to review productivity opportunities. In addition, insourcing commenced in Nov 25 to support existing capacity. NOUS continues to be challenged by the available workforce & the transfer of Lincolnshire patients from NWAFT who were already in breach of 6wws. These patients are now being actively managed in order of clinical priority, although this is likely to negatively impact performance for the next few months until this backlog is reduced. MRI - Additional activity is planned in CDCs, however this modality will remain challenged until admin workforce pressures are resolved.

Nottingham and Nottinghamshire

- In December, NUH delivered 34.9% and SFH delivered 6.8% above 6 weeks. Provisional data for January shows an improvement in the SFH position to 5.7%, the NUH position has deteriorated to 36.3%.
- There are challenges around MRI at NUH, which are linked to the balance between delivering the required financial position and hitting the operational plans. the decision has been made to keep the NEMS MRI scanner online and to extend scanner hours at the Treatment Centre which will add a further 45 scans per day. Saturday and Sunday scanning for further mitigation is being considered, however there are workforce and transition challenges that need to be worked through. Despite the mitigations, growth in the 13ww backlog volume has continued for MRI to 1,268 patients, from 392 at the end of September. A sight-line trajectory for MRI performance and the impact of mitigations is being worked through to forecast a year-end position.
- At SFH, there is a managed deterioration of performance in DEXA in November and December due to hoist and new scanner installation, it is expected to recover in January and there will be no 13ww impact. Performance across other modalities remains strong for the trust, with performance for patients waiting 6w+ below 10% in 8 of the 15 modalities monitored nationally in December.

7a. Urgent Care – 4 Hour ED Waits %

Derby and Derbyshire ICB

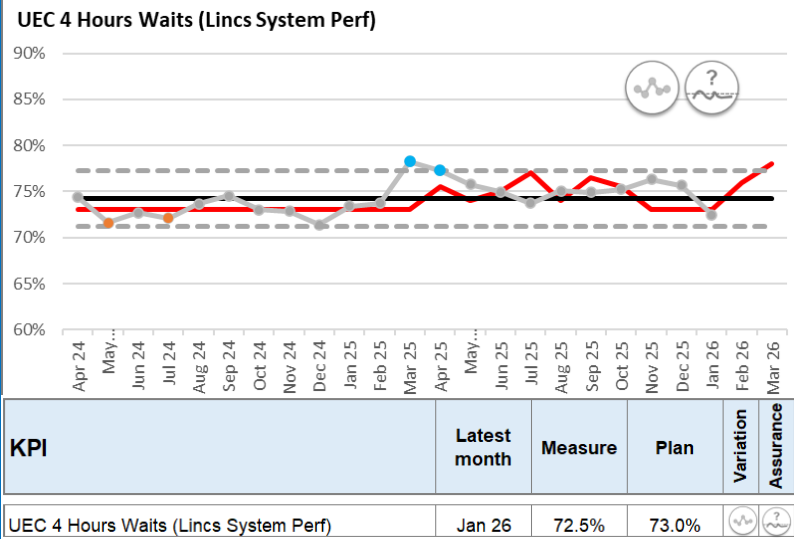


Both Acute Trusts are behind their 4-hr plans. UHDB had been hovering around the plan but are now below expectations – and lower than the same time last year. CRH are below plan expectations and lower than the same time last year.

Note: The national data overstates the AE 4-hour performance for DDICB. This is due to activity being duplicated in the national data submissions. The actual performance shows we have not achieved the performance plan all year

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Plan	74.63%	75.61%	75.71%	76.88%	76.67%	76.92%	77.40%
Actual	73.35%	74.31%	72.60%	74.50%	73.47%	71.97%	70.48%

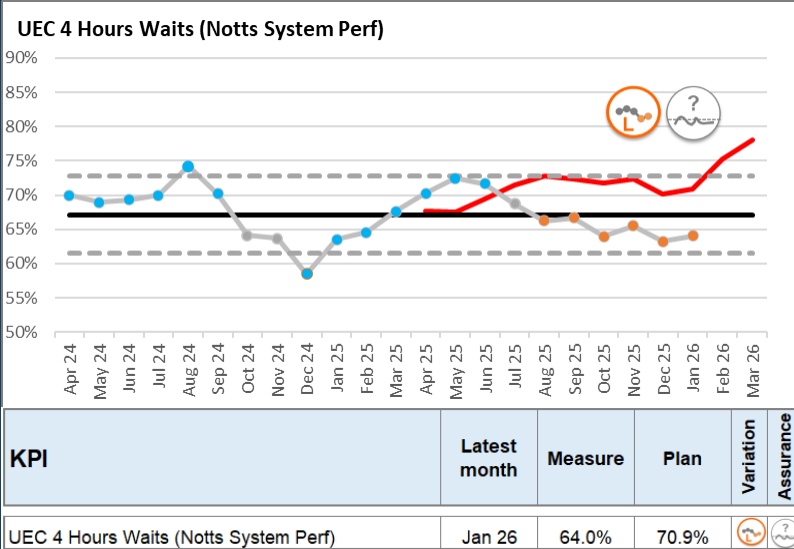
Lincolnshire ICB



All types (T1 and T3) 4 hour performance in January was 72.5%, below plan of 73%. The system ambition remains to delivery 78% 4 hour performance in March 2026 and the January position was only 0.5% below plan despite a significantly challenging month.

Demand has been under plan year to date but we continue to experience peaks at certain times of day and days of week causing operational pressures.

Nottingham and Nottinghamshire ICB



In January, the system achieved 64.0% performance for 4-hour waits against a plan of 70.9% and against national performance of 72.5%. As an ICB, Nottingham and Nottinghamshire were 39th of 42 nationally for 4-hour performance and 42nd for Type 3. With both providers failing to achieve plan in T1 and T3.

Demand continues to track under plan, although there is an increased level of pressure due to timing and grouping of presentations.

7b. Urgent Care – Actions and Recovery

Derby and Derbyshire

- **4 hour plan** - Both Acute Trusts are behind their 4-hr plans. For January 2026 UHDB are 12% below plan and CRH are 23% below planned expectations. The front door performance, hospital flow and system wide discharge processes are a real focus. The Community Transformation Programme ED turnaround workstream, piloting 4 Clinical Navigation Hub (CNH) community navigators in ED (2 per acute), has resulted in 42 admissions avoided, 20 of those 42 avoided admissions across the w/c 29th Dec & 5th Jan.
- **Central Navigation Hub**- In January 4,283 patients (82%) were found an alternative pathway . In Jan 1,645, 74% were found an alternative community pathway to ED, 327 of these were from direct calls from crews on scene to the CNH SPoA. Without CNH in our system in December our EDs would have received an extra 60 ambulances per day. CNH are also supporting the Community Transformation Programme with CNH ED Community Navigators on the ED Turnaround Workstream. To the end of January 2026 over the 5 -week pilot 64 admissions were avoided. BCF Performance Metrics dashboard for both Derbyshire County and Derby City Council reports for Q2 and Q3 25/26 emergency admissions to hospital for people aged 65+ per 100,000 population are below plan. CNH data collected as part of Protected characteristics to understand the needs of our population and CNH service developments demonstrates high deflection into community services for 60 – 89year-old age group. This includes the success of the long lie falls on anti coagulants automated dispositions from 999 and NHS 111 through CNH into the VW.
- **Cat 2 Mean** - The C2 mean performance in Derbyshire was 47m08s in January, an increase of 2m41s on the previous month.
- **45 minute handover** – Work to reduce ambulance handover delays is ongoing, with Release to Respond (R2R) implemented at RDH and supported by strong multi-agency working, agreed offload plans, and regular review meetings. Weekly provider discussions focus on missed deflection opportunities, CNH data, and operational pressures across Acutes and EMAS to enable targeted improvements. Data quality improvements are strengthening oversight of 45-minute breaches and informing focused actions. While R2R has been temporarily paused during periods of significant system pressure, mitigating actions are agreed and monitored in line with established governance processes.
- **Winter Plan** – System wide weekly Winter Monitoring Group has been established, which is led by the ICB and includes senior system partners; this group works through delivery against the winter plan, and the risks and mitigations. This Group reports and escalates up to the UECC Delivery Board monthly. The 25/26 Winter Wash up event has been scheduled for the 18th March 2026 and the plan for this workshop is being developed with system partners.

Lincolnshire

- **4-hour and 12 hour performance** – Actions continue to include focus on one front door and life and limb model evolution following the Lincoln Site go live in early January. This model is the standardised NHSE Initial Assessment and Acuity scoring in ED and covers the whole front door with patients being immediately categorised. It is anticipated that this model will support improvement of all metrics across the front door, but especially the 15 min TTIA measure. While the January 4-hour position was below plan it was only by 0.5% despite a significantly challenging month. With recent 12 hour performance, the ambition for no more than 10% of patients waiting >12hours will not be delivered.
- **CAT2 mean:** Ongoing focus on increased Hear & Treat supported by EMAS and CAS integration with additional ITK codes being moved to CS for calls from 26th January. CAT2 position does continue to correlate with handover performance across the whole division including NLaG, but also has some alignment with EMAS staff sickness and demand profile by time of day.
- **45 min handover:** While previously embedded as BAU across both sites, 95% performance has not been achieved. EMAS release to respond model go live for both sites as the 28th January.
- **Winter Plan Delivery** – System wide delivery group established reporting into UECPB. Oversight at operational level of health protection surveillance, winter risks and mitigation and delivery of winter initiatives. Provider winter plans delivery also report into this group. Currently demand levels remain within baseline, however time of day and day of week demand continues to cause increased pressure.

Nottingham and Nottinghamshire

- **4-hour plan** - January missed at NUH and SFHT footprints, with ICB ranking 39/42 nationally. NUH – GIRFT carrying out rapid review of primary and secondary assessment which will be tracked through UEC Board. Injuries business case with NEMS - intended to shift activity away from ED, being finalised with agreement of transfer arrangements to mitigate T1 pressure to be made. Active measures to limit corridor care and maintain early discharge focus being undertaken. All specialty bed waits now receiving either senior or expert decision maker review whilst in the dept. Improving flow through additional capacity. Reviewing all incidents arising from prolonged corridor waits. The trust will continue year end reprofiling of 4-hour performance. SFH – Speciality in reach and ownership of patients on the admission area – requires further work up. Ongoing development of Criteria to Admit Audit pathways. Ongoing work in minors and collaboration with PC24 to stabilise Type 3 performance. Focus on minors and continuity work; increased attention to P0 medically safe patients to accelerate discharge where possible.
- **Type 3** – Area of focus as position was lowest ranking as an ICB nationally. PC24 (KMH) and UTC (QMC) have action plans from NEMS to address delayed transfers, waits for results and staffing rotas. Booked appointments are now in place via 111 and the CAS. Type 3 4-hour performance declined further in January.
- **Ambulance handover lost hours:** QMC performance improved and no longer worst performing provider in EMAS region, now 5th. NUH Expanded corridor capacity and operational huddles to maintain handover flow. Will continue joint handover improvement work with EMAS, embed fire safety mitigations tied to ambulance offloading, and strengthen discharge and frailty pathway capacity to reduce the admitted delays that drive sustained ambulance queues. Will Incorporate ambulance risks and mitigation options into the SDEC decant modelling.
- **Winter Plan** – System wide winter delivery group is in place with daily operational activities supported by the SCC.

8. Primary Care – Actions and Recovery

Derby and Derbyshire

- **General Practice appointments:** Primary Care GP appointments were slightly higher against planned activity in December 25 and have increased by 2.5% in comparison to December 24 with approx. 585,000 appointments being delivered. 40% of overall appointments are seen same day compared with the national 46% in Dec 25, however 78% of acute/urgent appointments are seen same day/next day which closely follows the national trend.
- **GP experience:** the annual survey results showed that overall experience of General Practice has improved in Derby and Derbyshire. Health Insight Survey: The % of patients who rated it "easy" to contact their practice has increased from 66.4% in the Survey at the beginning of Jan 26 to 72.2% in the latest survey. In the latest Jan 26 survey DDICB % of patients able to see their preferred healthcare professional increased from 46.4% to 53.3% in the latest survey. Work is ongoing to understand and take action on the health insight survey results, with further information requested to allow some 'drill down' into the data so we can target support to specific practices
- **GP digital:** roll out of digital triage is progressing and whilst challenging for some practices, others are reporting positive benefits in terms of their ability to manage demand & capacity and improve access for patients. The number of online consultations delivered continues to increase with 118749 in Dec 25 which is an increase of 138% compared with Dec 24.
- **Urgent Dental appointments:** 10.9% of delivery has been reported up to 31st January 2026. This is lower than anticipated trajectories, which is broadly in line with performance across the region. The Local Dental Committee's video produced for patients/public on the 7 conditions under the Urgent Dental Appointments scheme and how to access has gone out widely via social media and within the region to support wider plans across the DLN area to communicate and raise awareness with patients & the public.

Lincolnshire

- **GP Appointments:** GP Appointments were above plan in December by 8.6% and 86.4% of GP non-urgent appointments were within two weeks of contact. Work to support GP practices with capacity and demand management is underway with five priority practices currently engaged with the Practice Level Support (PLS) programme.
- **Urgent dental:** It is acknowledged that Lincolnshire ICBs and colleague ICBs within East Midlands are underperforming against their planned trajectories. Whilst this is disappointing, it is in line with the performance of the county as a whole and all other areas which are also underperforming. Communication plans have been developed to support raising awareness with patients and the public. This includes easy to read and information in different languages. The work undertaken by Lincolnshire ICB has been promoted via the National Team. Further work is planned to take place around further promotion of the scheme including posters within GP practices and Pharmacies. In addition, all ICBs in East Midlands have agreed to support a collaborative comms campaign.

Nottingham and Nottinghamshire

- **GP Appointments** – were above plan for December by 11.3% and the ICB was above the booking target with 88.2% within 14 days against the NHSE expectation of 85%. Work is being undertaken with practices to further improve 0-14 days and have clarity on acute appointments across practices.
- **GP Digital** – NNICB is the highest performing Midlands system for online registration enrolment at 100%. In January 2026, 5,391 unique users accessed the Notts Care Record, with 73,543 records accessed. This is a significant increase on previous months and 20,000 record views more than a typical month across our previous Shared Care Records (CareCentric and the MIG).
- **Dental** – UDA Delivery for January was at 80% of monthly contracted levels. Children seen again achieved plan, with adults falling short of plan, despite seeing an increase from the previous month. Urgent dental session delivered remains below plan. However, there can be lags within the data, so these figures are expected to improve in the coming months.
- **Pharmacy** – The ICB is delivering additional pharmacy first consultations above the 1% expectation, however, is below the year-to-date plan. Pilots are being undertaken in relation to weight loss jabs. Transformation team are promoting the service with Primary care colleagues. Learnings are being shared across the cluster and wider within the region.

9. Community – Actions & Recovery

Derby and Derbyshire

- DCHS planned to have no patients waiting more than 52 weeks for treatment by the end of the financial year, and that at least 65% of patients will be waiting no more than 18 weeks, with an improvement of 5% for each service (with the exception of vasectomy). The Trust is largely on track to meet these targets
- **Vasectomy.** Having delivered all commissioned activity in 2023/24 yet building up a significant waiting list due to demand exceeding capacity in Derbyshire, DCHS stopped accepting further referrals in Quarter 1 of this year. The service is working through the backlog and is delivering activity in line with commissioned capacity for 2025/26. At Month 9, 430 patients were still waiting more than 52 weeks. Conversations are ongoing with commissioners and system partners on addressing the underlying problem of demand exceeding capacity, with DCHS being one of several providers of vasectomy services in the wider system.
- **Children's continence.** As per the previous section, capacity constraints continued to affect this small service resulting in long waits. At Month 9, 4 patients were waiting over 52 weeks. The team continues to adhere to the Clinical Harms Standard Operating Procedure whilst patients are waiting, and 75% of those waiting have an appointment in place.

Lincolnshire

- All 701 **CYP long waiters** are within the ULTH Community Paediatrician service currently which has significant waiting time for new and follow up appointments. The ICB business case has not been taken any further forward as many stakeholders no longer have capacity to take it through the last step of the framework to be considered again after comments made at the last panel for additional information.
- There were no Adult waiters are waiting above 52 weeks.

Nottingham and Nottinghamshire

- The 52ww position for the ICB remains over plan with 208 patients against a plan of 12, 2 are Adults and 206 are CYP. The key drivers are challenges in speech and language therapy and Occupational Therapy services at NHT.
- **SLT:** A system-wide workshop was held on 12th November. Five groups set up to address issues, which include Workforce, Shared Vision, Networks and Comms, Schools Offer and Tools/Screening. Options appraisal took place in December with findings presented to the Strategic Commissioning Group, followed by organisational governance for approval in Q4.
- **OT:** NHT expects to clear all 52-week Occupational Therapy waits by the end of August 2026, which has been revised from the end of March. The service is moving to an "assess to treat" model, reducing hidden waits and treatment blocks. Actions include hybrid assessments, triage of referrals, additional hours, and enhanced use of Band 4 staff. Data quality work and monthly RTT reviews continue.

10. DLN Mental Health – *Actions and Recovery*

Derby and Derbyshire

- Performance across key mental health access measures remains **strong for perinatal services, Individual Placement Support Access and Talking Therapies** reliable recovery (48%) improvement (70%) rates for December 2025, much improved from the November position and in line with constitutional standards.
- **Increase the number of Children & Young People accessing services:** In November, CYP Access achieved 14,505, representing 96% of the planned activity, below plan by 60, access numbers are monitored and assured with providers to ensure overall performance throughout the year is on track.
- The overall fall in **inappropriate out-of-area placements** has matched the expectations of opening new inpatient accommodation within the county. Since the noted uptick in placements during October and November, the OAPs numbers have broadly come back in line with planning assumptions by December 2025.
- The **acute bed** utilisation target, reducing average **length of stay** to 47 days by March 2026 – aligning with the national average – remains a challenge. In December, the length of stay at 62 days was almost back to Oct 2025 baseline, above trajectory. The main issue is Older People MH LoS. Twice weekly MADE sessions are focussing on Older People MH delays and Clinically Ready for Discharge delays, good joined up working with LAs, ICB and providers.

Lincolnshire

- **Talking Therapies:** Year to date, Talking Therapies is below plan with a Reliable Recovery rate of 47.5% and a Reliable Improvement rate of 69.7%, with some treatments continuing to be outsourced to provide additional capacity. Note that due to a submission error, there is no update for LPFT in December.
- **Increase the number of Children & Young People accessing services:** In December, CYP Access achieved 10,705, representing 94.9% of the planned activity, below plan by 572. Between Dec 2024 and Dec 2025 there has been a 23% increase in CYPMH Access for Lincolnshire, despite this achievement remains marginally below target (5.1% variance). Whilst continuing pressures are impacting performance the RAP remains in place and subject to ongoing review
- **Individual Placement Support Access:** Performance continues to fall short of the plan as expansion funding was delayed. All positions filled by January 2026. It's important to note that performance has not declined; rather, the target has been raised.
- **Beds:** Average length of stay has reduced at LPFT, Psychiatric Clinical Decisions Unit (PCDU) is now in place for hospital avoidance. On advice from NHSE this data is now flowing in MHSDS, from June onwards this has had a big impact on the national data.

Nottingham and Nottinghamshire

- **Inpatient Beds** – national ICB reporting is 10 inappropriate OAPs against the plan of 0 for December. NHT have an inpatient bed reduction recovery plan, which also includes expected reductions in IS bed utilisation, through actions including, LOS, in-reach, discharge planning and admission triage. The ICB is supporting partner engagement.
- **Talking Therapies** – delivered against the improvement trajectory for 1st to 2nd wait in December (6.1% v 10% plan), the 50% recovery rate YTD position is below target at 44.0% in December. The 68% reliable improvement target was not met, with December performance at 67.0%. Performance against the recovery rate metric has been in decline for several months; a recovery action plan has been provided to deliver to the 50% target by March 2026.
- **IPS** – The number of people accessing IPS has shown improvement with 1,420 people accessing support in December and achieved target. A revision to the data will be required following an audit at NHT by IPS Grow of their allowable activity. Performance is now being reported in line with national 12 month rolling standards. A review of DNAs is underway, and further actions are being developed and will be discussed at the Mental Health Programme Board.
- **Crisis** – concerns relating to the crisis service and crisis line were escalated to the system during the summer. NHT have a Crisis Improvement working group and are undertaking action to improve staffing capacity and capability and estate / telephony functionality, there are early improvements in call response rates.

11. DLN LD&A – *Actions and Recovery*

Derby and Derbyshire

- **Reducing reliance on inpatient care** – The number of **adults in an inpatient facility** in November is reflective of the Transforming Care definition error noted in October 2025. December 2025 position slightly reduced to **35 (+4): LDA 21** (vs 20 trajectory); **Autism 14** (vs 11 trajectory) and the number of **children and young people** stood at **7** (vs 3 trajectory) – both adult and CYP inpatient numbers are higher than planned, there are a number of discharges expected in January/Feb which have brought the CYP number back into line with planned activity. A remedial action plan is in place as well as additional commissioner and provider oversight meetings to support the recovery plan. A weekly LDA SRO system oversight call has been instigated .
- **Health checks** – despite the challenges in ensuring sufficient reach across all areas, the ICB is **ahead of plan** at the end of September 2025.

Lincolnshire

- **Reducing reliance on inpatient care:** LD Inpatients is off track for adults with 33 against a trajectory of 26; however children and young people remains on track at 1. All patients on the LD/A programme have an individualised plan in place to expedite discharge and work through any barriers that may be delaying discharge such as Accommodation, care provider, professional involvement, legal and clinical.
-
- **LD Annual Health checks** – 2,848 Learning disability annual health checks have been completed year to date against a trajectory of 2,665, remaining well above plan.

Nottingham and Nottinghamshire

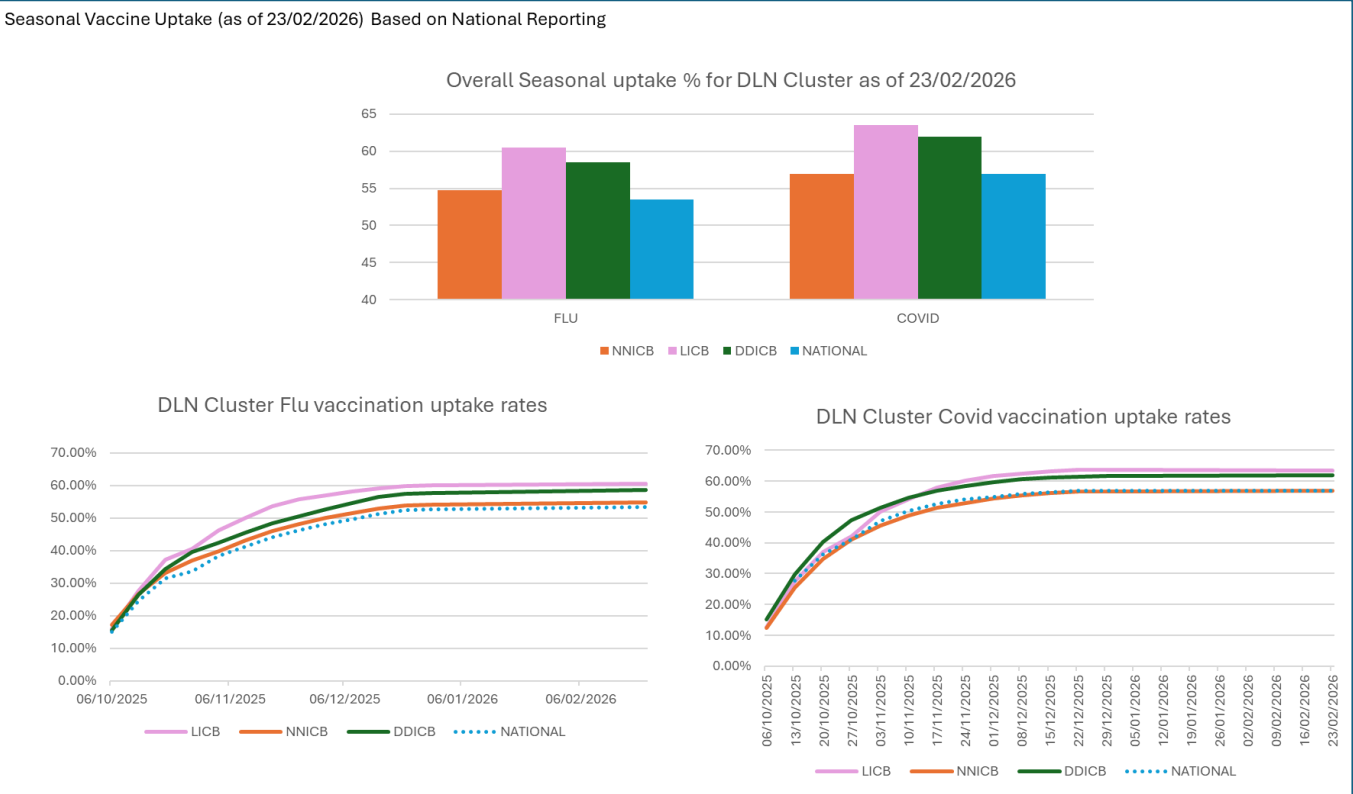
- **Adult inpatients** – 4 over plan in total for January for the system. Focus remains on long stay patient discharges to achieve planned level, with another 1 patients with stay of over 5 years being discharged in month. Service has had additional admissions in year due to care breakdown and late diagnosis, meaning patients are not on the DSR. Discussion of additional unplanned care beds is being undertaken with Local Authority colleagues to prevent inpatient MH admissions. The ICB is unlikely to achieve the end of year position due to more additions than planned through the year.
- **CYP inpatients** - on plan for January. Positive delivery is related to the strong community support in the system, zero admissions in month..
- **LD AHCs** – below plan for January with 4,037 v 4,180 plan AHCs completed, 96% are recorded to have a Health Action Plan. The system remains confident to deliver end of year target.
- **Neuro-diversity Waits** – Adult service by NeSS has completed data transfer and data cleanse on waiting lists to enable clear view of the 7749 patients waiting for assessment. CYP assessment waits vary across the county from 73 weeks in Nottingham City to 104 weeks in South Notts. A comprehensive improvement plan is in place across all parts of the pathway for adult and CYP, including standardised triage and referral form processes.

12a. DLN Seasonal Vaccinations

Actual Flu Uptake Against Ambition	Actual Autumn Winter 2025	Ambition Autumn Winter 2025
Derby And Derbyshire	360,578	382,601
Lincolnshire	277,052	291,862
Nottingham And Nottinghamshire	353,630	377,596

Actual Flu Uptake Against Ambition	Actual Autumn Winter 2025	Ambition Autumn Winter 2025
Age 65+	515,029	525,730
Care Home Residents	19,149	20,763
Children aged 2 and 3	27,074	30,098
Clinical risk group: Immunosuppressed (6m+)	20,897	22,522
Clinical risk group: Non-Immunosuppressed (6m+)	165,348	182,153
Frontline Healthcare Worker ESR	29,811	29,008
Household Contacts of Immunosuppressed	4,597	4,668
Primary	122,219	139,389
Secondary	87,136	97,728

This table shows the uptake against ambition



This table shows the uptake against the population cohort

12b. DLN Seasonal Vaccinations

Derby and Derbyshire

- **Comms & Engagement** – Covid campaign finished on the 31st January, Flu campaign and promotion will continue until 31st March. Planning for Covid Spring campaign has started with focus on lowest uptake areas from previous 2 campaigns.
- **Flu** – Programme due to finish on 31st March.
- **School Age Children** – out of school Flu clinics continue to the 31st March.
- **RSV** – programme continues, cohort has changed to include people age 80 from the 1st April, this will coincide with the COVID Spring Campaign and co administration is encouraged.
- **Covid** - The Spring Covid campaign is due to start on 13th April; eligibility criteria will remain the same as the AW25 programme. 26/109 practices did not sign up to the enhanced service, we have worked with LPC and ensured all eligible patients will have a vaccination offer via a local community pharmacy under the nationally agreed IOS, including those in care homes or who are housebound.

Lincolnshire

- **Healthcare workers** – Vaccination uptake has been higher than expected. ULTH is currently the highest acute trust in the midlands.
- **2-3 Year Olds** – Uptake is higher than previous years but still below system target. Focussed comms with target this cohort between now and the end of the program in March.
- **Low Uptake Areas** – East Coast to be supported by Lincolnshire Community Health Services Vaccination and Rapid Response Team. Engagement and education in relation to vaccine hesitancy continuing.
- **Communication and Engagement**- Weekly end of week press releases encouraging patients to come forward mainly now focused on small children. Local comms and engagement materials produced focussing on different eligible cohorts, these have been shared with system partners for use on their social media and websites

Nottingham and Nottinghamshire

- Flu vaccination campaign and promotion will continue until 31st March; however, Covid campaign finished on the 31st January. Covid Spring campaign planning process has already started.
- **2-3-year-olds** – flu vaccine uptake is below target and national average, with increased infection rates in this age group. Targeted communications to early years providers, family hubs, and public health trained health promoters to raise awareness and promote the vaccination in the light of increased infection rates in this age group. Promoting community pharmacies new offer for nasal flu vaccinations to improve access. Working proactively with lowest uptake GP practices to address local challenges and improve uptake.
- **School Age Children** – performance is below target and national average, due to school provider capacity issues and consent forms were not returned by parents. School immunisation providers are working closely with local authority colleagues to follow-up on unreturned consents in the lowest uptake schools. Additional week-end and school holiday clinics planned.
- **Pregnant Women** – flu vaccine uptake is below target but improving; staffing issues previously affected delivery. Staffing issues at both acute trusts (NUH & SFH) have been resolved. Exploring the use of patient stories to highlight benefits of vaccination in pregnancy. Ongoing communications including targeted messages to health advocates, community champions, GPs, midwives to encourage vaccination reminders.
- **Over 65s and Under 65 At Risk** - Inpatient and discharge vaccinations offered across all Trusts. Additional flu/RSV clinics funded for 13 practices with low uptake in Nottingham City. PCN collaborative flu clinics planned over a larger footprint targeting cohorts with low uptake. Text reminders being sent to all eligible unvaccinated adults attending outpatients at NUH and DBTH.
- **Healthcare Workers** - Promotion of incentives such as prize draws for shopping vouchers. Roving vaccination services deployed to make access easier for staff.
- **Communication and Engagement** – ongoing local comms campaigns, press release, bulletins, newsletters across the system to promote all vaccinations.

13a. NHS Provider Oversight Arrangements

Provider Performance Overview		NHSE NOF Assessments Q2				NHSE Quarter 3 Programme Tiering			
Organisation	Type	Q2 25-26 NOF Rating		Recovery Support		Elective	Diagnostics	Cancer	UEC
Nottinghamshire Healthcare (NHT)	MH & Comm	4*	↔	Y	↔	-	-	-	-
Nottingham University Hospitals (NUH)	Acute	4*	↓	Y	↔	2	2	1	2
United Lincolnshire Hospitals (ULTH)	Acute	4	↔	N	↔	2	2	2	1
Lincolnshire Community Health Services (LCHS)	Comm	4	↓	N	↔	-	-	-	-
University Hospitals of Derby and Burton (UHDB)	Acute	3	↑	N	↔	2	2	2	3
Chesterfield Royal Hospital (CRH)	Acute	3	↔	N	↔	2	2	2	3
Sherwood Forest Hospitals (SFH)	Acute	3	↔	N	↔	2	4	4	3
Lincolnshire Partnership (LPFT)	MH	3	↔	N	↔	-	-	-	-
Derbyshire Healthcare (DHcFT)	MH	3	↑	N	↔	-	-	-	-
Derbyshire Community Health Services (DCHS)	Comm	1	↑	N	↔	-	-	-	-
East Midlands Ambulance Service	Amb	1	↔	N	↔	-	-	-	-

Oversight Arrangements	Key: NOF Ratings	Key: Programme Tiering (distance from plan)
NHSE Led IOAG, ICB attend	NOF4* - National Conditions Applied	Significant failure - supports RSP 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

Overview:

ICBs are expected to fulfil their responsibilities as strategic commissioners in the agreeing, monitoring and managing of healthcare contracts on behalf of their populations, in order to deliver the operational plans agreed by the ICB Boards at the start of the year. As such routine oversight and management will be undertaken through contractual arrangements, while continuing to work collaboratively across the system to deliver improved access to services, and improved outcomes for the population following appropriate healthcare interventions.

ICBs will lead the direct management and oversight of performance with providers unless there is significant and / or sustained deterioration in operational performance.

This would lead to escalated oversight on a programme basis direct with the provider by NHSE under the NHSE Tiering arrangements, if the quarterly review leads to level 1 or 2 tiering level. Predominantly the tiering levels are determined by distance from plan and are based on prior quarters performance. A period of escalated oversight in relation to a clear improvement plan would follow, until such a time as sustained delivery is observed.

In additional enhanced NHSE oversight would also be triggered at an organisation level, depending upon the NOF ratings for the quarter, with financial override in place. NOF ratings determine the frequency of NHSE oversight with providers through Provider Review Meetings, levels 3 and 4 more frequent than levels 1 and 2.

13b. NHS Oversight Framework Rankings – Q2 2025-26

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

Provider Overview:

NOF 5 – RSP

The Nottingham and Nottinghamshire system has 2 Providers within PIP (RSP), NOF 5 – NUH & NHT.

Financial Downgrade

There are 6 Providers who have had the Financial Downgrade applied – UHDB, CRFT, LPFT, NUH, SFHT, NHT.

Metric League Ranking

There are 4 Providers with the lowest quartile ranking in the metrics league tables – ULTH, LCHS, NUH and NHT.

There are 2 organisations with the highest quartile ranking in the metrics league tables – DCHS and EMAS.

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	19/03/2026
Paper title:	Updated Governance Framework for the Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire Integrated Care Boards working in partnership
Paper reference:	ICB CIC 25 050
Paper author:	Lucy Branson, Director of Corporate Governance and Assurance
Paper sponsor:	Kathy McLean, ICB Chair Amanda Sullivan, Chief Executive
Presenter:	Lucy Branson, Director of Corporate Governance and Assurance

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

Report summary:
This paper seeks approval for a small number of refinements to the Governance Handbooks for the Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire ICBs, following a stock-take of the new cluster arrangements implemented in late 2025. The proposed changes update several committee terms of reference, align financial delegation arrangements to reflect the emerging single staffing structure, and prepare for the transfer of NHS England commissioning functions. The paper also asks Boards to approve the 2026/27 Midlands ICB Specialised Services and NHS England Commissioning Services Collaboration Agreement, which establishes a new Midlands Joint and Collaborative Committee to support multi-ICB joint governance ahead of the 2027 statutory transfer. Subsequent updates to governance documents and committee work programmes will follow, alongside actions to further embed effective Board and committee operations.

Recommendation(s):
The Boards are asked to: • Approve the proposed changes to the ICBs' Governance Handbooks as set out in paragraphs 4 to 6 of the paper. • Approve the Midlands ICB Specialised Services and NHS England Commissioning Services Collaboration Agreement 2026/27, including the establishment of the Midlands Joint and Collaborative Committee.

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 – Briefing Paper for ICB Boards.

Appendix B – Midlands ICB Specialised Services and NHS England Commissioning Services Collaboration Agreement 2026/27.

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

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

Introduction and context

1. In November 2025, the Boards approved a new Governance Framework to enable NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB ('the ICBs') to work in partnership as an ICB cluster.
2. Since this time, the new arrangements have been embedding, and a stock-take exercise has now been completed in order to identify any required refinements to arrangements ahead of the 2026/27 year commencing. As such, the purpose of this paper is to seek Board approval of a small number of proposed changes to the ICBs' Governance Handbooks.
3. In addition, the paper sets out proposed changes to the ICBs' current governance arrangements for certain NHS England delegated functions. This is in line with the national direction regarding the anticipated transfer of the majority of NHS England's direct commissioning functions to ICBs (subject to parliamentary approval of changes to primary and secondary legislation) – as referenced earlier in today's meeting as part of the Chief Executive's Report.

Proposed changes to Governance Handbooks

4. Each of the Boards' committees has been meeting since November/December 2025, and during the first few months of operation, a small number of proposed changes to committee terms of reference have been identified, as follows:
 - a) To amend the Audit Committees' terms of reference to include explicit reference to their responsibility for oversight of the ICBs' Freedom to Speak Up arrangements.
 - b) To amend the Joint Remuneration and Human Resource Committee's terms of reference to include a responsibility for oversight of any employment tribunals, including settlement arrangements and required learning.
 - c) To amend the Joint Strategic Commissioning Committee's terms of reference to include a responsibility for overseeing arrangements for the commissioning of specialised services.
5. Following discussion at the February 2026 meeting in common of the Audit Committees, it is also proposed to amend the ICBs' aligned Standing Financial Instructions to remove the requirement to report on the use of procurement

cards to the Audit Committees. This was agreed an unnecessary due to minimal and low value usage.

6. A minor change to the ICBs' Schemes of Reservation and Delegation is also proposed in order to align arrangements for delegated financial limits relating to the approval of requisitions/purchase orders and invoices in the ICBs' financial ledgers, as set out below. This is to reflect the move to a single staffing structure across the ICBs.

Delegated matter	Delegated to	Additional information
Approval of requisitions/purchase orders and invoices (in financial ledger)	Executive Directors (including the Chief Executive) (Budget Holders)	Budget Holders will define delegated financial approval limits to staff within their directorates, as appropriate to roles and responsibilities and in line with their Budget Holder responsibilities. The Budget Holders remain accountable for ensuring alignment with contractual agreements and expectations, and hence for budgetary control. A list of approved officers and their delegated limits is maintained by the Finance Directorate.

