NHS
Nottingham and Nottinghamshire
Integrated Care Board

Annual Report and Accounts 2024-25

For the year ended 31 March 2025

About this report

This document has been prepared, as directed by NHS England, in accordance with the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022). Integrated Care Boards (ICBs) are statutorily required to produce an annual report and accounts and to comply with the requirements as laid out in the Department of Health and Social Care (DHSC) Group Accounting Manual.

The structure of this report therefore follows that outlined in the guidance and includes:

- **Performance Report** – this section of the Annual Report includes an overview and a more detailed analysis of our performance during the reporting period, as follows:
  - **Performance Overview**, which describes the structure of our organisation and what we do and summarises our strategies and plans and how we have performed during the reporting period.
  - **Performance Analysis**, which describes our performance measures in more detail and illustrates the level of delivery achieved during the reporting period. It also sets out our risk profile and explains how we have discharged our key statutory duties.
- **Accountability Report** – this section of the Annual Report describes how we have met key accountability requirements and embodied best practice to comply with corporate governance norms and regulations. It comprises three sections:
  - **Corporate Governance Report**, which sets out how we have governed the organisation during the period 1 April 2024 to 31 March 2025 including membership and organisation of our governance structures and how they supported the achievement of our objectives.
  - **Remuneration and Staff Report**, which describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.
  - **Parliamentary Accountability and Audit Report**, which brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.
- **Annual Accounts** – this section of the Annual Report presents our financial statements for the reporting period.

This document can be made available in large print and in other languages by request to the organisation at:

Email: nnicb-nn.ics@nhs.net

Website: https://notts.icb.nhs.uk

Registered Address: Sir John Robinson House, Sir John Robinson Way, Arnold, Nottinghamshire, NG5 6DA.

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Foreword by Dr Kathy McLean OBE, Chair

It is my privilege to introduce this Annual Report, which reflects another year of progress, partnership and purpose for our Integrated Care Board and the wider Nottingham and Nottinghamshire Integrated Care System.

We have continued to operate in an evolving landscape, with high expectations from the Government, NHS England and, most importantly, from the public we serve. Despite considerable operational and financial pressures, our system has once again shown its strength; delivering care, transforming services, and keeping people and communities at the heart of everything we do.

Over the past year, I have had the privilege of visiting numerous services and teams across the system – from primary care hubs tackling urgent access, to voluntary, community and social enterprise (VCSE) organisations supporting some of our most vulnerable residents. These visits remind me, time and again, that behind every strategy and system aim lies the passion and commitment of people doing their best for patients every single day. Their insight and innovation shape how we work and why we must keep listening, learning and evolving together.

A particular focus this year has been the national ambition to make three significant shifts: from hospital to community, from analogue to digital, and from treatment to prevention. I am proud that our system is already demonstrating what these shifts look like in practice. From our award-winning community initiatives tackling health inequalities, to the continued development of digital tools and system intelligence, our partners have embraced change in ways that are both pragmatic and ambitious.

Our refreshed Integrated Care Strategy continues to guide us, and I remain encouraged by the energy and dedication shown by staff across our system in delivering its aims. I have been particularly inspired by the work underway on the 'health and work' agenda, and by the insight and innovation I see each time I visit local services – from targeted lung health checks to place-based partnerships making a tangible difference.

Towards the end of the year, the announcement of NHS management cost reduction targets and the recent development of a 'Model ICB Blueprint' has brought both challenge and reflection. I am grateful for the thoughtful and committed response of our Board, our executive team and our system partners as we navigate this period of change with integrity and a focus on impact. As Chair of both this ICB and NHS Derby and Derbyshire ICB, I have also welcomed the opportunity for greater alignment where it makes sense to do so, particularly as we deepen our collaboration with the East Midlands Combined County Authority and Mayor as part of the region's wider devolution agenda.

As always, I want to thank my fellow Board members, executive colleagues, and partners across all sectors for their leadership, challenge and support. And I extend my deepest thanks to our staff, whose dedication underpins everything we do.

We are entering a time of considerable national reform and financial constraint, but also of real opportunity. I look forward to continuing to work together, with purpose and ambition, to create a healthier, fairer future for the people of Nottingham and Nottinghamshire.

Dr Kathy McLean OBE, Chair of NHS Nottingham and Nottinghamshire Integrated Care Board

Performance Report

Signed:

Amanda Sullivan
Accountable Officer

19 June 2025

Performance Overview

Statement from our Chief Executive

As we publish our third annual report and accounts covering the year 2024/25, I am reminded once again what a privilege it is to lead our ICB and to work as part of the wider Nottingham and Nottinghamshire Integrated Care System. This year has continued to test health and care services across the country, and our system has not been immune. Despite this, we have seen our system respond with determination and resilience.

We have made progress in several areas that we identified as priorities for this year within our NHS Joint Forward Plan, in order to tackle health inequalities and improve health outcomes for our population. These include making it easier for people to access GP appointments, reducing the time people are waiting for diagnostics tests, consistent delivery of the faster cancer diagnosis standard, improving access to mental health services for children and young people, and strengthening arrangements for preventative care and long-term condition management. However, we have continued to experience significant operational challenges due to high demand across urgent and emergency care and delays in discharging patients from hospitals, which has impacted on our performance in these areas.

The independent review of maternity services at Nottingham University Hospitals NHS Trust, led by Donna Ockendon, and the independent reviews and recently announced statutory inquiry, led by Her Honour Deborah Taylor, into the Nottingham attacks in June 2023, have continued to shine a light on areas of serious concern regarding the quality of maternity and mental health services in our area. As a system, we are committed to listening, learning, and acting on the recommendations from these reviews, and we are supporting the delivery of improvement plans, ensuring they result in meaningful, sustained change.

Our financial position remains a significant area of focus for us. In May 2024, the ICB accepted formal undertakings from NHS England in relation to financial governance and our system's financial sustainability. In response we have committed to a clear financial recovery plan, strengthened oversight and tighter system-wide controls to ensure the delivery of our statutory duties. Throughout the year, we have worked closely with partners around shared priorities and have demonstrated what can be achieved through close collaboration. You can read more about our performance this year in the 'Performance Analysis' section of this Annual Report.

Looking ahead, the Government's forthcoming Ten-Year Health Plan is expected to present a renewed emphasis on prevention, digital innovation, and moving care to the community. ICBs will be central to delivering that vision. The shift to a more rules-based operating model and earned autonomy is already shaping how we work, and we are now positioning ourselves to lead these reforms locally. This requires difficult choices, but the changes we are making are about building a more focused, efficient and effective organisation that is fit for the future.

I want to thank everyone who has contributed to our work this year – colleagues within the ICB and from across our NHS and wider system partners. Their commitment, professionalism and compassion continue to drive healthcare improvements across Nottingham and Nottinghamshire. We have made progress on embedding our values and responding to staff feedback, but we know there is more we can do to support wellbeing and inclusion. We have both the opportunity and responsibility to shape this future locally. I remain confident that by working together, we will continue to build a better, fairer health and care system for our population.

Amanda Sullivan, Chief Executive and Accountable Officer of NHS Nottingham and Nottinghamshire Integrated Care Board

About us

NHS Nottingham and Nottinghamshire ICB was established by NHS England on 1 July 2022 under powers in the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022). The ICB is a statutory NHS organisation which covers the geographic areas of Ashfield, Bassetlaw, Broxtowe, Gedling, Mansfield, Newark, Rushcliffe, Sherwood, and the City of Nottingham.

We have four overarching aims:

- To improve outcomes 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 broader social and economic development.

In support of these aims, we have statutory responsibilities to develop a plan to meet the health needs of our population, to allocate NHS funding to deliver our plan, and to arrange for the provision of the following health services in line with our plan:

- Most planned hospital care for the diagnosis and treatment of illness (including responsibility for 59 specialised acute services delegated to us by NHS England since 1 April 2024).
- Urgent and emergency care (including out of hours services, accident and emergency services, ambulance services and NHS 111 services).
- Mental health services (including psychological therapies).
- Services for people with learning disabilities and autism.
- Maternity and new-born services.
- Children's healthcare services (mental and physical health).
- Most community health services.
- Rehabilitative care.
- Palliative care.
- NHS continuing healthcare.
- GP services (responsibility delegated to us by NHS England since 1 July 2022).
- Pharmacy, optometry and dental services (responsibility delegated to us by NHS England since 1 April 2023).

We are responsible for making certain that the healthcare provided is of a high standard, delivers quality improvements and offers value for money. We also have legal duties to safeguard the wellbeing of adults, young people and children who access the services we arrange, and to improve outcomes for children in care, and children and young people with special educational needs and disabilities (SEND).

Patients are at the heart of everything we do, and we actively encourage people living in Nottingham and Nottinghamshire to help shape our plans and the work we do to transform services.

The ICB is a category one responder under the Civil Contingencies Act (2004), which requires us to plan for, and respond to, a wide range of incidents and emergencies that could cause large numbers of casualties and affect the health of our communities or the delivery of patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. We work to the requirements of the NHS Emergency Preparedness, Resilience and Response Framework to demonstrate that we can deal with such incidents while maintaining services.

We have a leadership role, working with other local NHS organisations, to improve workforce and cultural development, deliver digital transformation, drive forward environmental sustainability, and ensure a more effective use of the NHS estate. Working together in this way, helps us to deliver our roles as ‘anchor organisations’, supporting social and economic development within the area we serve.

We are governed by a unitary Board, comprised of a Chair and Chief Executive, further non-executive and executive members, along with partner members that bring the perspectives of a range of different health and care sectors to the work of the Board. More information about our Board can be found in the Members report section of this Annual Report.

As of 31 March 2025, 649 people worked for the ICB (including staff, clinical and professional advisors, and Board members). This includes a team of staff that we have hosted since 1 July 2023, who work on behalf of our ICB and the other four ICBs across the East Midlands (NHS Derby and Derbyshire ICB, NHS Leicester, Leicestershire and Rutland ICB, NHS Lincolnshire ICB and NHS Northamptonshire ICB) to commission pharmacy, optometry, and dental services. The ICB has also hosted the East Midlands Cancer Alliance Team since 1 April 2024, who work on behalf of NHS England and the five ICBs across the East Midlands to improve cancer care.

Our organisational structure is divided into six directorates:

- Our Chief Executive leads on the ICB's operating model, NHS system leadership and system governance arrangements, involving and engaging people, communities and system partners, and internal and external communications.
- Our Delivery and Operations Directorate is responsible for commissioning hospital and other health services, development of new care models, data analytics and system intelligence, performance and system oversight arrangements, and emergency planning, resilience and response.
- Our Strategy and System Development Directorate is responsible for strategic needs assessments, strategy development and strategic planning, major service changes and reconfigurations, commissioning policy development, development of the system operating model, and social and economic development.
- Our Medical Directorate is responsible for clinical prioritisation and transformation, clinical and care professional leadership and involvement, health inequalities, prevention, medicines safety and optimisation, population health management, digital transformation and cyber security, research, evidence and evaluation, and innovation.
- Our Quality and Nursing Directorate is responsible for oversight of quality standards, quality improvement and learning, safeguarding, continuing healthcare and personalisation, individual funding requests, workforce and people planning, equality, diversity and inclusion, freedom to speak up arrangements, corporate governance, risk management, and information governance.
- Our Finance Directorate is responsible for financial planning and stewardship, resource allocation, capital planning, operational planning, procurement and provider selection, contract management, infrastructure management, environmental sustainability, and audit and counter fraud arrangements.

Our integrated care system

The ICB is part of the Nottingham and Nottinghamshire Integrated Care System (ICS), which is a partnership of local health and care organisations that have come together to plan and deliver joined up services to improve the health of people who live and work in our area.

By working together and collaborating as an ICS, we are better able to tackle complex challenges, such as: improving the health of children and young people; supporting people to stay well and independent; acting sooner to help those with preventable conditions; supporting those with long-term conditions or mental health issues; caring for those with multiple needs as populations age; and getting the best from collective resources so people get care as quickly as possible.

The leaders of partner organisations across our ICS have established a Partnership Agreement to demonstrate our collective commitment to working effectively together for the benefit of our communities and residents; this means working across organisational boundaries to maximise the use of our energies and resources. The Partnership Agreement sets out the core values that underpin our work as partners. These include being open and honest with each other, being respectful in working together, and being accountable in doing what we say we will do.

Our ICS structure includes:

- An Integrated Care Partnership (ICP), which is a statutory committee jointly formed between the ICB and the Nottingham City and Nottinghamshire County Councils. The ICP brings together a broad alliance of partners

concerned with improving the care, health and wellbeing of the population. The ICP is the 'guiding mind' of our local health and care system, and it is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population we serve (See the next section on Our strategies and plans for further details).

- Four place-based partnerships to lead the detailed design and delivery of integrated services across their localities and neighbourhoods. The partnerships involve the NHS, GP practices, local councils, community and voluntary organisations, local residents, people who use services, their carers and representatives and other community partners with a role in supporting the health and wellbeing of the population.
- 24 Primary Care Networks (PCNs), which are partnerships between General Practice surgeries who care for neighbourhoods of between 20,000 to 100,000 people. They work together to provide services designed for the specific needs of their communities. A key focus of our PCNs is helping residents to look after their own health, empowering people to live well by supporting them to achieve personal health and wellbeing goals.
- A provider collaborative at scale that brings local statutory NHS providers together to achieve the benefits of working at scale across multiple places, to improve quality, efficiency and outcomes and address unwarranted variation and inequalities in access and experience across different providers.

More information about the Nottingham and Nottinghamshire ICS can be found at https://healthandcarenotts.co.uk and you can read more about the key achievements of our partnerships and collaboratives in the Performance Analysis section of this Annual Report.

In line with our fourth aim to help the NHS support broader social and economic development, our ICS acts as an 'anchor system'. This means that we work together with our partners to address the physical, social and environmental factors that can cause ill health; sometimes called the wider determinants of health. Our Integrated Care Strategy sets out four key priorities in this area:

- To use our collective funding and influence to support our local communities and encourage people from the local area to consider jobs in our organisations.
- To add social value as major institutions in our area.
- To work together to reduce our impact on the environment and deliver sustainable health and care services.
- To focus on health, wellbeing and education for children and young people to help improve employability and life chances for future generations.

We are also an active strategic partner in the Universities for Nottingham Civic Agreement[1], which sets out a commitment to enhance the economic, social, and cultural life, and the health and wellbeing for the people and place of Nottingham and Nottinghamshire. The shared mission described within the Civic Agreement covers economic prosperity, education partnership, skills and employment, environmental sustainability, health and wellbeing, and community connections.

Key areas of focus during 2024/25, have included:

- Application of a 10% weighting on social value for all competitive tender processes, in line with our social value (procurement) strategy for ICS partners. This aims to gain efficiencies from our combined purchasing power in support of sustainability and social value in our communities.
- Evaluation by the University of Nottingham of the impact of Social Advice Prescribing Link Workers, which showed evidence of substantial financial gain among service users. For example, in Bulwell and Top Valley there was an estimated total annual gain of more than £380,000 for referred patients.
- Development of a food insecurity Joint Strategic Needs Assessment, which provided recommendations for local action and research, including the development of the Nottinghamshire Sustainable Food Plan.

[1] https://universitiesfornottingham.ac.uk/wp-content/uploads/2023/10/UfN_CivicAgreement_FINAL_Feb_2022.pdf.

- Continued provision of support to encourage young people, looked after children, care leavers and carers to consider working in health and care through work experience placements, support to job centres, school talks, and supporting career events.
- Partnership with the charity Become to provide a framework for onboarding care experienced young people and to provide training to raise awareness for staff.
- Delivery of national and local priorities and opportunities to reduce carbon emissions, as outlined in our ICS Green Plan. You can read more about our work in this area in the Our statutory duties section of this Annual Report, under 'Environmental matters'.

We have also participated in the initial stages of developing the East Midlands Combined County Authority Inclusive Growth Plan and will continue to engage with the Inclusive Growth Commission[2] in 2025/26 to consider how the NHS can contribute to the Plan as local anchor institutions.

Our strategies and plans

To make the best decisions for our population, we must understand the health and care needs of people living across Nottingham and Nottinghamshire. Joint Strategic Needs Assessments (JSNAs) provide the ICB with key information about the health and wellbeing of our local population. These demographics vary significantly between the City and County districts, including by age, by ethnicity, by disability, and by levels of deprivation. You can read more about the demographics and health needs of our population at https://www.nottinghaminsight.org.uk/ and https://www.nottinghamshireinsight.org.uk/.

The Nottingham and Nottinghamshire ICP has used this information, along with other evidence and data, to develop an Integrated Care Strategy to improve health and care outcomes and experiences for local people. The Strategy covers health and social care and addresses the wider determinants of health and wellbeing. It is based on three guiding principles:

- Prevention is better than cure – by focusing on prevention, we can make sure we use our limited resources most efficiently and improve people's health and wellbeing. This can mean that people need less treatment, we can stop more serious illness and can stop diseases getting worse.
- Integration by default – local people have told us that they want joined up and seamless services. By making collaboration between all the workforce and teams the normal way of working, and by harnessing our resource and ingenuity, we can re-shape services to become more integrated, treating the 'whole person'.
- Equity in everything – the principle of equity recognises that not all people have equal health and care access, experience or indeed outcomes. The strategy sets out that for some people and communities more support and resource might be required to achieve similar outcomes to others.

In March 2025, the ICP approved a refreshed Integrated Care Strategy, which can be read in full here: https://healthandcarenotts.co.uk/integrated-care-strategy-2023-2027/. The Strategy builds on existing system strategies, including the Joint Local Health and Wellbeing Strategies for Nottingham[3] and Nottinghamshire[4], and sets out our system's priorities to improve life expectancy and healthy life expectancy and to reduce health inequalities for the people of Nottingham and Nottinghamshire.