Midlands Joint and Collaborative Committee

7. As described in the briefing paper at Appendix A, it is anticipated that subject to parliamentary approval, ICBs will assume statutory responsibility for the majority of NHS England's direct commissioning functions from April 2027.
8. In preparation for the transfer of functions, each NHS Region is required to establish an Office for Pan-ICB Commissioning (OPIC), to maintain critical specialist commissioning capacity and an 'at scale' commissioning approach. A designated host ICB will be determined for each region by the end of April 2026, with NHS England staff transfers in April 2027. For the Midlands, the Birmingham and Solihull and Black Country ICB cluster will act as host ICBs.
9. Due to service complexity and population scale, ICBs will need to operate through multi-ICB joint governance. As such, the current East Midlands and West Midlands Joint Committees will be dissolved, and a new Midlands Joint and Collaborative Committee will be established by the Midlands ICBs and NHS England.
10. NHS England will continue to make decisions on NHS England statutory functions (via the NHS England Regional Director of Commissioning Integration), but ICBs will make decisions for all functions already delegated to them.
11. A Midlands ICB Specialised Services and NHS England Commissioning Services Collaboration Agreement 2026/27 is attached at Appendix B for Board approval. This sets out the joint working arrangements and includes the

proposed terms of reference for the Midlands Joint and Collaborative Committee, to be established from 1 April 2026.

12. These changes will require a different approach to the governance previously established in relation to delegated Pharmacy, Optometry and Dental functions, as these are currently within the remit of the East and West Midlands Joint Committee arrangements and will not form part of the proposed Midlands Joint and Collaborative Committee. Within the East Midlands it has been agreed that these functions will revert to ICBs to be governed through cluster specific arrangements. Arrangements for NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire ICB will mirror the arrangements established for delegated Primary Medical Services, and a proposal will be presented to the Joint Strategic Commissioning Committee for approval in March, to be enacted from 1 April 2026.

Next steps

13. Subject to approval by the Boards, the ICBs' Governance Handbooks will be updated to include the changes set out at paragraphs 4 to 6, and to reflect the establishment of the Midlands Joint and Collaborative Committee.
14. The Governance Handbooks will be further updated to reflect the new governance arrangements for delegated Pharmacy, Optometry and Dental functions following approval by the Joint Strategic Commissioning Committee.
15. Work Programmes for the Boards and their committees will be reviewed and updated for 2026/27 to ensure all responsibilities are able to be discharged effectively.
16. Actions to further embed effective Board and committee operations will be taken forward following the conclusion of the ICBs' management of change process. This will include the delivery of staff training to support consistent awareness and understanding of the ICBs' governance arrangements and high-quality reporting requirements.



Appendix A: Briefing Paper for ICB Boards

Date: January 2026

Paper Title: The Office of Pan ICB Commissioning in preparation for further delegations and transfers and the appropriate governance arrangements

Executive summary: This paper is to inform ICB Boards of the move from two Joint Committees (East Midlands & West Midlands) to a Midlands Joint and Collaborative Committee and requests that NHS England commissioning functions are agreed in collaboration with the ICBs at the Joint Committee to enable ICBs to take a greater role in NHS England's commissioning responsibilities and further develop the Office of Pan ICB Commissioning.

1. Introduction

- 1.1 From April 27 (subject to approval by Parliament to necessary legislative changes) Integrated Care Boards (ICBs) will take over statutory responsibility from NHS England for commissioning suitable specialised services; health and justice services; and screening and vaccination services. Collectively, these services account for £20bn of commissioning spend in 25/26; circa £5bn within the Midlands.
- 1.2 Seven 'Offices for Pan-ICB Commissioning' (OPICs) – one per NHS region - will be established to support all ICBs across a region in discharging these additional statutory functions. The OPIC model is designed to facilitate ICB collaboration and, where appropriate, 'at scale' commissioning (e.g. through joint ICB governance arrangements) as well as ensuring a critical mass of expert commissioning capability is maintained for these complex, high profile and often contentious areas of service provision.

2. Responsibilities and Accountabilities

- 2.1 The delegation of specialised commissioning does not change the accountability of the services. Transfers of commissioning functions are subject to the passage of legislation. For NHS public health functions (section 7A functions), which includes vaccination and screening services (including within the secure and detained estate), and Child Health Information Services (CHIS), this will be achieved through delegation of the Secretary of State's relevant public health functions directly to ICBs (currently delegated to NHSE). For all other transferring functions, commissioning accountability will move from NHS England directly to ICBs. In both cases the intent is the same, that ICBs have full responsibility for transferred commissioning functions.
- 2.2 Whilst it is intended that ICBs will be individually responsible, most of their new commissioning functions will require – due to the nature of the services and populations involved – a large planning and commissioning footprint. This will mean that ICBs will need to establish (or build upon existing) appropriate multi-ICB governance arrangements, such as a joint committee.
- 2.3 ICBs will need to determine the most appropriate commissioning/planning footprints, given their particular geographies and populations. DHSC Regions, in their role overseeing ICBs, will have a responsibility to support, encourage and potentially enforce multi-ICB working (where the need for it has been identified). For the Midlands, Birmingham and Solihull & the Black Country Cluster ICBs will be the host ICB for the Midlands.

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- 2.4 Other direct commissioning functions of NHS England, including highly specialised services; high secure mental health services; the management of high-cost drugs and devices; and services for the armed forces community will transfer to DHSC and become the responsibility of the Secretary of State for Health and Social Care.
 - 2.5 Staff currently delivering these commissioning functions within NHSE's seven regional teams will transfer to the host ICBs in April 2027 (or, at the point legislative provisions transferring these functions to ICBs are commenced), forming the seven OPICs. Until transfer NHS England will continue to host staff on behalf of ICBs for specialised services functions already delegated to ICBs.

3. Governance

- 3.1 In preparation for the transfer of functions and staff the national policy is for closer joint working with ICB taking a greater leadership role, as such ICBs have agreed to dissolve the current East Midlands and West Midlands Joint Committees and move to one Midlands Joint and Collaborative Committee with NHS England.
- 3.2 NHSE will continue to make decisions on NHS England statutory functions through the Regional Director of Commissioning Integration and in line with NHS England's SFI's and SORD but will do so with ICBs around the table at the Midlands Joint and Collaborative Committee. The Regional Director of Commissioning Integration will continue to report into the NHS England regional and national governance structures as required to meet NHS England's and statutory requirements.
- 3.3 ICBs will make decisions for functions already delegated to them at the Midlands Joint and Collaborative Committee, with NHSE through the Regional Director of Commissioning Integration having an advisory seat at the table.
- 3.4 The current Regional Commissioning Group (RCG) will be dissolved, and a Commissioning Operating Group will be formed to fulfil the NHSE operational commissioning responsibilities.
- 3.5 All current commissioning groups (by functional group) under RCG will become collaborative groups with ICBs and will report directly into the Joint and Collaborative Committee for Regional Director of Commissioning Integration in collaboration with ICBs.

4. Updated Agreements

- 4.1 The Delegation of Specialised Services requires ICBs to formally collaborate in a multi-ICB collaboration through a formal agreement; this is due to the population levels needed to plan and deliver specialised services safely and sustainably.
- 4.2 This multi-ICB collaboration was agreed and defined in a Collaboration Agreement which was been developed jointly between ICBs and NHSE Midlands and approved by ICB boards in March 2025.
- 4.3 There will be a new Collaboration Agreement for 2026/27 which will include the joint and collaborative working with NHS England in preparation for the transfer of responsibilities and further delegations. This new Collaboration Agreement will replace the 2025/26 Collaboration Agreement and will start making its way through the cluster boards for approval in February and March 2026. All documents will be confirmed through the commissioning report to RSG.



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- 4.4 The 2025 delegation agreement contained specific developmental arrangements for ICBs in NoF 3 & 4, these will be updated and taken through RSG in March 2026 prior to sending a formal delegation agreement variation to each of the ICBs
 - 4.5 The 2025 delegation agreement in schedule 10 contained details of services provided to ICBs by NHSE while staff continued to be employed by NHSE, this position was taken when staff were due to transfer to ICBs on the 1st July. This will be removed from the delegation agreement for April 2026 onwards through formal a delegation agreement variation. A Joint Working Agreement will be developed to detail the functions that NHSE will deliver to ICBs for their delegation functions through the development of the Office of Pan ICB Commissioning this will come to RSG in March 2026.

Midlands ICB Specialised Services and NHS England Commissioning Services Collaboration Agreement 2026/27

Table of contents

Clause heading and number	Page number
1. COMMENCEMENT AND DURATION	6
2. PRINCIPLES AND AIMS	6
3. SCOPE OF THE ARRANGEMENTS	7
4. FUNCTIONS	8
5. COMMISSIONING TEAM	9
6. STAFFING	9
7. JOINT COMMITTEE	9
8. GOVERNANCE	9
9. POOLED FUNDS, NON-POOLED FUNDS AND RISK SHARING	10
10. REVIEW	10
11. COMPLAINTS	10
12. FINANCES	10
13. VARIATION	10
14. DATA PROTECTION	11
15. IT INTER-OPERABILITY	12
16. FURTHER ARRANGEMENTS	13
17. FREEDOM OF INFORMATION	13
18. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY 13	
19. CONFIDENTIALITY	13
20. LIABILITIES	14
21. DISPUTE RESOLUTION	16
22. BREACHES OF THE AGREEMENT	16
23. TERMINATION AND DEFAULT	16
24. CONSEQUENCES OF TERMINATION	17
25. PUBLICITY	18
26. EXCLUSION OF PARTNERSHIP OR AGENCY	18
27. THIRD PARTY RIGHTS	18
28. NOTICES	18

29.	ASSIGNMENT AND SUBCONTRACTING	18
30.	SEVERABILITY	18
31.	WAIVER.....	18
32.	STATUS	19
33.	ENTIRE AGREEMENT.....	19
34.	GOVERNING LAW AND JURISDICTION.....	19
35.	FAIR DEALINGS	19
36.	COUNTERPARTS.....	19
	SCHEDULE 1: DEFINITIONS AND INTERPRETATIONS	21
	SCHEDULE 2: GOVERNANCE ARRANGEMENTS.....	29
	SCHEDULE 3: INDIVIDUAL SCHEMES	40
	SCHEDULE 4: FINANCIAL ARRANGEMENTS ERROR! BOOKMARK NOT DEFINED.	
	SCHEDULE 5: FURTHER INFORMATION GOVERNANCE AND SHARING PROVISIONS	70
	SCHEDULE 6: COMMISIONING TEAM AGREEMENT	

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THIS AGREEMENT is made on the first day of April 2026

BETWEEN the following clusters of ICBs & NHS England:

Cluster 1

- (1) **NHS Lincolnshire Integrated Care Board** of Bridge House, The Point, Lions Way, Sleaford, NG34 8GG ("Lincolnshire ICB"); and
- (2) **NHS Nottingham & Nottinghamshire Integrated Care Board** of Sir John Robinson House, Sir John Robinson Way, Arnold, Nottingham, NG5 6DA ("Nottingham & Nottinghamshire ICB"); and
- (3) **NHS Derby & Derbyshire Integrated Care Board** of Cardinal Square, 10 Nottingham Road, Derby, Derbyshire, DE1 3QT ("Derby & Derbyshire ICB"). and

Cluster 2

- (4) **NHS Leicester, Leicestershire & Rutland Integrated Care Board** Room G30, Pen Lloyd Building, County Hall, Glenfield, Leicester, LE3 8TB ("Leicester, Leicestershire & Rutland ICB"); and
- (5) **NHS Northamptonshire Integrated Care Board** of Haylock House, Kettering Parkway, Venture Park, Kettering NN15 6EY ("Northamptonshire ICB"); and

Cluster 3

- (6) **NHS Birmingham & Solihull Integrated Care Board** of Eighth Floor, Alpha Tower, Birmingham
- (7) ("Birmingham & Solihull ICB"); and
- (8) **NHS Black Country Integrated Care Board** of Civic Centre, St Peters Square, Wolverhampton WV1 1SD ("Black Country ICB"); and

Cluster 4

- (9) **NHS Herefordshire & Worcestershire Integrated Care Board** of Kirkham House, John Comyn Drive, Perdiswell, Worcester, WR3 7NS ("Herefordshire & Worcestershire ICB"); and
- (10) **NHS Coventry & Warwickshire Integrated Care Board** of Shire Hall, Market Place, Warwick CV34,4RL ("Coventry & Warwickshire ICB"); and

Cluster 5

- (11) **NHS Shropshire, Telford & Wrekin Integrated Care Board** of Halesfield 6, Halesfield, Telford, TF7 4BF ("Shropshire, Telford & Wrekin ICB"); and
- (12) **NHS Staffordshire & Stoke-on-Trent Integrated Care Board** of Stafford Education & Enterprise Park, Weston Road, Stafford, ST18 0BF ("Staffordshire & Stoke-on-Trent ICB");

and

- (13) **NHS England** of **Wellington House, 133-155 Waterloo Road, London, SE1 8UG** (acting under the name NHS England) ("**NHS England**").

each a "Partner" and together the "Partners".

Lincolnshire ICB, Nottingham & Nottinghamshire ICB, Leicester, Leicestershire & Rutland ICB, Northamptonshire ICB, Derby & Derbyshire ICB, Birmingham & Solihull ICB, Black Country ICB, Herefordshire & Worcestershire ICB, Coventry & Warwickshire ICB, Shropshire, Telford & Wrekin ICB and Staffordshire & Stoke-on-Trent ICB are together referred to in this Agreement as the “ICBs”, and “ICB” shall mean any of them.

BACKGROUND

- (A) NHS England has statutory functions to make arrangements for the provision of prescribed services for the purposes of the NHS.
- (B) The ICBs have statutory functions to make arrangements for the provision of services for the purposes of the NHS in their Areas, apart from those commissioned by NHS England.
- (C) Pursuant to section 65Z5 of the NHS Act, NHS England and the ICBs can establish and maintain joint arrangements in respect of the discharge of their Commissioning Functions.
- (D) Under the Delegation Agreement made pursuant to section 65Z5, NHS England has delegated the Delegated Functions to each of the ICBs. NHS England has retained responsibility for the NHS England Reserved Functions and commissioning of the Retained Services.
- (E) It is agreed that to exercise the Delegated Functions in the most efficient and effective manner, some of the Delegated Services are best commissioned collaboratively between multiple ICBs.
- (F) This Agreement sets out the arrangements that will apply between the ICBs and NHS England in relation to the collaborative commissioning of Specialised Services for the ICBs’ Populations.

NOW IT IS HEREBY AGREED as follows:

1. COMMENCEMENT AND DURATION

- 1.1 This Agreement has effect from the date of this Agreement and will remain in force unless terminated in accordance with Clause 23 (*Termination & Default*) below.

2. PRINCIPLES AND AIMS

2.1 BACKGROUND

- A. NHS England has statutory functions to make arrangements for the provision of prescribed services for the purposes of the NHS.
- B. The ICBs have statutory functions to make arrangements for the provision of services for the purposes of the NHS in their Areas, apart from those commissioned by NHS England.
- C. Pursuant to section 65Z5 of the NHS Act, NHS England and the ICBs can establish and maintain joint arrangements in respect of the discharge of their Commissioning Functions.
- D. Under the Delegation Agreement made pursuant to section 65Z5, NHS England has delegated the Delegated Functions to each of the ICBs. NHS England has retained responsibility for the NHS England Reserved Functions and commissioning of the Retained Services.
- E. It is agreed that to exercise the Delegated Functions in the most efficient and effective manner, some of the Delegated Services are best commissioned collaboratively between multiple ICBs.
- F. This Agreement sets out the arrangements that will apply between the ICBs and NHS England in relation to the collaborative commissioning of Specialised Services for the ICBs' Populations.
- G. This Agreement sets out the arrangement that will apply between ICBs and NHS England in relation to the collaborative commissioning of NHSE retained commissioning functions

- 2.2 The Partners acknowledge that, in exercising their obligations under this Agreement, each Partner must comply with the statutory duties set out in the NHS Act and must:

- 2.2.1 consider how it can meet its legal duties to involve patients and the public in shaping the provision of Services, including by working with local communities, under-represented groups, and those with protected characteristics for the purposes of meeting the obligation of the Equality Act 2010;
- 2.2.2 consider how, in performing its obligations, it can address health inequalities;
- 2.2.3 at all times exercise functions effectively, efficiently, and economically; and

2.2.4 act always in good faith towards each other.

2.3 The Partners agree:

2.3.1 that successfully implementing this Agreement will require strong relationships and an environment based on trust and collaboration;

2.3.2 to seek to continually improve whole pathways of care including Specialised Services and to design and implement effective and efficient integration;

2.3.3 to act in a timely manner;

2.3.4 to share information and best practice, and work collaboratively to identify solutions, eliminate duplication of effort, mitigate risks, and reduce cost;

2.3.5 to act at all times, ensuring the Partners comply with the requirements of the Delegation Agreements including Mandated Guidance;

2.3.6 to act at all times in accordance with the scope of their statutory powers; and

2.3.7 to have regard to each other's needs and views, irrespective of the relative contributions of the Partners to the commissioning of any Services and, as far as is reasonably practicable, take such needs and views into account.

2.4 The Partners' aims are:

2.4.1 to maximise the benefits to patients of integrating the Delegated Functions with the ICBs' Commissioning Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim;

2.4.2 to maximise the benefits to patients of integrating NHSE retained commissioning functions with the ICB Commissioning Functions through designing and commissioning services as part of the wider pathways of care of which they are a part

3. **SCOPE OF THE ARRANGEMENTS**

3.1 This Agreement sets out the Joint Working Arrangements through which the Partners will work together to commission Services. This may include one or more of the following commissioning mechanisms (the "Flexibilities") although this list is not exhaustive:

3.1.1 Lead Commissioning Arrangements: where agreed Commissioning Functions are delegated to a lead Partner (Lead Partner);

3.1.2 Aligned Commissioning Arrangements: where there is no further delegation of the Commissioning Functions. However, the Partners agree mechanisms to co-operate in the commissioning of identified Services;

3.1.3 Joint Commissioning Arrangements: where the Partners exercise agreed Commissioning Functions jointly;

3.1.4 the establishment of one or more Joint Committees;

3.1.5 the establishment of one or more Commissioning Teams;

- 3.1.6 the establishment of one or more Pooled Funds;
- 3.1.7 the use of one or more Non-Pooled Fund.
- 3.2 At the Commencement Date the Partners agree that the following Joint Working Arrangements shall be in place:
- 3.2.1 Delegation by NHS England of the Delegated Functions to each individual ICB in accordance with the relevant Delegation Agreement.
- 3.2.2 Establishment of the following Joint Working Arrangements for delegated and retained services:
- Maintenance of the established Commissioning Team, hosted by NHS England in accordance with Clause 5.1 through which agreed Delegated and Retained Services may be commissioned in line with the Commissioning Team Agreement in Schedule 6;
 - Delegation of responsibilities by the ICBs to a Joint Committee and other associated sub-groups established in accordance with Schedule 2;
 - Approval of the two schemes for the commissioning of delegated and retained services for the Midlands multi-ICBs and for the collaborative commissioning of retained services as set out in Schedule 3;
 - Establishment of financial risk share and pooled budget arrangement as set out in Schedule 4.

4. **FUNCTIONS**

- 4.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the commissioning of health services in accordance with the terms of this Agreement.
- 4.2 This Agreement shall include such Commissioning Functions as shall be agreed from time to time by the Partners and set out in the relevant Scheme Specifications.
- 4.3 The Scheme Specifications for the Individual Schemes included as part of this Agreement at the Commencement Date are set out in Schedule 3.
- 4.4 Where the Partners add a new Individual Scheme to this Agreement, a Scheme Specification for each Individual Scheme shall be completed and approved by each Partner in accordance with the variation procedure set out in Clause 13 (*Variations*).
- 4.5 The Partners shall work in co-operation and shall endeavour to ensure that all Services are commissioned with all due skill, care and attention irrespective of the Joint Working Arrangements utilised.
- 4.6 Where there are Lead Commissioning Arrangements in respect of any Individual Scheme, unless the Scheme Specification otherwise provides, the Lead Partner shall:
- 4.6.1 exercise the Functions of each Partner as identified in the relevant Scheme Specification;

- 4.6.2 endeavour to ensure that all Commissioning Functions included in the relevant Individual Scheme are funded as agreed by each Partner in respect of each Financial Year;
- 4.6.3 comply with all relevant legal duties and Guidance of all Partners in relation to the Services being commissioned;
- 4.6.4 perform all commissioning obligations with all due skill, care and attention;
- 4.6.5 undertake performance management and contract monitoring of all service contracts including (without limitation) the use of contract notices where Services fail to deliver contracted requirements;
- 4.6.6 make payment of all sums due to a Provider pursuant to the terms of any Services Contract; and
- 4.6.7 keep the other Partner(s) regularly informed of the effectiveness of the Joint Working Arrangements including any forecasted Overspend or Underspend where there is a Pooled Fund or Non-Pooled Fund.

5. **COMMISSIONING TEAM**

- 5.1 The Partners agree to establish a Commissioning Team(s) as set out in Schedule 6 (Commissioning Team Arrangements)

6. **STAFFING**

- 6.1 The staffing arrangements in respect of each Individual Scheme shall be as set out in the relevant Scheme Specification and Joint Working Arrangements.

7. **JOINT COMMITTEE**

- 7.1 Where Partners intend to form a Joint Committee then the arrangements for the Joint Committee shall be as set out in Schedule 2 (*Governance Arrangements*); and the relevant Joint Committee Terms of Reference.
- 7.2 An ICB may, at its discretion, table for discussion at any Joint Committee meeting an item relating to any ICB Function, in order to facilitate engagement and promote integration and collaborative working. Decision-making in respect of such discussions will remain with the relevant ICB. For the avoidance of doubt, the Joint Committee will not have any authority to take decisions in respect of ICB Functions, outside of services defined in Schedule 3.
- 7.3 NHSE may table for discussion at any Joint Committee meeting an item relating to NHSE's accountability to the Secretary of State and Parliament in respect of any NHSE delegated Functions or any such other of NHSE's Functions that it considers appropriate in order to facilitate engagement and promote integration and collaborative working.

8. **GOVERNANCE**

- 8.1 Overall strategic oversight of partnership working between the Partners shall be as set out in Schedule 2 (*Governance Arrangements*).

- 8.2 Each Partner has internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.
- 8.3 The Governance Arrangements shall set out how the Partners shall provide overall oversight and approval of Individual Schemes and variations to those Individual Schemes.
- 8.4 Each Scheme Specification shall confirm the Governance Arrangements in respect of the Individual Scheme and how that Individual Scheme is reported to each partner.

9. **POOLED FUNDS, NON-POOLED FUNDS AND RISK SHARING**

- 9.1 The Partners may establish Pooled Funds, Non-Pooled Funds and agree Risk Sharing in accordance with Schedule 4 (*Financial Arrangements*).

10. **REVIEW**

- 10.1 Save where the Partners agree alternative arrangements (including alternative frequencies) the Partners shall undertake an Annual Review of the operation of this Agreement, any Pooled Fund and Non-Pooled Fund and the provision of the Services within three (3) months of the end of each Financial Year.
- 10.2 Annual Reviews shall be conducted in good faith.

11. **COMPLAINTS**

- 11.1 Complaints will be managed by the specialised commissioning team hosted by NHSE England in line with the agreed complaints process.
- 11.2 A report summarising complaints, actions and lessons learnt will be provided to the Joint and Collaborative Committee annually.

12. **FINANCES**

- 12.1 The financial arrangements shall be as agreed between the Partners in the relevant Scheme Specification and Schedule 4 (*Financial Arrangements*).
- 12.2 Unless expressly provided otherwise in this Agreement or otherwise agreed in advance in writing by the Partners, each Partner shall bear its own costs as they are incurred.

13. **VARIATION**

- 13.1 The Partners acknowledge that the scope of the Collaboration Arrangements may be reviewed and amended from time to time.
- 13.2 This Agreement may be varied by the agreement of the Partners at any time in writing in accordance with the Partners' internal decision-making processes.
- 13.3 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.
- 13.4 Where the Partners agree that there will be:

- 13.4.1 a new Pooled Fund;
- 13.4.2 a new Individual Scheme; or
- 13.4.3 an amendment to a current Individual Scheme,

the Partners shall agree the new or amended Individual Scheme in accordance with the Governance Arrangements and, in respect of amendments, the Scheme Specification. Each new or amended Individual Scheme must be signed by each of the Partners. A request to vary an Individual Scheme, which may include (without limitation) a change in the level of Financial Contributions or other matters set out in the relevant Scheme Specification, may be made by any Partner but will require agreement from all the Partners. The notice period for any variation unless otherwise agreed by the Partners shall be three (3) months or in line with the notice period for variations within the associated Service Contract(s), whichever is the shortest.

13.5 Partners may propose additional schemes to be added to this agreement via the Joint Committees.

13.6 The following approach shall, unless otherwise agreed, be followed by the Partners:

13.6.1 on receipt of a request from one Partner to vary the Agreement including (without limitation) the introduction of a new Individual Scheme or amendments to an existing Individual Scheme, the Partners will first undertake an impact assessment and identify the likely impact of the variation including those Individual Schemes and Service Contracts likely to be affected;

13.6.2 the Partners will agree any action to be taken because of the proposed variation. This shall include consideration of:

13.5.2.1 governance and decision-making arrangements;

13.5.2.2 oversight and assurance arrangements;

13.5.2.3 contracting arrangements; and/or

13.5.2.4 whether the proposed variation could have an impact on a Commissioning Team and/or any Staff;

13.6.3 wherever possible agreement will be reached to reduce the level of funding in the Service Contract(s) in line with any reduction in budget; and

13.6.4 should this not be possible, and one Partner is left financially disadvantaged because of the proposed variation, then the financial risk will, unless otherwise agreed, be apportioned according to the financial risk share arrangement detailed in Schedule 4.

14. DATA PROTECTION

14.1 The Partners must ensure that all Personal Data processed by or on behalf of them while carrying out the Joint Working Arrangements is processed in accordance with the relevant Partner's obligations under Data Protection

Legislation and Data Guidance, and the Partners must assist each other as necessary to enable each other to comply with these obligations.

- 14.2 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a need-to-know basis. If any Partner:
 - 14.2.1 becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted, or unusable; or
 - 14.2.2 becomes aware of any security breach,in respect of the Relevant Information, it shall promptly notify the relevant Partners and NHS England. The Partners shall fully cooperate with one another to remedy the issue as soon as reasonably practicable.
- 14.3 In processing any Relevant Information further to this Agreement, each Partner shall at all times comply with their own policies and any NHS England policies and guidance on the handling of data.
- 14.4 Any information governance breach must be responded to in accordance with the Information Governance Guidance for Serious Incidents. If any Partner is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach, then, as soon as reasonably practical and in any event on or before the first such notification is made, the relevant Partner must fully inform the other Partners of the information governance breach. This clause does not require the relevant Partner to provide information which identifies any individual affected by the information governance breach were doing so would breach Data Protection Legislation.
- 14.5 Whether or not a Partner is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Partners acknowledge that a Partner may act as both a Data Controller and a Data Processor.
- 14.6 The Partners will share information to enable joint service planning, commissioning, and financial management subject to the requirements of Law, including the Data Protection Legislation in respect of any Personal Data.
- 14.7 Other than in compliance with judicial, administrative, governmental, or regulatory process in connection with any action, suit, proceedings or claim or otherwise required by any Law, no information will be shared with any third parties save as agreed by the Partners in writing.
- 14.8 Schedule 5 (*Further Information Governance and Sharing Provisions*) makes further provision about information sharing, information governance and includes the data controller agreement (Schedule 5 Appendix 1).

15. IT INTER-OPERABILITY

- 15.1 The Partners will work together to ensure that all relevant IT systems operated by the Partners in respect of the Joint Working Arrangements are inter-operable and that data may be transferred between systems securely, easily and efficiently.

- 15.2 The Partners will each use reasonable endeavours to help develop initiatives to further this aim.

16. FURTHER ARRANGEMENTS

- 16.1 The Partners must give due consideration to whether any of the Commissioning Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act. The Partners must comply with any Guidance around the commissioning of Specialised Services by means of arrangements under section 65Z5 or 75 of the NHS Act.

17. FREEDOM OF INFORMATION

- 17.1 Each Partner acknowledges that the others are a public authority for the purposes of the Freedom of Information Act 2000 ("FOIA") and the Environmental Information Regulations 2004 ("EIR").
- 17.2 Each Partner may be statutorily required to disclose further information about the Agreement and the FOIA or EIA Information in response to a specific request under FOIA or EIR, in which case:
- 17.2.1 each Partner shall provide the other Partners with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;
 - 17.2.2 each Partner shall consult the other Partners as relevant regarding the possible application of exemptions in relation to the FOIA or EIA Information requested; and
 - 17.2.3 each Partner acknowledges that the final decision as to the form or content of the response to any request is a matter for the Partner to whom the request is addressed.
- 17.3 The commissioning team will respond to all FOIA requests on behalf of Partners as part of the administrative responsibility set out in Schedule 6 (Commissioning Team Agreement and Standard Operating Framework).

18. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

- 18.1 The Partners must ensure that, in delivering the Joint Working Arrangements, all Staff comply with Law, with Managing Conflicts of Interest in the NHS and other Guidance, and with Good Practice, in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest.
- 18.2 Each ICB must maintain a register of interests in respect of all persons involved in decisions concerning the Joint Working Arrangements. This register must be publicly available. For the purposes of this clause, an ICB may rely on an existing register of interests rather than creating a further register.

19. CONFIDENTIALITY

- 19.1 Except as this Agreement otherwise provides, Confidential Information is owned by the disclosing Partner and the receiving Partner has no right to use it.

- 19.2 Subject to Clause 19.3, the receiving Partner agrees:
- 19.2.1 to use the disclosing Partner's Confidential Information only in connection with the receiving Partner's performance under this Agreement;
 - 19.2.2 not to disclose the disclosing Partner's Confidential Information to any third party or to use it to the detriment of the disclosing Partner; and
 - 19.2.3 to maintain the confidentiality of the disclosing Partner's Confidential Information.
- 19.3 The receiving Partner may disclose the disclosing Partner's Confidential Information:
- 19.3.1 in connection with any Dispute Resolution Procedure;
 - 19.3.2 to comply with the Law;
 - 19.3.3 to any appropriate Regulatory or Supervisory Body;
 - 19.3.4 to its Staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Partner's duty under Clause 19.2;
 - 19.3.5 to NHS bodies for the purposes of carrying out their functions; and
 - 19.3.6 as permitted under any other express arrangement or other provision of this Agreement.
- 19.4 The obligations in Clause 19 will not apply to any Confidential Information which:
- 19.4.1 is in or comes into the public domain other than by breach of this Agreement;
 - 19.4.2 the receiving Partner can show by its records was in its possession before it received it from the disclosing Partner; or
 - 19.4.3 the receiving Partner can prove it obtained or was able to obtain from a source other than the disclosing Partner without breaching any obligation of confidence.
- 19.5 This Clause 19 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by an ICB where necessary for the purposes of exercising its functions in relation to that ICB.
- 19.6 This Clause 19 will survive the termination of this Agreement for any reason for a period of five (5) years.
- 19.7 This Clause 19 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

20. LIABILITIES

- 20.1 Subject to Clause 20.2, and 20.3, if a Partner ("First Partner") incurs a Loss arising out of or in connection with this Agreement (including a Loss arising

under an Individual Scheme) as a consequence of any act or omission of another Partner ("Other Partner") which constitutes negligence, fraud or a breach of contract in relation to this Agreement then the Other Partner shall be liable to the First Partner for that Loss.

- 20.2 Clause 20.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner. Clause 20.1 shall not apply in respect of Loss where an alternative arrangement has been agreed by the Partners and set out in the relevant Scheme Specification.
- 20.3 If any third party makes a Claim or intimates an intention to make a Claim against any Partner, which may reasonably be considered as likely to give rise to liability under this Clause 20, the Partner that may have a Claim against the Other Partner will:
 - 20.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant Claim;
 - 20.3.2 not make any admission of liability, agreement, or compromise in relation to the relevant Claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed); and
 - 20.3.3 give the Other Partner and its professional advisers reasonable access to its premises and Staff and to any relevant assets, accounts, documents and records within its power or control so as to enable the Other Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant Claim.
- 20.4 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a Claim against the other pursuant to this Agreement.
- 20.5 Unless expressly agreed otherwise, nothing in this Agreement shall affect:
 - 20.5.1 the liability of NHS England to any person in respect of NHS England's Commissioning Functions; or
 - 20.5.2 the liability of any of the ICBs to any person in respect of that ICB's Commissioning Functions.
- 20.6 Each ICB must:
 - 20.6.1 comply with any requirements set out in the Delegation Agreement in respect of Claims and any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims or the pro-active management of Claims;
 - 20.6.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify the other Partners and send each relevant Partner all copies of such correspondence; and

- 20.6.3 co-operate fully with each relevant Partner in relation to such Claim and the conduct of such Claim.

21. DISPUTE RESOLUTION

- 21.1 Where any dispute arises between the Partners in connection with this Agreement, the Partners must use their best endeavours to resolve that dispute.
- 21.2 Where any dispute is not resolved under Clause 21.1 on an informal basis, any Authorised Officer may convene a special meeting of the Partners to attempt to resolve the dispute.
- 21.3 Where any dispute is not resolved under Clause 21.1 or 21.2 the Partners can appoint an independent mediator to attempt to resolve the dispute. The cost of mediation will be borne in equal shares between parties involved in the dispute.
- 21.4 Where any dispute remains unresolved after mediation, the Partners will commission an independent review. The Partners will abide by the independent review findings. The cost will be borne in equal shares between parties involved in the dispute.

22. BREACHES OF THE AGREEMENT

- 22.1 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 21 (*Dispute Resolution*).
- 22.2 Without prejudice to Clause 22.1, if any Partner does not comply with the terms of this Agreement (including if any Partner exceeds its authority under this Agreement), the other Partners may at their discretion agree to:
- 22.2.1 waive their rights in relation to such non-compliance;
- 22.2.2 ratify any decision;
- 22.2.3 terminate this Agreement in accordance with Clause 23 (*Termination and Default*) below; or
- 22.2.4 exercise the Dispute Resolution Procedure in accordance with Clause 21 (*Dispute Resolution*).

23. TERMINATION AND DEFAULT

- 23.1 If an ICB wishes to end its participation in this Agreement, the relevant ICB must provide at least six (6) months' notice to the other Partners of its intention to end its participation in this Agreement and must have given prior notification to NHS England. Such notification shall only take effect from the end of 31 March in any calendar year and shall only take effect where alternative arrangements for the provision of the Delegated Services and effective

exercise of the Delegated Functions are in place for the period immediately following termination.

23.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that each Partner is assured that the relevant Services will continue to be appropriately commissioned.

23.3 The ICBs will work together to ensure that there are suitable alternative arrangements in place in relation to the Services.

24. CONSEQUENCES OF TERMINATION

24.1 Upon termination of this Agreement (in whole or in part), for any reason whatsoever, the following shall apply:

24.1.1 the Partners agree that they will work together and co-operate to ensure that the winding down of these arrangements is carried out smoothly and with as little disruption as possible to patients, employees, the Partners and third parties, to minimise costs and liabilities of each Partner in doing so;

24.1.2 where there are Commissioning Team arrangements in place the Partners shall discuss and agree arrangements for the Staff and any financial arrangements;

24.1.3 where a Partner has entered a Service Contract in exercise of the Functions of any other Partner which continues after the termination of this Agreement, all Partners shall continue to provide necessary funding in accordance with the agreed contribution for that Service prior to termination and will enter all appropriate legal documentation required in respect of this;

24.1.4 where there are Lead Commissioning Arrangements in place, the Lead Partner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Partner in breach of the Service Contract) where the other Partner requests the same in writing provided that the Lead Partner shall not be required to make any payments to a Service provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment;

24.1.5 where there are Joint Commissioning Arrangements in place, the Partners shall co-operate with each other as reasonably necessary to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place any Partner in breach of the Service Contract) where a Partner requests the same in writing provided that no Partner shall be required to make any payments to a Service provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment;

24.1.6 where a Service Contract held by a Lead Partner relates all or partially to services which relate to the other Partner's Functions and provided that the Service Contract allows, the other Partner may

request that the Lead Partner assigns the Service Contract in whole or part upon the same terms as the original contract; and

24.1.7 termination of this Agreement shall have no effect on the liability, rights or remedies of any Partner already accrued, prior to the date upon which such termination takes effect.

24.2 The provisions of Clauses 14 (*Data Protection*), 1717 (*Freedom of Information*), 19 (*Confidentiality*), 20 (*Liabilities*) and 24 (*Consequences of Termination*) shall survive termination or expiry of this Agreement.

25. **PUBLICITY**

25.1 The Partners shall use reasonable endeavours to consult one another before making any public announcements concerning the subject matter of this Agreement, the Joint Working Arrangements or any Services provided under the Joint Working Arrangements.

26. **EXCLUSION OF PARTNERSHIP OR AGENCY**

26.1 Nothing in this Agreement shall create or be deemed to create a legal partnership under the Partnership Act 1890 or the relationship of employer and employee between the Partners.

26.2 Save as specifically authorised under the terms of this Agreement, no Partner shall hold itself out as the agent of any other Partner.

27. **THIRD PARTY RIGHTS**

27.1 The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the Partners to this Agreement do not intend that any third party should have any rights in respect of this Agreement by virtue of that Act.

28. **NOTICES**

28.1 Any notices given under this Agreement must be sent by e-mail to the relevant Authorised Officers or their nominated deputies.

28.2 Notices by email will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

29. **ASSIGNMENT AND SUBCONTRACTING**

29.1 This Agreement, and any rights and conditions contained in it, may not be assigned or transferred by a Partner, without the prior written consent of the other Partners, except to any statutory successor to the relevant Commissioning Function.

30. **SEVERABILITY**

30.1 If any term, condition, or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect the validity, legality or enforceability of the remaining parts of this Agreement.

31. **WAIVER**

- 31.1 No failure or delay by a Partner to exercise any right or remedy provided under this Agreement or by Law shall constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy.