The ICB and its five NHS Trust and NHS Foundation Trust partners (Sherwood Forest Hospitals NHS Foundation Trust, Nottingham University Hospitals NHS Trust, Nottinghamshire Healthcare NHS Foundation Trust, East Midlands Ambulance Services NHS Trust, and Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust) have developed a Joint Forward Plan that describes how the local NHS organisations will implement the NHS Mandate, tackle key issues and contribute to the delivery of the Integrated Care Strategy and the Joint Local Health and Wellbeing Strategies.

[2] The Inclusive Growth Commission - East Midlands Combined County Authority.
[3] https://www.nottinghamcity.gov.uk/media/gd0fxokf/nottingham-city-joint-health-and-wellbeing-strategy-2022-25.pdf.
[4] https://www.nottinghamshire.gov.uk/policy-library/38815/the-joint-health-and-wellbeing-strategy-for-2022-2026

Guided by the principles of prevention, integration and equity, the Plan focusses on four key areas:

- Reducing physical and mental illness and disease prevalence.
- Proactive management of long-term conditions and frailty.
- Improving navigation and flow to reduce emergency pressures in both mental and physical health settings.
- Timely access and early diagnosis for cancer and planned care.

You can read the latest iteration of the Joint Forward Plan, which was approved in March 2025, here: https://healthandcarenotts.co.uk/wp-content/uploads/2021/05/JFP-202526.pdf and you can read more about our key achievements in its delivery during 2024/25 in the Performance Analysis section of this Annual Report.

Our performance

Service delivery

Whilst we have maintained a robust and consistent focus on our performance this year through the mechanisms detailed in the Performance Analysis section of this Annual Report, it has been another challenging period for us in delivering against our national and local targets. Our focus has remained on delivering the ambitions as set out in our Integrated Care Strategy and Joint Forward Plan.

Urgent and emergency care services have been impacted by high levels of attendances in our Emergency Departments and high levels of patient acuity (severity of an illness or medical condition), leading to bed pressures through the hospital and longer waits in Emergency Departments. Despite this, early improvements are being seen with the implementation of schemes to avoid admission to hospital. In addition, ambulance handover performance has started to improve in-year with the implementation of a 45-minute handover process.

During the year, we have made good progress in making it easier for people to access GP appointments. We have also continued to tackle backlogs in waiting times for diagnostics tests and elective and cancer care, and while we have achieved significant reductions in these areas, we have been unable to meet our planned levels across all standards. However, we have consistently met the cancer faster diagnosis standard throughout the year.

We have also worked hard to improve access to mental health services, and we have exceeded our planned levels of access for children and young people and the national waiting time standard for talking therapies. We have also exceeded the national target for dementia diagnosis rates, and good progress is being made in the elimination of inappropriate adult acute out of area placements. However, further improvements in the quality and safety of services provided by Nottinghamshire Healthcare NHS Foundation Trust are still required.

Sustained progress has been made with supporting children and young people with learning difficulties and autism in the community, rather than needing to admit to inpatient services, and in ensuring timely access to annual health checks. However, we still have work to do to reduce the number of adults with learning difficulties and autism in inpatient settings.

Through the work of our Local Maternity and Neonatal System (LMNS) we have continued to make improvements to maternity and neonatal services, informed by the findings of the Independent Review of maternity services at Nottingham University Hospitals NHS Trust.

We continue to work closely with our health and social care partners to improve performance through implementation of robust recovery plans.

Financial performance

The ICB has a responsibility to manage our finances carefully to make sure we are able to deliver our everyday commitments, while securing the delivery of continuous improvements in the quality of services provided for our patients and citizens. It is therefore important that we have robust financial plans and deliver ongoing productivity and efficiency improvements.

The ICB achieved all its statutory financial duties for the reporting period, and you can read more about our financial and other key statutory duties in the Performance Analysis section of this Annual Report. For full details of our financial statements

please see the Annual Accounts section of this Annual Report.

Going concern

On 13 March 2025, the Government announced that NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. If services will continue to be provided in the public sector the financial statements should be prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2025, on a going concern basis.

Our principal risks

We have a clear and integrated approach to risk management, combined with defined ownership of risk at all levels within the organisation. Identifying and assessing risks at both strategic and operational levels is a well-embedded process within the ICB. Our Risk Management Policy clearly sets out how we identify, manage and monitor our strategic and operational risks in a consistent, systematic and co-ordinated manner. Operational risks arising from day-to-day activities are monitored through our Operational Risk Register and strategic risks are monitored via our Board Assurance Framework. Our operational risks can relate to challenges faced by both the ICB and those faced by the wider ICS.

The main risks identified and monitored through the Operational Risk Register during the reporting period, related to pressures on urgent and emergency care and primary care services, rising demand for mental health services, required improvements in the quality of mental health and maternity services, the need for better support for people with learning disabilities and autism, workforce challenges, financial pressures on the ICB and wider NHS system, barriers to digital transformation, and cybersecurity threats.

For more information on these risks and how we manage risk within the ICB and ICS, see the Governance statement section of this Annual Report.

Performance Analysis

This section of the report describes our performance measures in more detail and illustrates the level of delivery achieved during the reporting period. It also explains how we have discharged our key statutory duties.

How we measure our performance

We are required to report on key national health targets and performance standards, many of which are drawn from the NHS Constitution or are derived from national priorities. The responsibility for overseeing our performance in these areas sits with our Board, and routine reports are received at every meeting for this purpose, which cover all aspects of performance, including service delivery, quality, and finance. All Board papers are published on the 'Our Board' section of our website at https://notts.icb.nhs.uk.

The Board has established a Finance and Performance Committee to oversee the ICB's financial position and performance management framework; this includes scrutinising actions to address shortfalls in performance against national and local health targets and performance standards. A Quality and People Committee has also been established to ensure that the ICB is meeting its statutory requirements regarding continuous quality improvements and reducing heath inequalities to deliver improved health outcomes. You can read more about the work of these committees in the Governance statement section of this Annual Report.

We work in collaboration with NHS England to oversee local performance in line with the NHS Oversight Framework[5] (NOF), which reflects the ambitions of the NHS Long Term Plan, covering quality of care, access and outcomes; preventing ill-health and reducing inequalities; people; finance and use of resources; and leadership and capability. As at quarter 3 of 2024/25, NHS Nottingham and Nottinghamshire ICB was in segment 3 of the NOF due to the in-year financial position of the ICB and its NHS system partners, and the level of support required across a number of performance challenges. The ICB's quarter 4 position had yet to be confirmed by NHS England at the time of finalising this Annual Report.

NHS England has a statutory duty to undertake annual assessments of ICBs following the end of each reporting year. In undertaking this assessment, NHS England will consider how successfully the ICB has met its four core aims and delivered its system leadership role, while meeting its key statutory duties. The outcome of these assessments will be published by NHS England on its website at www.england.nhs.uk.

Performance review

2024/25 has been another challenging year with high demand for services from an increasingly older population with complex needs. Throughout the year we have worked hard with our ICS partners to deliver the ambitions we set out in our Joint Forward Plan and Integrated Care Strategy. Our focus has been on the three system strategic principles of promoting prevention, equity and integration to improve outcomes for people of Nottingham and Nottinghamshire. Partnership working has led to positive progress against these ambitions and has improved outcomes for patients in 2024/25.

The following sections set out our performance during the year in key service areas.

Primary care

We set ourselves an ambition of improving access to General Practices services as part of our Joint Forward Plan for 2024/25. We have progressed this through implementation of a Primary Care Access Improvement Plan, developed in response to NHS England's Delivery Plan for Recovering Access to Primary Care[6].

During the year, our focus has been on making it easier for people to contact a GP practice, with the aim of ensuring that everyone who needs an appointment gets one within two weeks, and those who contact their practice urgently are assessed

[5] https://www.england.nhs.uk/wp-content/uploads/2022/06/B1378_NHS-System-Oversight-Framework-22-23_260722.pdf.
[6] https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/.

the same or next day according to clinical need. The target for appointments offered in two weeks is 85%, and in Nottingham and Nottinghamshire during March 2025 we achieved 83.6%. Our performance against this standard has improved throughout the year. In addition, 67.2% of total appointments were held face to face, 42.2% were same day appointments, and 5.9% were next day appointments.

A range of initiatives have been undertaken during the year to deliver improved access to General Practice services:

- Our GP practices work together as part of Primary Care Networks (PCNs) to enable greater provision of proactive, personalised, coordinated and more integrated health and social care for people close to home. During 2024/25, our PCNs have continued to provide additional capacity for practices across Nottingham and Nottinghamshire, providing extra urgent same day appointments, supporting practices to be able to focus on chronic, complex patients.
- We have expanded patient self-referral routes across a range of services to offer patients more choice in how they access care, and to help prioritise GP appointments for issues that do need a GP. Self-referral services now include alcohol and drug use recovery services, carers support services, continence services, eye health services, falls services, talking therapies and emotional wellbeing services, musculoskeletal services, podiatry services, sexual health services, weight management services, and many more. This means that people can refer themselves for these key services without the need for a GP appointment. More details of our self-referral services are available on the 'Your Services' section of our website at https://notts.icb.nhs.uk.
- We have also expanded community pharmacy services to relieve pressure on General Practice by enabling patients with simpler conditions and requirements to be assessed and treated by pharmacists, including the ability to get certain prescription medications directly from a pharmacy, without a GP appointment. Our Pharmacy First service enables the supply of appropriate medicines for seven common conditions including earaches, sore throats, and urinary tract infections, and as of March 2025, 210 community pharmacies across Nottingham and Nottinghamshire (approximately 98%) were registered to provide the service, completing over 50,500 consultations between April 2024 and March 2025. Some community pharmacies also provide blood pressure services, and as of March 2025, 56,700 blood pressure checks had been undertaken across the 202 pharmacies offering these services. In addition, 199 community pharmacies provided oral contraception services (both initiation and continuation of oral contraception) and have delivered over 11,000 consultations which continues to increase. During 2024/25, four community pharmacy independent prescribing pathfinder sites were also launched, and so far, they have seen over 800 people for on the day illnesses, which resulted in these patients not requiring a GP appointment.
- We have made significant progress in modernising General Practice which we committed to in our 2024/25 Joint Forward Plan. All practices now have an online consultation tool in place and are at various stages in enabling patients to have access to both administrative requests (for example, a repeat prescription request) and medical requests (for example, asking for an appointment). Over the past 12 months, online consultations have increased with around 42,000 taking place monthly. We continue to be national leaders in the roll-out of the NHS App and Patient Engagement Portal. 58% of the Nottingham and Nottinghamshire population are now accessing the NHS App, resulting in over 115,000 repeat prescriptions ordered monthly, saving an estimated 30 seconds per order.

We have also focused during the year on increasing dental activity by implementing a plan to recover and reform NHS dentistry towards pre-pandemic levels. Performance for 2024/25 has improved for both adults and children's provision. As of March 2025, we have delivered 5.56% more units of dental activity in Nottingham and Nottinghamshire during 2024/25 than 2023/24.

As we look forward to 2025/26, we will continue to deliver improvements in primary care access in line with our system-wide plans.

Urgent and emergency care

The national four-hour waiting time standard requires that 76% of patients are admitted, transferred, or discharged within four hours of their arrival at an Emergency Department. In Nottingham and Nottinghamshire, we have been consistently below this target throughout the year, with performance at 63.9% as at March 2025 (this represents the combined performance of Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS Foundation Trust).

During 2024/25, we have seen patients waiting over 12 hours within an Emergency Department following a decision being made that they require admission into a hospital setting. While a zero tolerance for this remains, a recovery target of this impacting no more than 2% of Emergency Department attendances has been in place for the year. Performance has been variable during the year with levels generally exceeding the 2% target. The position for March 2025 was 9.9%. Harm reviews and thematic reviews are undertaken for all affected patients.

There are many factors that have impacted our performance against these standards, including an increased number of attendances at our Emergency Departments and high levels of patient acuity (severity of an illness or medical condition). We are working hard on our recovery plans to improve performance and are committed to reducing waiting times. Our focus is on reducing unnecessary admissions through Same Day Emergency Care (SDEC), improving patient flow through our hospitals, and reducing the number of medically fit to discharge patients in our hospitals. As per the commitment in our 2024/25 Joint Forward Plan, we have also introduced an Urgent Treatment Centre (UTC) at Nottingham University Hospitals NHS Trust on its Queens Medical Centre site. The UTC is managing 120 patients per day, which moves patients away from the Emergency Department.

Another ambition in our Joint Forward Plan was to improve discharge pathways and processes at our local hospitals, and as a result, we have expanded the number of patients that we can take to our discharge lounges. These are designated areas for patients to wait for their medication or transport when they are medically fit to leave the hospital, which releases hospital beds for patients that need them. Where appropriate, we have also ensured there is effective use of our virtual ward capacity. Virtual wards (also known as hospital at home) allow patients to get the care they need at home, safely and conveniently, rather than being in hospital. As of March 2025, 198 patients were utilising virtual wards, which is 90.4% of our total virtual ward capacity. This provides monitoring and support to people in the place they call home across Nottingham and Nottinghamshire.

Ambulance handover performance continues to be a challenge, although improvements have been seen following the implementation of the 45-minute handover protocol at Nottingham University Hospitals in December. This is a policy where ambulances are expected to handover patients to Emergency Departments within 45 minutes, allowing them to return to the community and respond to other emergencies. This has improved Category 2 (emergency calls) ambulance performance in Nottinghamshire and driven a reduction in lost hours through ambulances waiting to handover patients. Weekly meetings are taking place with a focus on improving ambulance handover performance.

A priority in our 2024/25 Joint Forward Plan was to introduce an urgent care coordination hub, which we have achieved in year. This is a service where health professionals identify how patient needs can be met in the community, avoiding people having to go to hospital. The hub receives an average of 290 calls per week, of which 61% are managed without an emergency response.

Diagnostics and elective care

Our focus this year has continued to be on tackling the Covid-19 related backlog of elective care and on improving diagnostic activity levels and waiting times to support this. During the year, we have significantly reduced the number of patients waiting for 78 weeks or more for treatment, and the number of patients waiting for 65 weeks or more have continued to decline. As of March 2025, we have achieved the standard of having zero patients waiting 78 weeks or more. However, we

had 83 patients waiting 65 weeks or more for treatment (against a plan of zero by March 2025). Focus remains on driving improvements against these standards and to reach zero patients waiting above 65 weeks.

Our system-wide Elective Hub continues to review the current waits of patients across our local NHS Trusts as well as independent sector providers, which was a priority area for us in our 2024/25 Joint Forward Plan. The aim is to ensure equity of waits and that patients are assessed based on clinical need and prioritisation, and that capacity and resources are aligned through mutual aid, as required.

The pandemic had a significant impact on diagnostic services in terms of reduced capacity and throughput, leading to a large increase in waiting times and backlogs. Nationally, there was an ambition to increase the percentage of patients receiving a diagnostic test within six weeks to 95% by March 2025. We have not been able to achieve this standard during the year; however, the position is improving, and good progress is being made. As of March 2025, we achieved 81.7%.

Our Community Diagnostic Centres in Mansfield and Nottingham City will be key to delivering long term sustainable reductions in waiting times for patients. This was a key development area for us in our 2024/25 Joint Forward Plan. The facility in Mansfield will open during 2025 and Nottingham City in 2026. While we wait for these new facilities to be built, we have established temporary and mobile diagnostic capacity to help address our backlog and we have plans in place to improve performance.

Cancer care

The cancer faster diagnosis standard was introduced to ensure patients who are referred for suspected cancer receive a timely diagnosis. Reducing the time between referral and diagnosis means that treatment can begin as soon as possible for patients who are diagnosed with cancer, and patients who do not have cancer can have their minds put at rest more quickly. The faster diagnosis standard requires that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days. Across Nottingham and Nottinghamshire, we have consistently met this standard throughout 2024/25, with performance at 79.4% as of March 2025.

The faster diagnosis standard works alongside delivery of the referral to treatment cancer waiting time standards. During 2024/25, we have been focused on reducing the backlog of people waiting over 62 days for treatment, and while the backlog is reducing gradually, this remains above the planned level. The backlog position as of March 2025 was 362 patients against a plan of 283 (this represents the combined performance of Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS Foundation Trust). Weekly meetings are held with both Trusts to monitor the backlog position, including consideration of mutual aid where possible and utilisation of independent sector capacity where appropriate. Improvement plans for the most challenged tumour sites have been developed and we plan to deliver 62-day waiting time performance at 75% by March 2026.

Lung cancer causes more deaths than any other cancer in the UK. There are often no signs or symptoms of lung cancer at an early stage, which often leads to late-stage diagnosis and poorer outcomes for patients. In Nottingham and Nottinghamshire, we have been part of the national Lung Health Check programme since April 2021; this aims to find lung cancer early, sometimes before symptoms are experienced, as early diagnosis can make lung cancer more treatable and make treatment more successful. We have achieved the ambition we set out in our 2024/25 Joint Forward Plan to expand our Targeted Lung Health Check programme across Nottingham City, building on the success of the programme in Mansfield and Ashfield, where lung health checks have contributed to a positive stage shift in lung cancer diagnosis (a reduction in stage four diagnosis and an increase in stage one diagnosis). Most lung cancers are caused by smoking, so areas have been prioritised for expansion based on smoking rates and lung cancer mortality rates, with the aim of reducing health inequalities for our population. People living in these areas who are aged between 55 and 74 and who have ever smoked have been invited to have a lung health check. Locally we have improved early diagnosis rates to 61% which is above the national average and the highest in the

Midlands. Further expansion is planned during 2025/26.

A new pancreatic cancer surveillance project has also been established to support our plans to improve early cancer diagnosis rates. It will target patients with new onset diabetes diagnosis and unexpected weight loss, fast tracking them to receive a CT scan. The aim is to improve the very low early diagnosis rates for pancreatic cancer and therefore survival rates.

Maternity and neonatal care

Work has continued this year to make progress against the national maternity and neonatal three-year delivery plan[7], with a strong local focus on equity, safety and personalisation. This work remains particularly important for us in Nottingham and Nottinghamshire, given the ongoing Independent Review led by Donna Ockendon into maternity services at Nottingham University Hospitals NHS Trust.