32. STATUS

- 32.1 The Partners acknowledge that they are health service bodies for the purposes of section 9 of the NHS Act. Accordingly, this Agreement shall be treated as an NHS contract and shall not be legally enforceable.

33. ENTIRE AGREEMENT

- 33.1 This Agreement constitutes the entire agreement and understanding of the Partners and supersedes any previous agreement between the Partners relating to the subject matter of this Agreement.

34. GOVERNING LAW AND JURISDICTION

- 34.1 Subject to the provisions of Clause 21 (*Dispute Resolution*) and Clause 32 (*Status*), this Agreement shall be governed by and construed in accordance with English Law, and the Partners irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

35. FAIR DEALINGS

- 35.1 The Partners recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of any Partner and that, if in the course of the performance of this Agreement, unfairness to any Partner does or may result, then the Relevant Partner(s) shall use reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

36. COUNTERPARTS

- 36.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

This Agreement has been entered into on the Commencement Date

SIGNED by Amanda Sullivan

..... (Signature)

for and on behalf of NHS Nottingham &
Nottinghamshire Integrated Care Board, Derby &
Derbyshire Integrated Care Board and
Lincolnshire Integrated Care Board

..... (Date)

SIGNED by Toby Sanders (Signature)

for and on behalf of NHS Northamptonshire
Integrated Care Board and NHS Leicester,
Leicestershire & Rutland Integrated Care Board (Date)

SIGNED by Simon Trickett (Signature)

for and on behalf of NHS Herefordshire &
Worcestershire Integrated Care Board and
Coventry and Warwickshire Integrated Care
Board (Date)

SIGNED by David Melbourne (Signature)

for and on behalf of NHS Birmingham & Solihull
Integrated Care Board and the Black Country
Integrated Care Board (Date)

SIGNED by Simon Whitehouse (Signature)

for and on behalf of NHS Shropshire, Telford &
Wrekin Integrated Care Board and Staffordshire &
Stoke on Trent Integrated Care Board (Date)

SIGNED by Roz Lindridge (Signature)

For and on behalf of NHS England
..... (Date)

SCHEDULE 1: DEFINITIONS AND INTERPRETATIONS

1. In this Agreement, unless the context otherwise requires, the following words and expressions shall have the following meanings:

“Agreement”	means this agreement between the Partners comprising these terms and conditions together with all schedules attached to it;
“Aligned Commissioning Arrangements”	means the arrangements by which the Partners agree to commission a Service in a co-ordinated and collaborative manner. For the avoidance of doubt, an aligned commissioning arrangement does not involve the delegation of any functions between ICBs;
“Annual Review”	means the annual review of the arrangements under this Agreement by the Partners;
“Area”	means the geographical area covered by the ICBs;
“Authorised Officer”	the individual(s) appointed as Authorised Officer in accordance with the agreed Terms of Reference;
“Claim”	means for or in relation to the Commissioning Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal, or the Secretary of State, any governmental, regulatory, or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by any governmental, regulatory or similar body or agency;
“Clinical Commissioning Policies”	a nationally determined clinical policy sets out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure, or intervention for patients with a condition requiring a specialised service;
“Clinical Reference Groups”	means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Specialised Services should be provided;
“Collaborative Commissioning Agreement”	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts;
“Commencement Date”	[means 1 April 2024];
“Commissioning Functions”	the respective statutory functions of the Partners in arranging for the provision of services as part of the health service;
“Commissioning Team”	means a staffing arrangement for commissioning agreed Services through an integrated team structure. This can be either set up using: 1. Lead Commissioning (one Partner hosts the Unit as Lead and all functions are delegated to that Partner); or 2. Joint Commissioning or Aligned Commissioning (one Partner may host but no functions are delegated). The Partners will need to agree whether decisions are taken via a Joint Commissioning

arrangement such as a Joint Committee or whether each Partner is required to take decisions;

"Confidential Information"	means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement or Joint Working Arrangements made pursuant to it and: i. which comprises Personal Data or which relates to any patient or his treatment or medical history; ii. the release of which is likely to prejudice the commercial interests of a Partner; or iii. which is a trade secret;
"Contracting Standard Operating Procedure"	means any contracting standard operating procedure produced by NHS England in respect of the Delegated Specialised Services;
"Data Controller"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Processor"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Sharing Agreement"	means any data sharing agreement entered in accordance with Schedule 5 (<i>Further Information Governance and Sharing Provisions</i>);
"Data Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy, or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency, and the Information Commissioner;
"Data Protection Legislation"	means the UK General Data Protection Regulation, the Data Protection Act 2018, the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699), the Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2426/2003), the common law duty of confidentiality and all applicable laws and regulations relating to the processing of Personal Data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner;
"Data Protection Officer"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Security and Protection Toolkit"	means the toolkit at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit or as amended or replaced from time to time
"Delegated Commissioning Group" "DCG"	means the advisory forum in respect of Delegated Services set up by NHS England currently known as the Delegated Commissioning Group for Specialised Services;

“Delegation Agreement(s)”	means the Delegation Agreements under which NHS England delegate specific NHS England Specialised Services Commissioning Functions to each ICB;
“Delegated Functions”	means the Specialised Services Commissioning Functions of NHS England delegated to each ICB under a Delegation Agreement;
“Delegated Services”	means those Specialised Services commissioned in exercise of the Delegated Functions;
“Dispute Resolution Procedure”	the procedure set out in Clause 21 (<i>Dispute Resolution</i>);
“EIR”	means the Environmental Information Regulations 2004;
“Finance Guidance”	guidance, rules and operating procedures produced by NHS England that relate to these Joint Working Arrangements, including but not limited to the following: • Commissioning Change Management Business Rules; • Contracting Standard Operating Procedure; • Cashflow Standard Operating Procedure; • Finance and Accounting Standard Operating Procedure; • Service Level Framework Guidance;
“Flexibilities”	Mean the flexibilities that the Partners may use to work in a co-ordinated manner as set out at Clause 3 (<i>Scope of the Arrangements</i>);
“Financial Contribution”	means the financial contributions agreed by each Partner in respect of an Individual Scheme in any Financial Year;
“Financial Year”	means each financial year running from 1 April in any year to 31 March in the following calendar year;
“FOIA”	the Freedom of Information Act 2000 and any subordinate legislation made under it from time to time, together with any guidance or codes of practice issued by the Information Commissioner or relevant government department concerning this legislation;
“FOIA or EIR Information”	has the meaning given under section 84 of FOIA or the meaning given for “environmental information” under the EIR as applicable;
“Good Practice”	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
“Governance Arrangements”	means the governance arrangements in respect of the Arrangements agreed by the Partners and as set out in Schedule 2 (<i>Governance Arrangements</i>);
“Guidance”	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the Partners have a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified by any relevant Regulatory or Supervisory Body;
“High-Cost Drugs”	means medicines not reimbursed though national prices and identified on the NHS England high-cost drugs list;
“ICB Reserved Functions”	Where there is any delegation of an ICB’s Commissioning Functions or further delegation of Delegated Functions, those functions that remain reserved to each ICB;

“Indemnity Arrangement”	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
“Individual Scheme”	means an arrangement in relation to how the ICBs will work together using one or more of the Flexibilities which has been agreed by the Partners to be included within this Agreement as part of the Joint Working Arrangements;
“Joint Committee”	means the joint committee(s) established by the partners that perform functions under this Agreement on the terms set out in their Terms of Reference;
“Joint Functions”	any Functions that are delegated to a Joint Committee;
“Joint Commissioning”	means Partners agreeing to jointly exercise agreed Commissioning Functions on behalf of each other in exercise of the functions of each Partner part of that Individual Scheme. This may, for example, be through agreeing to enter into the same contract or by use of a Joint Committee;
“Joint Working Arrangements”	means the Flexibilities that the Partners have agreed to use to work in a co-ordinated manner which, at the Commencement Date, are as set out in Clause 3;
"Law"	means: i. any statute or proclamation or any delegated or subordinate legislation; i. any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and i. any judgment of a relevant court of law which is a binding precedent in England;
“Lead Commissioning Arrangements”	means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of another Partner or Partners in exercise of the Commissioning Functions of the ICB Partners;
“Lead Partner”	means the Partner responsible for commissioning under a Lead Commissioning Arrangement;
“Loss”	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges whether arising under statute, contract or common law;
“Managing Conflicts of Interest in the NHS”	means the NHS publication by that name available at: https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/ or such publication that amends or replaces that publication;
“Mandated Guidance”	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of Delegated Functions and issued by NHS England from time to time as mandatory;

“National Standards”	means the service standards for each Specialised Service, as set by NHS England and included in Clinical Commissioning Policies or National Specifications;
“National Specifications”	the service specifications published by NHS England in respect of Specialised Services;
“Need to Know”	has the meaning set out in Schedule 5 (<i>Further Information Governance and Sharing Provisions</i>);
“NHS Act”	the National Health Service Act 2006;
“NHS England Functions”	NHS England’s Commissioning Functions exercisable under or by virtue of the NHS Act;
“NHS England Reserved Functions”	those aspects of the Specialised Commissioning Functions for which NHS England retains commissioning responsibility;
“Non-Personal Data”	means data which is not Personal Data;
“Non-Pooled Funds”	means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification;
“Operational Days”	means a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;
“Partners”	means the parties to this Agreement;
“Personal Data”	has the meaning set out in the Data Protection Legislation;
“Pooled Funds”	means any pooled fund established and maintained by the Partners as a pooled fund;
“Population”	means the population for which an ICB or all the ICBs have the responsibility for commissioning health services;
“Provider Collaborative”	means a group of Providers who have agreed to work together to improve the care pathway for one or more Services;
“Provider Collaborative Arrangements”	means the arrangements entered in respect of a Provider Collaborative;
“Provider Collaborative Guidance”	means any guidance published by NHS England in respect of Provider Collaboratives;
“Regional Quality Group”	means a group set up to act as a strategic forum at which regional partners from across health and social care can share, identify, and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated;
“Regulatory or Supervisory Body”	means any statutory or other body having authority to issue guidance, standards, or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: i. CQC; ii. NHS England; iii. the Department of Health and Social Care;

- iv. NICE;
- v. Healthwatch England and Local Healthwatch;
- vi. the General Medical Council;
- vii. the General Dental Council;
- viii. the General Optical Council;
- ix. the General Pharmaceutical Council;
- x. the Healthcare Safety Investigation Branch; and
- xi. the Information Commissioner;

“Relevant Information”	means the Personal Data and Non-Personal Data processed under this Agreement, and includes, where appropriate, “confidential patient information” (as defined under section 251 of the NHS Act), and “patient confidential information” as defined in the 2013 Report, The Information Governance Review – “ <i>To Share or Not to Share?</i> ”;
“Reserved Functions”	means NHS England Reserved Functions or ICB Reserved Functions;
“Relevant Networks”	Clinical means those clinical networks identified by NHS England as required to support the commissioning of Specialised Services for the Population;
“Retained Services”	means those Specialised Services for which NHS England shall retain commissioning responsibility, as set out the Delegation Agreement;
“Risk Sharing”	means an agreed arrangement for risk and benefit sharing between the Partners;
“Scheme Specification”	means a specification setting out the Joint Working Arrangements in respect of an Individual Scheme agreed by the Partners to be commissioned under this Agreement;
“Services”	means such health services as agreed from time to time by the Partners as commissioned under the Joint Working Arrangements and more specifically defined in each Scheme Specification;
“Service Contract”	means an agreement entered into by one or more of the Partners in exercise of its obligations under this Agreement to secure the provision of Services in accordance with the relevant Individual Scheme
“Single Point of Contact”	the member of Staff appointed by each relevant Partner in accordance with Paragraph 13 of Schedule 5 (<i>Further Information Governance and Sharing Provisions</i>)
“Special Category Personal Data”	has the meaning set out in the Data Protection Legislation;
“Specialised Commissioning Budget”	means the budget identified by NHS England in respect of each ICB for the purpose of exercising the Delegated Functions;
“Specialised Commissioning Functions”	means the statutory functions conferred on NHS England under Section 3B of the NHS Act 2006 and Regulation 11 of the National Health Service Commissioning Board and Clinical Commissioning

“Specified Purpose”	means the purpose for which the Relevant Information is shared and processed to facilitate the exercise of the Joint Working Arrangements as specified in Schedule 5 (<i>Further Information Governance and Sharing Provisions</i>) to this Agreement;
“Specialised Services”	means the services commissioned in exercise of the Specialised Commissioning Functions;
“Specialised Services Contract”	means a contract for the provision of Specialised Services entered in the exercise of the Specialised Commissioning Functions;
“Specialised Services Provider”	means a provider party to a Specialised Services Contract;
“Staff”	means the Partners’ employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of any Partner (whether the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors’ and their sub-contractors’ personnel;
“Standard Operating Framework”	means the agreement(s) that sets out the arrangements for a Commissioning Team;
“Terms of Reference”	means the Terms of Reference for the Joint Committee agreed between the Partners at the first meeting of the Joint Committee;
“Triple Aim”	means the duty on each of the Partners in making decisions about the exercise of their functions, to have regard to all likely effects of the decision in relation to: i. the health and well-being of the people of England; ii. the quality of services provided to individuals by the NHS; iii. efficiency and sustainability in relation to the use of resources by the NHS;
“Underspend”	means any expenditure from a Pooled Fund or Non-Pooled Fund in a Financial Year which is less than the value of the agreed contributions by the Partners for that Financial Year;
“UK GDPR”	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018 .

2. References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted (whether before or after the Commencement Date) from time to time.
3. The headings of the Clauses in this Agreement are for reference purposes only and shall not be construed as part of this Agreement or deemed to indicate the meaning of the relevant Clauses to which they relate. Reference to Clauses are Clauses in this Agreement.

4. References to Schedules are references to the schedules to this Agreement and a reference to a Paragraph is a reference to the paragraph in the Schedule containing such reference.
5. References to a person or body shall not be restricted to natural persons and shall include a company, corporation, or organisation.
6. Words importing the singular number only shall include the plural.
7. Use of the masculine includes the feminine and all other genders.
8. Where anything in this Agreement requires the mutual agreement of the Partners, then unless the context otherwise provides, such agreement must be in writing.
9. Any reference to the Partners shall include their respective statutory successors, employees and agents.
10. In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.
11. Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

SCHEDULE 2: GOVERNANCE ARRANGEMENTS

1. Joint & Collaborative Committee

- 1.1. The overall oversight and governance arrangements for these collaborative working arrangements will be discharged through a Joint Committee established by the ICBs.
- 1.2. The Terms of Reference and other detailed arrangements that support the operation of the Joint Committee are appended to this Schedule. They set out that the Joint Committee will have delegated authority on behalf of the ICBs respectively to discharge the functions delegated to the ICBs by NHS England in respect of Specialised Services, including establishing appropriate subsidiary arrangements to enable effective decision-making and detailed oversight of performance, finance, and quality.
- 1.3. The NHS England regional commissioning team will continue to work jointly with the Joint Committee on the commissioning of retained specialised services. This will include, where appropriate, discharging its authority (through accountable directors) in consultation with the Joint Committee.
- 1.4. The subsidiary arrangements established by the Joint Committee will include appropriate schemes of reservation and delegation in place to enable Sub-Groups of the Joint Committee and/or members of staff employed by Joint Commissioning Team to have the authority to make decisions. These arrangements will be developed in collaboration with NHS England to support effective working on both the delegated and retained services.

2. Subgroups

- 2.1.1 There will be joint subgroups established by the partners to support these arrangements, these being:
 - **Midlands Acute Specialised Commissioning Group (MASCg)**
 - **Mental Health Learning Disability & Autism Commissioning Group (MHLDACG)**
 - **Specialised Commissioning Quality Group**
 - **Finance and Contracting Group**
- 2.1.2 The following NHS England Subgroups for NHSE decision making with ICB colleagues in attendance
 - **Vaccination Governance Group**
 - **Screening Governance Group**
 - **Health and Justice Assurance and Improvement Group (HJAIG)**
- 2.1. Subsidiary arrangements established by the Joint Committees will include providing delegated authority to **Midlands Acute Specialised Commissioning Group (MASCg)** and **Mental Health Learning Disability & Autism Commissioning Group (MHLDACG)**, Joint Sub-Groups established by all the partners to make decisions on both the delegated and retained services.
- 2.2. The role of MASCg and the MHLDACG will be to support the partners and the Joint Committee in ensuring that the delivery of the delegated and retained services is effective, efficient, and economical and in line with each partner's statutory responsibilities. The role of these subgroups will be to
 - **Review** all business cases including for Contract Variations and extensions, investments, single tender actions, consultancy spend and CSU spend
 - **Approve** business cases within functional limits unless specifically escalated to the Joint Committee for approval
 - **Prepare** annual plans and monitor performance maintaining oversight and remediation

- **Review** detailed monthly financial information on actual, planned, forecast outturn
 - **Deliver** strategic and operational plans
- 2.3. MASCG and MHLDACG will report and make recommendations to the Joint Committees in respect of delegated services and to Midlands Commissioning Group in respect of the retained services and will always operate in accordance with its agreed terms of reference (which are set out in Appendix 1-7 of this schedule) and the relevant schemes of reservation and delegation and standing financial instructions for delegated and retained services.
- 2.4. Each of the partners will appoint a member of MASCG and MHLDACG who is authorised to act as part of the group and participate in collective decision making on behalf of their organisation. MASCG will also ensure that its decisions are taken with the advice of suitable subject matter experts.
- 2.5. **Specialised Commissioning Quality Group** – This group, chaired by the Regional Medical Director for Commissioning (RMDC) will provide a forum to share and discuss potential and known issues which impact on the quality and safety of Acute Specialised Commissioned services in the Midlands region and agree any remedial action.
- 2.6. The purpose of the Specialised Commissioning Quality Group is to provide a forum for routinely and systematically bringing together partners from across ICSs and the region to share insight and intelligence in relation to quality concerns, to identify opportunities for improvement and to develop regional responses as required. The focus of the discussions will be on intelligence, learning, issues and risks that are recurrent and/ or have an impact wider than individual ICSs.
- 2.9 **Finance and Contracting Subgroup** – will have responsibility to oversee the management of the pooled fund on behalf of the Joint Committees.
- 2.10 The purpose of the Finance and Contracting Subgroup is to provide robust joint financial management of the pooled fund on behalf of the ICBs in line with the terms set out in schedule 4 of this agreement.
- **Review** annual plan including investment plan
 - **Review** monthly update on financial position against plan and forecast outturn by service type
 - **Receive** a quarterly summary of clinical business cases, Contract variations or extensions approved by Joint Committee
 - **Review** STAs, losses and special payments and consultancy spend
- 2.11 **Vaccination Governance Group (VGG)** – will make decisions on the commissioning, quality and value of Vaccination Services and will always operate in accordance with its agreed terms of reference (which are set out in Appendix 1 of this schedule) and NHS England schemes of reservation and delegation and standing financial instructions for Vaccination services. The role of this subgroup will be to
- **Review** all business cases including for Contract Variations and extensions, investments, single tender actions, consultancy spend and CSU spend
 - **Approve** business cases within functional limits unless specifically escalated to the Joint Committee for approval
 - **Prepare** annual plans and monitor performance maintaining oversight and remediation
 - **Review** detailed monthly financial information on actual, planned, forecast outturn
 - **Deliver** strategic and operational plans
- 2.12 The Vaccination Governance Group will ensure ICB collaboration in all decisions in relation to the portfolio it holds

2.13 **Screening Governance Group (SGG)** – will make decisions on the commissioning, quality and value of Screening Services and will always operate in accordance with its agreed terms of reference (which are set out in Appendix 1 of this schedule) and NHS England schemes of reservation and delegation and standing financial instructions for Screening services. The role of this subgroup will be to

- **Review** all business cases including for Contract Variations and extensions, investments, single tender actions, consultancy spend and CSU spend
- **Approve** business cases within functional limits unless specifically escalated to the Joint Committee for approval
- **Prepare** annual plans and monitor performance maintaining oversight and remediation
- **Review** detailed monthly financial information on actual, planned, forecast outturn
- **Deliver** strategic and operational plans

2.12 The Screening Governance Group will ensure ICB collaboration in all decisions in relation to the portfolio it holds

2.13 **Health and Justice Assurance and Improvement Group (HJAIG)** - will make decisions on the commissioning, quality and value of Health and Justice (Including SARC) Services and will always operate in accordance with its agreed terms of reference (which are set out in Appendix 1 of this schedule) and NHS England schemes of reservation and delegation and standing financial instructions for Health and Justice and SARC Services. The role of this subgroup will be to

- **Review** all business cases including for Contract Variations and extensions, investments, single tender actions, consultancy spend and CSU spend
- **Approve** business cases within functional limits unless specifically escalated to the Joint Committee for approval
- **Prepare** annual plans and monitor performance maintaining oversight and remediation
- **Review** detailed monthly financial information on actual, planned, forecast outturn
- **Assure** performance and quality of commissioned service provider delivery against national and local requirements and standards
- **Deliver** strategic and operational plans

3. Clinical Governance

3.1. The ICBs will access the clinical, pharmaceutical, and quality governance functions provided by the Midlands Commissioning Multidisciplinary Team (employed by NHS England) via the Joint Working arrangements.

3.2. Clinical engagement and leadership will be secured at multiple tiers across the Midlands region and will draw upon established clinical networks including those formally commissioned plus the informal networks that have been recognised over time.

3.3. The Specialised Services Operational Delivery Networks (ODNs) will continue to be formally commissioned by NHS England. NHS England will retain the financial responsibility for the ODNs and will continue to play a key role in supporting understanding of clinical quality for the relevant services.

3.4. At a senior clinical level, the Collaborative Clinical Executive Forum (CCEF), a regional forum of Acute Provider and ICB Chief Medical Officers (CMOs), will continue to meet regularly and engage with the Midlands Commissioning Team. Advice offered via that forum will feed into the decision-making process via the Midlands Acute Specialised Commissioning Group (MASCG) and into the Joint Committees.

- 3.5. The Commissioning Team will include Medical Director, Pharmacy and Nursing roles which will provide a vital conduit to local systems and the national clinical leadership architecture.
- 3.6. Governance and decision-making for high-cost drugs assurance will be via Joint Committees and their sub-groups, with links to the Regional Pharmacy Leadership Board. The pharmacy team for High Costs Drugs will work across ICBs and NHS England informed by other senior pharmacists across the region e.g., HCD pharmacists, regional cancer pharmacists,
- 3.7. High-cost tariff excluded drugs will continue to be reimbursed through a national process by NHS England irrespective of whether they are used for delegated services, meaning that ICBs will not bear the financial risk of new specialised drugs growth.

4. Quality Governance

- 4.1. Key quality concerns requiring escalation relating to the Joint Services will be reported monthly to the Joint Committees by the Specialised Commissioning Quality Group, Vaccination Governance Group, Screening Governance Group and Health and Justice Assurance and Improvement Group. Furthermore, key quality concerns for all services will continue to be reported to and discussed at the NHSE led Regional Quality Group, of which all ICBs are members. These groups will ensure key quality concerns are fed back into systems to inform conversations at a local level.
- 4.2. Key quality concerns involving specialised services will also be reported into Midlands Acute Specialised Commissioning Group (MASCG) of which all 11 Midlands ICBs are members and have representation. Specialised Commissioning Quality Group will provide a forum for delegated decision making on quality matters.
- 4.3. Key quality concerns involving all other functions will also be reported to the Joint Committee as appropriate
- 4.4. To be proactive on identification of areas for quality improvement, a Quality Surveillance and Improvement Programme (QSIP) has been established to support implementation of the NHSE Midlands Acute Specialised Commissioning Quality Surveillance & Improvement Framework (QSIF). The QSIP aims to provide strategic direction and support implementation of the Quality Surveillance and Improvement Framework QSIF and will agree priorities for the Programme in addition to evaluating risks related to the Programme and to devise and implement mitigations and remedial action. The QSIF involves triangulating intelligence and data from several sources (e.g., CQC reports, specialised services dashboards, national audit etc) to monitor the quality of each service. This work is overseen by the QSIP Programme Board, has ICB representation, is chaired by the RMDC and reports to MASCG.
- 4.5. The Joint Committees will also agree a comprehensive Quality Assurance Framework which will provide a high-level description of the proposed overarching governance arrangements including for quality assurance in the Midlands region in terms of how decisions are made; outline reporting flows; where assurances will be sought, and the structures put in place to ensure that NHSE and ICB's act within their powers and discharge their responsibilities correctly and appropriately.

5. Financial Governance

- 5.1 The Financial governance arrangements in Schedule 4 shall apply to the Collaborative Arrangements.
- 5.7 **Risk Management Arrangements** - In line with their overall role to provide strategic decision-making, leadership, and oversight for the joint services the Joint Committee will establish a monitoring and management in relation to risk and issue management and escalation, and co-

ordinating the approach to intervention with providers where there are quality or contractual issues. This will include feeding back to individual ICBs for consideration of any impact on their own risk management arrangements.

- 5.8 A formal risk register will be maintained by the Midlands Commissioning Team and reported monthly through the Midlands Acute Specialised Commissioning Group to ensure ICBs are aware of any risks they may impact their systems.

6. Assurance arrangements

- 6.1. The Joint Committees will be responsible for ensuring that the ICBs are able to meet their obligations under the NHSE Oversight and Assurance Framework in relation to the delegation of specialised services which, requires that the ICBs must at all times operate in accordance with:
- (a) the Oversight and Assurance Framework published by NHS England;
 - (b) any national oversight and/or assurance guidance in respect of Specialised Services and/or joint working arrangements; and
 - (c) any other relevant NHS oversight and assurance guidance;
- collectively known as the “Assurance Processes”.

And that the ICBs must:

- (a) Develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes.
- (b) Oversee the provision of Delegated Services and the outcomes being delivered for their patients and Populations in accordance with the Assurance Processes.
- (c) Assure Providers are meeting, or have an improvement plan in place to meet, National Standards.
- (d) Provide any information and comply with specific actions in relation to the Delegated Specialised Services, as required by NHS England, including metrics and detailed reporting in accordance with the Terms of Reference.

Terms of Reference

Midlands Joint and Collaborative Committee

Introduction and purpose	The Joint & Collaborative Committee has been established by the ICBs & NHSE as listed: Cluster 1 (1) NHS Lincolnshire Integrated Care Board of Bridge House, The Point, Lions Way, Sleaford, NG34 8GG ("Lincolnshire ICB"); and (2) NHS Nottingham & Nottinghamshire Integrated Care Board of Sir John Robinson House, Sir John Robinson Way, Arnold, Nottingham, NG5 6DA ("Nottingham & Nottinghamshire ICB"); and (3) NHS Derby & Derbyshire Integrated Care Board of Cardinal Square, 10 Nottingham Road, Derby, Derbyshire, DE1 3QT ("Derby & Derbyshire ICB"). and Cluster 2 (4) NHS Leicester, Leicestershire & Rutland Integrated Care Board of Room G30, Pen Lloyd Building, County Hall, Glenfield, Leicester, LE3 8TB ("Leicester, Leicestershire & Rutland ICB"); and (5) NHS Northamptonshire Integrated Care Board of Haylock House, Kettering Parkway, Venture Park, Kettering NN15 6EY ("Northamptonshire ICB"); and Cluster 3 (6) NHS Birmingham & Solihull Integrated Care Board of Eighth Floor, Alpha Tower, Birmingham ("Birmingham & Solihull ICB"); and (7) NHS Black Country Integrated Care Board of Civic Centre, St Peters Square, Wolverhampton WV1 1SD ("Black Country ICB"); and Cluster 4 (8) NHS Herefordshire & Worcestershire Integrated Care Board of Kirkham House, John Comyn Drive, Perdiswell, Worcester, WR3 7NS ("Herefordshire & Worcestershire ICB"); and (9) NHS Coventry & Warwickshire Integrated Care Board of Shire Hall, Market Place, Warwick CV34,4RL ("Coventry & Warwickshire ICB"); and Cluster 5 (10) (NHS Shropshire, Telford & Wrekin Integrated Care Board of Halesfield 6, Halesfield, Telford, TF7 4BF ("Shropshire, Telford & Wrekin ICB"); and (11) NHS Staffordshire & Stoke-on-Trent Integrated Care Board of Stafford Education & Enterprise Park, Weston Road, Stafford, ST18 0BF ("Staffordshire & Stoke-on-Trent ICB") and (12) NHS England – Midlands Region, Cardinal Square, 10 Nottingham Road, Derby DE1 3QT The Committee has been established by the partners to fulfil the following core functions:
Introduction and purpose	

	- For the ICBs to jointly discharge commissioning responsibilities for Specialised Services that have been delegated to them by NHS England which NHS England requires them to exercise collaboratively - To act as a Collaborative forum for NHS England to discharge its retained Direct Commissioning responsibilities (including for retained Specialised Services, Health and Justice Services and Screening and Immunisation Services) in consultation with the ICBs. The Joint & Collaborative Committee will make decisions on the strategic planning and delivery, including resource allocation, oversight and assurance, to improve health and care outcomes and reduce health inequalities for services within its purview. The Joint & Collaborative Committee will establish sub-groups or sub-committees with such Terms of Reference and delegated responsibilities as it agrees.
The Terms of Reference	These Terms of Reference support effective partnership working between all Partners acting through this Joint & Collaborative Committee. They set out the role, responsibilities, membership, decision-making powers and reporting arrangements of the Joint & Collaborative Committee.
Statutory Framework	The Joint & Collaborative Committee is established pursuant to section 65Z6 of the NHS Act 2006. Apart from as set out in the Agreement, the Joint & Collaborative Committee does not affect, and must act in accordance with, the statutory responsibilities and accountabilities of the Partners.
Role of the Joint Committee	The Joint & Collaborative Committee and aligned subsidiary arrangements will be responsible for the safe, effective, efficient and economic discharge of the Joint Functions by the ICBs. It will also serve as a collaborative forum for NHS England to make decisions on retained Direct Commissioning services (Retained Specialised Services, Health and Justice Services and Immunisation and Screening services). This will involve the discharge of the following key responsibilities: Strategic Leadership: - Supporting setting the strategic direction for commissioning across the Midlands, ensuring clarity of purpose, outcomes and value for all services outlined in Schedule 3 of the Collaboration Agreement. - Oversight of the development and integration of Strategic Commissioning Frameworks for agreed Pan ICB commissioning across the Midlands. - Oversight of the development of system plans and strategies to enable the three shifts, with clear outcome metrics, financial sustainability, and public accountability for the defined population that are evidence based and responsive to population health needs. Population Health and Insight: - Oversight of work to ensure members have a deep understanding of population health needs through advance analytics, predictive modelling, and citizen insight. - Ensuring that there is effective use of robust, high-quality data and insight in the development of evidence-based prioritization frameworks aligned to value and equity. - Ensuring that there is alignment with other relevant plans and strategies including Integrated Care Strategies, Joint Strategic Needs Assessments and Health and Wellbeing Strategies. Value, Prioritisation and Investment: - Approving system-wide commissioning priorities based on value, equity, and outcomes to support investment and disinvestment decision making. - Developing subsidiary arrangements to enable effective and efficient operational decision making arrangements that will support the exercise of the Joint Functions by sub-groups and/or staff working on behalf of the partners

	Innovation and Delivery: • Supporting the development of strategies including setting expectations for outcome-based commissioning. • Oversight of collaborative commissioning across the Midlands for all services within its scope with other ICBs and NHS England. • Acting as a forum for discussion and making recommendations on issues where further joint action or working between ICBs and NHSE commissioners would be of benefit outside the arrangements delegated to it
Accountability and reporting	The Joint & Collaborative Committee will be formally accountable to the Boards of the ICBs for the functions delegated by them to the Joint & Collaborative Committee through their Schemes of Reservation and Delegation (SORDs). The Joint & Collaborative Committee operates as the collaborative body for NHS England to make decisions on direct and retained services in consultation with the ICBs through its accountable officers to NHS England's Regional Director and National Directors in line with NHSE the Scheme of Reservation and Delegation (SORDs). The Joint & Collaborative Committee may also report to NHS England's Delegated Commissioning Group (DCG) for Specialised Services on its proceedings and decisions relating to Specialised Services. The Chair (or, at their discretion, another member) may also attend the DCG to present reports on behalf of the committee. Where an ICB Board or National or Regional Directors requests that the Joint & Collaborative Committee provides information or reports on its proceedings or decisions, the Partners must comply with that request within a reasonable timescale.
Membership	<u>ICB Membership</u> The core voting membership of the Committee will be made up of one Authorised Officer (who must be the CEO or their nominated representative) from each of the ICB Clusters. Each of the ICB Clusters must ensure that the members nominated on their behalf are of a suitable level of seniority and duly authorised to act on its behalf and to agree to be bound by the final position or decision taken at any meeting of the Joint & Collaborative Committee. The Authorised Officers may nominate a named substitute who may attend meetings on their behalf with the same decision-making authority. <u>NHSE Membership</u> The NHSE Regional Director of Commissioning (or their nominated representative) will attend meetings of the Committee to take decisions in relation to the retained services in consultation with the wider committee. <u>Other Participants</u> Each of the Partners may be represented at meetings by representatives who may observe proceedings and contribute to the deliberations as required, but these will not have the right to vote. The Partners may also identify individuals or representatives of other organisations that may be invited to observe proceedings and contribute to the Joint & Collaborative Committee's deliberations as required. These representatives will not have the right to vote. <u>Term of Membership</u>

	Members (and any substitutes appointed) will hold their appointment until the partner they represent nominates an alternative member or they cease to hold their substantive role with the relevant partner. <u>Membership Lists</u> The Chair (or in the absence of a Chair, the Partners themselves) shall ensure that there is prepared (and updated from time to time) a list of the members and named substitutes and that this list is made available to the Partners. <u>Other Attendees</u> The Joint & Collaborative Committee will be supported by a Secretariat, who will be provided by the Office of Pan ICB Commissioning.
Chair	The Joint & Collaborative Committee will appoint two of the Authorised Officers as Co-Chairs of the Joint & Collaborative Committee. The Co-Chairs will serve as Strategic leads for Specialised Services and Health & Justice/Screenings & Immunisation respectively. The Joint & Collaborative Committee will confirm or appoint new Co-Chairs at the first meeting of each financial year.
Meetings	The Joint Committee shall meet at least quarterly. At its first meeting (and at the first meeting following each subsequent anniversary of that meeting) the Joint & Collaborative Committee shall prepare a schedule of meetings for the forthcoming year ("the Schedule"). The Co-Chair(s), or in the absence of a Chair, the Partners themselves, shall see that the Schedule is notified to the members. Any of the Partners may call for a special meeting outside of the Schedule as they see fit, by giving notice of their request to the Co-Chairs. The Co-Chairs may, following consultation with the Partners, confirm the date on which the special meeting is to be held and then issue a notice giving not less than four weeks' notice of the special meeting.
Quorum	A Joint & Collaborative Committee meeting will be quorate if at least one authorised representative member (or substitute) from each ICB Cluster is in attendance. Attendance at meetings by telephone/video conferencing will count towards the quorum.
Decisions and veto.	The Joint & Collaborative Committee must seek to make decisions relating to the exercise of the ICB Cluster Joint Functions on a consensus basis. The Partners must ensure that matters requiring a decision are anticipated and that sufficient time is allowed prior to Joint & Collaborative Committee meetings for discussions and negotiations between Partners to take place. Where it has not been possible, despite the best efforts of the Core Membership, to come to a consensus decision on any matter relating to ICB Cluster Joint Functions put before the Joint & Collaborative Committee, the Chair of Part may require the decision to be put to a vote. Where such a vote is required, each Authorised Officer will have one vote, per cluster ICB, with decisions being made by a simple majority of those voting. Any disputes will be resolved using the dispute resolution process outline in section 21 of the Collaboration agreement.
Conduct and conflicts of interest	Members will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and relevant organisational policies. The NHS Standards of Business Conduct policy is available from: https://www.england.nhs.uk/publication/standards-of-business-conduct-policy/ Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life): https://www.gov.uk/government/publications/the-7-principles-of-public-life

	Members should refer to and act consistently with the NHSE guidance: <i>Managing Conflicts of Interest in the NHS: Guidance for staff and organisations</i> . See: https://www.england.nhs.uk/ourwork/coi/
Confidentiality of proceedings	The Joint & Collaborative Committee is not subject to the Public Bodies (Admissions to Meetings) Act 1960. Admission to meetings is at the discretion of the Partners. All members in attendance are required to give due consideration to the possibility that the material presented to the meeting, and the content of any discussions, may be confidential or commercially sensitive, and to not disclose information or the content of deliberations outside of the meeting's membership, without the prior agreement of the Partners.
Publication of notices, minutes and papers	The Office of Pan ICB Commissioning shall provide sufficient resources, administration and secretarial support to ensure the proper organisation and functioning of the Joint & Collaborative Committee. The Chair(s), with the support of the Secretariat Lead, shall see that notices of meetings, together with an agenda listing the business to be conducted and supporting documentation, is issued to the Partners one working week (or, in the case of a special meeting, three calendar days prior to the date of the meeting). The proceedings and decisions taken shall be recorded in minutes, and those minutes circulated in draft form within one week of the date of the meeting. The Joint & Collaborative Committee shall confirm those minutes at its next meeting.
Review of the Terms of Reference	These terms of reference will be reviewed in six & twelve months of the Joint & Collaborative Committee establishment and then at least annually thereafter. Any changes to the Joint & Collaborative Committee decision-making membership or core functions must be approved by the partners. Other changes to the terms of reference may be agreed by the Joint & Collaborative Committee and reported to the Partners for assurance.
Date of Approval of Terms of Reference	TBC

The secretariat can be contacted on jomelling@nhs.net

SCHEDULE 3: INDIVIDUAL SCHEMES

PART 1 MIDLANDS SCHEME FOR DELEGATED SPECIALISED SERVICES IN 2026/2027

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

- 1.1 This scheme sets out the arrangements through which the Partners will work together to commission the specialised services delegated to the Midlands Integrated Care Boards (ICBs) by NHS England.
- 1.2 The Partners' aims are:
- (a) to maximise the benefits to patients of integrating the Delegated Functions with the ICBs' Commissioning Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

2 SERVICES AND FUNCTIONS

- 2.1 NHS England has delegated the statutory function for the commissioning of the specified specialised services to the ICBs. The key powers and duties that the ICBs will be required to carry out in exercise of the delegated functions being, in summary:
- (a) decisions in relation to the commissioning and management of the delegated services;
 - (b) planning delegated services for the population, including carrying out needs assessments;
 - (c) undertaking reviews of delegated services in respect of the population;
 - (d) supporting the management of the specialised commissioning budget for delegated services;
 - (e) co-ordinating a common approach to the commissioning and delivery of delegated services with other health and social care bodies in respect of the population where appropriate; and
 - (f) such other ancillary activities that are necessary to exercise the specialised commissioning functions.
- 2.2 A list of the delegated services included within the scheme are detailed within schedule 2 of the Delegation Agreement.