Through collaboration with maternity and neonatal providers, service users, and system partners, we have delivered targeted interventions to improve maternal and neonatal outcomes and experiences, particularly for those from our most disadvantaged communities. Health inequalities relating to ethnicity, deprivation and access to services continue to significantly impact outcomes, and addressing these inequalities remains central to our Local Maternity and Neonatal System (LMNS) projects.

In response to the national priority to ensure the voices of women and families are embedded in service design and delivery, our Maternity and Neonatal Voices Partnership has been strengthened this year and is now a well-established presence across both Trusts, integrated into established safety and governance structures and shaping ongoing improvement work.

There have been significant service developments this year, which we committed to in our 24/25 Joint Forward Plan. These include:

- The introduction of a system-wide bereavement counselling service pilot at both Nottingham University Hospitals NHS Trust (NUH) and Sherwood Forest Hospitals NHS Foundation Trust (SFH) to offer a more equitable experience to families following loss. The pilot will be regularly evaluated by the LMNS to determine the future service model.
- A 'Whose Shoes' engagement workshop informed the development of an equity improvement plan and led to a new social prescribing pilot to support pregnant people from communities facing the greatest barriers to accessing care. A cultural competency training programme has also been implemented across both Trusts.
- The use of digital tools has progressed with the CardMedic pilot, designed to improve communication between staff and patients with language or cognitive barriers, showing early benefits, particularly in triage settings. In addition, the BadgerNet digital maternity system is now in place across both Trusts, supporting continuity of care and improved data capture. Work has also continued to further develop the LMNS dashboard, which will include health inequalities filters in addition to current quality metrics.
- Both Trusts are continuing work towards full compliance with the requirements of the Saving Babies Lives Care Bundle[8], which provides evidence-based best practice for providers and commissioners of maternity care across England to reduce perinatal mortality. Current compliance is at 9% (SFH) and 87% (NUH). Both Trusts have also achieved full compliance with the safety actions set out in the NHS Resolution Maternity Incentive Scheme (MIS)[9] to continue to support the delivery of safer maternity care.
- New service developments, including preterm optimisation clinics and a perinatal pelvic health service, are progressing with dedicated leadership in place and evaluations planned.

In addition, the LMNS has supported the upskilling of maternity support workers through funded

[7] https://www.england.nhs.uk/publication/three-year-delivery-plan-for-maternity-and-neonatal-services/
[8] https://www.england.nhs.uk/publication/saving-babies-lives-version-three/
[9] https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

secondments and apprenticeships, helping to strengthen the maternity workforce and laying the foundations for sustainable models of care.

Whilst much progress has been made, we remain committed to the delivery of high quality, safe and equitable maternity and neonatal care. We will continue to act on feedback from service users, local intelligence and learning from the Independent Review.

Mental health services

During the year, we have worked to improve access to mental health services, including access to perinatal mental health services and access to mental health support for children and young people.

Performance in Nottingham and Nottinghamshire during March 2025 is 9.7% which is below the target of 10% for access to perinatal services; however, actions are being taken to increase the number of women accessing the service through a wider communication campaign and the use of alternative venues for service delivery across Nottingham and Nottinghamshire.

As of March 2025, 20,810 children and young people were recorded as having at least one contact with mental health services in the preceding 12 month period, exceeding our plan of 20,000. During 2024/25, we have also increased our mental health support for children and young people, which was an ambition in our 2024/25 Joint Forward Plan. All secondary schools and colleges and 70% of primary schools in Nottingham City now have a mental health support team in place, with 79% and 40% respectively in Nottinghamshire County. The number of support teams will increase in 2025/26, with 100% coverage across all educational settings expected by 2029/30. We have also introduced an initiative in Bassetlaw in response to increased waiting times for children and young people to access mental health services. A toolkit has been developed with engaging activities and links to videos that can be used by all young people in a way to support positive mental health, wellbeing and preventing illness.

Getting a dementia diagnosis is key to unlocking access to personalised care and support, as well as accessing treatments that can help to control symptoms; however, around 40% of those aged 65 or over thought to be living with dementia do not have a diagnosis. During 2024/25, we have focused on recovery of our dementia diagnosis rates, and as of March 2025, we have achieved 70.1%, which is in excess of the national target of 66.7%.

People with a Severe Mental Illness (SMI) such as schizophrenia, bipolar or other psychoses, often experience poor physical health and undiagnosed/untreated physical health conditions because of the focus on their mental health needs. During 2024/25, we have continued to support people with a SMI to receive a physical health check, and we have exceeded our target of 60% throughout the year.

Talking therapies, or psychological therapies, are effective treatments to support people struggling with feelings of depression, excessive worry, social anxiety or post-traumatic stress disorder (PTSD). Examples of talking therapies include guided self-help, cognitive behavioural therapy (CBT) and counselling. During 2024/25, we have aimed to increase the number of adults and older adults accessing talking therapies, and as of March 2025 there were 1,735 people that had completed talking therapies treatment against a plan of 1,282. During the year, our talking therapies provider has implemented a marketing and engagement plan to increase awareness and referrals into the service. The service continues to achieve and exceed the national waiting time standards, with performance as of March 2025 at 97% against the 75% six-week standard and 100% against the 95% 18-week standard. The 50% recovery standard has also been achieved at 50.6%.

During 2024/25, we have also been working towards eliminating inappropriate adult acute out of area placements. An ‘out of area placement’ for acute mental health inpatient care happens when a person with assessed acute mental health needs who requires adult mental health acute inpatient care, is admitted to a unit that does not form part of their usual local network of services. By this, we mean an inpatient unit that does not usually admit people living in the catchment of the person’s local community mental health service and where the person cannot be visited regularly by their care co-ordinator to ensure continuity of care and effective discharge planning. Patients should be treated in a location that helps them to retain the contact they

want to maintain with family, carers, and friends, and to feel as familiar as possible with the local environment. In Nottingham and Nottinghamshire, the volume of inappropriate out of area beds has significantly reduced throughout 2024/25, with only three patients in out of area placements as of March 2025.

Work remains ongoing to eliminate out of area placements in 2025/26 and we have also developed an Integrated Mental Health Pathway Strategic Plan[10], which we identified as a priority area for focus in our 2024/25 Joint Forward Plan. This aims to localise and realign mental health inpatient services over a three-year period to ensure the right care is being delivered, in the right place, at the right time, and in the least restrictive environment. The Plan has been co-developed with local partners across the NHS, Local Authorities and the Voluntary, Community and Social Enterprise (VCSE) sector, as well as with people with lived experience. We will focus our work together to deliver the Plan over the next three years.

During 2024/25 we have also taken action to improve people's experience and involvement in their care and treatment. We have held three carer, friends and family events to listen and hear their experiences to support and aid wider pathway improvements. As part of our commitment to delivering person-centred care, Nottingham and Nottinghamshire ICB has implemented the national Right Care, Right Person (RCRP) initiative, which aims to ensure individuals experiencing mental health needs receive timely and appropriate support from trained health professionals. The local roll-out went live in February 2025, supported by multi-agency training and strong cross-sector collaboration. This approach reduces inappropriate police involvement in mental health incidents and ensures that care is delivered by the right professionals, in the right setting, at the right time.

Services for people with a learning disability and autistic people

People with a learning disability often have poorer physical and mental health than other people, and on average, people with a learning disability will die 20 years earlier than the general population. The completion of annual health checks can improve people's health by spotting problems earlier, in turn reducing the health inequalities that this group of people face. For 2024/25, we were set a target of ensuring that 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by year-end. We have performed well in this area and have exceeded our target for the year, achieving 82% by March 2025.

During the year, we have also continued to focus on reducing the number of autistic people and those with learning disabilities in inpatient settings and on improving community-based services. For 2024/25, we were set targets of no more than 32 adults and no more than three children and young people (under 18s) being cared for in an inpatient unit by March 2025. As of March 2025, we have achieved our target for children and young people; however, we have ended the year in excess of our target for adults, having 41 adult inpatients. While we still have more to do to address this, we have been successful in reducing inpatient admissions from the community compared to previous years. This is mainly due to the embedding of key services and specialist roles to support people effectively within the community, and through successful implementation of the Dynamic Support Register (DSR), which identifies people at imminent risk of admission into adult services. In addition, oversight panels are in place to expedite discharges with partners. We will continue to prioritise our efforts to progress discharges from adult inpatient settings using a whole system escalation tool, which ensures appropriate oversight by senior leaders to remove barriers and agree next steps.

The ICB has a dedicated team that is responsible for coordinating a programme of work to learn from the lives and deaths of people with learning disabilities and autism (the LeDeR programme is a national initiative that aims to improve care for people with learning disabilities and autism). This has improved communication with key system colleagues to ensure that LeDeR themes are captured and acted upon. We publish an annual report each year setting out the progress and

[10] https://notts.icb.nhs.uk/wp-content/uploads/sites/2/2024/07/Nottingham-and-Nottinghamshire-ICS-3-Year-Mental-Health-Strategic-Plan.pdf.

impact of the LeDeR programme in Nottingham and Nottinghamshire, highlighting key achievements and areas where further improvement and development is needed. The reports are available in the 'Safeguarding' section of our website at https://notts.icb.nhs.uk.

During 2024/25, we have designed and implemented a series of Learning Disability Health and Wellbeing Roadshows, aimed at improving the outcomes and experiences of people with learning disabilities. The roadshows provided a safe space for people with learning disabilities to have their voices heard and to share experiences about what matters to them.

We have also rolled out the Oliver McGowan Mandatory Training on learning disability and autism, which aims to save lives by ensuring the health and social care workforce have the right skills and knowledge to provide safe, compassionate and informed care to autistic people and people with a learning disability. Whilst this has continued to be a pilot during 2024/25, plans to increase the roll out are in place, supported by local and national evaluations that will focus on the impact and local outcomes. Locally, we have not achieved the performance standards for the Oliver McGowan training during 2024/25; however, levels are increasing steadily, and discussions are ongoing to roll out the training on a business as usual basis.

Preventative care and management of long-term conditions

Effective preventative care and long-term condition management is fundamental to improving the health outcomes for our population. It is also critical in helping to address the increasing demands on our health and social care services by preventing illness and disease.

As part of our 2024/25 Joint Forward Plan, we committed to enhancing our preventative care and long-term conditions management. As a result, we have focused our work in the following areas during the year:

- We have been embedding our Making Every Contact Count (MECC) approach to ensure that opportunities for prevention are maximised. This involves using day-to-day interactions that organisations and individuals have with patients to support them to make positive changes in relation to their physical and mental health and wellbeing. We have developed a MECC training framework in collaboration with system partners, which will be rolled out to health and care staff, and our ambition is for 90% of frontline staff to have completed the MECC training by the end of March 2028.
- We have implemented NHS smoking cessation services across in-patient, acute, and mental health services, and we have introduced an NHS staff smoking cessation programme. As part of our lung health checks programme, we have also co-located a stop smoking advisor on the lung health check mobile unit, in support of our approach to MECC.
- We have increased uptake of the Digital Weight Management Programme and the Low-Calorie Diet to better support adults living with obesity who also have a diagnosis of diabetes, to manage their weight and improve their health.
- We have piloted an Alcohol Care Team at Nottingham University Hospitals NHS Trust and extended alcohol services at Sherwood Forest Hospitals NHS Foundation Trust to better support patients and their families who are experiencing harm as a result of alcohol use disorders.
- We have increased blood pressure checks and piloted an approach to better screen, diagnose and manage people with hypertension.
- We have increased skill levels in relation to diabetes care in primary care, implemented continuous glucose monitoring and increased uptake of the Diabetes Prevention Programme. We have also supported high risk individuals through our perioperative programme and seen a reduction in waiting times and length of stay due to improved diabetes management.
- We have focused on increasing spirometry testing so that individuals are supported with earlier and accurate diagnosis for respiratory disease. We have also worked to increase access to pulmonary rehabilitation and have seen an increase in referral and completion rates. We have increased the number of winter health checks to support high-risk chronic obstructive pulmonary disease (COPD) patients who are at risk of hospital admission, and self-

management plans have now been put in place for 47.6% of these patients, which is an increase on the previous year.

- During the winter months we offered COVID, flu and RSV (respiratory syncytial virus) vaccinations, to keep those most at risk from being unwell protected over the winter months. The COVID and flu vaccinations are offered every winter to those most at risk and we have rolled out the RSV vaccination for pregnant women over 28 weeks and those aged 75-79 years of age.
- We have continued to focus on increasing the uptake of our screening programmes. Targeted work through one Primary Care Network as part of the Women's Health Hub project increased breast screening uptake for women with Severe Mental Illness from 35% to 64% and overall cervical screening uptake has increased by 20%.
- We have introduced 'Best Years Hubs' as a new pilot ageing well service for residents of Newark and Sherwood, which we committed to delivering in our 2024/25 Joint Forward Plan. The service addresses frailty, social isolation and access to health services in a community setting, to ensure that healthcare is more accessible, patient-centred and preventative. The Hubs are delivered and supported by an integrated team of professionals and volunteers working across health, social care, local authority, community, and voluntary sectors. Volunteers will also help increase Advanced Care Planning so that every patient has a chance to discuss what matters to them.
- Through our 'Best Start in Life' schemes we have made a key achievement in 2024/25 focused on improving the health and development outcomes of children and young people. During the year, we have expanded our Family Mentor Programme to deprived areas in Nottingham City and have committed to supporting up to 327 babies over three years. The programme aims to provide an intensive, personalised home visiting programme designed to support with communication and language, social and emotional development and nutrition. Through the Tier 2 Plus Children and Young People's Obesity Service, which provides intensive support to reduce childhood obesity across Nottinghamshire, we have also supported 80% of participants to maintain or reduce their Body Mass Index (BMI). Clinics have been held in high-need areas, with 43% of participants having learning disabilities. In addition, we have fully vaccinated 89 children in Nottingham City who displayed vaccine hesitancy, this has been achieved through targeted outreach and education efforts to families.

Safeguarding children and young people

The ICB is committed to safeguarding the wellbeing of children, young people and adults who access the services we commission. Whilst we have our own distinct role regarding safeguarding, we also recognise that for the system to work most effectively, organisations and individuals need to work together to achieve our collective responsibilities. This is achieved by working in close partnership with our partner agencies and our commissioned services to continuously improve systems and processes.

We are partners to both the Nottingham City Safeguarding Children Partnership and the Nottinghamshire Safeguarding Children Partnership; statutory partnerships established to ensure the safeguarding arrangements under which the safeguarding partners (which also include the respective councils and the Nottinghamshire Police) and relevant agencies work together to provide the safeguarding arrangements required under the legislation[11]. The strategic aims of the ICB align closely with both partnerships' safeguarding priorities and the most recent annual reports for each partnership are published on the Nottingham City Council[12] and Nottinghamshire County Council[13] websites.

The Partnership arrangements are underpinned by a number of system safeguarding groups, which support established multi-agency working arrangements and strengthen our information-

[11] www.gov.uk/government/publications/working-together-to-safeguard-children.
[12] https://www.nottinghamcity.gov.uk/information-for-residents/children-and-families/safeguarding/safeguarding-children-partnership/about-nottingham-city-safeguarding-children-partnership/.
[13] https://nscp.nottinghamshire.gov.uk/about-the-partnership/.

sharing, oversight and assurance processes. The ICB's Safeguarding Team continues to be engaged in and participant in all child safeguarding practice rapid reviews and local child safeguarding practice reviews. In addition, national reports are reviewed in the Safeguarding Children Partnership meetings. The Nottingham and Nottinghamshire Child Death Overview Panel meets monthly to review the child death cases across the system. In 2024/25, there have been 64 child deaths with the highest number of deaths being reported as perinatal/neonatal events. There were 81 deaths reviewed in year.

There continues to be proactive involvement in workstreams to promote and gain assurance for the safeguarding of children and young people who reside in our system. We committed to prioritising safeguarding in our 2024/25 Joint Forward Plan and have achieved the following:

- Reviewing Section 47 and Multi-Agency Safeguarding Hub (MASH) processes to strengthen coordination.
- Improving care pathways for looked after children and care leavers.
- Developing integrated safeguarding responses for unaccompanied asylum seeking children.
- Supporting implementation of the Child Protection Information System (CPIS) across GP practices.
- Promoting system-wide implementation of the Female Genital Mutilation Information Sharing System (FGMIS).
- Auditing and improving the response to children as victims of domestic abuse.
- Embedding the Voice of the Child in all safeguarding activities through implementation of the Child Voice Strategy.

The ICB continues to embed the Voice of the Child across all safeguarding workstreams. A partnership response to reviewing and improving the care offers to children in care has been integral to the work delivered by the Designated Nurse for Looked After Children.

The ICB is also responsible for ensuring that our statutory responsibilities to safeguard and promote the welfare of children are embedded in the services that we commission and that providers work within the national and local legislation and guidance. Our Safeguarding Policy describes how the ICB discharges its safeguarding responsibilities for commissioning health services and is available on the 'Our Policies and Procedures' section of our website at https://notts.icb.nhs.uk/.

We use a range of self-assessment tools to ensure that ICB-commissioned services have robust safeguarding arrangements in place. These tools enable us to gain assurance from our commissioned services that they are fulfilling their requirements in line with Section 11 of the Children Act (2004) and the NHS England Safeguarding Children, Young People and Adults at Risk in the NHS; Safeguarding Accountability and Assurance Framework (2022).

In addition, the ICB's Safeguarding Team, which consists of nurses and doctors, provides expert advice and support to a broad range of health professionals. The team is proactive in implementing national and local guidance, directives and learning from reviews to continually improve our services. The ICB follows the statutory assurance processes set out in the Safeguarding Accountability and Assurance Framework and has met the duties set out in 'Working Together to Safeguard Children'. This is reflected in our joint annual reports and the ICB's business plans. Further information is available on the 'Safeguarding' section of our website at https://notts.icb.nhs.uk.

Financial review

The ICB has a responsibility to carefully manage the NHS funding it is allocated. This includes making sure we can deliver on our everyday commitments as well as investing to improve the quality of services provided to our patients and citizens. Many factors influence our ability to spend and manage within the financial allocations provided to us. These include factors associated with our national economy, unexpected increases in demand for local health services as well as projects taking longer than planned.

The ICB is statutorily required to deliver key financial targets including an income and expenditure target. This duty, to ensure the ICB's spend does not exceed the monies it receives, has continued to be challenging in 2024/25, requiring

delivery of a savings plan of £68.5 million. This required savings in areas that have seen significant growth, such as continuing healthcare and prescribing costs, ensuring the most appropriate and cost effective care is being provided. As a result, the ICB delivered £72.0 million savings against plan and delivered its statutory target.

We are also required to meet any joint financial objectives set for us and our NHS Trust and NHS Foundation Trust partners by NHS England. For financial apportionment purposes these partners are Sherwood Forest Hospitals NHS Foundation Trust, Nottinghamshire Healthcare NHS Foundation Trust and Nottingham University Hospitals NHS Trust, and our joint financial objective is to achieve a breakeven position across our NHS system at year-end. For 2024/25, the ICB and our NHS system partners agreed a financial plan to deliver a breakeven position against our collective system financial allocation. This required an overall savings target for the system of £257 million (including the ICB's savings plan). Despite this challenging target, the Nottingham and Nottinghamshire system delivered an overall breakeven position for 2024/25. The NHS system has worked collaboratively to deliver this position, introducing additional system-wide monitoring and control mechanisms, including the implementation of a national investigation and intervention programme early in the year to review the system's arrangements and to explore further productivity and efficiency opportunities.

To further support this collaborative work, NHS England provided £100 million of non-recurrent deficit support funding to the system during the financial year. This funding, in conjunction with the savings plan delivery, has helped mitigate in year financial pressures. £17.8 million was retained by the ICB and the balance distributed to our NHS system partners.

The following tables set out the ICB and wider NHS system financial performance for the reporting period, including an analysis of the ICB's total expenditure.

Table 1: Financial performance

Duty	Target (£000)	Actual (£000)
Income and expenditure (ICB): Expenditure not to exceed income	Breakeven	13 surplus
Income and expenditure (NHS system): Expenditure not to exceed income	Breakeven	101 surplus
Cash balance (ICB): Remain below allowed cash balance	3,155	13
Running costs (ICB): Remain within running cost allowance	22,487	20,980

Table 2: Analysis of total ICB spend

Category of expenditure	Total spend (£000)
Acute (hospital) care	1,533,362
Specialised acute (hospital) care	277,676
Community care	303,113
Mental health care	294,450
Primary care	398,843
Prescribing	205,729
Continuing care	175,904
Other non-healthcare	36,381
Corporate running costs	20,980
Total	**3,246,438**

Table 3: Better payment practice code (ICB)

Duty	Target (%)	Actual (%)
Pay NHS invoices by value within 30 days	95.00%	99.98%
Pay NHS invoices by number within 30 days	95.00%	99.64%
Pay non-NHS invoices by value within 30 days	95.00%	99.74%
Pay non-NHS invoices by number within 30 days	95.00%	99.91%

Full details of our financial statements, including our Balance Sheet position, can be found in the Annual Accounts section of this Annual Report.

Mental Health Investment Standard

The Mental Health Investment Standard (MHIS), set by NHS England, requires all ICBs in England to increase their planned spending on mental health services by a greater proportion than their overall increase in budget allocation each year. The target is set based on the previous year's outturn expenditure on mental services, increased by the programme allocation growth percentage.

The table below sets out the amount and proportion of expenditure incurred in total for 2024/25 and 2023/24. The proportion of mental

health spend of overall funding has reduced due to the level of specific funding received to support financial delivery in 2024/25.

Financial years	2024/25 (£000)	2023/24 (£000)
MHIS Target	223,290	208,340
Mental Health Spend	223,495	208,774
ICB Programme Allocation	2,583,004	2,295,091
Mental Health Spend as a proportion of ICB Programme Allocation	8.65%	9.10%

The ICB is required to report on its compliance with the MHIS in the form of a statement of compliance signed by our Accountable Officer, which will be published when available on our website alongside this Annual Report.

Joint Capital Resource Use Plan

Each year, the ICB and our NHS Trust and Foundation Trust partners (Sherwood Forest Hospitals NHS Foundation Trust, Nottinghamshire Healthcare NHS Foundation Trust and Nottingham University Hospitals NHS Trust) are required to produce and publish a Joint Capital Resource Use Plan. The aim of the joint plan is to provide transparency for local residents, patients, NHS health workers and other NHS stakeholders on the prioritisation and expenditure of capital funding towards the achievement of our strategic aims.

In 2024/25, our NHS system had a capital allocation of £94.34 million, and actual capital expenditure for the year was £94.15 million, leading to a small underspend of £0.19 million.

Capital expenditure	Plan (£000)	Actual (£000)	Variance (£000)
Capital allocation (Trusts)	92.21	92.10	0.11
Capital allocation (ICB)	2.13	2.05	0.08
Total capital spend	**94.34**	**94.15**	**0.19**

Our in-year capital expenditure was primarily used to address operational priorities, such as equipment replacement, information technology upgrades, backlog maintenance, and minor General Practice premises improvements.

Our NHS system has also been successful in attracting £105.13 million additional national funding, which has been earmarked for major capital projects including:

- The development and building of the 70-bed National Rehabilitation Centre near Loughborough.
- An energy centre and energy efficient glazing at Queens Medical Centre.
- Community Diagnostics Centres in Mansfield and Nottingham City Centre.
- Critical infrastructure funded schemes at Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS Foundation Trust.
- Electronic Patient Records systems at Nottinghamshire Healthcare NHS Foundation Trust and Sherwood Forest Hospitals NHS Foundation Trust.

Our statutory duties

The responsibility for discharging our key statutory duties rests with the Board and, as such, we have established a robust reporting framework, which ensures that the appropriate assurances on the delivery of key duties are received in a timely manner. The Board has delegated oversight and scrutiny responsibilities for its key duties to its Audit and Risk Committee, Finance and Performance Committee, Quality and People Committee, and Strategic Planning and Integration Committee. The following sections focus specifically on how we are meeting some of these duties, and you can read more about the work of the Board's committees in the Governance statement section of this Annual Report.

Quality improvement

ICBs are legally required to exercise their functions with a view to securing continuous improvement in the quality of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness. We ensure that quality is at the heart of our functions, and organisations that we commission healthcare services from must meet essential standards of quality and safety as defined by the Care Quality Commission (CQC).

We promote and deliver continuous quality improvement through a range of mechanisms,

which include the completion of quality impact assessments as an essential requirement of the ICB's decision-making processes. We also have robust mechanisms in place to monitor quality standards, including the monitoring of information and data in relation to serious incidents, patient and staff feedback, infection prevention and control, safeguarding processes and clinical outcomes.

These mechanisms are strengthened further by wider intelligence gathering through established relationships across our Integrated Care System, and we work closely with our partners to ensure we have an effective system quality architecture in line with the National Quality Board's (NQB) guidance[14]. Our priority is to ensure that high-quality care is demonstrated through effective arrangements for quality oversight, quality assurance and risk response, with escalation as necessary. As such, we have developed robust arrangements within our system to ensure the appropriate level of oversight and improvement for services where quality standards are not being met, which includes regulatory involvement where the concerns are of a very serious or complex nature.

We recognise that there are services, care pathways and providers that have not met these required quality standards during the year, and as such, they have been escalated for 'enhanced surveillance' as detailed in NQB guidance[15] and defined in our own operating model. In these cases, we have worked with regulators, services and our system partners to put robust oversight and support arrangements in place.

During 2024/25, significant quality concerns have persisted across three key providers: Nottingham University Hospitals NHS Trust (NUH), Nottinghamshire Healthcare NHS Foundation Trust (NHT) and Nottingham CityCare Partnership.

NUH has been subject to continued scrutiny in relation to its maternity services, with CQC inspections in June and July 2024 identifying significant concerns[16] and an independent review following serious failings still ongoing[17]. There has also been increased oversight of the Trust's leadership and urgent care services through local and national improvement forums. The ICB remains committed to supporting the Trust through its regular quality visits and collaboration on improvement plans to ensure sustained improvement and safer care for families.

Robust oversight arrangements remain in place in relation to NHT, as a result of widespread quality and safety concerns raised in the previous reporting year. Following publication of the independent investigation report into the care and treatment provided to Valdo Calocane[18], we have worked with the Trust to produce a joint action plan that describes how the recommendations within the report will be delivered. The action plan can be found on our website at https://notts.icb.nhs.uk/about-us/quality/.

Nottingham CityCare Partnership remains under enhanced surveillance related to the quality of service delivery; however, there has been positive engagement with the ICB over the year and constructive conversations are ongoing, with contractual mechanisms being utilised effectively to support quality improvement.

Challenges also continue across Nottingham and Nottinghamshire in delivering timely and consistent support for children and young people with Special Educational Needs and Disabilities (SEND). Nottingham City, in particular, has seen a decline in statutory performance for Education, Health and Care (EHC) plans. The ICB is supporting recovery plans, as well as leading on health service improvements, and strengthening oversight through shared risk management and joint commissioning strategies. Improving health support for children in care also remains a priority and whilst health assessments for looked after children have improved this year, the ICB continues to contribute to capacity issues by supporting transition planning and broader system work to improve outcomes. You can read more about our main quality risks in the 'Governance Statement' section of this annual report.

During the year, we have made positive progress in embedding the Patient Safety Incident

[14] https://www.england.nhs.uk/publication/national-guidance-on-system-quality-groups/
[15] https://www.england.nhs.uk/publication/national-guidance-on-quality-risk-response-and-escalation-in-integrated-care-systems/
[16] CQC publishes reports on maternity services run by Nottingham University Hospitals NHS Trust - Care Quality Commission
[17] https://www.ockendenmaternityreview.org.uk/
[18] NHS England » Independent mental health homicide report into the treatment of Valdo Calocane

Response Framework[19] (PSIRF) within the ICB and continue to oversee its implementation across NHS system partners. We have published a Patient Safety Incident Response Plan (PSIRP), established internal governance routes for patient safety reporting, and ensured key staff, including our Patient Safety Specialists, have completed the mandatory requirement for level 3-4 of the National Patient Safety Syllabus. Two Patient Safety Partners have also been recruited to provide enhanced patient involvement and challenge within our governance arrangements for patient safety.

As part of our PSIRF oversight role, we have supported NHS system partners to meet the national deadline for PSIRF implementation and we continue to monitor improvement activity linked to incident data. We also lead on system-wide initiatives, such as falls prevention and wound care improvement and are currently strengthening our arrangements regarding data sharing and shared learning. All NHS partners are now in the process of refreshing their PSIRPs using year-one data, supported by the ICB's Quality Improvement Network. The ICB's PSIRF policy is published on our website at https://notts.icb.nhs.uk in the 'Our policies and procedures' section.

2024/25 has seen us continue our work with our partners to develop our ICS Quality Strategy, building upon our shared quality principles. The Strategy is aligned to both our Integrated Care Strategy and Joint Forward Plan and is due to be approved by our Board in July 2025.

Our executive lead for quality is the ICB's Director of Nursing, who has explicit responsibility for the following population groups:

- Children and young people (aged 0 to 25).
- Children and young people with special educational needs and disability (aged 0 to 25).
- Safeguarding (all-age).
- Learning disability and autism (all-age).
- Down syndrome (all-age).

This responsibility ensures visible and Board-level leadership for addressing issues facing these groups, and to ensure that statutory duties related to safeguarding and special educational needs and disabilities receive sufficient focus.

Working with people and communities

The ICB is responsible for commissioning (planning and buying) healthcare services that meet the needs of local people. To do this well, we have to ensure the voice of our citizens is central to what we do. By taking this approach we will understand what health challenges and opportunities are present in our communities and be able to commission services that will deliver the most benefit to our population.

We are committed to ensuring that the views of patients, carers, stakeholders, partner organisations and the wider community are represented in decisions about how services are proposed, planned, and delivered, and how they can be improved. Our system-wide strategies for Citizen Intelligence[20] and Coproduction[21], remain the foundation for our approach. These strategies guide how we collect, understand, and use the views and experiences of local people to inform decisions and drive service transformation.

To understand what matters to people and communities, we continue to work jointly with our system partners, including Nottingham City Council, Nottinghamshire County Council, the Voluntary, Community and Social Enterprise (VCSE) sector, and Healthwatch Nottingham and Nottinghamshire, through the following approaches:

- Targeted engagement and formal consultation where significant service changes are proposed.
- Patient participation groups and local community engagement, alongside ongoing engagement through our Citizens Panel.
- Co-production through our 'My Life Choices' strategic co-production group, ensuring proposals are shaped alongside people with lived experience.

[19] https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/
[20] https://healthandcarenotts.co.uk/wp-content/uploads/2021/05/Working-with-people-and-communities-strategy.pdf.
[21] https://notts.icb.nhs.uk/wp-content/uploads/sites/2/2022/04/Nottingham-and-Nottinghamshire-ICB-Coproduction-Strategy-2022-to-2024.pdf.

- Engagement with our VCSE Alliance, which includes representatives from various organisations across Nottingham and Nottinghamshire, with an aim to encourage partnership working and put the voice of people and communities at the heart of what we do.

Over the past year, our approach has enabled us to drive real change in how we plan and deliver services. We have developed a Citizen Insight Report[22], summarising citizen feedback and spotlighting key topics, such as cancer pathways and services for children, young people and families, which has also informed the recent refresh of our Integrated Care Strategy. The ICB has also:

- Led targeted engagement to support system-wide delivery of the Targeted Lung Health Checks (TLHC) programme, working in partnership with local charities, councils and community groups. This included providing translated and easy-read materials and drop-in clinics for those experiencing severe disadvantage. The programme reached over 57,000 people and achieved the highest national uptake rate.
- Participated in testing the Care Quality Commission Framework, as one of four pilot sites engaged to help refine the draft model. Reviews of local children's speech and language services and the NottAlone website[23] offered insights as to how the framework could be used to drive equity and quality improvement.
- Worked with other regional ICBs in co-developing a fertility policy, which included a regional fertility policy listening exercise, engaging over 2,000 people across the East Midlands.
- Strengthened our approach to citizen intelligence by launching the Nottingham and Nottinghamshire Insights Hub, a shared online library supporting collaboration and reducing duplication.
- Expanded our Citizens Panel into Mid-Nottinghamshire, South Nottinghamshire and Bassetlaw, with the aim of achieving our target of 1,000 members across Nottingham and Nottinghamshire. The Panel supports ongoing engagement and provides a demographically representative platform for public insight. Panel findings are shaping service areas such as urgent and emergency care and the Newark Urgent Treatment Centre.

Our coproduction work has also continued to grow this year, with the launch of a bi-monthly Coproduction Newsletter, supporting connection, learning and visibility of coproduction work across the system, and through the delivery of coproduction training. We have also developed a new interactive coproduction toolkit, co-designed with people with lived experience. Work is currently underway to refresh our Coproduction Strategy, and through listening events and collaboration with lived experience partners, we are identifying the next phase of coproduction priorities. Themes include building trust, increasing diversity of voices, and simplifying access to involvement opportunities. The refreshed Strategy is due for completion in early 2025/26 and will be made available on our website once finalised.

Every year we produce an Annual Working with People and Communities Report to fully describe the work we have done over the last year in more detail. These reports are available on the 'Get Involved' section of our website at https://notts.icb.nhs.uk.

Reducing health inequalities

Health inequalities are defined as unfair and avoidable differences in health across the population, and between different groups within society. A person's chance of enjoying good health and a longer life is determined by the social and economic conditions in which they are born, grow, work, live and age. These conditions also affect the way in which people look after their own health and access services. Nationally, addressing health inequalities is a recognised factor in addressing the prevention of avoidable illness and in improving overall experience and health outcomes.

ICBs are statutorily required to have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved. This means that health inequalities must

[22] https://healthandcarenotts.co.uk/about-us/our-integrated-care-partnership/.
[23] https://nottalone.org.uk/.

be properly considered when we make commissioning decisions for our population. We do this by ensuring that the consideration of inequalities is firmly embedded within our strategic plans and key business activities, examples of which include:

- Ensuring our plans and strategies are in line with the needs of the local population.
- Ensuring our framework for generating citizen intelligence is fully inclusive; working with local forums that enable us to hear from those who are experiencing the greatest health inequalities.
- Following a clear decision-making framework to ensure that investment, disinvestment and service change decisions are made following a reasonable evaluation of available evidence. This includes an assessment of the health requirements of local communities.
- Ensuring that proposals to change or remove a service, policy or function clearly demonstrate the impact on reducing health inequalities.
- Ensuring appropriate oversight and scrutiny of our arrangements to tackle health inequalities and improve health outcomes through the ICB's Board and committee structure.

Health equity – the ability for all individuals to attain their full potential for health and wellbeing – is a core principle of our Integrated Care Strategy. This commitment is embedded across our system and reflected in our NHS Joint Forward Plan, where we continue to drive improvements in equitable access and inclusive care. You can read more about these strategies in the 'Our strategies and Plans' section of this Annual Report.

Our work is supported by the ICB's Strategic Analytics and Intelligence Unit (SAIU), which provides the data and analytical insight needed to identify at-risk groups, monitor disparities, and target action. We routinely report to our Board and its Quality and People Committee through a schedule of thematic reviews aligned to the Core20PLUS5 framework, population health management reporting, and updates on avoidable mortality.

Avoidable mortality is a key system indicator in our ICS Outcomes Framework, closely linked to health inequalities. Data shows that avoidable deaths – those that could be prevented or treated with timely, effective interventions – account for a significant proportion of the life expectancy gap in our area. The causes most associated with avoidable premature deaths locally include cardiovascular disease, cancer, respiratory illness, substance-related conditions and injury. These causes are more prevalent in areas of deprivation and among certain population groups, particularly in Nottingham City. By focusing on prevention, early intervention and equitable access to treatment, we aim to reduce avoidable deaths and narrow the gap in life expectancy between the most and least advantaged communities.