- 2.3 The services are being provided to the populations within the Midlands ICBs geographical footprints.

3 PARTNERS

- 3.1 The partners of this scheme are Lincolnshire ICB, Nottingham & Nottinghamshire ICB and Derby & Derbyshire ICB (Cluster 1), Leicester, Leicestershire & Rutland ICB and Northamptonshire ICB (Cluster 2), Birmingham and Solihull ICB and Black Country ICB (Cluster 3), Coventry & Warwickshire ICB and Herefordshire & Worcestershire ICB (Cluster 4) and Shropshire, Telford & Wrekin ICB and Staffordshire ICB & Stoke on Trent ICB (Cluster 5).

4 THE ARRANGEMENTS

- 4.1 The Scheme will be overseen by the Midlands Joint Committee whose role shall be to carry out the strategic decision-making, leadership and oversight functions relating to the commissioning of specified delegated specialised services as agreed by the partners and outlined in Schedule 2 of this Collaboration Agreement.
- 4.2 Administrative and management functions will be provided to the Partners by the Commissioning Team, which is hosted by NHS England. Details of which are set out in an Commissioning Team Agreement and Standard Operating Framework between all parties.
- 4.3 Details of the financial arrangements relating to this scheme are contained with Schedule 4 of the ICB Collaboration Agreement.

5 GOVERNANCE ARRANGEMENTS

- 5.1 The scheme shall be governed by the Midlands Joint Committee, as set out in Schedule 2 of the ICB Collaboration Agreement.
- 5.2 The terms of reference of the Midlands Joint Committee are set out in the in schedule 2 of the ICB Collaboration Agreement

6 COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

Delegated services will be commissioned from providers on behalf of the ICBs by the Commissioning Team hosted by NHS England in line with legislative requirements, NHS planning guidance and the Delegation Agreement between the ICBs and NHS England.

6.2 Contracting Arrangements

The list of contracts which are in place across the Midlands for delegated specialised services are contained in Appendix 1. This includes details of Lead Commissioning arrangements where this has been determined.

6.2.1 The contracting arrangement for the scheme will be as follows:

- The scheme will encompass all existing contracts.
- The contracts will be agreed in line with the National Contracting SOP, the Delegation agreement and the ICB Collaboration Agreement.
- The contracts will be funded in line with the pooled budget arrangements detailed in Schedule 4 of the ICB Collaboration Agreement.
- The contracts will be managed on behalf of the ICBs, by the Commissioning Team.

6.3 Access

The scheme will apply to all delegated specialised services provided via contracts with providers.

7. HIGH-COST DRUGS

7.1 All identified service lines that are delegated include any activities within these areas including High-Cost drugs and support through the networks. Financial responsibility for HCD and networks remains within NHSE, and responsibility will be managed through collaboration and appropriate decision making.

8. FINANCIAL GOVERNANCE ARRANGEMENTS

8.1. The financial governance arrangements are set out in Schedule 4 of the ICB Collaboration Agreement.

9. NON FINANCIAL RESOURCES

9.1. The non-financial resources required to deliver the scheme will be provided by NHS England in accordance with Schedule 6 of the Collaboration Agreement.

10. STAFF

- 10.1. The commissioning team responsible for the operational delivery of specialised commissioning for delegated services will be employed by NHS England covering both retained and delegated services.
- 10.2. The arrangement through which the commissioning team will provide this support to the ICBs is set out in agreed Joint Working Arrangements.

11. ASSURANCE AND MONITORING

- 11.1. The arrangements in relation to assurance and monitoring in relation to this scheme are contained Schedule 2 of this agreement.

12. AUTHORISED OFFICERS

- 12.1. The authorised officers for this scheme are as follows:

Partner	Name of Authorised Officer – Tier 1
Cluster 1 Nottingham & Nottinghamshire ICB Derby & Derbyshire ICB Lincolnshire ICB	Amanda Sullivan
Cluster 2 Northamptonshire ICB Leicester, Leicestershire & Rutland ICB	Toby Sanders
Cluster 3 Birmingham and Solihull ICB Black Country ICB	David Melbourne
Cluster 4 Herefordshire & Worcestershire ICB Coventry and Warwickshire ICB	Simon Trickett
Cluster 5 Shropshire Telford and Wrekin ICB Staffordshire & Stoke on Trent ICB	Simon Whitehouse

13. INTERNAL APPROVALS

- 13.1. The levels of authority relating to this scheme are described within Schedule 4 of the Collaboration Agreement.

14. REGULATORY REQUIREMENTS

- 14.1. Details in relation to regulatory requirements in relation to this scheme are contained within the delegation agreement and will be fulfilled on behalf of the ICBs by the Commissioning Team.

15. COMPLAINTS

- 15.1 Complaints for delegated services will be managed by the specialised commissioning team hosted by NHSE England in line with the agreed complaints process.
- 15.2 A report summarising complaints, actions and lessons learnt will be provided to the Joint Committee annually.

PART 2 – RETAINED SERVICES SCHEME

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF THE SCHEME FOR NHS ENGLAND RETAINED SPECIALISED SERVICES IN 2026/27

- 1.1 This scheme sets out the arrangements through which the Partners will work together to commission the specialised services for which responsibility is being retained by NHS England.
- 1.2 The Partners' aims are:
 - (a) to maximise the benefits to patients by working collaboratively on the Retained Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

2 SERVICES AND FUNCTIONS

- 2.1 NHS England will retain the statutory function for the commissioning of a number of specialised services. Whilst this responsibility is being retained by NHS England the staff involved will be also be working on the commissioning of delegated specialised services and it will involve the ICBs in the of delivery of these functions being, in summary:
 - (a) decisions in relation to the commissioning and management of the services;
 - (b) planning for the services for the population, including carrying out needs assessments;
 - (c) undertaking reviews of services in respect of the population;
 - (d) supporting the management of the specialised commissioning budget for the services;
 - (e) co-ordinating a common approach to the commissioning and delivery of the services with other health and social care bodies in respect of the population where appropriate; and
- 2.2 A list of the services included within the scheme are detailed within the Appendix of this Schedule.
- 2.3 The services are being provided to the populations within the Midlands ICBs geographical footprints.

3 PARTNERS

- 3.1 The partners for joint working within this scheme are NHS England, Lincolnshire ICB, Nottingham & Nottinghamshire ICB and Derby & Derbyshire ICB (Cluster 1), Leicester, Leicestershire & Rutland ICB and Northamptonshire ICB (Cluster 2), Birmingham and Solihull ICB and Black Country ICB (Cluster 3), Coventry & Warwickshire ICB and Herefordshire & Worcestershire ICB (Cluster 4) and Shropshire, Telford & Wrekin ICB and Staffordshire ICB & Stoke on Trent ICB (Cluster 5).

4 THE ARRANGEMENTS

- 4.1 NHS England will retain responsibility for the delivery of the functions covered by this scheme, working with the ICBs through appropriate consultation with and reporting to the Midlands Joint Committee.
- 4.2 Administrative and management functions will be provided to deliver the scheme by the multi-disciplinary commissioning team, hosted by NHS England. Details of which are set out in a commissioning team agreement between all parties.
- 4.3 Financial arrangements for this scheme will follow NHS England's budgetary and financial arrangements.

5 GOVERNANCE ARRANGEMENTS

- 5.1 NHS England will continue to hold responsibility for the delivery of the functions covered by the scheme.
- 5.2 Decision making will be in line with NHS England's Scheme of Reservation and Delegation subject to decisions being taken in consultation with the ICBs and the Joint Committee where appropriate.
- 5.3 The exercise of NHS England functions in consultation with the Joint Committee will be achieved by NHS England Officers with appropriate delegated authority attending meetings of the Midlands Joint Committee when exercising that authority.
- 5.4 NHS England will report on the delivery of the functions under this scheme to the Midlands Joint Committees.

6 COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

- 6.1.1 Services will be commissioned from providers by the Commissioning Team in line with legislative requirements and the NHS planning guidance.

6.2 Contracting Arrangements

- 6.2.1 The scheme will be administered by the Commissioning Team.
- 6.2.2 The contracting arrangement for the scheme will be as follows:
 - The scheme will encompass all existing contracts.
 - The contracts will be agreed in line with the National Contracting SOP and the ICB Collaboration Agreement.
 - The contracts will be funded by NHS England.
 - The contracts will be managed by the Commissioning Team.

6.3 Access

The scheme will apply to all delegated specialised services provided via contracts with providers.

7 HIGH-COST DRUGS

- 7.1 All identified service lines that are delegated include any activities within these areas including High-Cost drugs and support through the networks. Financial responsibility for HCD and

networks remains within NHSE, and responsibility will be managed through collaboration and appropriate decision making.

8 FINANCIAL GOVERNANCE ARRANGEMENTS

- 8.1 The financial governance arrangements will be in line with NHS England's Scheme of Reservation and Delegation and Standing Financial Instructions.

9 NON-FINANCIAL RESOURCES

- 9.1 The non-financial resources required to deliver scheme will be provided by NHSE in accordance with Schedule 6 of the ICB & NHSE Collaboration Agreement.

10 STAFF

- 10.1 The commissioning team responsible for the operational delivery of all specialised commissioning (delegated and retained) services will be employed by NHS England.

11 ASSURANCE AND MONITORING

- 11.1 NHS England's requirements in relation to Assurance and Monitoring will apply to this scheme.

12 INTERNAL APPROVALS

- 12.1 The levels of authority relating to this scheme will follow NHS England's Scheme of Reservation and Delegation and Standing Financial Instructions

13 REGULATORY REQUIREMENTS

- 13.1 NHS England will retain responsibility for fulfilling the regulatory requirements in relation to this scheme.

14 COMPLAINTS

- 14.1 Complaints will be managed by the specialised commissioning team within NHSE England in line with the agreed complaints process.

PART 3 – HEALTH AND JUSTICE & SCREENING AND VACCINATION SERVICES SCHEME

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF THE SCHEME FOR NHS ENGLAND RETAINED SPECIALISED SERVICES IN 2026/27

- 1.1 This scheme sets out the arrangements through which the Partners will work together to commission Health and Justice and Screening and Vaccination Services for which responsibility is being retained by NHS England in 2026/27 but will be delegated to the ICBs in the future.
- 1.2 The Partners' aims are:
 - (a) to maximise the benefits to patients by working collaboratively on the Retained Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

2 SERVICES AND FUNCTIONS

- 2.1 NHS England has determined that the statutory function for the commissioning of the Health and Justice and Screening and Vaccination services is suitable for future delegation to the ICBs. Whilst this responsibility is being retained by NHS England for 2025/26 it will involve the ICBs in the of delivery of these functions being, in summary:
 - (a) decisions in relation to the commissioning and management of the services;
 - (b) planning for the services for the population, including carrying out needs assessments;
 - (c) undertaking reviews of services in respect of the population;
 - (d) supporting the management of the specialised commissioning budget for the services;
 - (e) co-ordinating a common approach to the commissioning and delivery of the services with other health and social care bodies in respect of the population where appropriate; and
- 2.2 A list of the services included within the scheme are detailed within the Appendix of this Schedule.
- 2.3 The services are being provided to the populations within the Midlands ICBs geographical footprints.

3 PARTNERS

- 3.1 The partners for joint working within this scheme are NHS England, Lincolnshire ICB, Nottingham & Nottinghamshire ICB and Derby & Derbyshire ICB (Cluster 1), Leicester, Leicestershire & Rutland ICB and Northamptonshire ICB (Cluster 2), Birmingham and Solihull ICB and Black Country ICB (Cluster 3), Coventry & Warwickshire ICB and Herefordshire & Worcestershire ICB (Cluster 4) and Shropshire, Telford & Wrekin ICB and Staffordshire ICB & Stoke on Trent ICB (Cluster 5).

4 THE ARRANGEMENTS

- 4.1 NHS England will retain responsibility for the delivery of the functions covered by this scheme, working with the ICBs through appropriate consultation with and reporting to the Midlands Joint Committee.
- 4.2 Administrative and management functions will be provided to deliver the scheme by the multi-disciplinary commissioning team, hosted by NHS England. Details of which are set out in a commissioning team agreement between all parties.
- 4.3 Financial arrangements for this scheme will follow NHS England's budgetary and financial arrangements.

5 GOVERNANCE ARRANGEMENTS

- 5.1 NHS England will continue to hold responsibility for the delivery of the functions covered by the scheme.
- 5.2 Decision making will be in line with NHS England's Scheme of Reservation and Delegation subject to decisions being taken in consultation with the ICBs and the Joint Committee where appropriate.
- 5.3 The exercise of NHS England functions in consultation with the Joint Committee will be achieved by NHS England Officers with appropriate delegated authority attending meetings of the Midlands Joint Committee when exercising that authority.
- 5.4 NHS England will report on the delivery of the functions under this scheme to the Midlands Joint Committees.

6 COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

- 6.1.1 Services will be commissioned from providers by the Commissioning Team in line with legislative requirements and the NHS planning guidance.

6.2 Contracting Arrangements

- 6.2.1 The scheme will be administered by the Commissioning Team.
- 6.2.2 The contracting arrangement for the scheme will be as follows:
 - The scheme will encompass all existing contracts.
 - The contracts will be agreed in line with the National Contracting SOP and the ICB Collaboration Agreement.
 - The contracts will be funded by NHS England.
 - The contracts will be managed by the Commissioning Team.

6.3 Access

The scheme will apply to all delegated specialised services provided via contracts with providers.

7 FINANCIAL GOVERNANCE ARRANGEMENTS

- 7.1 The financial governance arrangements will be in line with NHS England's Scheme of Reservation and Delegation and Standing Financial Instructions.

8 NON-FINANCIAL RESOURCES

- 8.1 The non-financial resources required to deliver scheme will be provided by NHSE in accordance with Schedule 6 of the ICB & NHSE Collaboration Agreement.

9 STAFF

- 9.1 The commissioning team responsible for the operational delivery of these services will be employed by NHS England.

10 ASSURANCE AND MONITORING

- 10.1 NHS England's requirements in relation to Assurance and Monitoring will apply to this scheme.

11 INTERNAL APPROVALS

- 11.1 The levels of authority relating to this scheme will follow NHS England's Scheme of Reservation and Delegation and Standing Financial Instructions

12 REGULATORY REQUIREMENTS

- 12.1 NHS England will retain responsibility for fulfilling the regulatory requirements in relation to this scheme.

13 COMPLAINTS

Complaints will be managed by the specialised commissioning team within NHSE England in line with the agreed complaints process.

SERVICES

Page 51 of 94

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		58P	Neurosurgery LVHC local: thoracic discectomy
		58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia
		58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours
		58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)
		34R	Orthopaedic revision (adults)
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
		11T	Renal Transplantation
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery (adults)
		29Z	Adult thoracic surgery services: outpatients
29	Haematopoietic stem cell transplantation services (adults and children)	02Z	Haematopoietic stem cell transplantation services (adults and children)
		ECP	Extracorporeal photopheresis service (adults and children)
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
32	Children and young people's inpatient mental health service	23K	Tier 4 CAMHS (general adolescent inc eating disorders) MHLDA PC
		23L	Tier 4 CAMHS (low secure) MHLDA PC
		23O	Tier 4 CAMHS (PICU) MHLDA PC
		23U	Tier 4 CAMHS (LD) MHLDA PC
		23V	Tier 4 CAMHS (ASD) MHLDA PC
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services (adults and children)
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services (adults and children)
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services (adults and children)
		08Z	Complex neuro-spinal surgery services (adults and children)
45	Cystic fibrosis services (adults and children)	10Z	Cystic fibrosis services (adults and children)
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services (adults and adolescents)
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services (adults and children)
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services (adults and children)
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services (adults and children)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection (adults)
72	Major trauma services (adults and children)	34T	Major trauma services (adults and children)
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services (adults and children)
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
98	Specialist secure forensic mental health services for young people	24C	FCAMHS MHLDA PC
103A	Specialist adult haematology services	03C	Castleman disease
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer (adults)
		01K	Malignant mesothelioma (adults)
		01M	Head and neck cancer (adults)
		01N	Kidney, bladder and prostate cancer (adults)
		01Q	Rare brain and CNS cancer (adults)
		01U	Oesophageal and gastric cancer (adults)
		01V	Biliary tract cancer (adults)
		01W	Liver cancer (adults)
		01X	Penile cancer (adults)
		01Y	Cancer Outpatients (adults)
		01Z	Testicular cancer (adults)
		04F	Gynaecological cancer (adults)
		19V	Pancreatic cancer (adults)
		19C	Biliary tract cancer surgery (adults)
		19M	Liver cancer surgery (adults)
		19Q	Pancreatic cancer surgery (adults)
		24Y	Skin cancer (adults)
		29E	Management of central airway obstruction (adults)
		51A	Interventional oncology (adults)
		51B	Brachytherapy (adults)
		51C	Molecular oncology (adults)
		61M	Head and neck cancer surgery (adults)
		61Q	Ophthalmic cancer surgery (adults)
		61U	Oesophageal and gastric cancer surgery (adults)
		61Z	Testicular cancer surgery (adults)
		33C	Transanal endoscopic microsurgery (adults)
		33D	Distal sacrectomy for advanced and recurrent rectal cancer (adults)
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence (adults)
		33B	Complex inflammatory bowel disease (adults)
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
			Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children
112	Specialist gynaecology services for children	73X	Specialist paediatric surgery services - gynaecology
113	Specialist haematology services for children	23H	Specialist haematology services for children
114	Specialist haemoglobinopathy services (adults and children)	38S	Sickle cell anaemia (adults and children)
		38T	Thalassemia (adults and children)
115	Specialist immunology services for adults with deficient immune systems	16X	Specialist immunology services for adults with deficient immune systems
115A	Specialist immunology services for children with deficient immune systems	16Y	Specialist immunology services for children with deficient immune systems
115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta
118	Neonatal critical care services	NIC	Specialist neonatal care services
119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children
		07Y	Paediatric neurorehabilitation
		08J	Selective dorsal rhizotomy
120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services
124	Specialist perinatal mental health services (adults and adolescents)	22P	Specialist perinatal mental health services (adults and adolescents) MHLDA PC
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs (adults and children)
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
		19B	Specialist services for complex biliary diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05C	Specialist augmentative and alternative communication aids (adults and children)
		05E	Specialist environmental controls (adults and children)
		05P	Prosthetics (adults and children)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
135	Specialist paediatric surgery services	23X	Specialist paediatric surgery services - general surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital
ACC	Adult Critical Care	ACC	Adult critical care

Acute Services Standard Contracts

BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST
DERBYSHIRE COMMUNITY HEALTH SERVICES
GEORGE ELIOT HOSPITAL NHS TRUST
HCRG
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST
MIDLANDS PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST
NORTHAMPTON GENERAL HOSPITAL NHS TRUST
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST
SOUTH WARWICKSHIRE NHS FOUNDATION TRUST
THE DUDLEY GROUP NHS FOUNDATION TRUST
THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
THE ROYAL WOLVERHAMPTON NHS TRUST
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST
WALSALL HEALTHCARE NHS TRUST

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
WYE VALLEY NHS TRUST

Section 75 Contract

LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST

Specialised Mental Health, Learning Disability and Autism Lead Provider Contracts

Lead Provider	Coordinating Commissioner
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST (EM ADULT SECURE)	LLR ICB
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST (EM CYPMH)	LLR ICB
LEICESTERSHIRE PARTNERSHIP NHS TRUST (EM ADULT EATING DISORDER SERVICES)	LLR ICB
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST (EM PERINATAL SERVICES)	LLR ICB
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST (WM ADULT SECURE)	BSOL ICB
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST (WM CYPMH)	BSOL ICB
MIDLANDS UNIVERSITY PARTNERSHIP NHS FOUNDATION TRUST (WM ADULT EATING DISORDER SERVICES)	SSOT ICB
MIDLANDS UNIVERSITY PARTNERSHIP NHS FOUNDATION TRUST (WM PERINATAL SERVICES)	SSOT ICB

**APPENDIX 2 – NHS ENGLAND COMMISSIONING RESPONSIBILITY AND ACCOUNTABILITY
(RETAINED) SPECIALISED SERVICES**

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
4	Adult specialist respiratory services	29E	Management of central airway obstruction
		29V	Complex home ventilation
15	Adult specialist renal services	11T	Renal transplantation
29	Haematopoietic stem cell transplantation services (adults and children)	02Z	Blood and marrow transplantation services
		ECP	Extracorporeal photopheresis service
45	Cystic fibrosis services (adults and children)	10Z	Cystic fibrosis services
55	Gender dysphoria services (children and adolescents)	22A	Gender identity development service for children and adolescents
56	Gender dysphoria services (adults)	22Z	Gender identity services
		42A	Gender dysphoria: genital surgery (trans feminine)
		42B	Gender dysphoria - genital surgery (trans masculine)
		42C	Gender dysphoria: chest surgery (trans masculine)
		42D	Gender dysphoria - non-surgical services
		42E	Gender dysphoria: other surgical services
58	Specialist adult gynaecological surgery and urinary surgery services for females	04K	Specialised services for women with complications of mesh inserted for urinary incontinence and vaginal prolapse (16 years and above)
		04L	Reconstructive surgery and congenital anomalies of the female genital tract
65	Specialist services for adults with infectious diseases	18T	Tropical Disease
82	Paediatric and perinatal post mortem services	F23	Paediatric and perinatal post mortem services
87	Positron emission tomography-computed tomography services (adults and children)	01P	Positron emission tomography- computed tomography services (PETCT)
89	Primary malignant bone tumours service (adults and adolescents)	01O	Primary malignant bone tumours service (adults and adolescents)
101	Severe intestinal failure service (adults)	12Z	Severe intestinal failure service
103A	Specialist adult haematology services	03C	Castleman disease
105	Specialist cancer services (adults)	01L	Soft tissue sarcoma
		01X	Penile cancer
111	Clinical genomic services (adults and children)	20G	Genomic laboratory testing services
		20H	Pre-Implantation genetic diagnosis and associated in-vitro fertilisation services
		20Z	Specialist clinical genomics services
		MOL	Molecular diagnostic service
114	Specialist haemoglobinopathy services (adults and children)	38S (DPC)	Sickle cell anaemia -direct patient care
		38T (DPC)	Thalassemia - direct patient care
		38X (HCC)	Haemoglobinopathies coordinating centres (HCCs)
		38X (SHT)	Specialist Haemoglobinopathies Teams (SHTs)
115	Specialist immunology services for adults with deficient immune systems	16X	Specialist immunology services for adults with deficient immune systems
115A	Specialist immunology services for children with deficient immune systems	16Y	Specialist immunology services for children with deficient immune systems
134	Specialist services to support patients with complex physical disabilities	05C	Specialist augmentative and alternative communication aids

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
	(excluding wheelchair services) (adults and children)	05E	Specialist environmental controls
137	Spinal cord injury services (adults and children)	06A	Spinal cord injury services (adults and children)
6	Adult secure mental health services	22S(a)	Secure and specialised mental health services (adult) (Medium and low) - including LD / ASD / WEMS / ABI / DEAF
		22S(b)	Secure and specialised mental health services (adult) (Medium and low) - Excluding LD / ASD / WEMS / ABI / DEAF
		22S(c)	Secure and specialised mental health services (adult) (Medium and low) - ASD
		22S(d)	Secure and specialised mental health services (adult) (Medium and low) – LD
		22S(e)	Secure and specialised mental health services (adult) Medium Secure Female WEMS
		22S(f)	Secure and specialised mental health services (adult) (Medium and low) – ABI
		22S(g)	Secure and specialised mental health services (adult) (Medium and low) - DEAF
		YYY	Specialised mental health services exceptional packages of care
8	Adult specialist eating disorder services	22E	Adult specialist eating disorder services
32	Children and young people's inpatient mental health service	22C	Tier 4 CAMHS (MSU)
		24E	Tier 4 CAMHS (children's service)
		23K	Tier 4 CAMHS (general adolescent inc eating disorders)
		23L	Tier 4 CAMHS (low secure)
		23O	Tier 4 CAMHS (PICU)
		23U	Tier 4 CAMHS (LD)
		23V	Tier 4 CAMHS (ASD)
98	Specialist secure forensic mental health services for young people	24C	FCAMHS
102	Severe obsessive compulsive disorder and body dysmorphic disorder service (adults and adolescents)	22F	Severe obsessive compulsive disorder and body dysmorphic disorder service
116	Specialist mental health services for Deaf adults	22D	Specialist mental health services for Deaf adults
124	Specialist perinatal mental health services (adults and adolescents)	22P	Specialist perinatal mental health services
133	Specialist services for severe personality disorder in adults	22T	Specialist services for severe personality disorder in adults

Appendix 3 – NHS ENGLAND COMMISSIONING RESPONSIBILITY AND ACCOUNTABILITY (RETAINED) Health and Justice and Screening and Vaccinations Services

Screening Programmes

NHS England commissions 11 national population screening programmes:

Antenatal & Newborn Screening

- Infectious diseases in pregnancy (HIV, hepatitis B, syphilis)
- Fetal anomaly screening
- Sickle cell and thalassaemia screening
- Newborn blood spot screening
- Newborn hearing screening
- Newborn and infant physical examination (NIPE)

Adult Screening

- Abdominal Aortic Aneurysm (AAA) screening
- Bowel cancer screening
- Breast cancer screening
- Cervical screening
- Diabetic eye screening

Vaccinations

NHS England commissions the national immunisation programmes, which include:

- Routine Childhood Vaccinations
 - 6-in-1 vaccine
 - MMR (Measles, Mumps, Rubella)
 - Hib/MenC
 - MenB
 - MenACWY
 - HPV
 - Pre-school boosters
- Adult Vaccinations
 - Seasonal influenza (flu)
 - Pneumococcal
 - Shingles
- Targeted Vaccinations
 - Hepatitis B (including neonatal)

- BCG (Tuberculosis)
- Mpox (for at-risk groups)
- MenB for gonorrhoea (specific risk groups)
- COVID-19 Vaccination Programme
- School-age Immunisation Programmes (HPV, flu, MenACWY)

Child Health Information Services

Health and Justice Services

NHS England commissions healthcare for people in secure and detained environments, including:

- Prison Healthcare
 - Primary care (GP, nursing, optometry, therapies)
 - Mental health services
 - Substance misuse services
 - Dental services
 - Public health services (including screening and immunisation)
- Children and Young People's Secure Estate
 - Physical health
 - Mental health
 - Neurodevelopmental support
 - Substance misuse services
- National CYP Vanguard pilots
- Immigration Removal Centres (IRCs)
 - Adult healthcare
 - Mental health services
 - Primary care and dental care
- Short-Term Holding Facilities
 - Basic healthcare provision

Non-Custodial Settings

- Liaison and Diversion Services
 - Early identification and support for vulnerable individuals in police custody or courts
 - Referral into community services (eg mental health and social care referrals)
 - Recommendations to the court regarding sentencing options

- RECONNECT (not a treatment service)
 - Continuity of care support following release from prison
- Mental Health Treatment Requirements
 - Mental health interventions under a court order
- Court healthcare (Midlands and North of England) – co-commissioned with MoJ
 - Peripatetic paramedic based service

As well as commissioning services for survivors of sexual assault and abuse

- Sexual Assault Referral Centres (SARCs) – co-commissioned with Police and OPCCs
 - Section 7a services
 - Access to psychotherapies
 - Forensic medical services
- National Pathfinders (complex mental health)

SCHEDULE 4: FINANCIAL ARRANGEMENTS

PART A: FINANCIAL RISK MANAGEMENT

1 ESTABLISHMENT OF A RISK SHARE

- 1.1 The ICBs have agreed to establish and maintain a risk share arrangement for in-year financial management, based on the defined reserves held for elective activity under ERF and variable services within the specialised commissioning contracts.
- 1.2 The principles of the risk management agreement are that in year financial risk will be managed collectively across the ICBs in the Midlands. All allocations received for ERF and reserves specifically held for non-ERF variable services will be considered collectively as part of a notional pooled fund, managed by the specialised commissioning finance team on behalf of the ICBs. In year variation in contract performance will be monitored collectively and funds will be transferred between ICBs proportionately to fund the financial impact of in year variable activity to opening allocations.
- 1.3 The monies held in the notional Pooled Fund may only be expended on the following:
 - Performance payments associated with the Elective Recovery Scheme (ERF),
 - Activity above opening contract levels for defined variable services within the specialised commissioning contracts,
 - Approved expenditure agreed by all parties in the Pooled Fund.(collectively known as "Permitted Expenditure")
- 1.4 The Pooled Fund is explicitly for the management of in year expenditure against specialised services contractual commitments. This includes contractual commitments for the population of Midlands ICBs including any out of Region contractual arrangements.
- 1.5 The Pooled Fund is not intended to be the route for recurrent commissioning decisions for specialised services. Such decisions would be made through the governance structure established in East and West Midlands.
- 1.6 The Partners may only depart from the definition of Permitted Expenditure or exceed Pooled Fund budget with the express written agreement of each relevant Partner and in line with approved delegations.

- 1.7 The Specialised Commissioning Finance Team, on behalf of the Midlands ICBs, shall be responsible for providing the financial administrative systems for the Pooled Fund and the Pooled Fund Manager will be the Director of Commissioning of Finance. The Specialised Services Finance and Contracting subgroup will be responsible for oversight of the management of the pooled fund and ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

2. RISK EXPOSURE

2.1. Elective Services

2.1.1. Elective activity is managed through the Elective Recovery Fund. Baseline activity is outlined within the Indicative Activity Plan (IAP) and is included within the fixed element of ERF payments which are included in opening provider contracts.

2.1.2. Any financial impact of agreement of final IAPs will need to be managed from the performance reserve and are subject to the terms of this Pooled Fund Agreement.

2.1.3. The 2026/27 ERF process allows for additional activity payments under the Activity Management Process. These will be managed through the terms of this Pooled Fund Agreement.

2.2. Variable Activity

2.2.1. There are a small number of variable services within the contract, these being:

- Chemotherapy
- Diagnostic Imaging
- Nuclear Medicine
- PRT-CT
- Molecular Radiotherapy
- Renal Transplant

2.2.2. These services are paid on a cost per case basis. Opening baselines for variable services will be based on 2025/26 outturn.

2.2.3. For 2026/27 radiotherapy services have a blended payment approach with activity above planned levels being reimbursed at 50% of tariff. Performance payments are included within variable activity and therefore included within the risk share agreements.

2.2.4. All ICBs have created a reserve to manage 2026/27 activity growth in variable services.

Payments above opening contract values for variable services will be subject to the terms of this Pooled Fund Agreement.

3. POOLED FUND MANAGEMENT

3.1. The Pooled Fund Manager for Pooled Fund shall have the following duties and responsibilities:

- The day-to-day operation and management of the notional Pooled Fund and risk management arrangements,
- Ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification,
- Maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund,
- Ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund,
- Reporting to the relevant governance group as required by this Agreement,
- ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement, and
- preparing and submitting reports as required by the relevant Scheme Specification.

5. RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPEND

5.1. The Specialised Commissioning Team Pooled Fund manager shall manage expenditure within the notional pooled fund and shall use reasonable endeavours to ensure that the expenditure is limited to Permitted Expenditure.

5.2. The Pooled Fund Manager shall not be in breach of its obligations under this Agreement if an Overspend occurs provided that it has used reasonable endeavours to ensure that the only expenditure from a Pooled Fund has been incurred and it has informed the Partners of any variance.

5.3. In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Partners are informed as soon as reasonably possible.

- 5.4. If expenditure from the Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year, financial resources will be returned to the Partners proportionate to the contributions to the Pooled Fund. Arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions of the Partners.
- 5.5. Any unmitigated net variance will need to be recognised in the Agreement of Balances exercise completed as part of the month 09 financial reporting process.
- 5.6. Residual variances (under or overspend), after mitigations and application of contingency, will be allocated to ICBs proportionately to contributions to the Pooled Fund.
- 5.7. Illustrative examples of the application of the risk share

5.7.1. Variable Activity using Chemotherapy variable activity performance.

ICB	Contract	Forecast	Variance	% Variance	Apply risk share	Risk Shared Forecast	Risk Shared % variance	Impact of risk share
ICB 1	9,000	10,000	1,000	11.11%	653	9,653	7.25%	347
ICB 2	8,500	9,000	500	5.88%	617	9,117	7.25%	-117
ICB 3	7,500	9,000	1,500	20.00%	544	8,044	7.25%	956
ICB 4	8,500	10,000	1,500	17.65%	617	9,117	7.25%	883
ICB 5	11,000	11,000	0	0.00%	798	11,798	7.25%	-798
ICB 6	9,500	10,500	1,000	10.53%	689	10,189	7.25%	311
ICB 7	10,000	9,000	-1,000	-10.00%	725	10,725	7.25%	-1,725
ICB 8	9,000	9,500	500	5.56%	653	9,653	7.25%	-153
ICB 9	7,500	8,500	1,000	13.33%	544	8,044	7.25%	456
ICB 10	5,000	5,500	500	10.00%	363	5,363	7.25%	137
ICB 11	11,000	11,500	500	4.55%	798	11,798	7.25%	-298
Total	96,500	103,500	7,000	7.25%	7,000	103,500	7.25%	0

5.7.2. Elective Activity

ICB	Opening Contract	Finalisation of IAP	Performance Payments	Outturn	Variance	% Variance	Apply risk share	Risk Shared Forecast	Risk Shared % variance	Impact of risk share
ICB 1	90,000		2,000	92,000	2,000	2.22%	2,798	92,798	3.11%	-798
ICB 2	85,000	2,000	3,000	90,000	5,000	5.88%	2,642	87,642	3.11%	2,358
ICB 3	75,000		4,000	79,000	4,000	5.33%	2,332	77,332	3.11%	1,668
ICB 4	85,000		0	85,000	0	0.00%	2,642	87,642	3.11%	-2,642
ICB 5	110,000		3,000	113,000	3,000	2.73%	3,420	113,420	3.11%	-420
ICB 6	95,000		2,000	97,000	2,000	2.11%	2,953	97,953	3.11%	-953
ICB 7	100,000	4,000	4,000	108,000	8,000	8.00%	3,109	103,109	3.11%	4,891
ICB 8	90,000		1,000	91,000	1,000	1.11%	2,798	92,798	3.11%	-1,798
ICB 9	75,000		2,000	77,000	2,000	2.67%	2,332	77,332	3.11%	-332
ICB 10	50,000		0	50,000	0	0.00%	1,554	51,554	3.11%	-1,554
ICB 11	110,000		3,000	113,000	3,000	2.73%	3,420	113,420	3.11%	-420
Total	965,000	6,000	24,000	995,000	30,000	3.11%	30,000	995,000	3.11%	0

PART B: OTHER FINANCIAL ARRANGEMENTS

6. BUDGETARY DELEGATION

- 6.1. Commissioning decisions will be made in line with the Arrangements agreed by the East/West Midlands Joint Commissioning Committee which has Delegated Authority to set approval limits in line with those arrangements.
- 6.2. ICBs have agreed to delegate budgetary responsibility via the joint committees to the specialised commissioning team for the processing and delivery of specialised services transactions. These delegations are to facilitate the delivery of contract signature, purchase orders and non-purchase order invoices and budgetary virement.

7. AUDIT ARRANGEMENTS

- 7.1. Transactions through ICB ledgers will be subject to audit through existing internal audit arrangements. It will be the responsibility of ICBs to ensure that this appropriately referenced in the audit plan.
- 7.2. The Specialised Commissioning Team responsible for the management of specialised commissioning resources will be employed by NHS Birmingham and Solihull ICB but will access all ICB ledgers to process transactions for specialised services.

8. FINANCIAL MANAGEMENT

- 8.1. Financial transactions for the 70 delegated specialised services will be processed through the ISFE2 ledger system of the eleven Midlands ICBs. Specialised Commissioning team will have appropriate access to ICB ledgers enabled.
- 8.2. Financial monitoring reports will be produced by the hosted Specialised Commissioning Team on behalf of the ICBs.
- 8.3. Financial reports will be prepared monthly within ten working days of the end of the month. Forecast outturn positions will be included in the monitoring reports from quarter 2.
- 8.4. Monthly budget reporting with variance analysis and forecasting will be provided to Joint Committee Finance Subgroup, Host ICB, and Partner ICBs including:
- ICB reporting based on risk management arrangements,
 - Overall financial performance report to be shared with all ICBs,
 - Management and review of reserves and investments.

Appendix 1 to Schedule 4

Budgetary Delegation Schedule for Specialised Services Only

Contract award, signature and variation			
Description of delegation: Approval of contract award reports, providing requirements for competitive tendering have been met. Approval of contract signature and variation* Signature of contracts and contract variations must be made by the host providers			
Delegated Limit	Up to £2m	Up to £50m	Up to £250m
Limits are annual values			
Approvers and/or restrictions No variation can be granted to a contract awarded under the PCR threshold where the value of the variation results in the contract value exceeding the PCR threshold.	Commissioning Lead – Acute Specialised Commissioning (Contracting)	Director of Specialised Commissioning Director of Commissioning Finance (specialised) – for contract variations	Regional Director of Commissioning Director of Commissioning Finance (specialised) – for contract award

Purchase Requisitions, invoices and non POs			
Description of delegation: Approval of purchase requisitions, purchase credit notes, invoices and non-purchase order invoices. Approval of contract payments to NHS providers.			
Delegated Limit	Up to £50k	Up to £2m or 1/12 of contract value for NHS Providers	Over £2m
Approvers and/or restrictions Expenditure must be covered by a relevant budget. Purchase orders should be raised for all nonhealthcare goods and services and the non-purchase order route should only be used in exceptional circumstances.	Specialised commissioning: Contract Managers or Budget Holders	Director of Specialised Commissioning Director of Commissioning Finance (specialised)	Director of Specialised Commissioning or Director of Commissioning Finance (Specialised) And Pooled Fund Host CFO

Budget Virements			
Description of delegation: Approval of budget virements/movements within approved revenue and capital budgets.			
Delegated Limit	Up to £50k	Up to £2m	Over £2m
Approvers and/or restrictions Expenditure must be covered by a relevant budget. Purchase orders should be raised for all nonhealthcare goods and services and the non-purchase order route should only be used in exceptional circumstances.	Specialised commissioning Contract Managers or Budget Holders	Director of Specialised Commissioning Director of Commissioning Finance (specialised)	MASCG

Budgetary Delegation Schedule for Retained Services Only

Contract award, signature and variation				
Description of delegation: Approval of contract award reports, providing requirements for competitive tendering have been met. Approval of contract signature and variation* Signature of contracts and contract variations must be made by the host providers				
Delegated Limit	Up to £2m	Up to £50m	Up to £250m	£250m to £750m
Limits are annual values				
Approvers and/or restrictions No variation can be granted to a contract awarded under the PCR threshold where the value of the variation results in the contract value exceeding the PCR threshold.	Deputy/Assistant Directors For delegated and retained functions	Director of Specialised Commissioning Director of Commissioning Finance (specialised) – for contract variations For delegated and retained functions	Regional Director of Commissioning for NHSE functions Director of Commissioning Finance (specialised) – for contract award for NHSE functions Joint & Collaborative Committee for delegated functions	Regional Director of Commissioning for NHSE functions Joint & Collaborative Committee for delegated functions

Purchase Requisitions, invoices and non POs				
Description of delegation: Approval of purchase requisitions, purchase credit notes, invoices and non-purchase order invoices. Approval of contract payments to NHS providers.				
Delegated Limit	Up to £50k (Bands 8A-D)	Up to 100k (Band 9)	Up to £2m or 1/12 of contract value for NHS Providers	Over £2m
Approvers and/or restrictions Expenditure must be covered by a relevant budget. Purchase orders should be raised for all nonhealthcare goods and services and the non-purchase order route should only be used in exceptional circumstances.	Commissioning Assistant Directors Contract Managers or Budget Holders For delegated and retained functions	Deputy Directors For delegated and retained functions	Director of Specialised Commissioning Director of Commissioning Finance (specialised) For delegated and retained functions	Director of Specialised Commissioning for NHSE functions or Director of Commissioning Finance (Specialised) for NHSE functions or Regional Director of Commissioning for NHSE functions Joint & Collaborative Committee for delegated functions

Budget Virements				
Description of delegation: Approval of budget virements/movements within approved revenue and capital budgets.				
Delegated Limit	Up to £50k (Bands 8A-D)	Up to 100k (Band 9)	Up to £2m	Over £2m
Approvers and/or restrictions Expenditure must be covered by a relevant budget. Purchase orders should be raised for all nonhealthcare goods and services	Commissioning Assistant Directors Contract Managers or Budget Holders For delegated and retained functions	Deputy Directors For delegated and retained functions	Director of Specialised Commissioning Director of Commissioning Finance (specialised) For delegated and retained functions	Regional Director of Commissioning for NHSE functions Joint & Collaborative Committee for delegated functions

SCHEDULE 5: FURTHER INFORMATION GOVERNANCE AND SHARING PROVISIONS

PART 1

1. Introduction

- 1.1. This Schedule sets out the scope for the secure and confidential sharing of information between the Partners on a Need To Know basis, in order to enable the Partners to exercise their functions in pursuance of this Agreement.
- 1.2. References in this Schedule (*Further Information Governance and Sharing Provisions*) to the Need to Know basis or requirement (as the context requires) should be taken to mean that the Data Controllers' Staff will only have access to Personal Data or Special Category Personal Data if it is lawful for such Staff to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.
- 1.3. This Schedule and the Data Sharing Agreements entered into under this Schedule are designed to:
 - 1.3.1. provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the Partners;
 - 1.3.2. describe the purposes for which the Partners have agreed to share Relevant Information;
 - 1.3.3. set out the lawful basis for the sharing of information between the Partners, and the principles that underpin the exchange of Relevant Information;
 - 1.3.4. describe roles and structures to support the exchange of Relevant Information between the Partners;
 - 1.3.5. apply to the sharing of Relevant Information relating to Specialised Services Providers and their Staff;
 - 1.3.6. apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;
 - 1.3.7. ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;
 - 1.3.8. apply to the activities of the Partners' Staff; and
 - 1.3.9. describe how complaints relating to Personal Data sharing between the Partners will be investigated and resolved, and how the information sharing will be monitored and reviewed.

2. Purpose

- 2.1. The Specified Purpose of the data sharing is to facilitate the exercise of the Joint Working Arrangements.

- 2.2. Each Partner must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received from any third party organisations from which the Partners must obtain data in order to achieve the Specified Purpose. Where necessary specific and detailed purposes must be set out in a Data Sharing Agreement that complies with all relevant legislation and Guidance.

3. Benefits of information sharing

- 3.1. The benefits of sharing information are the achievement of the Specified Purpose, with benefits for service users and other stakeholders in terms of the improved delivery of the Services.

4. Lawful basis for sharing

- 4.1. The Partners shall comply with all relevant Data Protection Legislation requirements and Good Practice in relation to the processing of Relevant Information shared further to this Agreement.
- 4.2. The Partners shall ensure that there is a Data Protection Impact Assessment ("DPIA") that covers processing undertaken in pursuance of the Specified Purpose. The DPIA shall identify the lawful basis for sharing Relevant Information for each purpose and data flow.
- 4.3. Where appropriate, the Relevant Information to be shared shall be set out in a Data Sharing Agreement.

5. Restrictions on use of the Shared Information

- 5.1. Each Partner shall only process the Relevant Information as is necessary to achieve the Specified Purpose and shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.
- 5.2. Access to, and processing of, the Relevant Information provided by a Partner must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be always handled on a restricted basis, in compliance with Data Protection Legislation requirements, and the Partners' Staff should only have access to Personal Data on a justifiable Need to Know basis.
- 5.3. Neither the provisions of this Schedule nor any associated Data Sharing Agreements should be taken to permit unrestricted access to data held by any of the Partners.
- 5.4. Neither Partner shall subcontract any processing of the Relevant Information without the prior consent of the other Partner. Where a Partner subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.
- 5.5. The Partners shall not cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.
- 5.6. Any particular restrictions on use of certain Relevant Information should be included in a Data Sharing Agreement.

6. Ensuring fairness to the Data Subject

- 6.1. In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. To achieve fairness and transparency to the Data Subjects, the Partners will take the following measures as reasonably required:
 - 6.1.1. amendment of internal guidance to improve awareness and understanding among Staff;
 - 6.1.2. amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;
 - 6.1.3. ensuring that information and communications relating to the processing of data is clear and easily accessible; and
 - 6.1.4. considering carrying out activities to promote public understanding of how data is processed where appropriate.
- 6.2. Each Partner shall procure that its notification to the Information Commissioner's Office, and record of processing maintained for the purposes of Article 30 UK GDPR, reflects the flows of information under this Agreement.
- 6.3. The Partners shall reasonably co-operate in undertaking any DPIA associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.
- 6.4. Further provision in relation to specific data flows may be included in a Data Sharing Agreement between the Partners.

7. Governance: Staff

- 7.1. The Partners must take reasonable steps to ensure the suitability, reliability, training and competence, of any Staff who have access to Personal Data, and Special Category Personal Data, including ensuring reasonable background checks and evidence of completeness are available on request.
- 7.2. The Partners agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the Partners' Staff are not healthcare professionals (for the purposes of the Data Protection Act 2018) the employing Partners must procure that Staff operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.
- 7.3. The Partners shall ensure that all Staff required to access Personal Data (including Special Category Personal Data) are informed of the confidential nature of the Personal Data. The Partners shall include appropriate confidentiality clauses in employment/service contracts of all Staff that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Data Protection Legislation requirements, or cause damage to or loss of the Relevant Information.

- 7.4. Each Partner shall provide evidence (further to any reasonable request) that all Staff that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Data Protection Legislation and this Agreement.
- 7.5. The Partners shall ensure that:
- 7.5.1. only those Staff involved in delivery of the Agreement use or have access to the Relevant Information;
 - 7.5.2. that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller; and
 - 7.5.3. specific limitations on the Staff who may have access to the Relevant Information are set out in any Data Sharing Agreement entered in accordance with this Schedule.

8. Governance: Protection of Personal Data

- 8.1. At all times, the Partners shall have regard to the requirements of Data Protection Legislation and the rights of Data Subjects.
- 8.2. Wherever possible (in descending order of preference), only anonymised information, or strongly or weakly pseudonymised information will be shared and processed by the Partners. The Partners shall co-operate in exploring alternative strategies to avoid the use of Personal Data to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data or Special Category Personal Data.
- 8.3. Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need-to-Know basis.
- 8.4. If any Partner becomes aware of:
- 8.4.1. any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted, or unusable; or
 - 8.4.2. any security vulnerability or breach in respect of the Relevant Information, it shall promptly, within 48 hours, notify the other Partners. The Partners shall fully co-operate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Data Protection Legislation.
- 8.5. In processing any Relevant Information further to this Agreement, the Partners shall process the Personal Data and Special Category Personal Data only:
- 8.5.1. in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only

in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

- 8.5.2. to the extent as is necessary for the provision of the Specified Purpose or as is required by Law or any regulatory body; and
 - 8.5.3. in accordance with Data Protection Legislation requirements, in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR; and not in such a way as to cause any other Data Controller to breach any of their applicable obligations under Data Protection Legislation.
- 8.6. The Partners shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining, and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection Legislation, and in particular to protect the Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:
- 8.6.1. take account of the nature, scope, context, and purposes of processing as well as the risks, of varying likelihood and severity for the rights and freedoms of Data Subjects; and
 - 8.6.2. be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data and Special Category Personal Data and having the nature of the Personal Data (and Special Category Personal Data) which is to be protected.
- 8.7. Each Partner shall:
- 8.7.1. ensure that only Staff as provided under this Schedule have access to the Personal Data and Special Category Personal Data;
 - 8.7.2. ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display, or distribution, of the Relevant Information;
 - 8.7.3. obtain prior written consent from the originating Partner to transfer the Relevant Information to any third party;
 - 8.7.4. permit any other Partner or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors, or assigns) and comply with all reasonable requests or directions to enable each Partner to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and
 - 8.7.5. if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

The Partners shall adhere to the specific requirements as to information security set out in any Data Sharing Agreement entered in accordance with this Schedule.

8.8. The Partners shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

8.9. The Partners' Single Points of Contact set out in paragraph 13 will be the persons who, in the first instance, will have oversight of third-party security measures.

9. Governance: Transmission of Information between the Partners

9.1. This paragraph supplements paragraph 8 of this Schedule.

9.2. Transfer of Personal Data between the Partners shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net or gcsx) e-mail.

9.3. Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, to ensure that the correct patient record and/or data is identified.

9.4. Any other special measures relating to security of transfer should be specified in a Data Sharing Agreement entered in accordance with this Schedule.

9.5. Each Partner shall keep an audit log of Relevant Information transmitted and received during this Agreement.

9.6. The Partners' Single Point of Contact notified pursuant to paragraph 13 will be the persons who, in the first instance, will have oversight of the transmission of information between the Partners.

10. Governance: Quality of Information

10.1. The Partners will take steps to ensure the quality of the Relevant Information and to comply with the principles set out in Article 5 UK GDPR.

11. Governance: Retention and Disposal of Shared Information

11.1. A non-originating Partner shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically, the Relevant Information will be deleted, and formal notice of the deletion sent to the that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Partner they came from.

11.2. Each Partner shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, upon request and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

11.3. If a Partner is required by any Law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy

in accordance with this Schedule, it shall notify the other Partners in writing of that retention, giving details of the documents or materials that it must retain.

- 11.4. Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all Good Practice including the Records Management NHS Code of Practice, as updated, or amended from time to time.
- 11.5. The Partners shall set out any special retention periods in a Data Sharing Agreement where appropriate.
- 11.6. The Partners shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a crosscut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.
- 11.7. Each Partner shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.
- 11.8. Electronic records will be considered for deletion once the relevant retention period has ended.

In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Partner shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

12. Governance: Complaints and Access to Personal Data

- 12.1. The Partners shall assist each other in responding to any requests made under Data Protection Legislation made by persons who wish to access copies of information held about them ("Subject Access Requests"), as well as any other exercise of a Data Subject's rights under Data Protection Legislation or complaint to or investigation undertaken by the Information Commissioner.
- 12.2. Complaints about information sharing shall be reported to each Partner. Complaints about information sharing shall be routed through each Partner's own complaints procedure unless otherwise provided for in the Joint Working.
- 12.3. The Partners shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.
- 12.4. Basic details of the Agreement shall be included in the appropriate log under each Partner's publication scheme.

13. Governance: Single Points of Contact

- 13.1. The Partners each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

14. Monitoring and review

- 14.1. The Partners shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Data Protection Legislation and best practice.

Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

Appendix 1 to Schedule 5

Dated: 1 April 2026

(1) NHS ENGLAND (SPECIALISED COMMISSIONING)

and

(2) **MIDLANDS NHS INTEGRATED CARE BOARD**

Joint Controller Agreement for Delegated Specialised
Services support via NHS England Commissioning Teams in
Financial Year
2026/27

THIS AGREEMENT is made on the 1st day of April 2026

Between

(13) NHS Midlands Integrated Care Boards and NHS England.

(14)

Introduction

The ICBs and NHS England wish to enter into this Joint Controller Agreement (the “**Agreement**”) in respect of the administrative and management services (the “**Administrative and Management Services**”) to be provided by the NHS England regional teams currently commissioning Specialised Services (the “**Commissioning Teams**”) to the Midlands ICBs during the financial year 2026/27 (1 April 2026 – 31 March 2027) for all Delegated Specialised Services, as set out further in the Collaboration Agreement.

Background

- a) NHS England has statutory functions to arrange for the provision of prescribed services for the purposes of the NHS. This includes the services known as “**Specialised Services**”.
- b) The ICBs have statutory functions to arrange for the provision of services for the purposes of the NHS in their areas, apart from those commissioned by NHS England.
- c) NHS England has entered into a Delegation Agreement for Specialised Services with the ICB under Section 65Z5 of the NHS Act 2006, and also a Commissioning Team Agreement which outlines the scope and basis of the Administrative and Management Services which NHS England has agreed to provide to the ICB during the financial year 2026/27.
- d) This Agreement sets out the respective roles of the Parties in respect of Personal Data Processed in connection with the Administrative and Management Services, in accordance with the Data Protection Legislation.

It is agreed:

1 Commencement, duration and status of this Agreement

- 1.1 This Agreement shall come into force on the 1 April 2026 and continue until 31 March 2027 unless extended by written agreement from all Partners.
- 1.2 Termination of the Commissioning Team Agreement shall also have the effect of terminating this Agreement

- 1.3 Unless otherwise provided, the words and expressions defined in the Delegation Agreement and Commissioning Team Agreement shall have the same meaning and effect in this Agreement.
- 1.4 The following definitions shall apply this Agreement:
- 1.4.1 **"Commissioning Support Data"** means the Personal Data and Non-Personal Data Processed in connection with the Administrative and Management Services, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – *"To Share or Not to Share?"*), and as further defined in clause 2 below;
- 1.4.2 **"Data Protection Impact Assessment"** shall have the same meaning as set out in the UK GDPR;
- 1.4.3 **"Joint Controller"** shall have the same meaning as set out in the UK GDPR; and
- 1.4.4 **"Personal Data Breach"** shall have the same meaning as set out in the UK GDPR.

2 Key principles and aims

- 2.1 The Parties agree and acknowledge that it is necessary for NHS England to Process certain Personal Data in for it to perform the Administrative and Management Services, as comprised within the Commissioning Support Data.
- 2.2 The Parties record their understanding and agreement in relation to the Commissioning Support Data as follows:

(a)

Subject matter	The performance of the Administrative and Management Services by NHS England so as to assist the ICBs in being able to perform the Delegated Functions.
Duration	This Parties agree that this Agreement applies for the duration of the Commissioning Team Agreement, but for the avoidance of doubt, the Parties acknowledge that their legal obligations under the UK GDPR in respect of the Commissioning Support Data survive expiry or termination of this Agreement, however arising.
Nature and purpose of the processing	The Commissioning Support Data enables NHS England to undertake analysis on, and otherwise take account of, the health needs of the ICB's local population and to provide tailored advice and support to the ICB in connection with the ICB's Delegated Functions.
Type of personal data	Patient level, and so directly identifiable, data is shared by NHS providers with NHS England via its national data landing platform, whereupon it is

	pseudonymised by the Arden and GEM DSCRO before it is made available to commissioners, including NHS England, as needed and relevant for their particular functions.
Categories of Data Subject	Patients in England.

(b)

2.3 The Parties have determined the following in respect of their roles under the Data Protection Legislation:

2.3.1 they will together determine the purpose and means for which the Commissioning Support Data is Processed in order for NHS England to provide the Administrative and Management Services and therefore that they are Joint Controllers in this context;

2.3.2 the ICB is an independent Data Controller for any Personal Data it Processes in order for it to perform the Delegated Functions; and

2.3.3 NHS England is an independent Data Controller for any Personal Data Processed in order for it to perform the Retained Functions.

2.4 The Parties agree that NHS England is the **"Lead Controller"** in respect of the Commissioning Support Data. As Lead Controller, NHS England has responsibility for ensuring that the Processing of the Commissioning Support Data is performed in accordance with Data Protection Legislation.

2.5 The Parties agree that this Agreement is necessary to enable NHS England to carry out the Administrative and Management Services. This Agreement defines the principles and procedures that the Parties shall adhere to and the responsibilities the Parties owe to each other and to Data Subjects, in accordance with the Data Protection Legislation.

3 Lead Controller obligations

3.1 The Lead Controller is responsible for providing the Data Subjects with clear and sufficient information as to the way in which the Commissioning Support Data will be processed.

3.2 To comply with its obligation at clause 3.1 of this Agreement, the Lead Controller shall provide the Data Subjects with a privacy notice where the circumstances so require. The Lead Controller is responsible for ensuring that its privacy notice addresses all matters required to be included by Articles 13 and/or 14 of the UK GDPR.

3.3 The Lead Controller is responsible for making available to Data Subjects the essence of the arrangements contemplated by this Agreement in accordance with Article 26(2) of the UK GDPR.

4 Joint Controller obligations

- 4.1 The Parties are jointly responsible for determining the purposes and means for and by which the Commissioning Support Data may be processed, in light of the collective and shared purpose arising out of NHS England's performance of the Administrative and Management Services for the benefit of the ICB. The Parties agree and acknowledge that the legal bases which apply to the Processing of the Commissioning Support Data are as follows:
- 4.1.1 Article 6(1)(e) UK GDPR, on the basis that it is necessary for NHS England to Process the Commissioning Support Data in order for it deliver the Administrative and Management Services and in reliance on NHS England's statutory powers under section 2(2) of the NHS Act 2006; and
 - 4.1.2 Article 9(2)(h) UK GDPR, on the basis that is necessary for NHS England to Process the Commissioning Support Data in order for it to deliver the Administrative and Management Services as they relate to the management of health care systems and services.
- 4.2 The Parties agree to promptly inform each other if either Party becomes aware of any non-compliance with the terms of this Agreement or the Data Protection Legislation.
- 4.3 The Parties agree to cooperate and assist each other with fulfilling their obligations under the Agreement and complying with the Data Protection Legislation. In particular, it is agreed that:
- 4.3.1 NHS England shall assist the ICB as the Lead Controller with complying with Article 26 of the UK GDPR and as further set out in this Agreement;
 - 4.3.2 the Parties shall promptly inform each other of any request they receive under the FOIA, UK GDPR or any other Applicable Law which involves any Commissioning Support Data, but in any event no later than two working days after receiving the request;
 - 4.3.3 the Parties shall provide each other with such assistance as is necessary to enable each other to comply with any requests they receive under the FOIA, the UK GDPR or any other Applicable Law;
 - 4.3.4 if requested, the Parties shall make available to each other all information necessary to comply with auditing requirements and/or demonstrate compliance with the Agreement and Data Protection Legislation;
 - 4.3.5 To the extent permitted by law, the Parties shall promptly notify each other of any communication they receive or are made aware of that suggests non-compliance in

respect of the way in which the Commissioning Support Data has or is being controlled or processed under this Agreement; and

- 4.3.6 Taking account of the nature of Processing and the Commissioning Support Data, the Parties undertake to assist each other with meeting their respective obligations relating to security of processing, the notification of Personal Data Breaches and the completion of Data Protection Impact Assessments.

5 Personal Data Breaches

- 5.1 The Parties shall inform each other of any actual or suspected Personal Data Breach as soon as is practicable, but in any event no later than 24 hours after becoming aware of the actual or suspected Personal Data Breach, irrespective of whether there is a requirement to notify any Supervisory Authority or Data Subjects.
- 5.2 The Parties agree to provide each other with reasonable assistance to facilitate the handling of any Personal Data Breaches in an expeditious and compliant manner.

6 Effect of termination

- 6.1 This Agreement shall continue in force unless and until it has expired or is otherwise terminated in accordance with clause 1 above.
- 6.2 Notwithstanding expiry of termination of this Agreement the Parties will continue to retain Commissioning Support Data in accordance with the Data Protection Legislation and subject to any applicable legal, regulatory or professional retention periods.

7 Transfers

- 7.1 For the purposes of this clause 'transfers' means the sharing of the Commissioning Support Data by a Party (**Disclosing Party**) with a Third Party and shall include, but is not limited to, the following:
- 7.1.1 the Disclosing Party granting a Third Party access to the Commissioning Support Data; and/or
 - 7.1.2 the Disclosing Party sub-contracting the processing of Commissioning Support Data.
- 7.2 The Data Discloser may only transfer the Commissioning Support Data in circumstances where it is lawful to do so in accordance with Data Protection Legislation. If the Data Discloser grants a Third Party access to the Commissioning Support Data it must comply with Articles 28 and 30 of the UK GDPR, as applicable, and shall remain liable for any acts and/or omissions of the Third Party.

Midlands ICBs and NHS England Commissioning Team Agreement 2026/2027

Section	Content	Page
1	Introduction	3
2	Values and Principles	4
3	Key Terms	5
4	Key Elements	6
5	Administrative & Management Services (<i>Purpose, Roles & Responsibilities, and Functions</i>) 5.1 Overview 5.2 Commissioning Team 5.3 Pharmacy Team 5.4 Finance Team 5.5 Quality Team 5.6 Business Intelligence & Analytics Team 5.6 Commissioning Support	6
6	Costs and Liabilities	
7	Learning and Development	
8	Escalations, FoI and Incident Management	
9	Confidential Information	
10	Finance	
Appendix 1	Contracts & Contract Leads for NHSE Specialised Contracts	
Appendix 2	Specialised Pharmacy Contacts	
Appendix 3	Fulfilling statutory duties (13Q) & Communications & Engagement	

1. Introduction

This agreement sets out the purpose of the Office of Pan ICB Commissioning, how it will operate and how it will be governed from 1st April 2026 to 31st March 2027.

From April 27 (subject to approval by Parliament to necessary legislative changes) Integrated Care Boards (ICBs) will take over statutory responsibility from NHS England for commissioning suitable specialised Acute and Mental health, Learning Disability & Autism services; Health and Justice services; and Screening and Vaccination services. Collectively, these services account for circa £5bn within the Midlands in 2025/26.

Whilst it is intended that ICBs will be individually responsible, most of their new commissioning functions will require – due to the nature of the services and populations involved – a large planning and commissioning footprint. This will mean that ICBs will need to establish (or build upon existing) appropriate multi-ICB governance arrangements, such as a joint committee.

Seven 'Offices for Pan-ICB Commissioning' (OPICs) – one per NHS region - will be established to support all ICBs across a region in discharging these additional statutory functions. The OPIC model is designed to facilitate ICB collaboration and, where appropriate, 'at scale' commissioning as well as ensuring a critical mass of expert commissioning capability is maintained for these complex, high profile and often contentious areas of service provision.

The OPIC model is designed to facilitate ICB collaboration and, where appropriate, 'at scale' commissioning as well as ensuring a critical mass of expert commissioning capability is maintained for these complex, high profile and often contentious areas of service provision.

Staff currently delivering these commissioning functions within NHSE's seven regional teams will transfer to the host ICBs in April 2027 (or, at the point legislative provisions transferring these functions to ICBs are commenced) NHS England will continue to host staff working on behalf of ICBs for the commissioning of the Specialised Acute and MHLDA services that were delegated in April 2024 and April 2025.

This agreement will commence on 1st April 2026 for one year only. The year will operate as a transition in the development of for NHS England's commissioning functions some defined functions with NHSE remaining the employing organisation.

This agreement is BETWEEN the following clusters of ICBs & NHS England:

Cluster 1

(15) NHS Lincolnshire Integrated Care Board of Bridge House, The Point, Lions Way, Sleaford, NG34 8GG ("Lincolnshire ICB"); and

(16) NHS Nottingham & Nottinghamshire Integrated Care Board of Sir John Robinson House, Sir John Robinson Way, Arnold, Nottingham, NG5 6DA ("Nottingham & Nottinghamshire ICB"); and

(17) NHS Derby & Derbyshire Integrated Care Board of Cardinal Square, 10 Nottingham Road, Derby, Derbyshire, DE1 3QT ("Derby & Derbyshire ICB"). and

(18) Cluster 2

(19) NHS Leicester, Leicestershire & Rutland Integrated Care Board of Room G30, Pen Lloyd Building, County Hall, Glenfield, Leicester, LE3 8TB ("Leicester, Leicestershire & Rutland ICB"); and

(20) NHS Northamptonshire Integrated Care Board of Haylock House, Kettering Parkway, Venture Park, Kettering NN15 6EY ("Northamptonshire ICB"); and

(21) Cluster 3

(22) NHS Birmingham & Solihull Integrated Care Board of Eighth Floor, Alpha Tower, Birmingham ("Birmingham & Solihull ICB"); and

(23) NHS Black Country Integrated Care Board of Civic Centre, St Peters Square, Wolverhampton WV1 1SD ("Black Country ICB"); and

(24) **Cluster 4**

(25) NHS Herefordshire & Worcestershire Integrated Care Board of Kirkham House, John Comyn Drive, Perdiswell, Worcester, WR3 7NS ("Herefordshire & Worcestershire ICB"); and

(26) NHS Coventry & Warwickshire Integrated Care Board of Shire Hall, Market Place, Warwick CV34,4RL ("Coventry & Warwickshire ICB"); and

(27) **Cluster 5**

(28) NHS Shropshire, Telford & Wrekin Integrated Care Board of Halesfield 6, Halesfield, Telford, TF7 4BF ("Shropshire, Telford & Wrekin ICB"); and

(29) NHS Staffordshire & Stoke-on-Trent Integrated Care Board of Stafford Education & Enterprise Park, Weston Road, Stafford, ST18 0BF ("Staffordshire & Stoke-on-Trent ICB");

(30) and

(31) NHS England of Wellington House, 133-155 Waterloo Road, London, SE1 8UG (acting under the name NHS England) ("NHS England").

This Joint Working Agreement should be read in conjunction with:

- Overarching governance documents
 - Delegation Agreement
 - Joint and Collaborative Committee Terms of Reference
 - OPIC Commissioning & Operating Framework
- National guidance relating to the roles and responsibilities of NHS England in relation to directly commissioning services.

(32)

2. Values and Principles

In creating the Office of Pan ICB Commissioning we will continue to **transform the way health services are strategically commissioned across the Midlands**, by creating a **collaborative, resilient, and equity-driven system** that works at scale while remaining responsive to local needs.

The Office of Pan ICB Commissioning will:

- **Support a safe transfer / delegation of commissioning** responsibilities and accountabilities from NHSE to ICBs from 2027.
- **Bring together Strategic Commissioning of specialist services across the 5 cluster ICBs** - Establishing a **Midlands-wide centre of excellence** that supports all ICBs equally, hosted by one ICB on behalf of all. Enabling consistent, high-quality commissioning through a **shared operating model**, while allowing flexibility for local decision-making.
- **Improve Health Equity and Outcomes** - Use **data-driven planning** to tackle health inequalities and improve outcomes for underserved populations. Shift focus from service fragility to **population health, access, and equity**.
- **Empower Clinical and Community Leadership** - Embed **clinical leadership and co-production** at the heart of commissioning. Ensure services are shaped by **patients, providers, and communities**.
- **Deliver Value-Based, Outcome-Focused Care** - Align commissioning decisions with **measurable outcomes**, patient experience, and cost-effectiveness. Drive **efficiency and sustainability** across specialist services.
- **Enable Integration and Innovation** - Support **pathway redesign** and integration across care settings. Foster **provider collaboration** and innovation through shared governance and financial risk models.

Midlands ICBs are committed to collaborate and commission at scale, to maximise resilience and strategic commissioning capability in these important areas of healthcare provision. The Office for Pan ICB Commissioning will provide a Midlands wide centre of excellence focussing on specialist commissioning knowledge and expertise, connecting with and through colleagues at cluster, place and provider level. It will be built on the following principles of collaboration and co-production:

As Strategic Commissioners Our Guiding Principles Are:

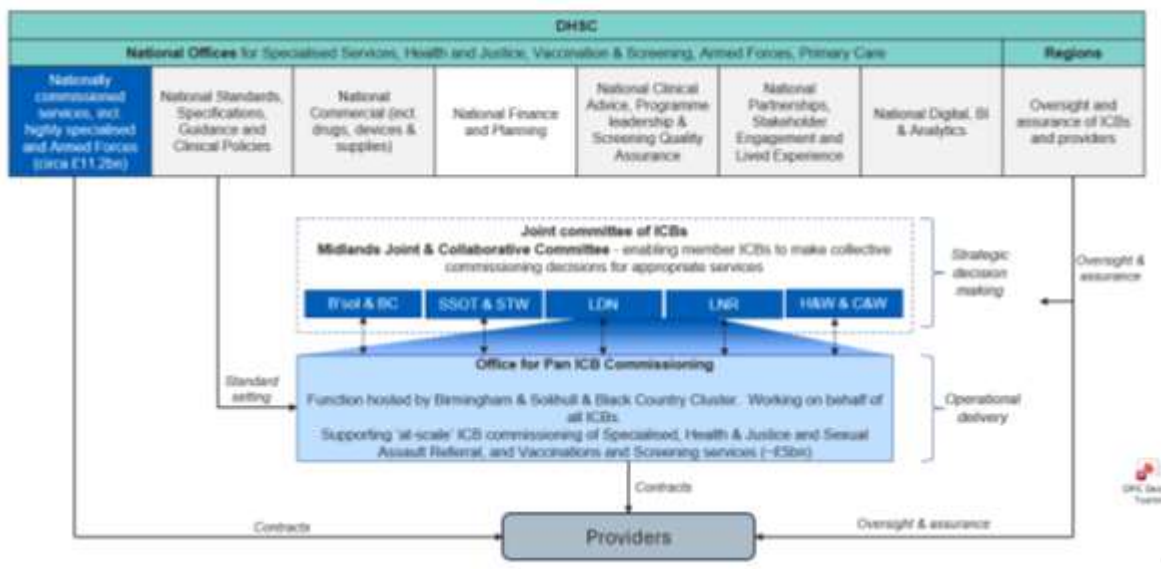


The Multidisciplinary Team will work coherently and consistently and will champion specialised care on behalf of the 12 commissioning partners. They will work as a part of a network of partners, enabling staff to deliver across complex geographies and as part of multi-layered systems and local collaboration.

3. Operating Model

The founding principles of the operating model are:

- Operate Midlands wide by default, whilst working at ICB Cluster or East/West footprints when it makes sense to do so.
- OPIC hosted by NHSE until transfer to the host ICB, so must fulfil its current statutory functions whilst being future proof and in line with ICBs development as strategic commissioners.
- Develop as a cohesive entity operating based on collaboration, co-production and transparency working with ICB leadership and guidance.
- Clear points of communication and relationship management across ICBs, OPIC and into national commissioning functions.
- The strategic commissioning framework, ICB blueprint and OPIC design toolkit will frame its core purpose.
- Financially sustainable within OPIC RCA envelope.



Delegated services

The Midlands Specialised Commissioning Team has been working with and on behalf of all Midlands ICBs since 2023/24 with a joint working agreement and subsequent set of delegation processes in April 2024 and April 2025.

We commission:

- Circa. 150 specialised services aligned to the prescribed service manual.
- Acute and Mental Health, Learning Disability and Autism Services (MHLDA).
- ICB delegated service responsibility and NHSE retained responsibility as well as contracting processes for current Highly Specialised Services (HSS).
- High-Cost Medicines, including medicines optimisation and care transformation.

We operate:

- A single integrated Midlands team working on behalf of ICBs and NHSE.
- Subject matter expertise aligned to 6 programmes of care (Women and Children's, Trauma, Internal Medicine, Cancer, Blood and Infection and MHLDA).

NHS England Commissioned Services

Health and Justice

Commissioning of healthcare for a range of individuals in touch with the criminal justice system

- *Custodial healthcare services:* Male Prisons, Female Estate, Young Offenders Institutes, & Secure Holding Facilities. *16 contracts across 4 providers operating within 28 establishments.*
- *Non-custodial healthcare services:* Liaison and Diversion Services, RECONNECT, Mental Health Treatment Requirements (MHTRs) *across 9 providers.* Court Healthcare co-commissioned with the MoJ (PECS) by the Midlands H&J team covering the North of England and the Midlands regions (*1 contract, 1 provider*).
- *Children and Young Peoples (CYP) Services:* 2 x secure children's homes and 1 planned new safe centre (welfare only unit) *2 contracts across 2 providers.*
- *Sexual Assault Referral Centres (SARCs) for Adults and for Children and Young People.* Co-commissioned with Police and Crime Commissioners / Police Forces. *12 locations, 8 contracts across 5 providers.*

Screening

Responsibility for delivery of:

Cancer Programmes: Cervical Screening, Breast Screening, Bowel Screening

Adult Non-Cancer Programmes: Diabetic Eye Screening, Abdominal Aortic Aneurysm (AAA) Screening, Antenatal and Newborn programme: Six separate programmes

Child Health Information Services (CHIS)

Commissioning functions include:

- Service transformation and improvement, develop innovative solutions and implementation plans to meet local need and ensure best value
- Coordinate management of screening incidents/issues.
- Oversee local end-to-end screening pathways to address gaps & ensure alignment Effective contract management, monitoring and development and delivery of improvement/equity plans
- Use data and insight to identify population needs

Vaccinations

Through our well-established vaccination governance group, we work with all ICB vaccination leads to ensure alignment with system prevention strategies, making joint decisions on vaccination delivery for routine and seasonal programmes (see annex for detail):

Childhood programmes – Measles, Mumps, Rubella, Varicella (MMRV), Diphtheria, Pertussis, Meningococcal C etc

Seasonal programmes – Covid (spring/winter) & Flu (winter)

School Age Programmes - flu, Human Papilloma Virus (HPV), Meningococcal ACWY (Men-ACWY), Tetanus/Diphtheria/Polio (Td/IPV), MMR / MMRV (catch-up)

Adult Programmes - Pertussis, Respiratory Syncytial Virus (RSV), Pneumococcal, Shingles, MPOX/Gonorrhoea

Maternal programmes – Flu, Pertussis, RSV

Neonatal Programmes – BCG for TB prevention, Hepatitis B

Commissioning Support Services

Finance

- Contract negotiation and management for all specialist services including all NHSE retained and delegated services – delivered, where appropriate through ICB lead contract arrangements.
- Development of activity plans for all contracts and services
- Management and processing of all contract variations.
- Provider relationships – contract management, review meetings across all NHS and Independent sector providers
- Management of payments for all specialist services

- Support to ICBs through finance and contracting governance groups, management of risk share arrangements, pricing policy
- Management of financial allocations including operational and strategic financial planning

Monthly reporting and ledger management

Healthcare Public Health

The key public health functions embedded in OPIC

- **Specialised commissioning:** At regional level, a full and integral member of specialised commissioning teams. Liaison with public health colleagues across the system to assist in optimising prevention, service planning and quality across whole pathways of care.
- **Health and Justice:** Provide public health expert advice and guidance to HMPPS and NHSE, in commissioning of health services in the secure and detained estate. Health needs through data analysis and interpretation, service audits and reviews.
- **Dental public health:** Provide specialist dental public health & clinical leadership, advice and guidance for Local Integrated Care Systems supporting the commissioning of ICB Dental services
- **Screening and Immunisations:** Technical PH knowledge and operational experience in screening and immunisation pathways, including quality assurance, incident response, and compliance with national standards.

Clinical and Quality

Delivery of Statutory Quality Duties for commissioned services through three separate Clinical & Quality teams:

- Acute Specialised Commissioning
- Mental Health, Learning Disability & Autism (MHLDA) Specialised Commissioning
- Health & Justice (Custodial and Non-Custodial) and Vaccination & Screening
- **Quality Surveillance (Control):** through Provider Contract Review Meetings
- **Quality Assurance:** Undertaking Desktop/Peer Reviews, Clinical Quality Visits (CQVs), Audits **Quality Improvement & Quality Planning:** Working with Clinical Networks/Programme of Care, including thematic learning e.g. from Deaths in Custody (DICs) and PSIRF
- **Clinical Leadership:** providing specialist advice and support

Corporate and Governance

Ensure all activities across commissioning are aligned, efficient and well-managed, as the operational backbone for governance and delivery.