As part of annual reporting requirements, ICBs are required to publish a statement demonstrating how they are meeting their legal duties to reduce health inequalities. Out statement for 2024/25 reflects both our progress and challenges and informs our ongoing efforts to target resources where need is greatest and ensure equitable care for all communities. The statement is published alongside this Annual Report on our website at https://notts.icb.nhs.uk in the 'Annual Reports and Accounts' section.

Equality, diversity and inclusion

The ICB recognises and values the diverse needs of the population we serve and is committed to embedding equality, diversity and inclusion considerations into all aspects of our work, including policy development, commissioning processes and employment practices.

As a public body, we are subject to the Public Sector Equality Duty (PSED) of the Equality Act 2010. This duty requires us to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity and foster good relations. Having due regard requires the ICB to consider removing or minimising disadvantages, taking steps to meet people's needs, tackling prejudice, and promoting understanding.

We recognise that equality is about ensuring that access to opportunities is available to all and that no one should have poorer life chances because of the way they were born, where they come from, what they believe, or whether they have a disability. We believe that diversity is about recognising and valuing differences by being

inclusive, regardless of age, disability, gender re-assignment, marriage or civil partnership status, pregnancy and maternity, race, religion or belief, sex, or sexual orientation. We are committed to:

- Improving equality of access to health services and health outcomes for the diverse population we serve.
- Building and maintaining a diverse, culturally competent ICB workforce, supported by an inclusive leadership team.
- Creating and maintaining an environment where dignity, understanding and mutual respect, free from prejudice and discrimination, is experienced by all and where patients and staff feel able to challenge discrimination and unacceptable behaviour.

In practice, delivery against these commitments is achieved by ensuring the following actions are undertaken across our business activities:

- Assessing the health needs of our population – We work with Local Authority Public Health colleagues to ensure that Joint Strategic Needs Assessment chapters reflect protected characteristics and disadvantaged groups, informing equality in commissioning.
- Using data effectively – Our System Analytics and Intelligence Unit integrates protected characteristics and socio-demographic indicators (e.g. sex, deprivation, disability) into health analyses, enabling targeted interventions and evidence-based system planning.
- Public engagement and communications – We involve protected and disadvantaged groups – especially underrepresented voices – through varied channels to ensure that we have the right information to commission the right health services that can be accessed by the people who need them. We also deliver tailored messages to reach the right audiences effectively.
- Equality impact assessments – We complete equality impact assessments whenever we plan, change or remove a service, policy or function. These are completed through integrated equality and quality impact assessments that also incorporate wider quality considerations (patient safety, patient experience and clinical effectiveness); these are treated as 'live' documents and are revisited at key stages and post-engagement to inform decision-making.
- Procurement and contract management – We include an assessment of compliance with equality legislation requirements as a routine aspect of all procurement exercises. We use the national NHS Standard Contract, which mandates providers of NHS services to implement the NHS Equality Delivery System, NHS Accessible Information Standard, NHS Workforce Race Equality Standard (WRES) and NHS Workforce Disability Equality Standard (WDES). Compliance is then monitored through regular quality and performance reviews.
- Recruitment, selection and the working environment – We operate a fair, inclusive and transparent recruitment and selection process and maintain workforce accreditations that reflect our equality commitments. We implement WRES, follow WDES standards, meet our gender pay gap reporting requirements; these reports are published on the 'Equality, Diversity and Human Rights' section of our website at https://notts.icb.nhs.uk. We also promote staff wellbeing through our suite of human resource policies, which have been assessed from an equality perspective.

During the year, our Board has completed a self-assessment against the Race Health Inequalities Maturity Matrix developed by the Nottingham City Place Based Partnership, in line with our commitment to inclusive leadership and governance. The insights gained from this assessment have informed actions to strengthen the Board's ownership of equality objectives and align executive sponsorship with our staff networks.

In 2024/25, we have also taken forward a number of other actions in line with our commitment to improve equality of access to health services. These have included:

- Work to improve communications and access to information for families whose first language is not English when using maternity and neonatal services. This has included the introduction of a digital tool to improve the

transfer of critical information, and the roll-out of cultural competency training for healthcare professionals.

- Improvements to services for people with a learning disability and autistic people. This has included the roll-out of the Oliver McGowan Mandatory Training on learning disability and autism, which aims to save lives by ensuring the health and social care workforce have the right skills and knowledge to provide safe, compassionate and informed care to autistic people and people with a learning disability.
- Improvements to age-specific services for children and young people, and frail older adults.

You can read more information about the above work in the Performance Analysis section of this Annual Report. We also publish an annual Equality, Diversity and Inclusion Assurance Report on our website, providing a detailed account of how we meet our legal duties and deliver on our equality objectives. This is informed by our annual assessment against the NHS Equality Delivery System and responses from our staff to the NHS Staff Survey. The report for 2024/25 can be found in the 'Equality, Inclusion and Human Rights' section of our website at https://notts.icb.nhs.uk/.

Health and wellbeing strategies

Section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007 requires us to have regard to joint health and wellbeing strategies when exercising our functions. The Nottingham City and Nottinghamshire County Health and Wellbeing Boards are statutory partnerships established to lead and advise on work to improve the health and wellbeing of the populations of Nottingham City and Nottinghamshire County and specifically to reduce health inequalities experienced by citizens. These Boards bring partners together to address city and county-wide issues where collaborative approaches between partners are essential. In addition to the ICB and City and County Councils, the Boards' memberships include a range of local partners, including Nottinghamshire Police, Nottinghamshire Fire and Rescue Service, Healthwatch Nottingham and Nottinghamshire, NHS England, local NHS Trusts and representatives from the voluntary sector.

We are active members of the Nottingham City and Nottinghamshire County Health and Wellbeing Boards, and our NHS Joint Forward Plan describes how the ICB, together with the NHS organisations within our ICS, will contribute to the delivery of the Nottingham City and Nottinghamshire County Joint Local Health and Wellbeing Strategies and the Nottingham and Nottinghamshire Integrated Care Strategy, produced by our Integrated Care Partnership (of which the two Health and Wellbeing Board Chairs are joint vice-chairs).

Both Health and Wellbeing Boards were engaged in developing the content of this annual report and throughout the development of our Joint Forward Plan; they have provided positive statements of support for the Plan, confirming that it clearly articulates the ICB's commitment and contribution to the delivery of their Joint Local Health and Wellbeing Strategies. During the year, we have presented regular updates to meetings of the Health and Wellbeing Boards and the Integrated Care Partnership to demonstrate progress in delivery of our Joint Forward Plan, towards achievement of their strategies.

Environmental matters

Sustainable development is recognised as an integral part of delivering healthcare. Climate change is not only a major threat to our planet, but to our health as well. NHS England aims to be the world's first net zero national health service, which requires us all to act on our NHS Carbon Footprint (emissions we control directly) and our NHS Carbon Footprint Plus (emissions we can influence). As an ICB, we have a key leadership role in supporting this ambition. Sustainability is a core component of our Integrated Care Strategy, which includes a system wide commitment to reducing environmental impact and delivering sustainable health and care services.

Our strategy for tackling climate change is set out in our ICS Green Plan 2022-25[24], which has been developed in collaboration with system partners. The plan outlines how we will work across health and care in our system to meet NHS England's

[24] https://healthandcarenotts.co.uk/wp-content/uploads/2021/05/ICS-Green-Plan-2022-to-2025.pdf.

interim target of 80% carbon net zero by 2028, and full net zero by 2040. The ICB leads co-ordination of the Plan's delivery, with operational oversight of delivery through our ICS Net Zero Group.

We have made great strides in delivering the Plan to date, with 75 of our 90 objectives achieved or on track for completion. We are now in the process of refreshing the Plan for 2025-28, with outstanding objectives forming part of the new document.

The ICB also continues to reduce its own environmental footprint. Hybrid working and consolidation of our estate have contributed to assumed reductions in energy use, paper consumption, business travel, and water usage. We continue to follow the NHS Net Zero Supplier Roadmap[25] and related guidance, applying a mandatory minimum weighting of 10% on net zero and social value in all procurements, as well as requiring all suppliers bidding for contracts to have a Carbon Reduction Plan.

We continue to build clinical engagement into our approach. In August 2024, a new cohort of clinical sustainability fellows began placements across the NHS system, supported by Health Education England. Their work focusses on low carbon innovation in key areas including primary care prescribing, community nursing and paediatric dialysis, helping us explore and test more sustainable models of care.

The Group Accounting Manual[26] has adopted a phased approach to incorporating the recommended Taskforce on Climate-related Financial Disclosures (TCFD), as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports.

Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally, by NHS England.

TCFD recommended disclosures, as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year. For 2024/25, the phased approach requires disclosures in the following areas:

Governance

Oversight of sustainability activity is embedded within the ICB's governance structures, with formal oversight and scrutiny of the ICS Green Plan provided by our Finance and Performance Committee and executive leadership from our Director of Finance. The Board is committed to ensuring that climate-related risks and opportunities are considered as part of its strategic and operational decision-making and further work is planned during 2025/26 to fully embed net zero considerations into existing arrangements. This will include incorporating sustainability considerations into our equality and quality impact assessment processes and ensuring that environmental risk and opportunity is considered in all ICB business cases.

Risk management

As described in the Governance statement section of this Annual Report, risk management is fully embedded within all ICB activities, enabling robust risk identification, assessment and scrutiny. We recognise that failure to work effectively as a system to deliver high-quality and efficient care and the net zero commitment is a key strategic risk and routinely provide assurance, via our Board Assurance Framework, that appropriate controls are in place to manage this and that mitigating actions are being progressed.

Operationally, climate change and adverse weather events are identified as a key risk to service delivery within our system and an Adaptation Working Group has been established to coordinate and accelerate climate resilience across the ICS. In addition, we are currently developing an ICB Adaptation Strategy, which will complement those already in place within our NHS Trust partners. This will set out our mitigation and response to physical and transitional climate risks across the ICB's operations. We have also developed an ICS Infrastructure Strategy[27], which will serve as a key enabler for sustainable service

[25] www. england.nhs.uk/greenernhs/get-involved/suppliers
[26] https://www.gov.uk/government/publications/dhsc-group-accounting-manual-2024-to-2025
[27] https://healthandcarenotts.co.uk/plans-and-priorities/

transformation and climate resilience across our estate and capital planning.

Metrics and targets

As part of our ICS Green Plan delivery, we track key metrics including greenhouse gas emissions, energy consumption and waste management. We continue to improve our ability to measure emissions at system and organisational levels. However, as emissions data are calculated centrally by NHS England, we focus locally on delivering carbon reduction initiatives and improving reporting quality. We track a range of performance measures, including:

- Energy consumption, fleet data and waste management returns across our partner organisations.
- Implementation of Heat Decarbonisation Plans across our partner NHS Trusts.
- Monitoring carbon literacy uptake and sustainability training across staff groups.
- Implementation of measurable interventions, such as: walking aid refurbishment and reuse schemes; inhaler waste reduction and patient education; and reduction in single-use plastics and digitisation of services.

We also benchmark our system's overall performance against NHS England's Greener NHS metrics. In 2024/25, we maintained 100% compliance with Net Zero supply chain roadmap requirements, active travel options for staff, and central data returns – positioning the system as one of the highest performing in the Midlands region. We are committed to improving the quality and availability of emissions data, including through the development of a System Carbon Footprint Dashboard and local 'scorecard' tools, which will feature in our 2025-28 ICS Green Plan.

Promoting patient involvement

ICBs must promote the involvement of patients, and their carers and representatives, in decisions that relate to the prevention or diagnosis of illness in the patients or their care or treatment. We recognise that a 'one-size-fits-all' health and care system simply cannot meet the increasing complexity of people's needs and that through personalised care, people can have more control and choice when it comes to the way their physical and mental health care is planned and delivered; and be actively involved in the decision-making process by speaking up on things that matter and are most important to them.

In line with the national Comprehensive Model of Personalised Care, we have worked collaboratively with our system partners to establish a whole-population approach to supporting people of all ages and their carers to manage their physical and mental health and wellbeing, build community resilience, and to make informed decisions and choices when their health changes. We have been recognised nationally as a leader in shared decision-making and are committed to ensuring the embedment of co-production within the ICB's activities; ensuring that people with lived experience are involved in the design and commissioning of services.

During 2024/25, in addition to continuing to strive for our targets relating to personal health budgets, we have focused on a wider breadth of personalised care initiatives, including patient choice, self-care, community-based support and use of digital technologies. We have continued to evolve our arrangements for social prescribing link workers, who focus on individuals as a whole person, not just their physical or mental health needs. This includes our work in relation to 'GreenSpace', which is a green social prescribing initiative focused on improving mental health through a closer connection to nature. More information on personalised care can be found on the 'Personalised Care' section of our website at https://notts.icb.nhs.uk.

Our work to support personalised care also dovetails with our digital transformation activities, as this enables people to access services, seek advice and manage prescriptions in line with their individual needs. More information about our digital transformation work is described later in this section of this Annual Report, under the heading 'Promoting innovation'.

Ensuring patient choice

Patients have a legal right of choice and ICBs are required to act with a view to enabling patient choices with respect to aspects of health services provided to them. This duty is implicit within our established arrangements. We commission healthcare services (in line with our commissioning

responsibilities, as described in the About us section of this Annual Report) from a range of NHS and independent sector providers, ensuring that these are made known to patients at the point of referral via the contracts we hold with our primary care providers.

In practice, this means that patients requiring elective care can consider factors such as where waiting times are the shortest (including those outside of our area where possible) or a personal preference when considering their treatment. We have established our Referral Support Service and Elective Referral Hub to ensure that patients referred by their GP for a diagnostic test or specialist treatment are offered a choice of healthcare provider. We also operate a Patient Initiated Digital Mutual Aid System (PIDMAS), which enables us to proactively offer patients the ability to 'opt-in' to move provider, when they have been waiting over 40 weeks for care.

Patients can make a choice of mental health provider and team for a consultant-led assessment and subsequent treatment. This applies from the point of referral from a GP and options can be discussed with GPs in the first instance to ensure that the patient's choice is clinically appropriate, and that care can continue to be delivered in an integrated way to ensure that their needs continue to be met. Some exclusions to patient choice include using urgent, emergency or crisis services, when people are in a hospital setting under the Mental Health Act 1983, and when the patient is already receiving care and treatment for the condition.

Patients also have the right to choose their GP practice, whether it be a local GP surgery or a medical practice that best suits their needs. Patients can also change their GP if they are not satisfied with the care provided. We also ensure that appropriate choices are offered in end-of-life care for our population, to ensure people experience end of life according to their personal and individual wishes.

We also operate a formal Accreditation Process for providers seeking to be awarded an NHS Standard Contract by the ICB for services to which patient choice applies. This enables new providers to enter the NHS market or existing providers to deliver additional services.

During the year, we have also had a focus on digital solutions to improve choice – to increase use of digital correspondence; improve patient access to services through the use of digital and NHS App engagement; and provide accessible information to our population digitally. Patient self-referral routes have also been expanded to offer patients more choice in how they access care. You can read more about these initiatives in the in the Performance Analysis section of this Annual Report.

Obtaining appropriate advice

All ICBs have a statutory duty to obtain appropriate advice from people who, collectively, have a broad range of professional expertise in relation to the prevention, diagnosis or treatment of illness, and the protection or improvement of public health.

We recognise that this duty enables us to discharge our functions effectively and we place great importance on clinical and care professional leadership and engagement.

We have a dedicated clinical leadership team within the ICB; as such, we employ a number of healthcare professionals who as part of their roles provide expert advice to support the ICB's decision-making arrangements. These include our Medical Director and Director of Nursing, three Deputy Medical Directors, two Deputy Directors of Nursing and a Chief Pharmacist, along with their supporting teams, who collectively have expertise in primary care, proactive care, mental health, learning disabilities and autism, planned care, urgent and emergency care, children and young people's services, quality and clinical safety, use of medicines, population health management and research. These clinical leaders also support the embedding of the wider system clinical partnership into the ICB and ICP arrangements.

We have established an ICS Collaborative Clinical and Care Leadership and Transformation Group, comprised of senior clinical and care giving leaders from across all system partners and our four place-based partnerships. This Group is responsible for the development of clinical policy and ensuring that clinical transformation plans lead to desired outcomes. The Group also oversees our work to ensure we are making progress in our five key priority areas to ensure effective clinical and care professional leadership by:

- Integrating clinical and care professionals in decision making at every level of the ICS.
- Creating a culture of shared learning, collaboration and innovation, working alongside patients and local communities.
- Ensuring clinical and care professional leaders have appropriate resources to carry out their system roles.
- Providing dedicated leadership development for all clinical and care professional leaders.
- Identifying, recruiting and creating a pipeline of clinical and care professional leaders.

The Group is supported by a broader assembly of clinical and care professionals who lead on pathway and clinical and care model development. This work directly informs the ICB's decision-making arrangements.

The Board has also ensured that it has the right skills, knowledge and experience to operate effectively, which includes securing the expertise of our local Directors of Public Health at Board meetings. The Board has also ensured that the memberships of its key decision-making committees also include appropriate professional expertise. More information about the Board and its committees can be found in the Members report and Governance statement sections of this Annual Report.

Promoting innovation

ICBs are statutorily required to promote innovation in the provision of health services in the exercise of its functions; an example of which can be demonstrated by our approach to ensuring the innovative use of technology as part of our Digital, Data and Technology (DDaT) Strategy[28]. Our system is well placed to be a national exemplar for digital and intelligence, with a well-established digital health and care community, supported by a robust infrastructure guided by a system-wide digital charter that sets out the principles and responsibilities of how we work together.

Nationally, the over-arching digital aspiration is set out within the 'What Good Looks Like' (WGLL) Framework[29]. This framework draws on local learning; building on established good practice and providing clear guidance on the transformation of digital services to improve outcomes, experience and safety of our citizens.