- **Programme Management** – Ensures projects and initiatives are coordinated, managed and deliver outcomes.
- **Change Management** – Designing and implementing change programmes, managing people, processes and transitions.
- **OD, EDI and HR** - Improving directorate effectiveness and capability
- **Comms and Engagement** - Media and stakeholder advice, incident & issue management, proactive media management
- **Corporate Governance** - – Ensure accountability, transparency and compliance
- **Business coordination** - Risk and issue management, reporting and assurance

4. Governance

In April 2026, the former East Midlands and West Midlands Joint Committee will stand down and be replaced by the Midlands Joint and Collaborative Committee. Decision Making bodies will be:

- **Joint & Collaborative Committee:** Approves strategic commissioning plans, major service changes, and decommissioning decisions and high-value/high risk changes.

-
- The organizational chart illustrates the structure of the Midlands Joint and Collaborative Committee (MJCC). At the top is the **NHSE Executive Board**. Below it are the **Delegated Commissioning Group**, **National Commissioning Groups**, and **Regional Support Group**. The **Midlands Joint and Collaborative Committee made up of Midlands ICB Joint Committee and ROG meeting as Committees in Common (ICBs Clusters & NHSE)** is a central body. This committee oversees several groups: **Midlands Basic Specialist Commissioning Group (ICB & NHSE)**, **Midlands M&D Commissioning Group (ICB & NHSE)**, **Clinical & Quality Advisory (ICB & NHSE)**, **Finance and (voluntary) support (ICB & NHSE)**, **Midlands Health and Justice commissioning group (cluster leads & Specialist team)**, **Midlands Vaccination, Commissioning Group (cluster leads & Specialist team)**, **Midlands Screening Commissioning Group (cluster leads & Specialist team)**, **Office of care (ICB and NHSE) Commissioning Management Group**, and **Health & Social Care (commissioning) organisation**. To the right, the **Midlands Regional Executive Team & other regional groups** and the **Midlands Transition Board** are shown. A legend on the far right explains the color coding: Blue for ICBs, Green for NHSE, and Yellow for Joint and Collaborative Committees.

NHSE commissioning team (working on delegated ICB services and NHSE commissioned services) will operate seamlessly across NHSE and cluster ICBs. NHSE will meet all associated costs of employing staff commissioning NHSE services working jointly with ICBs and hosting staff who support services already delegated to ICBs, this will include but not limited to the following

- ## Liabilities

NHS England will meet the liabilities as a result of:

- ## MaST training and professional development

100% compliance is required by all staff for the MaST training detailed below:

Equality, Diversity and Inclusion

As part of the system leadership arrangements for the NHS, we recognise the importance of becoming a role model for the rest of the NHS in respect of issues relating to equality, diversity, and inclusion in the workplace.

Fraud Awareness

This course focuses on providing you with awareness of the key aspects of fraud and corruption in the NHS and help you know your responsibilities to combat it.

Data Security Awareness

This course focuses on the importance of data security in health and social care. It will help you understand how to comply with the law, define potential threats and how to identify and avoid breaches.

Health and Safety

This course focuses on health and safety in the workplace. You will gain an understanding for responsibilities under Health and Safety Law, different types of safety signage, basic fire safety principle, basic moving, and handling techniques and why incident reporting is so important.

Safeguarding Children & Adults at Risk of Harm or Abuse

This course introduces safeguarding children and adults at risk of harm or abuse. It focuses on safeguarding in the NHS, data sharing, domestic abuse, and associated legislation as well as what you can do when raising a concern.

Records Management

This course introduces you on the importance of records management, legal and contractual requirements, and guidance on how to keep information secure.

Patient Safety

This course introduces patient safety for all NHS staff. It focuses on the essentials for creating patient safety and helps recognise that the NHS is a system of essential and interconnected parts; a team with a common goal.

Appraisal and Dynamic Conversations

NHSE will meet all costs and requirements of ensuring all members of the have regular performance and development through regular Appraisal & Dynamic Conversations.

Appraisals are an opportunity for both line managers and team members to have meaningful, fluid, and organic 1:1s. Dynamic Conversations put wellbeing at the forefront of initial conversations and will help to support colleagues through change.

NHSE will ensure that monthly 1:1s with line managers are regularly scheduled.

(a) Freedom of Information and Parliamentary Requests

- (b) All Freedom of Information and Parliamentary Requests relating to Delegated Services should be forwarded to the NHSE commissioning team will ensure the appropriate handling, management, and response, ensuring where appropriate that ICBs are informed and engaged. The team will also ensure they provide reasonable support to ICBs in responding to freedom of information and parliamentary correspondence as required.

(c)

(d) Incident Response and Management

- (e) The NHSE commissioning team shall provide such reasonable support as required by an ICB in relation to local incident management for Delegated Services and NHSE commissioning services.

(f)

(g) Provider Selection and Procurement

- (h) The NHSE commissioning team shall act on instructions from the ICBs in relation to provider selection and procurement processes for the Delegated Services.

Escalations

If an ICB has cause to raise concerns regarding the performance, actions or conduct of a member of the Multi-Disciplinary Team the ICB will in the first instance contact by email the Director of Specialised & Collaborative Commissioning, who will where possible provide an acknowledgement within 7 days of receipt.

The Director of Specialised & Collaborative Commissioning will provide the ICB with feedback and action taken within 30 days.

If for any reason the ICB is unhappy with the response the concerns can be escalated to the NHS England Regional Director of Commissioning

Confidential information

The ICBs and NHSE shall always use its best endeavours to keep confidential and ensure that its employees and agents keep confidential any information in relation to the business and affairs of another Partner.

If the information referred to herein is subject to a freedom of information (FOI) or other request to share the data, then NHS England will be responsible for the fulfilment of the request, but will seek views from the ICBs before undertaking this in accordance with the Freedom of Information Code of Practice issued by the Cabinet Office under section 45 of the Freedom of Information Act 2000.

The ICBs and NHSE will not make any press announcements about this Agreement or publicise this Agreement or any of the terms in any way. The ICBs and NHSE shall ensure that any such information disclosed is solely for the purpose of performing its obligations under this Agreement.

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	19/03/2026
Paper title:	Board Assurance Framework: Year-end Update
Paper reference:	ICB CIC 051
Paper author:	Siân Gascoigne, Assistant Director of Corporate Affairs, NHS Nottingham and Nottinghamshire ICB Lucy Branson, Director of Corporate Governance and Assurance
Paper sponsor:	Amanda Sullivan, Chief Executive
Presenter:	Lucy Branson, Director of Corporate Governance and Assurance

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

Report summary:

The joint Board Assurance Framework (BAF) provides a structured approach for identifying and managing the strategic risks that may impact the delivery of the ICBs' core objectives. It maps key controls and sources of assurance, enabling the Boards to gain confidence that appropriate arrangements are in place and operating effectively.

Since the approval of the joint strategic risks in November 2025, a comprehensive exercise with Executive risk owners has been undertaken to populate the Assurance Framework. This exercise identified areas of duplication and overlap, as well as opportunities to strengthen clarity and alignment across the emerging cluster arrangements. As a result, the strategic risks have been refined; some risks have been consolidated where there was overlap, one risk has been disaggregated into two distinct risks, and one risk has been removed. The Assurance Framework has been developed with a forward-looking perspective, focusing on the controls and assurance mechanisms that will be established across the cluster. Many of the identified 'gaps' reflect the ongoing development and alignment of cluster-wide processes rather than weaknesses in control. The Assurance Framework, therefore, provides the Boards with a structured view of the future control environment and the evolving assurance landscape.

The Assurance Framework will operate throughout 2026/27, with further updates reported to the Boards bi-annually, following committee review and oversight, in line with the ICBs' Risk Management Policy.

Recommendation(s):

The Boards are asked to **approve** the revised joint strategic risks and **receive** the joint Board Assurance Framework for scrutiny and review.

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

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

Appendix A: Revised joint strategic risks

Appendix B: 2026/27 Board Assurance Framework

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Board Assurance Framework: Year-end Update

Introduction

1. The ICBs' joint strategic risk management processes are centred on the Board Assurance Framework. The Assurance Framework provides a structured approach to identifying and managing the principal strategic risks that may impact the delivery of the ICBs' core aims and objectives. It also maps the key controls and sources of assurance that support the management of these risks, enabling the Boards to gain confidence that appropriate arrangements are in place and operating effectively.
2. In particular, the Assurance Framework enables the Boards to:
 - a) Gain a clear and comprehensive understanding of the control environments established to manage the ICBs' strategic risks.
 - b) Consider the types and sources of assurance currently in place, and whether these are proportionate, effective and efficient.
 - c) Identify areas where controls have yet to be fully established or where existing controls may not be operating as intended (i.e. control gaps), and therefore where risks may be more likely to materialise.
 - d) Identify areas where assurance activities may be absent, insufficient, duplicated or disproportionate (i.e. assurance gaps).
3. At the first meeting in common of the Boards in November 2025, a set of 12 strategic risks was approved to form the basis for development of a joint Board Assurance Framework. These risks were developed following a review of the existing strategic risk sets across Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire ICBs, alongside consideration of key national policy drivers, including the Ten-Year Health Plan for England, the Model ICB Blueprint and the Strategic Commissioning Framework.
4. Since this time, a comprehensive exercise has been undertaken with Executive risk owners to initially populate the joint Board Assurance Framework. In developing the Assurance Framework, particular emphasis has been placed on ensuring that it is forward-looking, both in terms of the controls that are being established and the assurance mechanisms that will provide the Boards with confidence over time.
5. The exercise identified duplication and overlap across some strategic risks when mapping the emerging control environment, and as such, a small number of changes are proposed for Board consideration. The exercise also highlighted that, while a number of 'gaps' have been identified, many of these do not relate to the absence of controls, but to the ongoing alignment, development and formalisation of arrangements at a cluster-wide level.

6. The purpose of this paper is to present the fully populated Assurance Framework, attached at Appendix B, for scrutiny and comment by the Boards. The paper also seeks the Boards' approval for the proposed refinements to the strategic risk set, together with the rationale for these changes.
7. The Assurance Framework will operate throughout 2026/27, with further updates reported to the Boards bi-annually, following committee review and oversight, in line with the ICBs' Risk Management Policy.

Strategic risks

8. As highlighted above, a number of changes to the strategic risks are proposed, resulting in a reduction from twelve to nine risks. More specifically:
 - a) Risks relating to the development of commissioning strategies and plans and delivery of the three strategic shifts through transformation (risks 2 to 5) have been combined into a single strategic risk. Population of the Assurance Framework has highlighted that many of the same controls apply across these areas, as they relate to the development, delivery and oversight of commissioning strategies and plans. As such, the consolidation reduces duplication and also reflects that the joint Strategic Commissioning Committee oversees all assurances in these areas.
 - b) In contrast, the former financial sustainability risk (risk 7) has been split into two related risks. Risk 7a focuses on the prioritisation and allocation of resources, including shaping provider markets to meet local population needs. Risk 7b focuses on contract management and the delivery of financial sustainability, covering controls applied after decisions have been made to manage contracts effectively and maintain financial oversight. Both risks are supported by robust controls, and it is important that they are clearly differentiated for governance and assurance purposes.
 - c) Risk 8, relating to the evaluation of commissioned services, has been removed as a standalone strategic risk, as this is felt to be sufficiently captured within other strategic risks, particularly those relating to system transformation, quality improvement, and access to services. This reflects the view that evaluation and learning are core enablers, embedded across strategic commissioning and quality improvement, rather than being a discrete strategic risk.
9. All other risks have been retained without material change, as they continue to represent distinct and significant threats to the delivery of the ICBs' objectives within the current and emerging operating context.
10. At this stage, current risk scores have been assigned, reflecting high or medium risk as expected for strategic-level risks. It should be noted that target risk

scores have not yet been determined; this will be addressed following a Board development session on risk appetite, currently scheduled for June 2026. A 'heat map' showing current and target risk scores will be included in future reports, once target scores are agreed.

Population of the Board Assurance Framework

Control framework

11. In populating the controls within the Assurance Framework, a future-focused approach has been taken. The controls described reflect the arrangements that are being established across the three clustered ICBs, rather than a retrospective review of existing controls at individual ICB level.
12. Through this process, a number of actions have been identified; however, these do not necessarily represent genuine gaps in control. In most cases, areas currently described as 'gaps' reflect the work required to develop or align cluster-wide processes and oversight arrangements, recognising that historic control arrangements exist within the individual ICBs but operate differently. Examples of these actions relate to:
 - a) Population health management and intelligence, focusing on aligning analytical capability, data sources and decision-making processes to support a consistent population health approach across the ICBs.
 - b) Equality, diversity and inclusion (EDI), including the development of a shared framework and governance arrangements, building on existing local practices.
 - c) The use of research and evidence, strengthening how research, evaluation and evidence are systematically incorporated into commissioning and strategy development.
 - d) Resource allocation and prioritisation, reflecting the move towards an aligned and consistent approach to investment and prioritisation decisions across the ICBs.
 - e) Contract management arrangements, including the standardisation of reporting and escalation routes to support a consistent cluster-wide model of oversight.
 - f) Operational governance, including further alignment of governance arrangements across key areas such as commissioning oversight and digital transformation.
13. This approach reflects the scale and complexity of the transition underway, supported by the move towards a single staffing structure. It is recognised that the control environment will continue to evolve as cluster-wide arrangements

are established and formalised. The Boards are, therefore, asked to consider the Assurance Framework within this context.

14. Notwithstanding the above, a small number of genuine gaps have been identified through engagement with Executive Directors. These relate to controls that do not currently exist and are being introduced to support the ICBs' transition to a strategic commissioner. Examples include developing a cluster-wide Organisational Development Plan, defining and strengthening the ICBs' payer function, and establishing a strategic approach to prevention.

Planned assurances

15. The assurances recorded within the Assurance Framework are also intentionally future-focused, recognising that many of the cluster-level controls and associated oversight arrangements are still being developed. As a result, the majority of assurances are currently recorded as 'pending', reflecting that they are scheduled within committee annual work programmes but have not yet been received.
16. It is important to note that the work to populate the Assurance Framework has been undertaken alongside a review of committee annual work programmes, with each process informing the other, ensuring that the Assurance Framework continues to drive the work of the Boards' committees. This has supported consideration of whether planned committee agendas provide appropriate coverage of the key controls set out in the Assurance Framework and has helped identify where additional internal assurances may be required.
17. When considering external assurances, account has been taken of the interaction the ICBs have with NHS England through a range of oversight and assurance forums. In addition, where internal audit reports have been published since clustering (November 2025). Although the ICBs' 2026/27 internal audit plans have not yet been formally approved, indicative audit areas have been reflected within the Assurance Framework against relevant controls. These areas include, but are not limited to, transition support, procurement, quality and safeguarding oversight, data quality, contract management, and IT business continuity.
18. As the majority of assurances recorded within the Assurance Framework are currently 'pending', it is not yet possible to fully assess whether assurances should be considered positive or negative. However, processes have already been established to ensure that the Boards' committees apply assurance ratings (i.e. full, adequate, partial, or limited) to the assurance reports they receive. Over time, these ratings will inform the assessment of assurances recorded within the Assurance Framework.

Mitigating actions

19. Where 'gaps' have been identified in relation to controls or assurances (whether these represent genuine gaps or areas where further work is required to align arrangements at a cluster-wide level), an Executive lead has been identified alongside a proposed implementation date. It should be noted that these dates may change, as implementation may be affected by the management of change process, or by factors outside the ICBs' direct control, such as the publication of national guidance.
20. Progress against the identified actions will be overseen by the Boards' committees through their consideration of the Assurance Framework, and as work progresses, the actions may be subject to further review and refinement. Once target risk scores have been determined, further discussions with Executive Directors may identify the need for additional actions to ensure that risks can be managed within the ICB's agreed risk appetite.

Monitoring and reporting

21. Work has been undertaken to develop the monitoring and reporting arrangements that will support operation of the Assurance Framework during 2026/27.
22. The Assurance Framework will be reported to the Boards twice yearly, in line with the requirements set out in the ICBs' joint Risk Management Policy. This will be supported by bi-annual reporting of the relevant strategic risks to their lead committees. The purpose of this reporting is to enable committees to assess whether the assurances provided are robust and sufficient to give confidence that the strategic risks are being effectively managed, and to consider whether any 'gaps' in control or assurance require further action.
23. The Audit Committees will also have a key role in providing independent oversight of the effectiveness of the ICBs' strategic risk management processes. In line with the NHS Audit Committee Handbook, the role of the Audit Committees is not to manage the risks themselves, but to review the robustness and effectiveness of the systems and processes that support governance, risk management and internal control. This includes reviewing whether the Assurance Framework, and the processes that support its development and maintenance, are robust and 'fit for purpose'.
24. The Audit Committees will discharge this responsibility through the bi-annual risk management updates included within their work programme. These updates will include an overview of strategic risk management processes and activity undertaken during the previous six-month period, presentation of the full Assurance Framework, and progress against mitigating actions.

Appendix A: Revised joint strategic risks

Risk No.	Strategic Risk Narrative	Risk No.	(Revised) Strategic Risk Narrative
Risk 1	Failure to develop and maintain a comprehensive, evidence-based understanding of local population health needs (Risk that the ICBs do not use joined-up, person-level data and intelligence to identify current and future needs, drivers of risk, and underserved communities, leading to ineffective or inequitable commissioning decisions) <i>Executive owner(s): Director of Commissioning</i>	Risk 1	No change.
Risk 2	Failure to set and deliver a long-term, outcomes-focused commissioning strategy (Risk that the ICBs do not establish a robust, evidence-based commissioning strategies and plans, or implement these using effective commissioning approaches, resulting in missed opportunities to improve health outcomes, reduce inequalities, and deliver system priorities) <i>Executive owner(s): Director of Strategy and Citizen Experience, Director of Commissioning</i>	Risk 2-5	Failure to deliver a coordinated transformation of commissioned services, including prevention, community care models, and digital enablement (Risk that the ICBs do not develop or implement a robust, long-term, outcomes-focused commissioning strategy; fail to shift system focus from sickness to prevention; do not redesign services to deliver integrated care closer to home; and do not adopt or embed digital technologies. Taken together, these could result in missed opportunities to improve population health and reduce inequalities, persistent reliance on reactive and hospital-based care, poor patient experience, inefficiencies, and an inability to achieve system priorities or national expectations)
Risk 3	Failure to shift the system focus from sickness to prevention (Risk that the ICBs do not prioritise or invest sufficiently in preventative approaches, resulting in continued high demand for reactive care, missed opportunities to improve population health, and inability to reduce long-term system pressures and health inequalities) <i>Executive owner(s): Director of Outcomes (Medical)</i>		

Risk No.	Strategic Risk Narrative	Risk No.	(Revised) Strategic Risk Narrative
Risk 4	Failure to transform care delivery from hospital to community settings (Risk that the ICBs do not redesign pathways or commission integrated, community-based services, leading to over-reliance on hospital care, poor patient experience, and failure to deliver care closer to home or address the needs of people with long-term conditions) <i>Executive owner(s): Director of Commissioning, Director of Strategy and Citizen Experience</i>		<i>Executive owner(s): Director of Strategy and Citizen Experience, Director of Commissioning, Director of Outcomes (Medical), Director of Finance</i>
Risk 5	Failure to drive digital transformation and harness technology (Risk that the ICB does not adopt or embed digital solutions, resulting in inefficiencies, limited access to innovation, and inability to improve outcomes, patient experience, or system productivity in line with national expectations) <i>Executive owner(s): Director of Finance</i>		
Risk 6	Failure to involve people and communities meaningfully in commissioning and service design (Risk that the ICBs do not systematically co-produce solutions with service users, carers, and communities, leading to services that do not meet local needs or legal requirements for engagement) <i>Executive owner(s): Director of Strategy and Citizen Experience</i>	Risk 6	No change.

Risk No.	Strategic Risk Narrative	Risk No.	(Revised) Strategic Risk Narrative
Risk 7	Failure to allocate resources effectively and manage provider markets to achieve best value, increased productivity, and deliver financial sustainability (Risk that the ICBs do not align funding to needs, shape provider markets, or use contracting and procurement mechanisms effectively, leading to poor value for money, inefficiencies, or inability to meet national and local priorities) <i>Executive owner(s): Director of Finance</i>	Risk 7a	Failure to allocate resources effectively and shape provider markets to deliver value, productivity and system priorities (Risk that the ICBs do not align funding to population needs, optimise resource use, or proactively shape and manage provider markets. This could result in poor value for money, reduced productivity, inequitable access, and an inability to achieve national and local priorities or deliver sustainable improvement in health outcomes) <i>Executive owner(s): Director of Commissioning, Director of Finance</i>
		Risk 7b	Failure to commission services through effective procurement and contract management arrangements, compromising financial sustainability (Risk that the ICBs do not utilise robust procurement frameworks, contracting mechanisms, or contract management processes, leading to inefficiencies, unmanaged demand, poor provider performance, increased financial risk, or inability to deliver statutory financial duties and long-term sustainability) <i>Executive owner(s): Director of Commissioning, Director of Finance</i>

Risk No.	Strategic Risk Narrative	Risk No.	(Revised) Strategic Risk Narrative
Risk 8	Failure to evaluate and respond to the impact of commissioned services (Risk that the ICBs do not rigorously evaluate the outcomes of commissioned services, resulting in an inability to improve health outcomes and reduce health inequalities) <i>Executive owner(s): Director of Outcomes (Medical)</i>	Risk 8	Removed.
Risk 9	Failure to systematically improve the quality of healthcare services (Risk that the ICBs do not rigorously monitor, evaluate, and adapt services, resulting in persistent gaps in quality and safety and an inability to identify and act promptly on emerging quality concerns) <i>Executive owner(s): Director of Quality (Nursing)</i>	Risk 9	No change.
Risk 10	Failure to ensure timely and equitable access to healthcare services in line with national and local performance standards (Risk that the ICBs do not rigorously monitor, evaluate, and adapt services, resulting in persistent non-delivery of access targets) <i>Executive owner(s): Director of Commissioning</i>	Risk 10	No change.
Risk 11	Failure to develop and deploy an effective ICB cluster operating model with the necessary workforce skills and capabilities for strategic commissioning (Risk that the ICBs do not build or maintain the strategic commissioning skills required, while supporting the wellbeing of the ICBs' combined workforce, limiting their ability to deliver strategic commissioning effectively) <i>Executive owner(s): Director of Transition</i>	Risk 11	No change.

Risk No.	Strategic Risk Narrative	Risk No.	(Revised) Strategic Risk Narrative
Risk 12	Failure to maintain cyber resilience (Risk that the ICBs do not establish robust cyber security arrangements, which could compromise delivery of core functions and disrupt access to critical data and systems) <i>Executive owner(s): Director of Outcomes (Medical)/SIRO, Director of Finance</i>	Risk 12	No change.

Board Assurance Framework

March 2026

How to navigate the Board Assurance Framework

Strategic risks: High-level risks that threaten the achievement of the ICBs' joint aims/objectives and/or statutory duties.

Controls: The mechanisms put in place by management to mitigate potential risks. These can be joint controls, across the cluster, or specific to each individual ICB.

Gaps in control or assurance: These are identified where an additional/enhanced system or process is needed to better control the risk, or where there is a lack of evidence that controls are effective (e.g. where no assurances been, or are planned to be, received).

Risk score(s): These are the opening and current risk ratings for each period which consider the controls that are in place (e.g. those remedial actions to reduce the impact/likelihood). The target risk score is set by the relevant Executive, in line with risk appetite.

Risk XX		Opening Risk Level and Score (I x L)	Current Risk Level and Score (I x L)	Risk Appetite and Target Risk Score (I x L)	Movement in risk score (since last reporting period)		
Strategic Risk Narrative:							
Executive Risk Owner:							
Lead Committee:							
Control Description (How are we going to stop the risks happening?)	Assurances (How do we know the controls are working?)	I	E	+	-	Gaps in Control / Assurance (Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)	Action ref:
Action(s):						Responsible Officer	Implementation Date
Related high/extreme (>15) operational risks from the ICBs' Joint Operational Risk Register:							

Action(s): Where gaps have been identified, these are the actions required to address them. Actions will have a named lead and target date; progress is reported via the Audit Committee.

Relevant operational risks from the ICBs' Operational Risk Register with a score of 15 or above.

Assurance(s): Documented evidence that provides assurance that appropriate controls are in place and operating effectively.

Internal/External Assurances: Assurances can be provided from within the organisation (internal) or by an independent body, such as NHS England or Internal/External Audit (external).

Positive/Negative Assurances: Assurances can be positive (e.g. telling us that the control is working) or negative (e.g. that the control is not effective).

Risk 1 – Failure to develop and maintain a comprehensive, evidence-based understanding of local population health needs

Strategic Risk Narrative:	Risk that the ICBs do not use joined-up, person-level data and intelligence to identify current and future needs, drivers of risk, and underserved communities, leading to ineffective or inequitable commissioning decisions.	Opening Risk Level and Score (I x L)	Current Risk Level and Score (I x L)	Risk Appetite and Target Risk Score (I x L)	Movement in risk score (since last reporting period)
Executive Risk Owner:	Director of Commissioning, Director of Outcomes	High (4 x 4)	High (4 x 4)	<i>Not yet determined</i>	N/A
Lead Committee:	Joint Strategic Commissioning Committee				

Control Description (How are we going to stop the risks happening?)	Assurances (How do we know the controls are working?)	I	E	+	-	Gaps in Control / Assurance (Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)	Action ref:
Establishment and embedding of a structured, data-sharing architecture to ensure equitable access to appropriately shared data across all three geographies. This includes formal data-sharing arrangements, federated or integrated platform capability, and robust information governance controls. Alignment of SAIU analytical processes across the three geographies to ensure data availability is routinely assessed and that shared data is systematically analysed to support population health management, predictive analytics and strategic decision-making.	Population Health updates to the Joint Strategic Commissioning Committee and Boards (<i>pending</i>)					To design and implement a structured, system-wide data-sharing architecture and aligned SAIU analytical processes across all three geographies.	1.1
The development of Joint Strategic Needs Assessment (JSNA) arrangements, with ICBs contributing as statutory NHS partners, using joined-up data and insight to shape strategic commissioning priorities.	Population Health updates to the Joint Strategic Commissioning Committee and Boards (<i>pending</i>)					None identified.	
The establishment and embedment of a research and evidence framework , ensuring that commissioning decisions across the cluster are informed by high-quality research, national guidance, local evaluation, and evidence, to support effective, equitable, and value-based service planning and delivery.	Arrangements for the promoting and using evidence from research update to the Joint Strategic Commissioning Committee (<i>pending, May and Nov 2026</i>)					To align research and evidence arrangements across the cluster.	1.2

Action(s):	Responsible Officer	Implementation Date
1.1: To design and implement a structured, system-wide data-sharing architecture and aligned SAIU analytical processes across all three geographies.	Director of Commissioning	September 2026
1.2: To align research and evidence arrangements across the cluster.	Director of Outcomes	July 2026

Related high/extreme (≥15) operational risks from the ICBs' Joint Operational Risk Register:

No related high/extreme (≥15) operational risks currently.

Risk 2-5 – Failure to deliver a coordinated transformation of commissioned services, including prevention, community care models, and digital enablement

Strategic Risk Narrative:	Risk that the ICBs do not develop or implement a robust, long-term, outcomes-focused commissioning strategy; fail to shift system focus from sickness to prevention; do not redesign services to deliver integrated care closer to home; and do not adopt or embed digital technologies. Taken together, these could result in missed opportunities to improve population health and reduce inequalities, persistent reliance on reactive and hospital-based care, poor patient experience, inefficiencies, and an inability to achieve system priorities or national expectations.	Opening Risk Level and Score (I x L)	Current Risk Level and Score (I x L)	Risk Appetite and Target Risk Score (I x L)	Movement in risk score (since last reporting period)
Executive Risk Owner:	Director of Strategy and Citizen Experience, Director of Commissioning, Director of Outcomes (Medical), Director of Finance	High (4 x 4)	High (4 x 4)	<i>Not yet determined</i>	N/A
Lead Committee:	Joint Strategic Commissioning Committee				

Control Description (How are we going to stop the risks happening?)	Assurances (How do we know the controls are working?)	I	E	+	-	Gaps in Control / Assurance (Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)	Action ref:
The implementation and alignment of a Population Health Management (PHM) approach across the three ICBs, using linked datasets and predictive analytics to proactively identify at-risk cohorts, understand unwarranted variation and population need, and inform the tailoring of equitable, preventative and value-based commissioning interventions.	Population Health Strategy and Commissioning Plan presented to the Boards (February 2025) Population Health Strategy and Population Health Outcomes Framework updates to the Joint Strategic Commissioning Committee (November 2025 and January 2026, <i>pending July 2026</i>)					To embed and scale the use of the Strategic Analytics and Intelligence Unit (SAIU) consistently across all three ICBs. To develop and align a consistent Population Health Management (PHM) approach across the cluster.	2.1 2.2
The development of the Five-Year Population Health Strategy , which sets out the ICBs' long-term vision, priorities and ambitions for improving population health outcomes, access to high-quality care and reducing health inequalities across the cluster. <i>The development of the Five-year Population Health Strategy has been informed by the three Integrated Care Strategies which exist across the three ICSs.</i>	Population Health Strategy and Commissioning Plan presented to the Boards (February 2025) Population Health Strategy and Population Health Outcomes Framework updates to the Joint Strategic Commissioning Committee (November 2025 and January 2026, <i>pending July 2026</i>) Population Health Improvement Plan updates to the Joint Strategic Commissioning Committee (November 2025 and January 2026) Clustered System Review Meetings (SRMs) with NHSE Regional Teams (monthly) DLN Internal Audit Reviews – Strategic commissioning (inc. strategy oversight) (<i>indicative</i>)					None identified.	
Establishment of an Executive-led Strategy and Planning Coordination Group , which has senior ICB leadership representative from strategy, commissioning, planning, performance and finance has the responsibility to ensure alignment across the ICBs' planning outputs.	Population Health Strategy and Commissioning Plan presented to the Boards (February 2025) Population Health Strategy and Population Health Outcomes Framework updates to the Joint Strategic Commissioning Committee (November 2025 and January 2026, <i>pending July 2026</i>)					To refocus the Strategy and Planning Coordination Group from strategy development to oversight of operational delivery.	2.3
The development of the Five-Year Commissioning Plan (Population Health Improvement Plan) , which translates the strategic ambitions of the Population Health Strategy into actionable, resourced, and measurable commissioning programmes across the three ICBs.	Population Health Improvement Plan updates to the Joint Strategic Commissioning Committee (November 2025 and January 2026)					None identified.	

Control Description (How are we going to stop the risks happening?)	Assurances (How do we know the controls are working?)	I	E	+	-	Gaps in Control / Assurance (Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)	Action ref:
The development of the Five-year Commissioning Plan has been informed by the three Joint Forward Plans which exist across the three ICSs.	Medium Term Planning updates to the Boards (December 2025 and January 2026) (<i>open and/or confidential sessions</i>)						
Establishment of commissioning oversight and governance arrangements, including: - A Commissioning Oversight Group, with a clearly defined role and remit, meeting fortnightly to monitor commissioning plan delivery, review performance, and escalate issues requiring system leadership intervention. ICB-hosted delivery programmes overseeing priority transformation areas, including neighbourhood and community transformation, urgent and emergency care, and planned care. Cluster-wide hosted delivery programmes providing strategic oversight and coordination across key commissioning portfolios, including cancer, mental health, learning disability and autism, children and young people, specialised commissioning, and pharmacy, dental and optometry (PODs).	Population Health Improvement Plan updates to the Joint Strategic Commissioning Committee (November 2025 and January 2026) Medium Term Planning updates to the Boards (December 2025 and January 2026) (<i>open and/or confidential sessions</i>) Assurance on Dental, Pharmacy and Optometry Services update to the Joint Strategic Commissioning Committee (February 2026)					To develop and implement the cluster Commissioning Oversight and Escalation Framework.	2.4
Establishment of a cluster-wide Outcomes Framework , incorporating measurable indicators across quality, population health and health inequalities, underpinned by regular performance reporting, to evaluate and evidence the impact of delivery of the Strategy and Commissioning Plan.	Population Health Strategy and Population Health Outcomes Framework updates to the Joint Strategic Commissioning Committee (November 2025 and January 2026)					To finalise the cluster-wide Outcomes Framework.	2.5
Development and implementation of a cluster-wide neighbourhood model , supported by a defined implementation framework, to enable place-based, multi-agency delivery and inform commissioning decisions that shift care towards prevention and community-based services.	Neighbourhood health update to the Boards Development Session (February 2026) Strategic approach to neighbourhood health development update to the Joint Strategic Commissioning Committee (February 2026 and <i>pending</i>)					To review the strategic approach to neighbour health development following the publication of national guidance.	2.6
Development and implementation of a cluster-wide strategic approach to prevention , incorporating population health insights, evidence-based interventions, and outcome measures, to guide commissioning decisions, reduce health inequalities, and support the shift from sickness to proactive, preventative care across the system.	Strategic approach to prevention and early intervention the Joint Strategic Commissioning Committee (March 2026 and <i>pending</i>)					To establish the cluster-wide strategic approach to prevention.	2.7
The development of a Digital and Data Strategy across the cluster, which will set out clear priorities for digital transformation, interoperability, and innovation across partners, and align digital solutions with commissioning, pathway redesign, and transformation programmes across the three ICBs.	Strategic update to digital transformation update to the Joint Strategic Commissioning Committee (<i>pending, due March 2026</i>) NNICB Internal Audit Review – Delivering Digital Transformation (Significant assurance)					To develop cluster-wide Digital and Data Strategy, based on existing Strategies across the three ICBs.	2.8
The establishment of cluster-level governance arrangements, including a Digital Transformation Board , which will provide oversight, strategic decision-making, and alignment of digital programmes across the three ICBs.	Strategic update to digital transformation update to the Joint Strategic Commissioning Committee (<i>pending, due March 2026</i>) NNICB Internal Audit Review – Delivering Digital Transformation (Significant assurance)					To align digital transformation governance arrangements across the cluster.	2.9

Action(s):	Responsible Officer	Implementation Date
2.1: To embed and scale the use of the Strategic Analytics and Intelligence Unit (SAIU) consistently across all three ICBs.	Director of Commissioning	November 2026
2.2: To develop and align a consistent Population Health Management (PHM) approach across the cluster.	Director of Commissioning	November 2026
2.3: To refocus the Strategy and Planning Coordination Group from strategy development to oversight of operational delivery.	Director of Strategy and Citizen Experience	September 2026
2.4: To develop and implement the cluster Commissioning Oversight and Escalation Framework.	Director of Commissioning	September 2026
2.5: To finalise the cluster-wide Outcomes Framework.	Director of Strategy and Citizen Experience	December 2026
2.6 To review the strategic approach to neighbour health development following the publication of national guidance.	Director of Strategy and Citizen Experience	August 2026 *
2.7: To establish the cluster-wide strategic approach to prevention.	Director of Outcomes	November 2026
2.8: To develop cluster-wide Digital and Data Strategy, based on existing Strategies across the three ICBs.	Director of Finance	September 2026
2.9: To align digital transformation governance arrangements across the cluster.	Director of Finance	October 2026

Related high/extreme (≥15) operational risks from the ICBs' Joint Operational Risk Register:

No related high/extreme (≥15) operational risks currently.

* Dependent on national guidance publication.

Risk 6 – Failure to involve people and communities meaningfully in commissioning and service design								
Strategic Risk Narrative:	Risk that the ICBs do not systematically co-produce solutions with service users, carers, and communities, leading to services that do not meet local needs or legal requirements for engagement.	Opening Risk Level and Score (I x L)	Current Risk Level and Score (I x L)		Risk Appetite and Target Risk Score (I x L)		Movement in risk score (since last reporting period)	
Executive Risk Owner:	Executive Director of Strategy and Citizen Experience	Medium (4 x 3)	Medium (4 x 3)		Not yet determined		N/A	
Lead Committee:	Joint Strategic Commissioning Committee							
Control Description (How are we going to stop the risks happening?)	Assurances (How do we know the controls are working?)	I	E	+	-	Gaps in Control / Assurance (Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)		Action ref:
Development of a robust Engagement Strategy across all three ICBs, aligned with the Strategic Commissioning Framework's requirement for systematic community involvement and co-production.	Citizen Stories presented to the ICB Boards (each meeting) Arrangements for public and patient involvement update to the Joint Strategic Commissioning Committee (February 2026 and <i>pending, June and Oct 2026 and February 2027</i>)					To produce an aligned, cluster-wide Engagement Strategy.		6.1
Establishment of an Operational Oversight Group to provide structured oversight of community engagement activity and ensure clear alignment into strategic development and commissioning decisions.	Arrangements for public and patient involvement update to the Joint Strategic Commissioning Committee (February 2026 and <i>pending, June and Oct 2026 and February 2027</i>)					To establish the Operational Oversight Group, chaired by the Director of Strategy and Citizen Engagement.		6.2
Development of a Co-production Framework to provide a consistent, structured approach for involving service users, carers, and communities. The framework will define how engagement activity integrates with co-production, ensuring that lived experience systematically informs strategy, service design, and commissioning decisions.	Arrangements for public and patient involvement update to the Joint Strategic Commissioning Committee (February 2026 and <i>pending, June and Oct 2026 and February 2027</i>) Arrangements for personalised care update to the Joint Strategic Commissioning Committee (<i>pending, due May and Nov 2026</i>)					To produce an aligned, cluster-wide Co-production Framework.		6.3
Maintenance of a system-wide Patient and Public Involvement (PPI) infrastructure across all three ICBs, providing structured mechanisms, including patient and citizen panels, public meetings, online engagement platforms, Public and Patient Partners, communities of practice, and engagement steering groups, to support bespoke engagement activities.	Arrangements for public and patient involvement update to the Joint Strategic Commissioning Committee (February 2026 and <i>pending, June and Oct 2026 and February 2027</i>) DDICB Internal Audit Review – Public Involvement (Moderate assurance)					None identified.		
Completion and review of Equality and Quality Impact Assessments (EQIA/QIA) for all proposed service changes and commissioning decisions, ensuring that identified potential impacts on service users, carers, and communities inform the design and focus of engagement activities.	Arrangements for public and patient involvement update to the Joint Strategic Commissioning Committee (February 2026 and <i>pending, June and Oct 2026 and February 2027</i>)					To align EDI policies, processes and procedures across the cluster, building on existing arrangements within the three ICBs.		6.4
Formalised partnerships and engagement with Voluntary, Community and Social Enterprise (VCSE) organisations, Healthwatch, Local Authorities, Primary Care Networks (PCNs), and Health and Overview Scrutiny Committees (HOOSCs) to support neighbourhood-level engagement, gather local insights, and ensure community intelligence systematically informs service design and commissioning decisions.	Arrangements for public and patient involvement update to the Joint Strategic Commissioning Committee (February 2026 and <i>pending, June and Oct 2026 and February 2027</i>) Strategic approach to neighbourhood health development update to the Joint Strategic Commissioning Committee (<i>pending</i>)					None identified.		