Our DDaT Strategy sets out how we will use digital technologies to transform healthcare delivery across Nottingham and Nottinghamshire. The Strategy is underpinned by five programmes:

- Public facing digital services (for example, providing individuals with access to their digital health and care record and enabling online appointments).
- Digital and social inclusion (for example, providing support, training and equipment to our population and workforce to enable them to use digital assets).
- Frontline digitalisation (including utilising state of the art automation technologies to reduce burdensome processes).
- Interoperability (including the appropriate sharing of records between primary and secondary care clinicians, ensuring patients receive the right care and support first time).
- Supporting intelligent decision making (for example, using data to better understand the health and care needs of our population).

By embracing digital transformation, we continue to drive advancements in healthcare, ultimately improving outcomes and enhancing experience. An ICS Digital Executive Group has been established comprising of relevant leads from our system partners to ensure operational ownership of the Strategy's delivery. This Group is supported by a number of fora that provide digital, clinical and operational input into the digital agenda.

Key achievements in digital transformation during 2024/25 include:

- 99% of GP practices are now enabled with online consultations (75% via the NHS App), handling 41,500 consultations per month. Over 1.2 million repeat prescriptions have also been ordered via the NHS App, saving over £400,000 in administrative costs.

[28] https://prezi.com/view/WAlBPVywyhc231fdWMlx/.
[29] https://transform.england.nhs.uk/digitise-connect-transform/what-good-looks-like/what-good-looks-like-publication/.

- 31% of hospital letters have been sent digitally, saving money, reducing carbon emissions, and lowering 'Did Not Attend' rates by 2%.
- 5,521 people have been supported in becoming more confident and capable of using digital tools for their health and care needs. 41 members of staff and volunteers have also been trained as Digital Health Champions.
- Our NHS Trust partners have been supported in the deployment of the Electronic Patient Record through expansion, optimisation, and procurement to deliver productivity gains and improve patient flow. Electronic prescribing and medicines administration technology has also been rolled out. 88% of adult social care providers have also been funded for digital care records.
- Phase one of the Notts Care Record is also well underway, which enables primary and secondary care clinicians to see the same information about patients, meaning patients only need to share their health and care history once instead of multiple times.

Innovation can also be demonstrated through our approach to research, which is detailed further in the following section.

Promoting research

ICBs must in the exercise of their functions, facilitate or otherwise promote research on matters relevant to the health service, along with promoting the use in the health service of evidence obtained from research. We know that research leads to improvements in clinical and care practice, reduces the cost of health and care, leads to a healthier population and supports a happier workforce. As such, it is essential for research to be embedded in our work as an ICB to improve our population's health and wellbeing, to deliver joined up care, and to reduce inequalities.

In July 2024, the ICB approved our first Nottingham and Nottinghamshire ICS Research Strategy[30], which was developed collaboratively with ICS partners and is aligned to the Integrated Care Strategy. This sets a collective vision and ambition for the ICS and will enable us to build on existing opportunities and harness our collective strengths to work together in an integrated and effective way to drive and develop research and increase the implementation of the outcomes of research. The Strategy is framed around the following four priorities:

- Undertaking research to improve health and care outcomes and reduce health inequalities for our local population.
- Supporting our workforce to drive and deliver research in a culture where research is everyone's business.
- Maximising the collective capabilities and strengths of system partners through collaboration and shared infrastructure.
- Increasing the implementation of research outcomes that are shown to improve health and care.

Key achievements in implementing the Strategy during the year include:

- Establishment of an ICS Research and Innovation Hub to bring together information and resources into one virtual place for the whole ICS workforce. The Research and Innovation Hub includes information about research opportunities, available support, case studies and signposting to other resources to enable equitable access to information, opportunities, and support.
- Establishment of an ICS Research Pipeline Group to bring partners together to co-produce research proposals that meet ICS key priorities and challenges, with a focus on prevention, that require multiple partners to be involved.
- Establishment of a Research Engagement Network, which aims, through community engagement, to ensure research is representative of our diverse and underserved populations and that communities are involved in both shaping and participating in health and care research studies so that everyone can benefit from research.
- Development of a Research Engagement Dashboard through collaboration with the Voluntary Community and Social Enterprise (VCSE) National Observatory at Nottingham Trent University and NHS Surrey Heartlands

[30] https://healthandcarenotts.co.uk/wp-content/uploads/2021/05/ICS-Research-Strategy-2024-29-FINAL.pdf.

ICB. This digital platform enables VCSE organisations to articulate their research priorities, set boundaries for engagement and connect with researchers. It also allows researchers to discover and collaborate with organisations that align with their research interests. The objective is to remove barriers to engagement in research for underserved communities and enable more equitable, balanced and inclusive research relationships that are mutually beneficial.

- Initiation of a series of ICS Thought Labs, in collaboration with the University of Nottingham and Nottingham Trent University, to widen our collective understanding of research and evidence to inform service transformation plans. The first two Thought Labs were held in January and March 2025, focused on preventing and reducing the level of frailty in older adults, and the social factors of frailty. Recommendations from the sessions will be taken forward as part of the ICS Frailty Transformation Programme and a rolling programme of future Thought Labs will be developed for 2025/26.
- Planning for an ICS Engage, Enthuse and Empower Conference, which will be held in June 2025 for nurses, midwives, allied health professionals, healthcare scientists, psychologists, pharmacists, social care, and public health practitioners. The conference will celebrate research, innovation, education, and practice development that is being led by colleagues from across the ICS.

As part of the ICB's system leadership role, we have put in place a robust infrastructure to oversee delivery of the Strategy. This includes an ICS Research Leaders Group and ICS Research Partners Group, which bring together senior representatives from local NHS providers, Nottingham City and Nottinghamshire County Councils, our two local Universities and the National Institute for Health and Care Research (NIHR) East Midlands Regional Research Delivery Network.

We also have a well-established ICB Research Strategy Group to oversee arrangements for the strategic development of research activity, capacity and culture within the ICB and primary care. In 2024/25, we expanded the Group's remit to include community pharmacy, dentistry and optometry. We have continued to utilise our NIHR Research Capability Funding to fund two Primary Care Research Champions (a GP and Practice Manager) working across the ICB area and a Primary Care Research Lead for Mid-Nottinghamshire to continue to focus on equity of access to research opportunities for patients and the workforce, promoting and supporting research being delivered where population need is greatest and increasing the diversity of people participating in research studies. We also accessed NIHR East Midlands Regional Research Delivery Network (RRDN) funding to support two Primary Care Network (PCN) Clinical Pharmacists and two PCN Care Coordinators to integrate health and care research into their roles. During a seven month period they increased their knowledge and experience of primary care research, promoted research opportunities to patients and the primary care workforce and delivered a range of research studies including osteoporosis, diabetes and mental health studies. They are continuing to include research in their roles going forward.

During 2024/25, 24,398 people in Nottingham and Nottinghamshire participated in 508 unique NIHR research studies. 80% of these people were recruited from our three local NHS Trusts, 17% from primary care and 3% from other settings. 4,256 people participated in 42 primary care studies. 44% of GP practices were part of the NIHR East Midlands RRDN Research Site Initiative Scheme and 68% of GP practices were involved in research in some way. Research involvement varies from delivering research studies, contacting eligible patients about studies that are suitable for them that are being undertaken in other organisations, and promoting research studies via the practice website or notice boards and posters in the practice.

Promoting education and training

When exercising our functions, we have a statutory duty to have regard to the need to promote education and training for persons who are employed, or who are considering becoming employed, in an activity related to the provision of services as part of the health service in England.

We satisfy this duty through our system leadership role in developing and delivering our ICS People

and Workforce Plan, which can be found on the 'Strategies and Plans' section of our website at https://notts.icb.nhs.uk. This has been reviewed and refreshed during 2024/25 to ensure that it continues to meet the ambitions of our Integrated Care Strategy and Joint Forward Plan.

This has a focus on co-designing and developing an integrated workforce development plan, including developing new roles and new ways of working to ensure our workforce is deliberately designed and developed to meet current and future health and care needs. By prioritising education and training, our workforce is equipped with the necessary knowledge and skills to ensure our population continues to receive high-quality healthcare services.

Our ICS People and Workforce Plan has the following ten priorities:

- Supporting the health and wellbeing of all staff.
- Growing the workforce for the future and enabling adequate workforce supply.
- Supporting inclusion and belonging for all and creating a great experience for.
- Valuing and supporting leadership at all levels, and lifelong learning.
- Leading workforce transformation and new ways of working.
- Educating, training and developing people, and managing talent.
- Driving and supporting broader social and economic development.
- Transforming people services and supporting the people profession.
- Leading coordinated workforce planning using analysis and intelligence.
- Supporting system design and organisational development.

A multifaceted approach is taken across Nottingham and Nottinghamshire in relation to the education and training agenda. In 2024/25, this has included:

- Roll-out of the Oliver McGowan training, which aims to save lives by ensuring the health and social care workforce have the right skills and knowledge to provide safe, compassionate and informed care to autistic people and people with a learning disability.
- Delivery of cultural competence training to health professionals working in maternity and neonatal services, to equip staff with the knowledge, skills, and attitudes to effectively interact with people from diverse cultural backgrounds. We have also supported the upskilling of maternity support workers through funded secondments and apprenticeships, helping to strengthen the maternity workforce and lay the foundations for sustainable models of care.
- Holding a successful ICS leadership event, attended by over 70 health, social care, education and third sector leaders from across Nottingham and Nottinghamshire, with the aim of attendees 'lifting their gaze' and developing their roles through a deeper understanding of systems leadership and collaboration through shared learning.
- Delivery of a Middle Management Development Programme for ICB staff and the use of our apprenticeship levy to support employees to undertake apprenticeships in areas including leadership and management, project management, systems thinking, data analysis and business administration.

Looking forward to 2025/26, we have planned the delivery of Active Bystander training across our NHS system partners from May 2025. This is innovative and award winning training that gives staff the skills to challenge unacceptable behaviours, including those which may have become normalised over time.

Promoting integration

We have a duty to ensure that health, social care and health-related services are provided in an integrated way where this would improve the quality of the services, reduce inequalities of access or reduce inequalities in outcomes. This is included as one of three core principles within our Integrated Care Strategy – Prevention is better than cure; Integration by default; and Equity in everything. Integration by default was included as a core principle based on the view of local people who want joined up and seamless services, that support the whole person.

Achieving integration will depend on a culture of collaboration, bringing together:

- Our communities, who will help shape the delivery of services to meet their needs.
- NHS providers, including primary care, community, mental health, and hospitals.
- Local authorities, including social care, public health, housing, and planning.
- Voluntary and community sector organisations that are involved in health and care as well as supporting broader determinants of health.
- Other public services such as schools, police, fire, and job centres.

We have worked successfully with Nottingham City and Nottinghamshire County Councils to develop an ICS Carers Strategy[31], which has been co-produced with carers, health and care providers and voluntary, community and social enterprise (VCSE) organisations. In line with this, we have jointly commissioned carers services with Nottingham City and Nottinghamshire County Councils, which means that carers now have:

- A single point of access Carers Hub to provide advice, assessments and coordinate seamless support with social care based on support plans for improved health and wellbeing.
- A flexible offer of respite and breaks to enable the carer to take an effective break from their caring responsibilities.
- A single point of access Young Carers Hub to provide advice, information, and support for those age 18 years and under with family focused assessments and support plans.

We have also worked with the Councils and the Office of the Police and Crime Commissioner to establish a Sexual Violence Hub and therapy service provided by Nottinghamshire Sexual Violence Support Services. The service provides integrated support for survivors of sexual violence and assault. The hub acts as a gateway to other services that can support the needs of survivors as well as providing specialist therapy. A delivery partnership has also been established with Nottinghamshire Healthcare NHS Foundation Trust, whereby a Mental Health Practitioner is seconded into the service to facilitate the joining up of services and support survivors to access secondary mental health care and navigate to the right care at the right time.

We are continuing to develop and embed our approach to integrated neighbourhood working and Integrated Neighbourhood Teams. This brings together a broad range of partners at a neighbourhood level, working collaboratively to deliver clinical transformation to meet local population need supported by population health data. Our Integrated Neighbourhood Teams are expected to deliver streamlined access to services, decrease pressure on hospital care (especially emergency care), slow deterioration of poor health, maximise use of community-based services, and improve staff and patient experience. Our initial areas of focus are providing support for children and young people with complex needs, the prevention, early identification and ongoing management of frailty in older adults, and support for people living with severe multiple disadvantages. We are aiming to embed integrated neighbourhood working across all of our Primary Care Networks by March 2026.

Having regard to the wider effects of decisions

The Health and Care Act 2022 introduced a new duty for ICBs, along with other NHS organisations, to have regard to the effects of their decisions on the 'Triple Aim' of: the health and wellbeing of the people of England (including inequalities in that health and wellbeing); the quality of services provided or arranged by NHS organisations (including inequalities in benefits from those services); and the efficient and sustainable use of NHS resources.

We recognise that only through effective co-ordination and collaboration with our system partners, drawing on their knowledge, experience and expertise, can we make the right decisions to ensure the delivery of integrated, person-centred care.

Across our ICS, we are aligned around a common set of aims and guiding principles, which are described within our Integrated Care Strategy. We have also developed a Joint Forward Plan with our NHS Trust and NHS Foundation Trust partners that describes how our local NHS organisations

[31] https://www.nottinghamshire.gov.uk/media/5081744/final-joint-carers-strategy-2023-28.pdf.

will implement the NHS Mandate, tackle key issues and contribute to the delivery of the Integrated Care Strategy. This joint approach to planning ensures that we consider the wider effects of our decisions by default.

The ICB has developed a decision-making framework that is applied to all service change and resource allocation proposals, which ensures that the 'Triple Aim' is embedded in decision-making and evaluation processes. Our Strategic Planning and Integration Committee has a key role in exercising the ICB's commissioning functions and ensures the robustness of decision-making in line with relevant statutory duties and the aims of the ICS. You can read more about the work of this committee in the Governance statement section of this Annual Report.

Skills, knowledge and experience of members

The ICB is required to keep under review the collective skills, knowledge and experience that it considers necessary for its Board members to have, to enable the Board to effectively carry out its functions.

In establishing our Board's membership, consideration was given to the fact it is a unitary Board, collectively and corporately accountable for the performance of the organisation and the delivery of its functions and duties, making decisions as a single group. In line with this, we have sought to strike the right balance in membership, ensuring it is of an appropriate size to enable effective decision-making, whilst also providing for the right balance of skills, knowledge and experience that is appropriate for the organisation.

Since the ICB's establishment the Chair and wider Board members have kept these arrangements under review, and during 2024/25 the Board's membership has been expanded to include two new members; one additional executive member to reflect the evolving role of the ICB since its establishment, and one additional non-executive member to increase the Board's capacity for independent scrutiny. The Board's membership is now comprised of the ICB's Chair and Chief Executive, five Non-Executive Directors, the ICB's Director of Finance, Director of Nursing, Medical Director, Director of Strategy and System Development and Director of Operations and Delivery, and five Partner Members nominated by our system partner organisations.

Executive accountability for each of the ICB's functions and duties has been explicitly allocated; Our Executive Directors' portfolios are summarised in the About us section of this Annual Report and described in more detail within the ICB's Governance Handbook, which can be found in the 'About us' section of our website at https://notts.icb.nhs.uk.

The Partner Members bring knowledge and a perspective from their relevant sectors to the work of the Board; these cover primary and community care services, hospital, urgent and emergency care services, services relating to the prevention, diagnosis and treatment of mental illness, and the social care needs and health and wellbeing characteristics of people and communities living across Nottingham and Nottinghamshire.

The non-executive members of the Board are all independent of system partners, ensuring they are able to provide an independent view on the running of the organisation. Collectively, they bring the right skills, knowledge and experience to provide purposeful, constructive scrutiny and challenge to Board discussions. Where relevant, this includes holding the specific qualifications required for their roles (for example, our Audit and Risk Committee Chair is a qualified accountant).

Further information on Board members can be found in the Members report section of this Annual Report and on the Board pages of our website here: https://notts.icb.nhs.uk/about-us/our-icb-board/.

The Board has also secured regular attendance at its meetings by senior colleagues with subject matter expertise in public health, human resources and governance, to advise Board Members when discharging their responsibilities. The Chair of the Nottingham and Nottinghamshire Voluntary, Community and Social Enterprise (VCSE) Alliance also routinely attends meetings; to bring the perspective of this sector and the people and communities it supports to the work of the Board.

More information about how the Board secures the right professional expert advice is described earlier in this section of this Annual Report, under the heading 'Obtaining appropriate advice'.

Accountability Report

Signed:

Amanda Sullivan
Accountable Officer

19 June 2025

Corporate Governance Report

Members report

Composition of the Board

The ICB's Board is responsible for ensuring that the ICB has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the principles of good governance. It is a unitary Board in which all members have shared corporate accountability for the ICB's performance and delivery of the ICB's functions and duties.

The Board's full membership for the period 1 April 2024 to 31 March 2025 is as follows:

Name	Role
Professor Marios Adamou	Non-Executive Director
Dr Dave Briggs	Medical Director
Gary Brown	Non-Executive Director (from 1 March 2025)
Lucy Dadge	Director of Integration (to 30 September 2024)
Stephen Jackson	Non-Executive Director
Mehrunnisa Lalani	Non-Executive Director (from 1 January 2025)
Dr Kelvin Lim	Primary Care Partner Member
Ifti Majid	NHS Trust/Foundation Trust Partner Member
Caroline Maley	Non-Executive Director (to 30 September 2024)
Victoria McGregor-Riley	Acting Director of Strategy and System Development (from 1 October 2024)
Dr Kathy McLean	Chair
Vicky Murphy	Local Authority Partner Member (from 6 January 2025)
Stuart Poynor	Director of Finance (to 6 July 2024)
Marcus Pratt	Acting Director of Finance (from 8 July 2024)
Maria Principe	Acting Director of Delivery and Operations (from 1 October 2024)
Paul Robinson	NHS Trust/Foundation Trust Partner Member (to 17 February 2025)
Amanda Sullivan	Chief Executive
Jon Towler	Non-Executive Director (Deputy Chair and Senior Non-Executive member)
Catherine Underwood	Local Authority Partner Member (to 30 June 2024)
Rosa Waddingham	Director of Nursing
Melanie Williams	Local Authority Partner Member

During the year, our Board's membership has increased from 15 to 17 members. This increased membership of one additional executive member and one additional non-executive member took effect from 1 October 2024. From this date, our Board's membership has been comprised of our Chair, our Chief Executive and five further Executive Directors, five Non-Executive Directors (one of whom is the ICB's Deputy Chair and Senior Non-Executive member), and five Partner Members nominated by our system partner organisations.

Member profiles

Full biographies of our Board members are available here: https://notts.icb.nhs.uk/about-us/our-icb-board/. You can also read more about the work of the Board and its committee structure in the Governance statement contained within this Annual Report.

Audit and Risk Committee

The following Non-Executive Directors were members of the Audit and Risk Committee during the period 1 April 2024 to 31 March 2025 and up to the signing of our Annual Report and Accounts:

- Caroline Maley (Chair of the committee until 30 September 2024, when membership ceased)
- Stephen Jackson (Interim Chair of the committee from 1 October 2024 to 28 February 2025)
- Gary Brown (Chair of the committee from 1 March 2025, when membership commenced)
- Professor Marios Adamou

The Governance statement contained within this Annual Report provides further details on all committees of the Board, including details of their memberships. Details regarding the ICB's Remuneration and Human Resources Committee can also be found in the Remuneration report section of this Annual Report.

Register of interests

We are committed to ensuring that our organisation inspires confidence and trust, avoiding any potential situations of undue bias or influence in decision-making and protecting the NHS, the ICB, and the individuals involved, from any appearance of impropriety. The ICB maintains a Register of Declared Interests for all ICB staff, and the declared interests of all Board members are published on the 'About us' section of our website at https://notts.icb.nhs.uk . Further details on how we manage conflicts of interest are detailed in the Governance statement contained within this Annual Report.

Provider Selection Regime

The Provider Selection Regime (PSR) is the set of rules governing the way the NHS and public health commissioners arrange healthcare services in England. Introduced in January 2024, the PSR aims to provide a flexible and proportionate process for selecting providers, with a stronger focus on collaboration, continuity of care, and value for patients and the public. Under regulation 16 of the PSR, ICBs are required to publish an annual summary of the decisions made under the PSR in the preceding year. The summary of PSR decisions for the period 1 January 2024 to 31 March 2025 is available on the 'Provider Selection and Contracts Awarded' section of our website at https://notts.icb.nhs.uk.

Personal data related incidents

We are committed to reporting, managing and investigating all information governance incidents and near-misses. We actively encourage staff to report all incidents and near misses to ensure that learning can be collated and disseminated within the organisation.

There have been no serious incidents that required external reporting during the reporting period, as prescribed by national guidance: Guide to the Notification of Data Security and Protection Incidents. There were 25 personal data related incidents and four near misses; however, these were not rated as serious in nature and were managed in line with the ICB's incident reporting and management procedures.

Modern Slavery Act

The ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the period ending 31 March 2025 is published on the 'Equality, Inclusion and Human Rights' section of our website at https://notts.icb.nhs.uk.

Statement of Accountable Officer's responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each ICB to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the NHS Nottingham and Nottinghamshire ICB and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed and disclose and explain any material departures in the accounts.
- Prepare the accounts on a going concern basis.
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board

shall have an Accountable Officer, and that Officer shall be appointed by NHS England.

NHS England has appointed the Chief Executive, Amanda Sullivan, to be the Accountable Officer of the ICB. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the ICB and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the ICB's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the ICB's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Governance statement

Introduction and context

NHS Nottingham and Nottinghamshire ICB is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

The ICB's statutory functions are set out under the National Health Service Act 2006 (as amended).

The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population. The ICB discharges these responsibilities by developing strategies and plans to meet the health needs of its population and by commissioning planned hospital and rehabilitation care, maternity services, urgent and emergency care, community services, and mental health and learning disability and autism services, while managing the NHS budget.

Upon its establishment, the ICB was delegated responsibility from NHS England for commissioning primary medical services for the people of Nottingham and Nottinghamshire. After this, the ICB took on delegated responsibility from NHS England for commissioning primary dental services and prescribed dental services, primary ophthalmic services and pharmaceutical services and local pharmaceutical services from 1 April 2023, and responsibility for commissioning 59 specialised services from 1 April 2024.

Between 1 April 2024 and 31 March 2025 the ICB was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended). However, during May 2024, NHS England agreed to accept and the ICB has agreed to give formal undertakings[32] with regard to the non-achievement of ICB financial duties and joint financial objectives between the ICB and its partner NHS Trusts and Foundation Trusts.

The ICB is part of the Nottingham and Nottinghamshire Integrated Care System (ICS), which is a partnership of local health and care organisations that have come together to plan and deliver joined up services to improve the health of people who live and work in our area. ICS partner organisations include the ICB, Nottingham University Hospitals NHS Trust, Sherwood Forest Hospitals NHS Foundation Trust, Nottinghamshire Healthcare NHS Foundation Trust, East Midlands Ambulance Services NHS Trust, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, Nottingham CityCare Partnership Community Interest Company, Nottinghamshire County Council and Nottingham City Council. Also involved in the ICS are District and Borough Councils, Healthwatch Nottingham and Nottinghamshire, general practices, and voluntary, community and social enterprise organisations.

On 13 March 2025, the Government announced that NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged but they have been tasked with significant reductions in their cost

[32] https://www.england.nhs.uk/publication/nhs-nottingham-and-nottinghamshire-icb/.

base. Discussions are ongoing regarding the impact of these announcements, including the impact of staffing reductions, together with the costs and approvals of any exit arrangements. ICBs are currently being asked to implement any plans during quarter three of the 2025/26 financial year.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the ICB's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in the ICB's Accountable Officer Appointment Letter.

I am responsible for ensuring that the ICB is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the ICB as set out in this governance statement.

Governance arrangements and effectiveness

The ICB has a constitution that sets out the statutory framework within which we operate. The Constitution also confirms the geographic area we cover, our Board membership and associated appointment requirements (including disqualification criteria), along with arrangements for discharging functions, demonstrating accountability, making decisions, managing conflicts of interests, and for public involvement.

The ICB also has a set of Standing Orders, which form part of our Constitution. These set out the arrangements and procedures to be used at meetings of the Board and its committees, including arrangements for deputies, quorum requirements and decision-making arrangements.

Alongside the ICB's Constitution is our Governance Handbook, which brings together the following key documents:

- The terms of reference for all committees of the Board that exercise ICB functions and make decisions.
- The Standing Financial Instructions, which set out the arrangements for managing the ICB's financial affairs.
- The Scheme of Reservation and Delegation, which sets out functions and decisions that are reserved to the Board, functions and decisions that have been delegated to an individual or to committees, and functions and decisions delegated to another body or bodies or to be exercised jointly with another body or bodies.

The ICB has developed a suite of key policy documents covering various aspects of its corporate and commissioning responsibilities. This includes its Standards of Business Conduct Policy (which incorporates the ICB's policy and procedures for the identification and management of conflicts of interest and the acceptance of gifts and hospitality) and its Freedom to Speak Up Policy, which describes how concerns relating to the activities of the ICB can be raised and responded to. In line with these policies, the ICB has appointed two of its Non-Executive Directors in the roles of Conflicts of Interest Guardian and Non-Executive Lead for Freedom to Speak Up.

All of the ICB's governing documents and policies are available in the 'About us' section of our website at https://notts.icb.nhs.uk.

The Board

The main functions of the ICB's Board are to ensure that the organisation has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it. The Board is responsible for setting the ICB's vision, values and strategic objectives, and formulating strategies, plans and policies, then holding the organisation to account for the delivery of these; by being accountable for ensuring the organisation operates with openness, transparency and candour and by seeking assurance that systems of control are robust and reliable and that statutory duties are being met. The Board is also responsible for shaping a healthy culture for the organisation and the wider

system through its interaction with system partners.

As part of the ICB's commitment to openness and accountability, meetings of the Board are open to members of the public to attend and observe. Members of the public may ask questions of the Board in relation to its agenda items by submitting these in advance of each meeting. The Chair will also accept questions on the day of meetings if sufficient time is available and they are pertinent to items on the agenda.

In accordance with good governance practice, the Board is supported by an annual cycle of business that sets out a coherent overall programme for meetings. The Board's forward plan is a key mechanism by which appropriately timed governance oversight, scrutiny and transparency can be maintained in a way that does not place an onerous burden on those in executive roles or create unnecessary or bureaucratic governance processes.

The Board's membership has increased in year, from 15 to 17 members and is now comprised of the ICB's Chair and Chief Executive, five Non-Executive Directors, the ICB's Director of Finance, Director of Nursing, Medical Director, Director of Delivery and Operations and Director of Strategy and System Development, and five partner members nominated by our system partner organisations to the Board. The Partner Members bring knowledge and a perspective from their relevant sectors to the work of the Board; these cover mental health, hospital, urgent and emergency care services, primary and community care, and social care. The Board also co-opts attendees with speaking rights to attend meetings as required to advise members when discharging their responsibilities; this includes subject matter experts on public health, governance and human resources, and the Chair of the Voluntary, Community and Social Enterprise Alliance. The members of the Board are named within the Members report section of this Annual Report.

The Board meets formally every two months, with extraordinary meetings scheduled as necessary. During these meetings, the Board has overseen delivery of the NHS Joint Forward Plan and approved a refreshed plan for 2025/26, approved the Operational and Financial Plan for 2025/26, approved the ICS Research Strategy and ICS People and Workforce Plan, and received delivery updates against the ICS Digital, Data and Technology Strategy and ICS Green Plan. Reports providing assurance regarding the ICB's arrangements for clinical and care professional leadership, working with people and communities, meeting the public sector equality duty, and emergency preparedness, resilience and response were also received. The Board also discussed the ICB's Health Inequalities Statement and received reports from Nottingham and Nottinghamshire Healthwatch, the local Voluntary, Community and Social Enterprise Sector Alliance, and the Provider Collaborative in Nottingham and Nottinghamshire.

The Board has also routinely:

- Received leadership updates via the Chair's report and the Chief Executive's report, which enabled the Board to be updated on a range of local and national developments and policy directions.
- Oversighted ICB and system performance relating to finance, quality standards, service delivery targets, health inequalities and workforce. This included periodic updates against the ICB's delivery plan for improving access to primary care.
- Reviewed highlight reports from its committees, receiving assurance that delegated duties are being discharged and noting key messages escalated for the Board's attention. These highlight reports also ensure the Board is sighted on high and extreme risks being overseen by each committee. Strategic risks have also been overseen through the receipt of the Board Assurance Framework.

The Board met formally on seven occasions during the reporting period. All meetings were quorate in accordance with the ICB's Standing Orders and members achieved an average annual attendance of 75%.

In addition to its formal meetings, the Board also held three development sessions, designed to support ongoing Board maturity and effectiveness. These sessions focused on the development of in-year priorities; productivity and efficiency and service transformation requirements; agreement of strategic risks; consideration of the ICB's performance against a locally developed race health inequalities maturity matrix; and ongoing development of the local provider collaborative and

place-based partnerships. A further two Board seminars focused on mental health and primary care services were held during the year, which were attended by wider system partners, including leaders of local place-based partnerships and representatives from Nottingham and Nottinghamshire Healthwatch.

At the time of finalising this Annual Report, the Board is in the process of establishing appropriate governance arrangements to ensure effective oversight and scrutiny of the ICB's transition to its new operating model in line with national requirements.

Committees of the Board

The Board has established a number of committees to assist it with the discharge of its functions. Some committees are statutory requirements, whilst others are established 'by design' considering any relevant national guidance and best practice. Together, they support the delivery of the ICB's statutory duties and enable effective oversight, scrutiny and decision-making arrangements.

The Board has approved and keeps under review the terms of reference for all its committees. Memberships of committees consist of non-executive directors, executive directors and other senior leaders and clinical members (as appropriate to the remit of the committee). All committees routinely report to the Board through the submission of highlight reports and other appropriate updates, as necessary.

A mid-year review of committee work programmes was conducted to ensure responsibilities were on track to be delivered by year end, supporting the annual effectiveness review each committee is required to undertake. Since the ICB's inception, committee effectiveness has largely been assessed in-house, so this year the ICB requested an independent review by its internal auditors, which provided a substantial assurance rating.

Details on each of the Board's committees are provided in the following sections.

Audit and Risk Committee

The Audit and Risk Committee exists to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities. It provides the Board with an independent and objective view of the ICB's financial systems, financial information and compliance with laws, regulations and directions governing the organisation, in so far as they relate to finance. The Committee scrutinises every instance of non-compliance with the ICB's Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions and monitors compliance with the ICB's Standards of Business Conduct Policy. The Committee also has delegated authority to approve the ICB's Annual Report and Accounts.

The Committee's membership is comprised of three Non-Executive Directors; the Committee's Chair having qualifications and expertise in finance and audit matters. Members are supported by the ICB's internal auditors, external auditors and local counter fraud specialist. The Committee met six times during 2024/25. All formal meetings were quorate in line with the Committee's terms of reference and its members achieved an overall annual average attendance rate of 93% at meetings.

The members of the Committee are named within the Members report section of this Annual Report.

During the year, the Committee has received a range of comprehensive reports providing assurance across the breadth of its responsibilities, which have included reports on financial controls, standards of business conduct, the corporate policy framework, information governance, mandatory and statutory training, health and safety and emergency preparedness, resilience and response (EPRR). Members have also scrutinised reports from the ICB's internal and external auditors, which will culminate in the receipt of year-end opinions and conclusions that will feed into the year's Annual Report and Accounts process.

In line with the Committee's key responsibilities for risk management, members have also oversighted the arrangements in place for strategic and operational risk management and on behalf of the Board, received detailed reports on the development of system-wide risk management arrangements and the progress of strategic risks

described within the ICB's Board Assurance Framework.

Remuneration and Human Resources Committee

The main purpose of the Remuneration and Human Resources Committee is to exercise the ICB's functions as set out in paragraphs 18 to 20 of Schedule 1B to the National Health Service Act 2006 (as amended). This includes ensuring that the ICB has clear and transparent remuneration policies that enable the recruitment, motivation and retention of staff, and seeking assurance on all aspects of strategic ICB people management and organisational development, ensuring that the ICB maintains an appropriate structure, size, and balance of skills to support the strategic objectives of the organisation. The remit of the Committee excludes the remuneration, fees, allowances and other terms of appointment for the Chair of the ICB and for the non-executive members of the Board (which are set by NHS England and the Non-Executive Director Remuneration Panel respectively).

The Committee's membership has been reviewed during the year and is now comprised of three Non-Executive Directors of the Board, which includes the Chair of the ICB. The Committee met nine times during the year, achieving an average annual attendance rate of 97%. Further details on the membership of the Committee are provided in the Remuneration report within this Annual Report.

During the year, the Committee has received routine ICB workforce reports covering staff engagement activities, health and wellbeing, and equality objectives and reporting requirements, including the ICB's 2024 Gender and Ethnicity Pay Gap, Workforce Race Equality Standard and Workforce Disability Equality Standard reports. The Committee has also overseen appointments to the ICB's Executive Team, development of the ICB's succession and talent management plan, progress against the organisation's Staff Survey Action Plan, and monitored performance against a range of workforce metrics in relation to the ICB's funded establishment, vacancy rates, staff turnover, sickness absences, and appraisal rates. Pay awards for Very Senior Managers and medical and dental staff were also approved in line with recommendations by the national Review Body on Senior Salaries and Doctors and Dentists Review Body.

Finance and Performance Committee

The Finance and Performance Committee exists to oversee arrangements for ensuring the delivery of the ICB's statutory financial duties in line with sections 223GB to 223N of the National Health Service Act 2006 (as amended). It oversees the ICB's performance management framework which includes addressing shortfalls in performance against national and local health targets and performance standards. The Committee's duties also include overseeing the ICB's arrangements and delivery in relation to operational planning, estates, environmental sustainability (including statutory duties as to climate change) and data and digital, ensuring continuous improvements in performance and outcomes.

The Committee also oversees non-healthcare contracts, making decisions on investments and contract awards in line with the ICB's Scheme of Reservation and Delegation. The Committee's remit incorporates the relevant requirements set out within the Delegation Agreement between NHS England and the ICB for primary medical services, insofar as they relate to finance, performance and estates.

The Committee's membership has been reviewed during the year and is now comprised of three Non-Executive Directors of the Board, the ICB's Director of Finance, Director of Nursing and Director of Delivery and Operations, and senior representatives from the Medical and Strategy and System Development Directorates. The Committee met ten times during the reporting period, achieving an average annual attendance of 85%.

During the year, the Committee has had a particular focus on financial recovery plans for the ICB and wider NHS system and has monitored progress on delivery of the Joint Capital Resource Use Plan. Members have overseen development of the annual Operational Plan prior to Board approval. On behalf of the Board, the Committee has also overseen progress against the financial undertakings agreed with NHS England. The Committee has also routinely received comprehensive service delivery reports, detailing key performance targets and actions being taken to address performance issues. More detailed

reports have been provided across a number of areas where further assurance has been required, which has included diagnostics, continuing healthcare, severe mental illness (adults) and mental health for children and young people. In addition, the Committee has received other assurance reports across the range of its duties, which have included progress in delivering the ICS Digital Data and Technology Strategy, progress against the ICS Green Plan, and the work being done to develop the ICS Infrastructure Strategy.

Quality and People Committee

The Quality and People Committee has been established to ensure that the ICB is meeting its statutory requirements regarding continuous quality improvements and enabling a single understanding of, and shared commitment to, quality care across the ICS that is safe, effective, equitable, and that provides a personalised experience and improved outcomes. Its responsibilities include scrutinising actions to tackle heath inequalities and deliver improved health outcomes and ensuring the development of robust arrangements with system partners to support the principle of having 'one workforce,' by leading on the development and implementation of the ICS People Plan. The Committee also scrutinises the robustness of safeguarding, medicines optimisation and compliance with equality legislation (including the Public Sector Equality Duty). The Committee's remit incorporates the relevant requirements set out within the Delegation Agreement between NHS England and the ICB for primary medical services, insofar as they relate to quality and people.