Action(s):	Responsible Officer	Implementation Date
6.1: To produce an aligned, cluster-wide Communications and Engagement Strategy.	Director of Strategy and Citizen Experience	November 2026
6.2: To establish the Operational Oversight Group, chaired by the Director of Strategy and Citizen Engagement.	Director of Strategy and Citizen Experience	September 2026
6.3: To produce an aligned, cluster-wide Co-production and Engagement Framework.	Director of Strategy and Citizen Experience	November 2026
6.4: To align EDI policies, processes and procedures across the cluster, building on existing arrangements within the three ICBs.	Director of Quality	September 2026

Related high/extreme (≥15) operational risks from the ICBs' Joint Operational Risk Register:

No related high/extreme (≥15) operational risks currently.

Risk 7a – Failure to allocate resources effectively and shape provider markets to deliver value, productivity and system priorities

Strategic Risk Narrative:	Risk that the ICBs do not align funding to population needs, optimise resource use, or proactively shape and manage provider markets. This could result in poor value for money, reduced productivity, inequitable access, and an inability to achieve national and local priorities or deliver sustainable improvement in health outcomes.	Opening Risk Level and Score (I x L)	Current Risk Level and Score (I x L)	Risk Appetite and Target Risk Score (I x L)	Movement in risk score (since last reporting period)
Executive Risk Owner:	Director of Commissioning, Director of Finance	Medium (4 x 3)	Medium (4 x 3)	<i>Not yet determined</i>	N/A
Lead Committee:	Joint Strategic Commissioning Committee				

Control Description <i>(How are we going to stop the risks happening?)</i>	Assurances <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Control / Assurance <i>(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)</i>	Action ref:
Development and implementation of a cluster-wide, aligned commissioning decision-making process (phase one), with a planned transition to a more refined approach, including a weighted prioritisation methodology (phase two). The weighted value framework (phase two) will be based on criteria including strategic 'fit' and anticipated benefits aligned with the commissioning priorities identified in the Five-Year Population Health Strategy, Five Year Strategic Commissioning Plan, and the ICBs' Outcomes Framework.	Joint Decision-Making Framework and establishment of a Joint Commissioning Review Group update to the Joint Strategic Commissioning Committee (February 2026)					To finalise and implement the phase 2 weighted value framework to strengthen commissioning decision-making and prioritisation.	7a.1
Role, remit and operating framework of the Joint Commissioning Executive Group (JCEG) , supported by the Joint Commissioning Review Group (CRG) , to ensure commissioning decisions are evidence-based, prioritised against population need, and subject to robust scrutiny, enabling effective allocation of resources and delivery of population outcomes.	Joint Decision-Making Framework and establishment of a Joint Commissioning Review Group update to the Joint Strategic Commissioning Committee (February 2026) Joint Commissioning Executive Group Assurance Reports to the Joint Strategic Commissioning Committee (each meeting)					To deliver training to embed understanding of aligned commissioning decision-making processes and governance structures across the cluster.	7a.2
Development and implementation of a provider market strategy to identify service gaps, stimulate innovation, and ensure sufficient provider capacity, supporting prioritised investment and resource allocation.	Arrangements for shaping and managing the provider market update to the Joint Strategic Commissioning Committee (<i>pending, April and Oct 2026</i>)					To develop and implement a provider market strategy across the cluster to identify gaps, stimulate innovation, and ensure sufficient provider capacity to meet system priorities.	7a.3
Develop and embed a joint procurement framework across the three ICBs to ensure all provider selection, contract award, and contract management processes are PSR-compliant, deliver value for money, and are consistently applied; as described within the ICBs' joint Procurement and PSR Policy.	Provider Selection Regime Annual Report to the Audit Committees (<i>pending, April 2026</i>) Joint Commissioning Executive Group Assurance Reports to the Joint Strategic Commissioning Committee (each meeting) DDICB Internal Audit Review – Provider Selection Regime (Significant assurance) NNICB Internal Audit Review – Provider Selection Regime (Significant assurance) DLN Internal Audit Reviews – Procurement (<i>indicative</i>)					None identified.	

Action(s):	Responsible Officer	Implementation Date
7a.1: To finalise and implement the phase 2 weighted value framework to strengthen commissioning decision-making and prioritisation.	Director of Commissioning	September 2026
7a.2: To deliver training to embed understanding of aligned commissioning decision-making processes and governance structures across the cluster.	Director of Commissioning	December 2026
7a.3: To develop and implement a provider market strategy across the cluster to identify gaps, stimulate innovation, and ensure sufficient provider capacity to meet system priorities.	Director of Finance	December 2026

Related high/extreme (≥15) operational risks from the ICBs' Joint Operational Risk Register:

No related high/extreme (≥15) operational risks currently.

Risk 7b – Failure to commission services through effective procurement and contract management arrangements, compromising financial sustainability

Strategic Risk Narrative:	Risk that the ICBs do not utilise robust procurement frameworks, contracting mechanisms, or contract management processes, leading to inefficiencies, unmanaged demand, poor provider performance, increased financial risk, or inability to deliver statutory financial duties and long-term sustainability.	Opening Risk Level and Score (I x L)	Current Risk Level and Score (I x L)	Risk Appetite and Target Risk Score (I x L)	Movement in risk score (since last reporting period)
Executive Risk Owner:	Director of Commissioning, Director of Finance	High (4 x 4)	High (4 x 4)	<i>Not yet determined</i>	N/A
Lead Committee:	Joint Finance and Performance Committee				

Control Description (How are we going to stop the risks happening?)	Assurances (How do we know the controls are working?)	I	E	+	-	Gaps in Control / Assurance (Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)	Action ref:
The development and delivery of a three-year operational plan for 2026/27 to 2028/29 , including integrated revenue, workforce, and operational performance and activity plans. The plan sets out how the ICBs will deliver statutory duties, meet performance standards, manage resources, and align financial, workforce, and operational arrangements.	Medium Term Planning updates to the Boards (December 2025 and January 2026) (<i>open and/or confidential sessions</i>) Operational and Financial Plan update to the Joint Finance and Performance Committee (January and February 2026) Finance reports to the Boards (each meeting) Financial and efficiency reports presented to the Joint Finance and Performance Committee (each meeting) Service delivery reports presented to the Joint Finance and Performance Committee (each meeting) Thematic service delivery reviews to the Joint Finance and Performance Committee (February 2026 and <i>pending</i>) Clustered System Review Meetings (SRMs) with NHSE Regional Teams (monthly) System Review Meetings (QSRMs) (including Providers) with NHSE Regional Teams (quarterly) Ad-hoc Assurance Meetings with NHSE Regional Team (bi-monthly)					None identified.	
Develop and embed a joint contract management framework across the three ICBs to ensure all provider contracts are actively monitored, outcomes and KPIs are assessed, and payments are aligned to services delivered. This will include the establishment of a formal control framework for payer mechanisms to ensure providers are paid for services delivered.	Contract Management Reports presented to the Joint Finance and Performance Committee (<i>pending June, Oct 2026 and Feb 2027</i>) Financial and efficiency reports presented to the Joint Finance and Performance Committee (each meeting) Service delivery reports presented to the Joint Finance and Performance Committee (each meeting) DLN Internal Audit Review (<i>indicative</i>) – Contract Management					To establish an aligned contract management framework across the ICBs. To develop and embed a formal control framework for payer mechanisms once national guidance is published.	7b.1 7b.2
Alignment and development of performance management and productivity monitoring controls across the cluster to oversee provider	Financial and efficiency reports presented to the Joint Finance and Performance Committee (each meeting)					See action 2.4. See action 7b.1.	

Control Description (How are we going to stop the risks happening?)	Assurances (How do we know the controls are working?)	I	E	+	-	Gaps in Control / Assurance (Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)	Action ref:
performance and system outputs, supporting delivery of operational plans, improved productivity and value for money. This includes a commissioning oversight model comprising of Activity, Finance and Performance Technical Group(s), which monitor activity, finance and performance metrics and report to the overarching Activity, Finance and Performance Group. The latter will provide oversight of commissioning and operational plan delivery, with alternating meetings focused on Acute services and Mental Health and Community services. Contract Review Meetings with individual providers monitor delivery against contractual, activity, quality and financial requirements. Issues are escalated as required to Contract Executive Board meetings between the ICBs and provider leadership.	Service delivery reports presented to the Joint Finance and Performance Committee (each meeting) Contract Management Reports presented to the Joint Finance and Performance Committee (<i>pending June, Oct 2026 and Feb 2027</i>) DDICB Internal Audit Review – Data quality and performance management framework (Advisory) 360 Assurance Internal Audit Review (<i>indicative</i>) – Data Quality						
Alignment and embedment of robust 'grip and control' measures across the three ICBs to oversee financial performance, alongside routine monitoring of budgets, efficiency programmes, and compliance with the ICBs' standing documents (e.g., the Scheme of Reservation and Delegation and Standing Financial Instructions).	Financial and efficiency reports presented to the Joint Finance and Performance Committee (each meeting) Internal Audit – Financial ledger and reporting reviews (<i>indicative</i>) External Audit – Year-end financial accounts reviews (<i>pending</i>) DDICB Internal Audit Review – Cost Improvement Plan (Significant Assurance) Clustered System Review Meetings (SRMs) with NHSE Regional Teams (monthly) System Review Meetings (QSRMs) (including Providers) with NHSE Regional Teams (quarterly)					None identified.	

Action(s):	Responsible Officer	Implementation Date
7b.1: To establish an aligned contract management framework across the ICBs.	Director of Commissioning	July 2026
7b.2: To develop and embed a formal control framework for payer mechanisms once national guidance is published.	Director of Finance	September 2026 (dependent on national guidance publication)

Related high/extreme (≥15) operational risks from the ICBs' Joint Operational Risk Register:

RR007 If the Derby and Derbyshire NHS system cannot rapidly implement sustainable recurrent financial efficiencies, there is a risk that the underlying deficit will worsen, undermining progress toward long-term financial sustainability.

RR010 If Derby and Derbyshire system plans do not align activity, workforce, and finance, there is a risk of uncoordinated planning. This may reduce the likelihood of achieving financial, productivity, workforce, and activity targets, leading to inefficiencies, undermining system-wide financial sustainability.

RR030 If the clinical coding backlog of admission data at Nottingham University Hospitals remains unaddressed, the necessary data granularity for informed decisions will be inaccessible. This could hinder the Nottingham and Nottinghamshire ICB's ability to make timely, evidence-based decisions for service planning, affecting financial and operational efficiencies.

RR034 If cash flow shortages occur during the 2025/26 financial year, NHS system partners across Nottingham and Nottinghamshire may need to seek loans, increasing debt levels and associated interest costs. This could further exacerbate financial instability and reduce capacity for future investments.

RR036 If NHS Nottingham and Nottinghamshire ICB is unable to implement sustainable recurrent financial efficiency solutions, there is a risk that the underlying deficit (UDL) will worsen, limiting the ICB's ability to meet population needs within available financial resources.

RR038 If the Nottingham and Nottinghamshire NHS system cannot rapidly implement sustainable recurrent financial efficiencies, there is a risk that the underlying deficit will worsen, undermining progress toward long-term financial sustainability.

Related high/extreme (≥15) operational risks from the ICBs' Joint Operational Risk Register:

RR046 If Nottingham and Nottinghamshire NHS system partners' workforce plans are not aligned with the system financial plan and/or do not include a clear, actionable plan of the workforce reductions required to achieve affordability, then the anticipated financial efficiencies may fail to materialise, risking overspend and undermining system-wide financial sustainability.

RR047 In pursuit of NHS financial efficiencies and operational delivery for 2025/26 for Nottingham and Nottinghamshire, there is a risk that ICB relationships may decline (with ICS partners and wider stakeholders). This may lead to deterioration in collaborative efforts, communication breakdowns and wider stakeholder dissatisfaction.

RR092 If NHS Lincolnshire ICB is unable to implement sustainable recurrent financial efficiency solutions, there is a risk that the underlying deficit (UDL) will worsen, limiting the ICB's ability to meet population needs within available financial resources.

Risk 9 – Failure to systematically improve the quality of healthcare services

Strategic Risk Narrative:	Risk that the ICBs do not rigorously monitor, evaluate, and adapt services, resulting in persistent gaps in quality and safety and an inability to identify and act promptly on emerging quality concerns.	Opening Risk Level and Score (I x L)	Current Risk Level and Score (I x L)	Risk Appetite and Target Risk Score (I x L)	Movement in risk score (since last reporting period)
Executive Risk Owner:	Executive Director of Quality (Nursing)	High (4 x 4)	High (4 x 4)	<i>Not yet determined</i>	N/A
Lead Committee:	Joint Quality and Service Improvement Committee				

Control Description <i>(How are we going to stop the risks happening?)</i>	Assurances <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Control / Assurance <i>(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)</i>	Action ref:
Development and alignment of the ICBs' approach to quality across the cluster, leading to the development of formal Quality Strategy. The approach supports the development of quality oversight and reporting within the ICBs' joint arrangements. This includes establishing clear quality priorities for 2026/27, based on existing ICB strategies, and aligned with commissioning intentions and strategic plans: - Access and capacity: Ensuring timely and equitable access to services. - Patient safety and experience: Reducing harm, learning from incidents, and improving user experience, with particular focus on maternity and mental health. - Reducing health inequalities: Targeted interventions for underserved groups, using population health management approaches. - Workforce: Focusing on training, retention, sickness management, and staff wellbeing to support quality delivery. - Clinical effectiveness: Ensuring evidence-based care, pathway redesign, and robust outcome measurement. - Digital maturity: Leveraging technology for safer, more effective care, with attention to CHC transformation. - Safeguarding and health protection: Maintaining robust frameworks for vulnerable groups, including children and people with mental health conditions, learning disabilities, and autism (LDA).	Derbyshire, Lincolnshire and Nottinghamshire Quality Approach update to the Joint Quality and Service Improvement Committee (January 2026) Quality Strategy and Improvement Priorities/Plans presented to the Joint Quality and Service Improvement Committee (February 2026 and <i>pending March 2026 and Feb 2027</i>) Quality Priorities 2026/27 update to the Joint Quality and Service Improvement Committee (February 2026) Delivery of Quality Improvement Plans to the Joint Quality and Service Improvement Committee (<i>pending, July and Nov 2026</i>) Clustered System Review Meetings (SRMs) with NHSE Regional Teams (monthly) System Review Meetings (QSRMs) (including Providers) with NHSE Regional Teams (quarterly) DLN Internal Audit Reviews – Quality oversight arrangements (<i>indicative</i>)					To develop and implement a formal cluster-wide Quality Strategy, establishing agreed priorities and mechanisms for quality oversight and reporting across the three ICBs. To develop clear, measurable plans to oversee delivery of the quality priorities.	9.1 9.2
The ICBs' quality framework and commissioning processes, which monitor quality improvement in line with the ICBs' statutory duties relating to nursing and quality (e.g., safeguarding, infection prevention and control, complaints). This will also include the development of robust quality schedules for 2026/27 that will be embedded within contract management	Quality Oversight reports to the Joint Quality and Service Improvement Committee (each meeting) Focused reports on NOF 4 and 3 Providers (January 2026 and <i>pending May and Sept 2026</i>) Thematic Quality Reports to the Joint Quality and Improvement Committee (every other meeting)					To develop robust quality schedules and associated monitoring arrangements (in conjunction with contracting colleagues).	9.3

Control Description (How are we going to stop the risks happening?)	Assurances (How do we know the controls are working?)	I	E	+	-	Gaps in Control / Assurance (Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)	Action ref:
arrangements, supporting quality assurance and improvement within the ICBs' providers. This includes continued embedment of the Patient Safety Incident Response Framework (PSIRF), which sets out the systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.	Learning, Safety and Continuous Improvement Reports to the Joint Quality and Service Improvement Committee (<i>pending, May and Nov 2026</i>) LICB Internal Audit Review – Patient Safety NNICB Internal Audit Review – Patient Safety Incident Response Framework (PSIRF) DLN Internal Audit Reviews – Safeguarding arrangements (<i>indicative</i>)						
Establishment of quality oversight infrastructure across the cluster, providing assurance on the delivery, monitoring, and improvement of commissioned services and delivery of statutory duties. This includes operational quality governance arrangements at ICB-level, as well as cluster-level oversight to support consistency and alignment across the three ICBs. The arrangements will cover key service areas, including primary care, specialised services, safeguarding, maternity (LMNS), and services for children, young people, and people with learning disabilities and autism (including SEND), ensuring statutory duties and patient safety obligations are met.	Quality Oversight reports to the Joint Quality and Service Improvement Committee (each meeting) Focused reports on NOF 4 and 3 Providers (January 2026 and <i>pending May and Sept 2026</i>) Thematic Quality Reports to the Joint Quality and Improvement Committee (every other meeting) Safeguarding Vulnerable Adults update to the Joint Quality and Service Improvement Committee (<i>pending, Sept 2026</i>) Safeguarding Children update to the Joint Quality and Service Improvement Committee (<i>pending, Oct 2026</i>) Regional LMNS oversight and performance meetings with NHSE Regional LDA oversight and performance meetings with NHSE DLN Internal Audit Reviews – Quality oversight arrangements (<i>indicative</i>)					To review and rationalise operational quality oversight arrangements, ensuring the balance of ICB-level and cluster-wide oversight is appropriate.	9.4

Action(s):	Responsible Officer	Implementation Date
9.1: To develop and implement a formal cluster-wide Quality Strategy, establishing agreed priorities and mechanisms for quality oversight and reporting across the three ICBs.	Director of Quality (Nursing)	September 2026
9.2: To develop clear, measurable plans to oversee delivery of the quality priorities.	Director of Quality (Nursing)	September 2026
9.3: To develop robust quality schedules and associated monitoring arrangements (in conjunction with contracting colleagues).	Director of Quality (Nursing)	June 2026
9.4: To review and rationalise operational quality oversight arrangements, ensuring the balance of ICB-level and cluster-wide oversight is appropriate.	Director of Quality (Nursing)	November 2026

Related high/extreme (≥15) operational risks from the ICBs' Joint Operational Risk Register:

- RR003 If excessive handover delays in Derby and Derbyshire prevent timely ambulance responses, patients waiting in the community may experience significant delays in care, increasing the risk of clinical harm and compromising patient safety.
- RR022 If ambulance handover times at acute trusts within Nottingham and Nottinghamshire increase and cause delayed ambulance arrival in the community, there is a risk of potential harm to citizens who are waiting for an ambulance, which may lead to further deterioration of their condition.
- RR029 If Nottingham University Hospitals NHS Trust (NUH) fail to sustain improvements made to date following CQC and external recommendations, there is a risk quality of services may decline. This may lead to compromised quality of care issues which could result in poor experience and adverse health outcomes for the population of Nottingham and Nottinghamshire.
- RR048 If adverse media coverage relating to key health services commissioned by the Nottingham and Nottinghamshire ICB (e.g. maternity, mental health, primary care) persists, public confidence in the ICB may decline. This may lead to reduced trust, and impact on public confidence.
- RR072 If NHCT lacks the capacity and capability to implement sustainable quality improvements identified through serious incidents, deaths, quality reviews, and broader performance concerns, then similar failures may recur, leading to harm and poor health outcomes for the population of Nottingham and Nottinghamshire.

Risk 10 – Failure to ensure timely and equitable access to healthcare services in line with national and local performance standards

Strategic Risk Narrative:	Risk that the ICBs do not rigorously monitor, evaluate, and adapt services, resulting in persistent non-delivery of access targets.	Opening Risk Level and Score (I x L)	Current Risk Level and Score (I x L)	Risk Appetite and Target Risk Score (I x L)	Movement in risk score (since last reporting period)
Executive Risk Owner:	Executive Director of Commissioning	High (4 x 4)	High (4 x 4)	<i>Not yet determined</i>	N/A
Lead Committee:	Joint Finance and Performance Committee				

Control Description <i>(How are we going to stop the risks happening?)</i>	Assurances <i>(How do we know the controls are working?)</i>	I	E	+	-	Gaps in Control / Assurance (Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)	Action ref:
The development and delivery of a three-year operational plan for 2026/27 to 2028/29, including integrated revenue, workforce, and operational performance and activity plans. The plan sets out how the ICBs will deliver statutory duties, meet performance standards, manage resources, and align financial, workforce, and operational arrangements.	Medium Term Planning updates to the Boards (December 2025 and January 2026) (<i>open and/or confidential sessions</i>) Operational and Financial Plan update to the Joint Finance and Performance Committee (January and February 2026) Service Delivery reports to the Boards (each meeting) Service delivery reports presented to the Joint Finance and Performance Committee (each meeting) Thematic service delivery reviews to the Joint Finance and Performance Committee (February 2026 and <i>pending</i>) NNICB Internal Audit Review – Delivery of Operational Plans (Significant assurance) Clustered System Review Meetings (SRMs) with NHSE Regional Teams (monthly) System Review Meetings (QSRMs) (including Providers) with NHSE Regional Teams (quarterly) Ad-hoc Assurance Meetings with NHSE Regional Team (bi-monthly)					None identified.	
Alignment and development of commissioning oversight and performance management controls across the cluster to oversee provider performance and system outputs, supporting delivery of operational plans. This includes a commissioning oversight model comprising of Activity, Finance and Performance Technical Group(s), which monitor activity, finance and performance metrics and report to the overarching Activity, Finance and Performance Group. The latter will provide oversight of commissioning and operational plan delivery, with alternating meetings focused on Acute services and Mental Health and Community services. Contract Review Meetings with individual providers monitor delivery against contractual, activity, quality and financial requirements. Issues are escalated as required to Contract Executive Board meetings between the ICBs and provider leadership.	Contract Management Reports presented to the Joint Finance and Performance Committee (<i>pending June, Oct 2026 and Feb 2027</i>) Service Delivery reports to the Boards (each meeting) Service delivery reports presented to the Joint Finance and Performance Committee (each meeting) Contract Management Reports presented to the Joint Finance and Performance Committee (<i>pending June, Oct 2026 and Feb 2027</i>) DDICB Internal Audit Review – Data quality and performance management framework (Advisory) DLN Internal Audit Reviews – Data quality of a Board-level indicator (<i>indicative</i>)					See action 2.4. See action 7b.1.	

Control Description (How are we going to stop the risks happening?)	Assurances (How do we know the controls are working?)	I	E	+	-	Gaps in Control / Assurance (Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)	Action ref:
Establishment of commissioning oversight and governance arrangements, including: • A Commissioning Oversight Group, with a clearly defined role and remit, meeting fortnightly to monitor commissioning plan delivery, review performance, and escalate issues requiring system leadership intervention. • ICB-hosted delivery programmes overseeing priority transformation areas, including neighbourhood and community transformation, urgent and emergency care, and planned care. • Cluster-wide hosted delivery programmes providing strategic oversight and coordination across key commissioning portfolios, including cancer, mental health, learning disability and autism, children and young people, specialised commissioning, and pharmacy, dental and optometry (PODs).	Service Delivery reports to the Boards (each meeting) Service delivery reports presented to the Joint Finance and Performance Committee (each meeting) Thematic service delivery reviews to the Joint Finance and Performance Committee (February 2026 and <i>pending</i>) NHS England delegated functions: Specialised Services updates to the Joint Strategic Commissioning Committee (<i>pending</i>) NHS England delegated functions: Dental, Ophthalmic, and Pharmaceutical Services updates to the Joint Strategic Commissioning Committee (<i>pending, March and Oct 2026</i>)					See action 2.4	
Role and remit of the Primary Medical Services Contracting Panel, which provides operational governance for primary medical services, delivering robust contract management, performance oversight and quality assurance. This includes systematic monitoring and evaluation of service performance against access standards and the implementation of remedial actions to support delivery of access targets.	NHS England delegated functions: Primary Medical Services updates to the Joint Strategic Commissioning Committee (<i>pending, Jan, May and Sept 2026 and Jan 2027</i>)					To establish a consistent, cluster-wide model for primary care operational governance, aligning contract management and performance oversight across the three ICBs.	10.1
Daily system calls and On-call arrangements, alongside alignment of the System Co-ordination Centres (SCC) across the cluster; the purpose of which is to ensure the safest and highest quality of care possible for the entire population across every area by balancing the clinical risk within and across all health and care settings. Operational Pressures Escalation Level (OPEL) Framework across primary and secondary care providers.	Service Delivery reports to the Boards (each meeting) Service delivery reports presented to the Joint Finance and Performance Committee (each meeting)					To align and integrate the three System Co-ordination Centres (SCCs) into a single, consistent cluster-wide operating model.	10.2

Action(s):	Responsible Officer	Implementation Date
10.1: To establish a consistent, cluster-wide model for primary care operational governance, aligning contract management and performance oversight across the three ICBs.	Director of Commissioning	October 2026
10.2: To align and integrate the three System Co-ordination Centres (SCCs) into a single, consistent cluster-wide operating model.	Director of Commissioning	September 2026

Related high/extreme (≥15) operational risks from the ICBs' Joint Operational Risk Register:

RR002 If delays in treatment for Derby and Derbyshire patients on provider waiting lists continue, there is a risk of increased clinical harm due to prolonged waits, potentially compromising patient outcomes and quality of care.

RR023 If there are ineffective discharge processes within Nottingham and Nottinghamshire, there is a risk of increased length of stay and potential for individuals to experience harm when leaving the hospital and returning home. This may lead to deconditioning and poor experience.

RR049 If cancer service demand continues to exceed available system capacity, the ICB may be unable to fulfil its statutory duty to commission timely and effective services that support the diagnosis and treatment of cancer across Nottingham and Nottinghamshire. This could result in non-compliance with national cancer standards, including the 62-day referral-to-treatment target and the 28-day Faster Diagnosis Standard, leading to poorer clinical outcomes and diminished experience for the population.

Related high/extreme (≥15) operational risks from the ICBs' Joint Operational Risk Register:

RR051 If operational performance pressures persist due to capacity constraints and rising demand, the ICB may be unable to fulfil its statutory duty to commission hospital and medical services across Nottingham and Nottinghamshire that meet the reasonable requirements of the population. This could result in Trusts being unable to deliver planned levels of elective activity, leading to missed waiting time targets, delayed treatment, poorer health outcomes, and increased reliance on urgent and emergency care pathways.

RR082 If elective and cancer care performance does not recover to required levels by March 2026, there is a risk of delayed diagnosis and treatment leading to poorer health outcomes and reduced patient experience across the population of Derby and Derbyshire.

RR083 If improvements in urgent and emergency care access are not delivered by March 2026, there is a risk of delayed or unsafe care, poorer health outcomes, and reduced confidence in NHS services across Derby and Derbyshire.

RR084 If adult mental health bed use in Derby and Derbyshire is not reduced by March 2026, there is a risk of unsafe, delayed care, resulting in poorer outcomes and experience and greater system pressure.

Risk 11 – Failure to develop and deploy an effective ICB cluster operating model with the necessary skills and capabilities for strategic commissioning

Strategic Risk Narrative:	Risk that the ICBs do not build or maintain the strategic commissioning skills required, while supporting the wellbeing of the ICBs' combined workforce, limiting their ability to deliver strategic commissioning effectively.	Opening Risk Level and Score (I x L)	Current Risk Level and Score (I x L)	Risk Appetite and Target Risk Score (I x L)	Movement in risk score (since last reporting period)
Executive Risk Owner:	Director of Transition	Medium (4 x 3)	Medium (4 x 3)	<i>Not yet determined</i>	N/A
Lead Committee:	Joint Transition Committee				

Control Description (How are we going to stop the risks happening?)	Assurances (How do we know the controls are working?)	I	E	+	-	Gaps in Control / Assurance (Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)	Action ref:
The establishment and ongoing delivery of a jointly agreed ICB Transition Programme Plan, providing a structured and coordinated approach to managing the transition across the three ICBs. The Programme Plan is underpinned by defined workstreams, with assigned Senior Responsible Officers (SROs) including: - the Estates workstream, which is responsible for delivering efficiencies and establishing future corporate HQ and satellite space. - the Commissioning Support Unit (CSU) Transition workstream, which is responsible for reviewing CSU functions and determining proposals for future delivery models. - the Finance workstream, which is responsible for monitoring budgets, allocations, and cost efficiencies. - the Governance workstream, which is responsible for ensuring robust decision-making, oversight, and risk management. - the Communications and Engagement workstream, which is responsible for supporting staff and stakeholder communications, including consultation processes. - the Management of Workforce Change workstream, which is responsible for overseeing staff transition, voluntary redundancy planning, and associated consultation processes.	Transition programme updates to the ICB Boards (each meeting) (<i>open and/or confidential sessions</i>) Transition Programme Plan delivery and risk reporting updates to the Joint Transition Committee (each meeting) Operating Model development updates to the Joint Transition Committee, including a focused update in Q3 2026/27 on plans (where relevant) for the transfer of ICB functions to other NHS bodies (each meeting) Strategic Commissioning Development Plan updates to the Joint Transition Committee (<i>pending</i>) Assessment of proposals set out within the NHS Reform Bill to the Joint Transition Committee (<i>pending Q1 2026/27</i>). Assessment of merger/boundary change preparation requirements to the Joint Transition Committee (<i>pending Q2 2026/27</i>), subject to confirmation of future ICB footprints in line with the anticipated timetable for local government reorganisation decisions. Merger/boundary change plan updates to the Joint Transition Committee (<i>pending Q3 2026/27</i>), with delivery updates in Q4 2026/27. 360 Assurance Internal Audit – Independent support and assurance on transition and merger due diligence (<i>indicative</i>) Clustered System Review Meetings (SRMs) with NHSE Regional Teams (monthly) System Review Meetings (QSRMs) (including Providers) with NHSE Regional Teams (quarterly) Ad-hoc Assurance Meetings with NHSE Regional Team (bi-monthly)					To develop and implement detailed merger plans once the future ICB footprint is confirmed, informed by the publication of the NHS Reform Bill and aligned with local government reorganisation decisions.	11.1
Development and delivery of a Management of Change process and supporting business case , providing a structured approach to aligning	Workforce Change and Exit Plan progress updates to the Joint Transition Committee (<i>pending Q4 2025/26, Q1 2026/27 and Q2</i>					None identified.	

Control Description (How are we going to stop the risks happening?)	Assurances (How do we know the controls are working?)	I	E	+	-	Gaps in Control / Assurance (Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)	Action ref:
the ICBs workforce structures, roles and capacity across the cluster to enable safe and effective transition.	2026/27), including a specific focus in Q1 2026/27 on staff training and development plans. Voluntary Redundance Scheme Progress Reports to the Remuneration and HR Committees (Jan 2026) Management of Change Process Progress Reports to the Remuneration and HR Committees (Jan 2026) Freedom to Speak Up report to the Audit Committees (<i>pending, due Oct 2026</i>) NHS Staff Survey results (<i>pending, Feb 2026</i>)						
Development of a cluster-wide Organisational Development (OD) Plan , informed by the commissioning competency framework and self-assessment process, to address system capability, leadership development, cultural alignment and skills requirements necessary to support the transition and future operating model.	Strategic Commissioning Framework self-assessment update to the Joint Transition Committee (<i>pending</i>), subject to publication of the NHS England Toolkit. Strategic Commissioning Development Plan updates to the Joint Transition Committee (<i>pending Q1 2026/27, Q2 2026/27, Q3 2026/27 and Q4 2026/27</i>).					To develop and implement a cluster-wide Organisational Development (OD) Plan, informed by the commissioning competency framework and self-assessment.	11.2
Staff support and wellbeing arrangements to support the management of change process, including occupational health, Employee Assistance Programmes, HR advice and mental health support, ensuring workforce wellbeing is maintained during transition.	Freedom to Speak Up report to the Audit Committees (<i>pending, due Oct 2026</i>) NHS Staff Survey results (<i>pending, Feb 2026</i>) DLN Internal Audit Reviews – Support mechanisms for staff (<i>indicative</i>)					None identified.	

Action(s):	Responsible Officer	Implementation Date
11.1: To develop and implement detailed merger plans once the future ICB footprint is confirmed, informed by the publication of the NHS Reform Bill and aligned with local government reorganisation decisions.	Director of Transition	August 2026
11.2: To develop and implement a cluster-wide Organisational Development (OD) Plan, informed by the commissioning competency framework and self-assessment.	Director of Transition	December 2026

Related high/extreme (≥15) operational risks from the ICBs' Joint Operational Risk Register:

RR069 If services currently delivered by Commissioning Support Units (CSUs) cease or reduce ahead of the new ICB cluster operating model being implemented, due to recent announcements regarding abolition of CSUs, there is a risk to the effective delivery of functions of the ICBs, which may have financial implications and an impact on compliance with statutory requirements.

RR079 If a policy position on CSU abolition is developed which determines that ICBs must take on all functions, staff and stranded costs for the services they currently buy from CSUs, there is a risk that the current management of change process and financial position will be impacted, with additional staff coming within scope and subsequently further redundancy liabilities.

Risk 12 – Failure to maintain cyber resilience									
Strategic Risk Narrative:	Risk that the ICBs do not establish robust cyber security arrangements, which could compromise delivery of core functions and disrupt access to critical data and systems.	Opening Risk Level and Score (I x L)	Current Risk Level and Score (I x L)	Risk Appetite and Target Risk Score (I x L)	Movement in risk score (since last reporting period)				
Executive Risk Owner:	Director of Outcomes (Medical)/SIRO, Director of Finance	Medium (4 x 3)	Medium (4 x 3)	<i>Not yet determined</i>	N/A (New)				
Lead Committee:	Audit Committee								
Control Description (How are we going to stop the risks happening?)	Assurances (How do we know the controls are working?)	I	E	+	-	Gaps in Control / Assurance (Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)		Action ref:	
Development and alignment of a cluster-wide Cyber Security Strategy across the three ICBs, building on existing organisational strategies and frameworks to provide consistent governance, risk management, and assurance over cyber security, protecting systems, data, and services across the cluster.	Cyber Security focused Board Development Session (<i>pending</i>) Information Governance Assurance Reports to the Audit Committee (February 2026 and <i>pending</i>) Senior Information Risk Owner (SIRO) Annual Report to the Audit Committee (<i>pending</i>) Senior Information Risk Owner (SIRO) Annual Report to the Board (<i>pending</i>) IT Providers' Cyber Essentials and Cyber Essentials Plus Accreditations Dionach pen testing reported to the SIRO (<i>pending</i>) NHS England (NHSE) phishing exercise reported to the SIRO (<i>pending</i>)					To review existing cyber security strategies across the three ICBs and develop a single, aligned cluster-wide Cyber Security Strategy.		12.1	
Role and remit of the Information Governance, Data Protection and Cyber Steering Group , which is a cluster-wide operational forum that coordinates and strengthens information governance, data protection and cyber security arrangements across the three ICBs. The Group is responsible for: - coordinating and overseeing cyber resilience and information security assurance across the cluster. - monitoring and assessing each ICB's compliance with the Cyber Assurance Framework (CAF) through the CAF-aligned Data Security and Protection Toolkit (DSPT), in line with the annual profile set by NHS England. - providing collective oversight of cyber and information security risks. - supporting the proactive management of cyber security threats, vulnerabilities and incidents across the cluster.	Information Governance Assurance Reports to the Audit Committee (February 2026 and <i>pending</i>), including updates in relation to the ICBs' compliance with the DSPT. Cyber Security Updates to the Information Governance, Data Protection and Cyber Steering Group, which summarise cyber security progress and cyber risk mitigations, including patching, password hygiene, and strategic infrastructure upgrades (to every other meeting) Communications via the ICBs; Staff News relating to cyber security (as per IG Comms Plan and TNA) 360 Assurance Internal Audit Reviews – DSPT (<i>pending</i>)					None identified.			
Establishment of cluster-wide digital and cyber governance structures , providing strategic oversight, alignment, and assurance for digital resilience, IT investment prioritisation, and cyber security across the three ICBs.	Senior Information Risk Owner (SIRO) Annual Report to the Audit Committee (<i>pending</i>) Senior Information Risk Owner (SIRO) Annual Report to the Board (<i>pending</i>)					To review, align, and consolidate digital and cyber governance arrangements across the three ICBs.		12.2	

Control Description (How are we going to stop the risks happening?)	Assurances (How do we know the controls are working?)	I	E	+	-	Gaps in Control / Assurance (Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)	Action ref:
These structures will coordinate strategy, monitor delivery, and ensure compliance with national cyber standards, while recognising the need to align existing arrangements across multiple IT providers in preparation for the planned merger in April 2027.	Information Governance Assurance Reports to the Audit Committee (February 2026 and <i>pending</i>), including updates in relation to the ICBs' compliance with the DSPT.						
Role of the joint Senior Information Risk Owner (SIRO) for the three ICBs, responsible for overseeing and managing information governance and cyber security risks across the cluster. The SIRO ensures organisational data is protected, cyber threats are mitigated, and compliance with legal, regulatory, and NHS cyber standards is maintained across all three ICBs.	Senior Information Risk Owner (SIRO) Annual Report to the Audit Committee (<i>pending</i>) Senior Information Risk Owner (SIRO) Annual Report to the Board (<i>pending</i>)	✓				None identified.	
Role of the Emergency Preparedness, Resilience and Response (EPRR) Team across the three ICBs, ensuring that Business Impact Assessments (BIA) identify critical digital systems and services across the cluster. This will enable the cluster to understand cyber risks and maintain continuity plans that support rapid recovery from cyber disruptions.	Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity updates to the Audit Committee (December 2025 and <i>pending</i>) DDICB Internal Audit Review – Business Continuity (Significant assurance) EPRR NHSE Core Standards Self-Assessment (all three ICBs) DLN Internal Audit Reviews – IT Disaster Recovery/Business Continuity (<i>indicative</i>)	✓				To undertake testing across all ICBs' BIA critical systems.	12.3

Action(s):	Responsible Officer	Implementation Date
12.1: To review existing cyber security strategies across the three ICBs and develop a single, aligned cluster-wide Cyber Security Strategy.	Director of Finance	October 2026
12.2: To review, align, and consolidate digital and cyber governance arrangements across the three ICBs.	Director of Finance	October 2026
12.3: To undertake testing across all ICBs' BIA critical systems.	Director of Finance	June 2026

Related high/extreme (≥15) operational risks from the ICBs' Joint Operational Risk Register:

No related high/extreme (≥15) operational risks currently.

Annex 1: Alignment of BAF Strategic Risks to ICBs' Joint objectives/core aims

Strategic Risks <i>(What could prevent us from achieving our strategic aims/objectives and statutory duties?)</i>	To improve outcome in population health and healthcare.	To tackle inequalities in outcomes, experience, and access.	To enhance productivity and value for money.	To help the NHS support social and economic development.
Risk 1: Failure to develop and maintain a comprehensive, evidence-based understanding of local population health needs <i>Risk that the ICBs do not use joined-up, person-level data and intelligence to identify current and future needs, drivers of risk, and underserved communities, leading to ineffective or inequitable commissioning decisions.</i>	✓	✓		
Risk 2, 3, 4 and 5: Failure to deliver system transformation through delivery of a long-term, outcomes-focused commissioning strategy <i>Risk that the ICBs do not establish or implement a robust, evidence-based commissioning strategy that delivers the three strategic shifts of the 10-Year Health Plan: from sickness to prevention, from hospital to community-based care, and from analogue to digital; resulting in missed opportunities to improve health outcomes, reduce inequalities, and deliver system priorities.</i>	✓	✓	✓	✓
Risk 6: Failure to involve people and communities meaningfully in commissioning and service design <i>Risk that the ICBs do not systematically co-produce solutions with service users, carers, and communities, leading to services that do not meet local needs or legal requirements for engagement.</i>	✓	✓		
Risk 7a: Failure to prioritise resources and shape provider markets to meet local needs <i>Risk that the ICBs do not prioritise investment or allocate resources according to local needs, resulting in inefficiencies, reduced productivity, and an inability to deliver services that meet population needs.</i>			✓	✓
Risk 7b: Failure to manage contracts effectively and achieve financial sustainability <i>Risk that the ICBs do not effectively manage contracts or ensure providers deliver agreed services, leading to poor value for money and inability to achieve financial balance.</i>	✓	✓	✓	✓
Risk 9: Failure to systematically improve the quality of healthcare services <i>Risk that the ICBs do not rigorously monitor, evaluate, and adapt services, resulting in persistent gaps in quality and safety and an inability to identify and act promptly on emerging quality concerns.</i>	✓	✓		
Risk 10: Failure to ensure timely and equitable access to healthcare services in line with national and local performance standards <i>Risk that the ICBs do not rigorously monitor, evaluate, and adapt services, resulting in persistent non-delivery of access targets.</i>	✓	✓	✓	
Risk 11: Failure to develop and deploy an effective ICB cluster operating model with the necessary workforce skills and capabilities for strategic commissioning <i>Risk that the ICBs do not build or maintain the strategic commissioning skills required, while supporting the wellbeing of the ICBs' combined workforce, limiting their ability to deliver strategic commissioning effectively.</i>			✓	
Risk 12: Failure to maintain cyber resilience <i>Risk that the ICBs do not establish robust cyber security arrangements, which could compromise delivery of core functions and disrupt access to critical data and systems.</i>	✓	✓	✓	

Impact ↑	5 Catastrophic	5	10	15	20	25
	4 Major	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Minor	2	4	6	8	10
	1 Negligible	1	2	3	4	5
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
		Likelihood →				
Risk Profile		Very Low (1-3)	Low (4-6)	Medium (8-12)	High (15-20)	Extreme (25)

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
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For assurance ☒ For decision ☐ For discussion ☐ For information ☐

Report summary:

This report provides an overview of the work undertaken by the Boards' committees since the last meeting in January 2026. The report is intended to provide assurance that the committees are discharging their delegated duties and to escalate any matters requiring the Boards' attention.

The report includes the committees' assessments of the levels of assurance they have gained from the items received and any actions instigated to address any areas where low levels of assurance have been provided.

Recommendation(s):

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

Relevant statutory duties:

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

Appendices

Appendix 1 – Joint Finance and Performance Committee Highlight Report
Appendix 2 – Joint Quality and Service Improvement Committee Highlight Report
Appendix 3 – Joint Strategic Commissioning Committee Highlight Report
Appendix 4 – Joint Remuneration and Human Resource Committee Highlight Report
Appendix 5 – Joint Transition Committee Highlight Report
Appendix 6 – Audit Committees' Highlight Report
Appendix 7 – Auditor Panels' Highlight Report
Appendix 8 – Description of levels of assurance

Appendices

Appendix 9 – Current high-level operational risks being oversighted by the Boards' committees

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Appendix 1: Joint Finance and Performance Committee Highlight Report

Meeting Dates:	04 February 2026 04 March 2026
Committee Chair:	Stephen Jackson, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
2024/25 System and ICB Finance and Efficiency Report (Months 9 and 10)	In preparation for the end of the financial year, all systems and ICBs had now submitted their year-end outturn positions to NHS England. This was a combined £221 million deficit forecast position. Nottingham and Nottinghamshire providers remain the key driver of the year-to-date position at £117 million adverse to plan; and NHS Nottingham and Nottinghamshire ICB was now forecasting to be £6.2 million adverse to plan, following confirmation that deficit support funding would be withheld. All providers stating a deficit position have been required to write to NHS England with a clear and credible plan on the actions that would need to be taken to achieve financial balance during the next financial year. Noting that there was still considerable risk to the ICBs achieving their forecast positions, the Committee explored the actions that were being taken to mitigate the risks; acknowledged the significant amount of efficiency savings that had been achieved to date within what had been a challenging year; and members took assurance that the ICBs had in place sufficient controls and mitigations to achieve their year-end forecasts.	Partial (providers) Full (ICBs)	Limited (providers) Adequate (ICBs) <i>(awarded at the meeting held on 04 February 2026)</i>

Item	Summary	Level of Assurance	Previous Level of Assurance
Operational Plan 2025/26 Delivery and Service Delivery report	All systems continued to experience significant urgent care pressures, with four-hour Emergency Department standards off trajectory across all three ICB areas, with significant ambulance handover delays. Elective recovery remained below plan, with continued pressure on 52- and 65-week wait performance, particularly in Derby and Derbyshire and Nottingham and Nottinghamshire. Diagnostic performance was significantly off plan in all three ICBs and remained a key constraint on elective and cancer delivery. Areas of improved performance across all three ICBs were also highlighted, including progress on reducing reliance independent sector bed utilisation in mental health services and improved performance in early intervention psychosis services.	Partial	Partial <i>(awarded at the meeting held on 04 February 2026)</i>

Other considerations

Information items and matters of interest:
a) Following the presentation of the ICBs' financial plans for approval at the Boards' extraordinary meeting in common on 10 February 2026, the Committee received updates on their further development. Negotiations with acute providers on 2026/27 contracts are ongoing, with different assumptions between commissioners and providers regarding recurrent funding and levels of elective activity growth. If resolution cannot be reached, the matter may proceed to formal arbitration, with any variance managed as a cost pressure. b) Following a recent NHS policy announcement regarding the transfer of NHS Property Services (NHSPS) assets to NHS Trusts and Foundation Trusts, the Committee endorsed the proposed system principle to prioritise the transfer of all core NHSPS properties into local Trust ownership where appropriate. The ICBs would co-ordinate and approve local expressions of interest, prior to submitting to NHS England.

Information items and matters of interest:

- c) The Committee reviewed the 22 risks within its remit at both meetings (noting seven risks were rated as 'high' and one as 'extreme'). In February, members considered a new risk relating to implementation of the ISFE2 ledger, which will be monitored closely.

Appendix 2: Joint Quality and Service Improvement Committee Highlight Report

Meeting Dates:	14 January 2026 11 February 2026
Committee Chair:	Sharon Robson, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
Quality Oversight Report	The Committee received an overview of the quality and safety position across the three ICBs, noting that work to standardise reporting across the organisations would be completed by its meeting in March 2026. The Committee received updates on the launch of the Maternity Outcomes Signal System and a review of the Oliver McGowan Mandatory Training programme in Nottinghamshire. Members also discussed interim quality management arrangements, ongoing oversight of Nottinghamshire Healthcare Foundation Trust following publication of its latest CQC review, and the need to strengthen system-wide infection prevention and control and align quality oversight and reporting across the three ICBs. The Committee emphasised the importance of aligned quality approaches across the three ICBs, with clear benchmarking, narrative consistency, visibility of risks and the impact of actions, particularly given the challenging year ahead.	Limited	Limited <i>(awarded at the meeting held on 14 January 2026)</i>

Item	Summary	Level of Assurance	Previous Level of Assurance
Focused Report on Providers in NOF 3 or 4	The Committee received a report on providers in NOF Segments 3 and 4 across the ICB footprint, noting that all Trusts remained on an escalation route and that quality teams were managing substantial improvement activity across organisations. Particular concern remained regarding Nottinghamshire Healthcare NHS Foundation Trust (NHFT), where early Well-Led findings indicated ongoing governance and equality, diversity and inclusion issues. The Committee agreed that future reports would include benchmarking data to support clearer comparison of provider performance. Members also discussed the number of providers on escalation and sought assurance on clinical harm review arrangements; it was confirmed that the ICBs maintain oversight through system partnerships, although this does not sit within contractual mechanisms.	Limited	Not applicable
Update on ICB actions following Independent Homicide Review	The Committee received an update on the ICB's response to the Independent Homicide Review, which identified significant system failures across NHFT, NNICB and the Police. Members noted that oversight arrangements had been strengthened and improvements were underway, although not yet fully embedded. Ongoing joint work with NHFT and the Police to improve information sharing and cross-agency risk management was highlighted, including new arrangements such as the Potentially Dangerous Person	Adequate	Not applicable

Item	Summary	Level of Assurance	Previous Level of Assurance
	Panel, with further alignment expected as ICB structures evolve ahead of the public inquiry hearings.		

Other considerations

Decisions made:
Members approved a shared set of quality priorities for the three ICBs, which provides clearer visibility of quality metrics and their impact. Priorities are focused on key population groups, including children and young people and people at End of Life, alongside common areas such as frailty, primary care, urgent and emergency care, and digital healthcare.

Information items and matters of interest:
The Committee also: a) Discussed the developing quality approach across the three ICBs, noting alignment with the emerging Population Health Strategy. Members supported the direction of travel and emphasised the importance of strengthened engagement, citizen voice and neighbourhood focus. b) Reviewed the strategic approach to immunisations and vaccinations, noting targeted work with vulnerable communities and an ambition to increase uptake by 2–3% in 2025/26, with further service development planned for 2026/27. c) Discussed provision of Palliative and End of Life Care, noting significant variation across the three ICBs and pressures relating to funding, capacity and workforce. Members highlighted the need for a more consistent and equitable commissioning approach supported by improved data and system-wide strategy. d) Discussed Urgent and Emergency Care (UEC) delivery across the three ICBs, noting strengthened collaboration, winter planning and real-time oversight arrangements.

Information items and matters of interest:

- e) Reviewed operational risks under the Committee's remit, spanning mental health, UEC, maternity, primary care, planned care and SEND, noting that pressures such as ambulance delays, discharge issues, long waits, workforce constraints and compliance risks continued to drive the quality risk profile.

Appendix 3: Joint Strategic Commissioning Committee Highlight Report

Meeting Dates:	29 January 2026 26 February 2026
Committee Chair:	Jon Towler, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
Joint Commissioning Executive Group Assurance Report	Members received reports summarising the broad range of commissioning proposals considered by the Joint Commissioning Executive Group in December 2025, January 2026 and February 2026. A significant number of decisions were taken during these meetings, supported by appropriate clinical, financial and equality assessments, with none requiring escalation to the Joint Strategic Commissioning Committee. Following a request from members, reporting has been enhanced to clarify whether the proposals required investment or disinvestment, confirm the budget status and describe whether proposals relate to new or continued services.	Full	Full <i>(awarded at the meeting held on 29 January 2026)</i>
Primary Medical Care Services Assurance Report	Members received an overview of primary medical care services across the ICBs, covering current contractual arrangements, performance and quality assurance, financial position and key risks, in line with the ICBs' delegated responsibilities and the Primary Care Commissioning Assurance Framework. It was noted that work was underway to address variation in the data informing performance and quality assurance, particularly appointment-based metrics where data quality and consistency differed across the three ICBs, and to support practices in meeting the new online access requirements by February 2026.	Full	Not applicable

Item	Summary	Level of Assurance	Previous Level of Assurance
	Members asked that future reports clearly highlight high-risk issues and associated mitigations, including data on areas where practices were off track, the reasons for the position, the mitigating actions, and the level of confidence in returning to plan. Members also requested further detail on the actions being taken to strengthen engagement with practices.		
Arrangement for Public and Patient Involvement	Members received a report on the arrangements for public and patient involvement across the three ICBs. It outlined how the ICBs demonstrated legal compliance, including processes for assessing statutory duties, meeting requirements for engagement with Health Overview and Scrutiny Committees, ensuring meaningful and ethically grounded involvement, and maintaining appropriate governance. Although current approaches were broadly similar, further alignment and embedding of these processes would take place over the coming months. Members acknowledged the importance of consistent engagement principles whilst recognising that approaches should be tailored to the needs of different communities. Opportunities were noted to strengthen collaboration with local authority partners, reduce duplication, enhance engagement with the Voluntary, Community and Social Enterprise and ensure an appropriate balance between working at scale and localism.	Adequate	Not applicable
Dental, Pharmacy and Optometry Services Report	The Committee received an overview of pharmacy, optometry and dental (POD) services across the ICBs, covering the current contractual arrangements, performance, quality assurance, financial position, and key risks associated with delegated responsibilities. The future plans were also outlined and included the introduction of national dental contract reforms from April 2026 and the	Partial	Not applicable

Item	Summary	Level of Assurance	Previous Level of Assurance
	implementation of three-year dental commissioning plans, which would remain agile to respond to national changes. Members discussed the Pharmacy Pathfinder programme, which improved patient access and was a critical component of pharmacy transformation. Discussions were ongoing regarding its continuation, which would require a financial contribution from each ICB. Given the scale of challenge within pharmacy services, the frequency of Committee updates would be reviewed. The need for clearer analysis of dental access and activity was highlighted and members requested that a detailed report be presented to the Committee in April 2026 to provide a comprehensive assessment of current dental issues, future requirements and potential commissioning options.		

Other considerations

Decisions made:
The Committee endorsed: a) The proposed Five-Year Population Health Strategy for formal approval by the Boards at their extraordinary meeting in common on 10 February 2026, subject to the amendments put forward throughout the discussion being made. b) The proposed Five-Year Strategic Commissioning Plan for formal approval at the ICBs' Boards meeting in common on 10 February 2026, subject to the amendments put forward throughout the discussion being made. The Committee approved: c) The terms of reference for the Primary Medical Services Commissioning Group, pending conclusion of the Senior Leadership Team consultation. The Terms of Reference would be reviewed within six months, once the oversight routes for delivery of the Strategic Commissioning Plan (2026/27–2030/31) and the governance arrangements for PODs had been clarified.

Decisions made:

- d) The adoption of an initial (Phase One) single approach for the consideration of commissioning proposals, noting that further development was planned to introduce a more sophisticated weighted prioritisation methodology in Phase Two.
- e) The proposed approach to the implementation of the 2026/27 Transformation Fund, which would support delivery of the Five-Year Population Health Strategy and Five-Year Strategic Commissioning Plan through a small number of large-scale bids in 2026/27.

Information items and matters of interest:

The Committee:

- a) Noted the emerging national policy and planning requirements for Neighbourhood Health and their implications for the ICBs' role as strategic commissioners. Ahead of the publication of national neighbourhood guidance, the three ICBs had developed a high-level 'Neighbourhood Core Offer' to articulate their strategic commissioning intent.
- b) Reviewed risks within its remit, noting 14 identified medium risks. Key themes related to primary care sustainability, transformation pressures across urgent and emergency care services and mental health services. Future reports would provide additional detail on key controls, mitigating actions and progress for each risk. Work to strengthen the articulation of these controls and mitigations had commenced.

Appendix 4: Joint Remuneration and Human Resource Committee Highlight Report

Meeting Dates:	22 January 2026
	5 February 2026 (extraordinary meeting)
	10 March 2026 (extraordinary meeting)
Committee Chair:	Margaret Gildea, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
Workforce Report	Members received a report that provided data on whole time equivalent staffing, turnover, sickness absence and starters and leavers for the three ICBs over the past twelve months. Members discussed how workforce metrics would evolve to reflect best practice in Human Resource reporting and more effectively support future recruitment. They noted that future reports would benefit from including data on staff retention, engagement with training and appraisals, and grievance processes. As the reported sickness absence rate of 3.6% was 2% below the Midlands regional average for September, it was agreed that the underpinning data and methodology would be verified and, if confirmed, the rationale for the variance explored in more detail.	Adequate	Not applicable
Management of Change Update	Members received a report that provided assurance on the ongoing development of the ICBs' new operating model, along with a progress update on the Wave One, Wave Two and Voluntary Redundancy processes. Members discussed staff uptake of the wellbeing offer, highlighted the importance of understanding the impact of the management of change process on the ICBs'	Full	Not applicable

Item	Summary	Level of Assurance	Previous Level of Assurance
	diversity profile, and expressed concern about the potential loss of individuals with critical future skills through the voluntary redundancy process. It was noted that the high-level wave three structures would inform the voluntary redundancy approval process to ensure sufficient staffing and the retention of critical skills across all the ICBs' functions.		

Other considerations

Decisions made:
The Committee: a) Agreed that NHS Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire ICBs would continue with the current approach to 'Reckonable service for the purposes of an NHS redundancy payment' and would not exercise the discretion allowed under section 16.5 of the NHS Terms and Conditions of Service Handbook. b) Approved a number of employment-related matters, including elements of the wave three consultation process, remuneration arrangements associated with the jointly appointed Senior Leadership Team across the three ICBs, and related workforce changes arising from the senior leadership appointments, including redundancy matters where applicable.
Information items and matters of interest:
The Committee: a) Discussed its terms of reference and proposed draft work programme, requesting that the Equality Act and oversight of employment tribunals be explicitly referenced in the work programme. b) Reviewed the risks within its remit, noting five medium 'live' risks, all of which were joint risks across the three ICBs and noted that future reports would include enhanced detail to support the Committee's assessment of the effectiveness of mitigating actions.

Information items and matters of interest:

- c) Received, for information, a report on ongoing employment tribunal cases across the three ICBs.
- d) Received progress updates on the ICBs' Voluntary Redundancy Scheme at its extraordinary meetings in February and March 2026.

Appendix 5: Joint Transition Committee Highlight Report

Meeting Dates:	5 February 2026 5 March 2026
Committee Chair:	Jon Towler, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
Finance Update, including Cost Reduction Finance Tracker	The Committee was assured that the Transition Programme remains financially deliverable, with planned workforce changes expected to deliver the required recurring savings, supported by non-recurrent mitigation to manage the timing gap in 2026/27. Progress with pay-related reductions is aligned with consultation and exit arrangements, while delivery of non-pay savings remains dependent on Commissioning Support Unit (CSU) cost reductions, estates rationalisation and future audit fee changes. Robust programme governance and financial tracking arrangements are in place to monitor delivery and manage risks.	Full	Adequate <i>(awarded at the meeting held on 05 February 2026)</i>
Estates Update	The Committee received an update on ICB headquarters provision. An estates workstream was gathering the detail required to prioritise estates efficiencies, including options for a central, corporate headquarters and satellite sites. Key challenges were noted, including difficulties identifying suitable premises in Mid-Nottinghamshire for a central headquarters, risks associated with ending current leases,	Adequate	Adequate <i>(awarded at the meeting held on 05 February 2026)</i>

Item	Summary	Level of Assurance	Previous Level of Assurance
	and concerns about ensuring all staff were able to reasonably access an office location.		
Transition Programme Plan update a) Wave Two and Voluntary Redundancy Wrap-up b) Summary Transition Programme Plan c) Workstream Highlight Reports	The Committee received an update on the management of change process, noting progress across the three consultation waves, with wave one redundancies approved and implemented, wave two recruitment underway and wave three consultation launched in February 2026. Voluntary redundancy applications were largely reviewed, with ongoing discussions regarding CSU applications and potential TUPE implications. Members noted that redundancy costs continue to be tightly managed within the agreed financial envelope and acknowledged the operational challenges and impact on staff morale as the transition programme progresses.	Adequate	Adequate <i>(awarded at the meeting held on 05 February 2026)</i>
Commissioning Support Unit Update	Members discussed ongoing work associated with the abolition of Commissioning Support Units (CSUs), noting concerns regarding potential liabilities and the viability of service delivery during transition.	Adequate	Adequate <i>(awarded at the meeting held on 05 February 2026)</i>

Other considerations

Information items and matters of interest:
The Committee also:

Information items and matters of interest:

- a) Received verbal updates from the Chief Executive, including feedback from the NHS England assurance meeting held on 29 January 2026, which was broadly positive. Members noted that further clarity is expected on the regional workforce model and that workforce governance arrangements will be reviewed once the three ICBs establish a stable operating model. NHS England also indicated that discussions may commence regarding potential future ICB mergers.
- b) Discussed the Operational Risk Report, noting updates to existing risks and the addition of new risks. Members highlighted potential legal risks linked to estates changes and staff base locations and were assured that mitigation arrangements were in place, including strengthened regional delegation for voluntary redundancy processes and work underway to align key ICB policies.

Appendix 6: Audit Committees Highlight Report (meeting in common)

Meeting Date:	18 February 2026
Committee Chair:	John Dunstan, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
Financial Stewardship Assurance Report	The report had provided assurance of compliance with the ICBs' Standing Financial Instructions, NHS England governance and HM Treasury's Management of Public Monies across the three ICBs. As this was the first report following the implementation of cluster arrangements, it also discussed cross ICB risks, highlighting control strengths and outlining areas for alignment and improvement. Overall, the Committees took assurance of robust control arrangements within each ICB and welcomed the move towards the alignment of financial procedures. One area highlighted and discussed as an outlier was the over-reliance of NHS Derby and Derbyshire ICB on single tender waivers. Although it was noted that all decisions were compliant, the Committees took assurance that action had already been taken to strengthen arrangements.	Adequate	Not applicable
Information Governance Assurance Report	The report provided assurance on progress to align information governance, data protection and cyber security arrangements across the three ICBs, supporting compliance with relevant legislative and regulatory requirements. The Committees discussed the emerging cluster-wide approach, noting that while governance, oversight and assurance arrangements for information governance and data protection were being aligned, cyber security delivery arrangements necessarily remain separate due to the use of different IT providers.	Adequate	Not applicable

Item	Summary	Level of Assurance	Previous Level of Assurance
	The Committees received a detailed status update on progress towards submission of the 2025/26 Cyber Assessment Framework (CAF)-aligned Data Security and Protection Toolkits for each ICB. Members explored progress, risks and areas of challenge, including discussion around organisational capacity to deliver the Toolkit requirements. In particular, capacity pressures within Lincolnshire ICB were highlighted; however, assurance was provided that these challenges had been identified, were subject to active management, and were being mitigated through appropriate support and strengthened oversight arrangements. Overall, the Committees took assurance that the ICBs remained on track to meet DSPT requirements and that capacity and delivery risks were recognised and being managed.		
Annual Fraud Risk Assessment	Members received a report on the outcome of the annual fraud risk assessment. This was a process driven by the requirements set out by the NHS Counter Fraud Authority. It provided a list of the ICBs' potential fraud risks, their ratings, potential impact, and the controls and mitigations in place to prevent each potential risk from materialising. The outcome of this piece of work would in turn help to inform the ICBs' annual Counter Fraud Plans for 2026/27.	Full	Not applicable
Policy Management Assurance Report	Members received assurance on progress with the programme of work to align and strengthen corporate policy management across the ICBs.	Full	Not applicable
Outstanding Internal Audit Actions	A full review of outstanding actions across the ICBs had been completed to confirm that actions remained relevant and timescales for delivery were achievable.	Full	Not applicable

Other considerations

Decisions made:

The Committees:

- a) Approved the joint Policy for the Development and Management of Policies, which established a consistent approach to policy development and underpinned the approach to the development of all policies.
- b) Approved the cancellation of the Mental Health, Learning Disabilities and Autism internal audit within NHS Derby and Derbyshire ICB's Internal Audit Plan, as it was considered that a wider audit across the three ICBs would be more beneficial following the alignment of policy and processes.

Information items and matters of interest:

- a) The Committee received a further update on issues arising from implementation of the ISFE2 financial ledger in October 2025. Members noted that the system continues to present operational, financial reporting and governance risks, with potential implications for the 2025/26 accounts and a credible risk of external audit qualification. The Committee requested that these concerns be escalated to the Boards' attention.
- b) The Committees also received updates and reviewed progress on:
 - The ICBs' Counter Fraud Plans for 2025/26, noting that good progress was being made overall.
 - The ICBs' Internal Audit Plans for 2025/26, noting that good progress was being made against the agreed plans.
 - The external audits of the ICBs.
 - The ICBs' approach to the production of the ICBs' 2025/26 Annual Reports and Accounts.

Appendix 7: Auditor Panels Highlight Report (meeting in common)

Meeting Date:	29 January 2026
Committee Chair:	John Dunstan, Non-Executive Director

Decisions made:	
a)	Following consideration of proposals to align external audit arrangements across the ICB Cluster, NHS Lincolnshire ICB's Auditor Panel endorsed the appointment of KPMG as external auditor for 2025/26 and 2026/27, with an option to extend for a further two years should national timelines for potential ICB mergers require this.
b)	The Auditor Panels of NHS Derby and Derbyshire ICB and NHS Nottingham and Nottinghamshire ICB subsequently endorsed amendments to the existing contracts with KPMG to include a contingency option for a further two years, should national timelines for potential ICB mergers require this.
c)	The Panels' recommendations were subsequently approved by the ICBs' Boards at their extraordinary meeting on 10 February 2026.

Appendix 8 - Description of levels of assurance

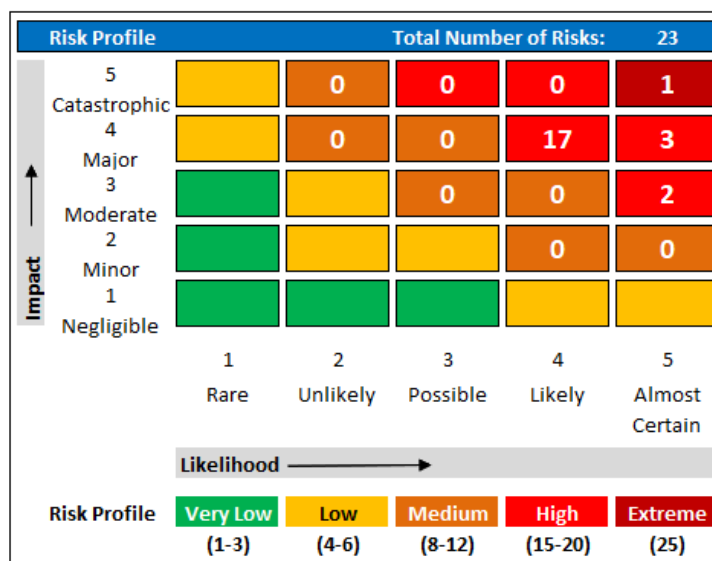
Levels of assurance:	The report demonstrates that:
Full Assurance	- Desired outcomes are being achieved; and/or - Required levels of compliance with duties is in place; and/or - Robust controls are in place, which are being consistently applied. Highly unlikely that the achievement of strategic objectives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

Appendix 9: Current high-level operational risks being overseen by the Boards' committees

Risk Profile

There are 87 'live' risks within the Operational Risk Register. Of these 87 risks; 23 risks are scored at a high-level, accounting for 26% of the total risks. 7 of the high scoring risks originate from NHS Derby and Derbyshire ICB, one originates from NHS Lincolnshire ICB, and 13 from NHS Nottingham and Nottinghamshire ICB. 2 'joint' high scoring risks have also been identified. The ICB's total risk profile is shown in figure 1 below.

Figure 1



The 23 high-level operational risks include three risks classed as confidential. In rare circumstances, a risk may also be held confidential if it relates to sensitive topics, such as ongoing legal matters, contractual negotiations, or personnel issues, where early

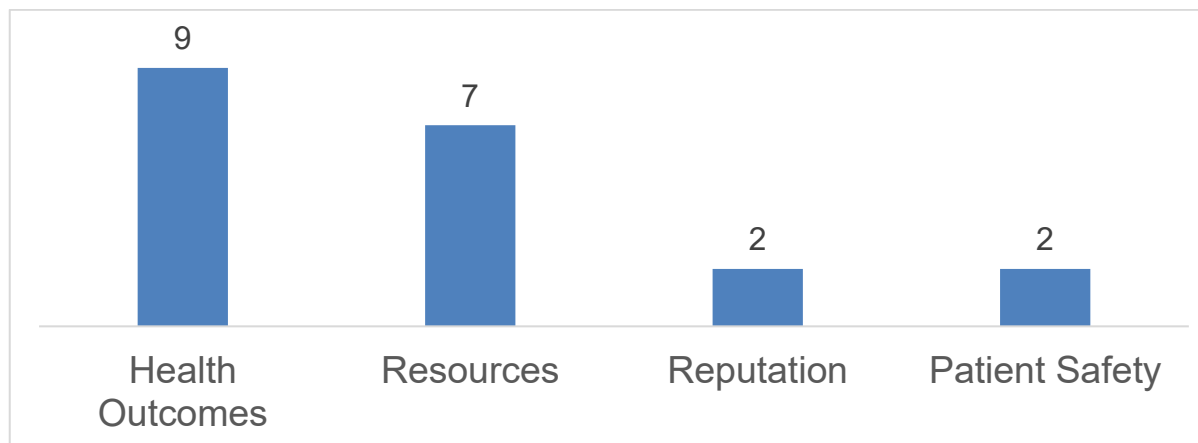
disclosure could be inappropriate or compromise effective management. The confidential risks are reported separately and excluded from the analysis and detail of this report.

The remaining twenty high-level operational risks included in this paper are detailed in the below table.

Risk Domains

As a reminder, there are nine risk domains used when classifying operational risks. Figure 2 below shows the risk domains where the high-level risks sit. There are no high-level risks within the risk domains of health inequalities, legal, people, strategy and operations and social and economic development.

Figure 2



Details of High-Scoring Risks

Operational risk reports continue to be routinely presented to the committees of the Boards, enabling the ongoing review and scrutiny of all risks, including those high-level risks.

Risk Ref.	ICB	Risk Description	Score	Responsible Committee
RR038	NNICB	If the Nottingham and Nottinghamshire NHS system cannot rapidly implement sustainable recurrent financial efficiencies, there is a risk that the underlying deficit will worsen, undermining progress toward long-term financial sustainability.	Extreme 25 (I5 x L5)	Joint Finance and Performance Committee
RR034	NNICB	If cash flow shortages occur during the 2025/26 financial year, NHS system partners across Nottingham and Nottinghamshire may need to seek loans, increasing debt levels and associated interest costs. This could further exacerbate financial instability and reduce capacity for future investments.	High 20 (I4 x L5)	Joint Finance and Performance Committee
RR007	DDICB	If the Derby and Derbyshire NHS system cannot rapidly implement sustainable recurrent financial efficiencies, there is a risk that the underlying deficit will worsen, undermining progress toward long-term financial sustainability.	High 20 (I4 x L5)	Joint Finance and Performance Committee
RR010	DDICB	If Derby and Derbyshire system plans do not align activity, workforce, and finance, there is a risk of uncoordinated planning. This may reduce the likelihood of achieving financial, productivity, workforce, and activity targets, leading to inefficiencies, undermining system-wide financial sustainability.	High 16 (I4 x L4)	Joint Finance and Performance Committee
RR036	NNICB	If NHS Nottingham and Nottinghamshire ICB is unable to implement sustainable recurrent financial efficiency solutions, there is a risk that the underlying deficit (UDL) will worsen, limiting the ICB's ability to meet population needs within available financial resources.	High 16 (I4 x L4)	Joint Finance and Performance Committee
RR046	NNICB	If Nottingham and Nottinghamshire NHS system partners' workforce plans are not aligned with the system financial plan and/or do not include a clear, actionable plan of the workforce reductions required to achieve affordability, then the anticipated financial efficiencies may fail to materialise, risking overspend and undermining system-wide financial sustainability.	High 16 (I4 x L4)	Joint Finance and Performance Committee
RR047	NNICB	In pursuit of NHS financial efficiencies and operational delivery for 2025/26 for Nottingham and Nottinghamshire, there is a risk that ICB relationships may decline (with ICS partners and wider stakeholders). This may lead to deterioration in collaborative efforts, communication breakdowns and wider stakeholder dissatisfaction	High 16 (I4 x L4)	Joint Finance and Performance Committee
RR092	LICB	If NHS Lincolnshire ICB is unable to implement sustainable recurrent financial efficiency solutions, there is a risk that the underlying deficit (UDL) will worsen, limiting the ICB's ability to meet population needs within available financial resources.	High 16 (I4 x L4)	Joint Finance and Performance Committee

Risk Ref.	ICB	Risk Description	Score	Responsible Committee
RR003	DDICB	If excessive handover delays in Derby and Derbyshire prevent timely ambulance responses, patients waiting in the community may experience significant delays in care, increasing the risk of clinical harm and compromising patient safety.	High 20 (I4 x L5)	Joint Quality and Service Improvement Committee
RR002	DDICB	If delays in treatment for Derby and Derbyshire patients on provider waiting lists continue, there is a risk of increased clinical harm due to prolonged waits, potentially compromising patient outcomes and quality of care.	High 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR022	NNICB	If ambulance handover times at acute trusts within Nottingham and Nottinghamshire increase and cause delayed ambulance arrival in the community, there is a risk of potential harm to citizens who are waiting for an ambulance, which may lead to further deterioration of their condition.	High 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR023	NNICB	If there are ineffective discharge processes within Nottingham and Nottinghamshire, there is a risk of increased length of stay and potential for individuals to experience harm when leaving the hospital and returning home. This may lead to deconditioning and poor experience.	High 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR029	NNICB	If Nottingham University Hospitals NHS Trust (NUH) fail to sustain improvements made to date following CQC and external recommendations, there is a risk quality of services may decline. This may lead to compromised safety and quality of care issues which could result in poor experience and adverse health outcomes for the population of Nottingham and Nottinghamshire.	High 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR048	NNICB	If adverse media coverage relating to key health services commissioned by the Nottingham and Nottinghamshire ICB (e.g. maternity, mental health, primary care) persists, public confidence in the ICB may decline. This may lead to reduced trust, and impact on public confidence.	High 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR049	NNICB	If cancer service demand continues to exceed available system capacity, the ICB may be unable to fulfil its statutory duty to commission timely and effective services that support the diagnosis and treatment of cancer across Nottingham and Nottinghamshire. This could result in non-compliance with national cancer standards, including the 62-day referral-to-treatment target and the 28-day Faster Diagnosis Standard, leading to poorer clinical outcomes and diminished experience for the population.	High 16 (I4 x L4)	Joint Quality and Service Improvement Committee

Risk Ref.	ICB	Risk Description	Score	Responsible Committee
RR051	NNICB	If operational performance pressures persist due to capacity constraints and rising demand, the ICB may be unable to fulfil its statutory duty to commission hospital and medical services across Nottingham and Nottinghamshire that meet the reasonable requirements of the population. This could result in Trusts being unable to deliver planned levels of elective activity, leading to missed waiting time targets, delayed treatment, poorer health outcomes, and increased reliance on urgent and emergency care pathways.	High 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR082	DDICB	If elective and cancer care performance does not recover to required levels by March 2026, there is a risk of delayed diagnosis and treatment leading to poorer health outcomes and reduced patient experience across the population of Derby and Derbyshire.	High 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR083	DDICB	If improvements in urgent and emergency care access are not delivered by March 2026, there is a risk of delayed or unsafe care, poorer health outcomes, and reduced confidence in NHS services across Derby and Derbyshire.	High 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR084	DDICB	If adult mental health bed use in Derby and Derbyshire is not reduced by March 2026, there is a risk of unsafe, delayed care, resulting in poorer outcomes and experience and greater system pressure.	High 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR072	NNICB	If NHCT lacks the capacity and capability to implement sustainable quality improvements identified through serious incidents, deaths, quality reviews, and broader performance concerns, then similar failures may recur, leading to harm and poor health outcomes for the population of Nottingham and Nottinghamshire.	High 15 (I3 x L5)	Joint Quality and Service Improvement Committee