The Committee's membership has been reviewed during the year and is now comprised of three Non-Executive Directors of the Board, the Board's Primary Care Partner Member, the ICB's Director of Nursing, Medical Director and Director of Delivery and Operations, and senior representatives from the Finance and Strategy and System Development Directorates. The Committee met ten times during the reporting period and achieved an average annual attendance rate of 77%.

During the year, the Committee has had a particular focus on the status of service quality and safety within the Trusts for which the ICB has principal responsibility for system oversight purposes (Nottingham University Hospitals NHS Trust, Sherwood Forest Hospitals NHS Foundation Trust and Nottinghamshire Healthcare NHS Foundation Trust) and areas under enhanced surveillance, in line with National Quality Board guidance[33]. This has included examination of service quality and safety in community services, maternity and neonatal care, learning disabilities and autism services, care homes and home care provision, and primary medical service provision. The Committee has also received a range of assurance reports aligned to the ICB's responsibilities, covering adults and children's safeguarding arrangements, healthcare associated infections, management of medicines, avoidable mortality, and learning from complaints, patient experience, patient safety incidents and never events. Detailed assurance reports on the work being done to address health inequalities have also been received, aligned to the Core20PLUS5 approach for adults and children and young people. The Committee has also monitored in-year delivery of the ICS people and culture priorities and overseen a refresh of the ICS People and Workforce Plan, which culminated in its endorsement for Board approval towards year-end.

Strategic Planning and Integration Committee

The Strategic Planning and Integration Committee exists to exercise the ICB's duties and powers to commission certain health services, as set out in sections 3 and 3A of the National Health Service Act 2006 (as amended), other than those explicitly delegated elsewhere. In exercising these functions, the Committee makes strategic commissioning decisions to further the four aims of the ICB to: improve outcomes in population health and healthcare; tackle inequalities in outcomes, experience and access; enhance productivity and value for money; and help the NHS support broader social and economic development. The Committee also actively promotes system development in line with the principles of subsidiarity, integration and collaboration, and

[33] NHS England » National Guidance on Quality Risk Response and Escalation in Integrated Care Systems

compliance with the general duties of ICBs, public sector equality duties, social value duties and the rules set out in NHS Provider Selection Regime. The Committee also has responsibility for scrutinising the robustness of research arrangements and the effectiveness of patient and public engagement arrangements, and for overseeing the development of the ICB's Joint Forward Plan. In addition, the Committee has responsibility for the relevant requirements set out within the Delegation Agreement between NHS England and the ICB for primary medical services, insofar as they relate to the planning, design and commissioning of services.

The Committee's membership has been reviewed during the year and is now comprised of three Non-Executive Directors of the Board, the ICB's Chief Executive, Medical Director, Director of Strategy and System Development and Director of Communications and Engagement, senior representatives from the Finance, Delivery and Operations and Nursing and Quality Directorates, and health and social care commissioning representatives from Nottingham City Council and Nottinghamshire County Council. The Committee met 10 times during the reporting period achieving an average annual attendance rate of 77%.

During the year, the Committee has overseen the development and delivery of a range of commissioning strategies and plans, including the NHS Joint Forward Plan, Place-Based Partnership Plans, the Primary Care Strategy (covering plans for general practice, community pharmacy, optometry and dentistry), Mental Health Inpatient Strategic Plan, and Special Educational Needs and Disabilities Joint Commissioning Strategy. The Committee has also reviewed progress against a range of key service transformation programmes, including preventative care and long-term conditions management and community services, and maintained oversight of the mobilisation and evaluation of the Health Inequalities and Innovation Fund schemes. The Committee also considered and approved a number of business cases relating to healthcare investments, contract awards and commissioning policies, in addition to having strategic commissioning discussions regarding the future direction of services, with a focus on long-term service transformation and financial sustainability. Detailed assurance reports were also received in relation to the ICB's arrangements for discharging its delegated primary medical services contracting responsibilities, making individual funding request decisions, implementing the NHS Provider Selection Regime and patient choice accreditation requirements, and working in partnership with people and communities through use of citizen intelligence and coproduction activities. Development and delivery of the ICS Research Strategy was also overseen.

Non-Executive Director Remuneration Panel

The Non-Executive Director Remuneration Panel has been established to set the remuneration, fees, allowances and other terms of appointment for the non-executive members of the Board (excluding the ICB's Chair, whose remuneration is set by NHS England). The Panel is comprised of the ICB's Chair, the Director of Corporate Affairs and one of the Partner Members of the Board. The Panel is convened to meet only as required, which has not been necessary during the reporting period.

Auditor Panel

The Auditor Panel exists to advise the Board on the selection and appointment of the organisation's external auditor. Its responsibilities include agreeing and overseeing a robust process for selecting the external auditors in line with the organisation's normal procurement rules. The Panel's membership is comprised of three Non-Executive Directors of the Board. There has been no requirement to convene a meeting of the Auditor Panel during the reporting period.

Joint Committees

The Board has also established the following joint committees to assist with the discharge of the ICB's statutory duties and functions:

Nottingham and Nottinghamshire Integrated Care Partnership – Section 116ZA of the Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Care Act 2022), requires ICBs and upper tier Local Authorities to establish Integrated Care Partnerships (ICPs) as equal partners. In Nottingham and Nottinghamshire, an ICP has

been established as a joint committee of Nottingham City Council, Nottinghamshire County Council and NHS Nottingham and Nottinghamshire ICB. The primary role of the ICP is to lead on creating an Integrated Care Strategy and Outcomes Framework to reduce health inequalities and improve health and care outcomes and experiences for the Nottingham and Nottinghamshire population. In doing so, the ICP acts as the 'guiding mind' of the local health and care system, providing a forum for NHS leaders and Local Authorities to come together with important stakeholders from across the wider system and communities.

The ICP met twice during the reporting period, maintaining oversight of delivery against the Integrated Care Strategy, with continued focus on prevention, equity and integration. Members endorsed a 'light touch' refresh of the Strategy, narrowing focus to areas where system-wide collaboration adds the most value, including frailty, early years and integrated neighbourhood working. The development of an outcomes framework was also supported to enable the tracking of progress against the Strategy. The ICP reviewed its own membership and structure in-year, agreeing to increase the frequency of meetings from two to three per year.

More information about the ICP's terms of reference and membership is available here: https://healthandcarenotts.co.uk/about-us/our-integrated-care-partnership/.

East Midlands Joint Commissioning Committee – NHS England has delegated some of its direct commissioning functions to ICBs, with the aim of breaking down barriers and joining up fragmented pathways to deliver better health and care, so that patients can receive high quality services that are planned and resourced where people need it. NHS Nottingham and Nottinghamshire ICB has established a formal Joint Working Agreement with NHS Derby and Derbyshire ICB, NHS Leicester, Leicestershire and Rutland ICB, NHS Lincolnshire ICB and NHS Northamptonshire ICB under section 65Z5 of the NHS Act, to jointly exercise its delegated commissioning functions relating to primary pharmacy and optometry services, primary and secondary dental services, and specialised acute services. The joint working arrangements include the establishment of an East Midlands Joint Commissioning Committee to jointly govern the exercise of these commissioning functions.

Membership of the East Midlands Joint Commissioning Committee is comprised of the Chairs and Chief Executives of the five ICBs and is currently chaired by the Chair of NHS Nottingham and Nottinghamshire ICB. The Committee met five times during the year, with a key focus on strengthening governance arrangements in anticipation of the full delegation of specialised services. The Committee also addressed a range of service-specific issues. It reviewed and approved updates across primary care areas, including dental recovery plans, pharmacy expansion, and optometry initiatives. Assurance reports on financial performance, quality and system pressures were regular agenda items.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, compliance with relevant principles of the Code is good practice.

This governance statement is intended to demonstrate how the ICB had regard to the principles set out in the code (as appropriate to ICBs) during the reporting period and up to the date of signing this statement.

Discharge of statutory functions

The ICB has reviewed all the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that the ICB is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to an Executive Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all the ICB's statutory duties.

Risk management arrangements and effectiveness

A fundamental aspect of the ICB's governance structure is the establishment and implementation of sound risk management arrangements. The ICB's Risk Management Policy clearly sets out the processes in place to ensure the systematic identification, assessment, evaluation and control of risks; both operational and strategic, via the Operational Risk Register and Board Assurance Framework respectively.

The ICB's Risk Management Policy was developed in recognition that well-managed risk-taking can contribute positively to organisational and system performance, allowing for innovation and improvement. A key part of the policy is the ICB's defined risk appetite, which sets out the level of risk agreed by the Board in terms of risk-taking and risk-tolerance.

The organisation's strategic risks are outlined within the Board Assurance Framework, which provides the Board with confidence that the ICB has identified its strategic risks and has robust systems, policies and processes in place that are effective and driving the delivery of its strategic objectives. The Assurance Framework is managed as a continuous process, which informs the development of Board and committee annual work programmes and ensures sufficient planned assurances are in place to support the management of the ICB's strategic risks across the year. All strategic risks are owned by an Executive Director of the ICB, and the Board receives bi-annual updates on their status.

Operational risks are current, 'live' risks that the organisation is facing, which are by-products of day-to-day business delivery. They arise from definite events or circumstances and have the potential to impact negatively on either the organisation's objectives or system priorities. Operational risks are captured within the ICB's Operational Risk Register and are owned by members of the ICB's Senior Leadership Team.

Within our ICS, we have defined system risk management as the collective identification, assessment and mitigation of risks where improved outcomes can be achieved by system partners working together through shared accountability arrangements. We see it as a value-added activity that complements individual organisational arrangements. In line with the ICB's leadership role within the system, we have taken forward the co-ordination and facilitation of system risk management arrangements, and the ICB's Operational Risk Register is used to capture the system risks that require more than one system partner to manage or that are not unique to a single system partner.

A separate fraud risk register is also maintained by the ICB and reported to the Audit and Risk Committee once a year, in line with the ICB's annual fraud risk assessment. Mitigations identified in relation to the potential fraud risks largely relate to processes already in place as part of the ICB's system of internal control.

Risk management is fully embedded within ICB activities, enabling robust risk identification, assessment and scrutiny. Risks are identified, both proactively and reactively, through an assortment of means, such as horizon scanning, external and self-assessments (including internal and external audits), formal risk assessments and during committee, system group and routine team meetings. Regular meetings are held with Executive Directors and senior managers to discuss new or evolving risks within their respective portfolios/teams, both in terms of statutory ICB responsibilities and system priorities. How risks may impact on the public, and/or other stakeholders, is considered at the initial risk identification stage and then in more depth by relevant senior managers, including the ICB's Director of Communication and Engagement, to ensure that the correct approach to any communication is taken.

All risks are assessed by defining qualitative measures of impact and likelihood and scored methodically using the organisational risk scoring matrix. Risks and risk scores are initially subject to challenge from senior managers to ensure that the full consequences of the risk have been considered. Risks are then prioritised for management action dependent on the current (residual) risk score, in line with the ICB's risk appetite.

Robust mechanisms are in place to ensure effective reporting and scrutiny mechanisms of all risks, incidents and near misses. All committees of the Board are responsible for monitoring risks that relate to their terms of reference and all major operational risks are reported at every meeting of

the Board. Incidents and near misses are captured, and reported to, the Health and Safety Steering Group or the Information Governance Steering Group and upwards to the Audit and Risk Committee, if appropriate, to ensure action has been taken and lessons learnt.

The Audit and Risk Committee has delegated responsibility for ensuring the effectiveness of the ICB's risk management arrangements, discharging this through receipt of comprehensive bi-annual risk management updates and a rolling programme of Executive-led Board Assurance Framework targeted assurance reports.

Capacity to handle risk

The ICB ensures its ongoing capacity to handle risk in several ways. The Risk Management Policy is owned by the Board and its members provide leadership to the total risk management function. However, risk is the business of all staff, and managers are expected to lead by example by ensuring that risk management is acknowledged and embedded throughout the organisation and across the system.

All members of the Executive and Senior Leadership Team are accountable for the effective management of risk within their areas of responsibility. This includes ensuring that appropriate controls are in place and that appropriate risk identification, and mitigating actions are progressed and monitored.

Operational Risk Reports are routinely reported to the each of the Board's committees. Reports outline relevant operational risks that are in the remit of the respective committee, including any risks scored as being high or extreme, any new risks that have been identified, as well as any risks where the risk score has been mitigated to a level that they can be removed from the Operational Risk Register. All high and extreme operational risks are reported to each meeting of the Board.

Risk awareness is a key element of the organisation's approach to risk management, ensuring that all staff understand and can discharge their roles and responsibilities in relation to risk. This approach is led by officers with in-house expertise in risk management who proactively raise awareness of the policy through the delivery of training and provision of ongoing support to committees, teams and individuals to enable them to discharge their responsibilities. A suite of risk training guidance and presentation materials support staff in understanding their responsibilities in relation to risk management.

Risk assessment

During the year, the ICB has identified and monitored a number of key risks that may impact patient care, service delivery, and financial sustainability. Below is a summary of these risks, along with the actions being taken to address them.

- Pressures on urgent and emergency care – The potential for patient harm due to delays in ambulance response times and long hospital stays. This risk is being mitigated through better alignment of capacity and demand, discharge pathway reviews, quicker handovers, and strengthened monitoring and oversight arrangements.
- Rising demand for mental health services – The potential for treatment delays and worsening mental health outcomes due to increasing numbers of people requiring mental health support, combined with higher complexity and comorbidities. This risk is being mitigated through work to expand integrated mental health pathways, with a focus on enhanced crisis services, accessible therapies and early intervention initiatives.
- Mental health bed shortages – The potential for delayed care and out-of-area placements due to a lack of inpatient mental health beds and limited community placements. This risk is being mitigated through admission audits and strengthening of bed management processes, with clearer discharge procedures and pathway improvements.
- Mental health service quality – The potential for longer-term service improvements to be delayed due to ongoing concerns regarding the quality of mental health services at Nottinghamshire Healthcare NHS Foundation Trust. This risk is being mitigated through implementation of the Trust's improvement plan, with strengthened monitoring and oversight arrangements.

- Support for people with learning disabilities and autism – The potential for some individuals to remain in restrictive or inpatient settings longer than necessary, due to a lack of appropriate community support. This risk is being mitigated through the establishment of a new support register, updated discharge processes, and plans for self-contained accommodation.
- Maternity care improvements – The potential for poor experiences and outcomes for mothers and babies due to ongoing challenges in maternity services at Nottingham University Hospitals NHS Trust. This risk is being mitigated through delivery of a dedicated improvement plan, which includes learning from the Independent Maternity Review, and strengthened monitoring and oversight arrangements, which include a programme of ICB quality insight visits.
- Primary care challenges and GP collective action – The potential impact on long-term conditions management and overall patient care, including delivery of national primary care access targets, due to workforce and resource constraints and potential collective action. This risk is being mitigated through strengthened engagement with GPs and proactive partnership working, and through delivery of plans to improve appointment availability and patient access.
- Staff wellbeing and burnout – The potential for increased exhaustion and sickness absence due to high workloads and staff shortages, particularly in primary care. This risk is being mitigated through strengthened workforce planning, resource optimisation, and transformation programs being implemented to manage demand.
- Long-term workforce planning challenges – The potential challenge to meeting future healthcare demands due to a short-term and inconsistent approach to workforce planning. This risk is being mitigated through a more standardised and long-term approach to workforce planning, which is being developed across NHS partners.
- Financial pressures on the ICB and wider NHS system – The potential challenge to ICB and wider NHS system financial recovery and sustainability due to rising costs, slow progress on transformation programs, reliance on short-term financial solutions, and unmet efficiency targets. This risk is being mitigated through strengthened financial 'grip and control' processes, with executive-led recovery plans in place. Financial monitoring oversight arrangements have also been reinforced, including system-wide productivity and efficiency meetings and vacancy control measures.
- Barriers to digital transformation – The potential for limitations in available resources to impact the pace of new digital health technologies being adopted. This risk is being mitigated through strengthened monitoring and oversight arrangements, which are ensuring prioritisation of key projects, such as Electronic Patient Records.
- Cybersecurity threats – The potential for healthcare services to be disrupted and access to records and essential equipment impacted due to a successful cyber-attack. This risk is being mitigated through delivery of a system-wide cyber security strategy, focused on enhancing digital solutions to reduce vulnerabilities and reducing risks related to emerging technologies.
- Public confidence in healthcare services – The potential for public trust to be undermined because of high-profile service quality concerns, particularly in maternity and mental health services. This risk is being mitigated through targeted public engagement and communication activities, alongside transformation programs to improve service quality.

These risks will continue to be closely monitored, with ongoing improvements and governance in place to ensure high-quality, sustainable care across Nottingham and Nottinghamshire.

Other sources of assurance:

Internal control framework

A system of internal control is the set of processes and procedures in place in the ICB to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised

and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The ICB has established a wide range of monitoring procedures to ensure that the organisation's system of internal control continues to operate effectively and that controls do not deteriorate over time. These include the work of a range of operational steering groups and the work of the Board and its committees. Of note is the role of the Audit and Risk Committee in relation to the scrutiny of the Board Assurance Framework and progress against any gaps in controls and assurances that have been identified.

Management of conflicts of interest

The National Health Service Act 2006 (as amended) places specific conflicts of interest duties upon ICBs, which are described further in NHS England guidance on Managing Conflicts of Interest in the NHS. In summary, this guidance stipulates the requirement for clear and well communicated processes, defined roles and responsibilities, the provision of advice, training and support and the maintenance of a register of interests.

The ICB has established robust arrangements in line with all of these requirements, which are over overseen by the Audit and Risk Committee. We maintain a register with the declared interests of all ICB employees and appointees and an annual assurance exercise is completed to confirm the completeness and accuracy of the register. As described in the Members report section of this Annual Report, the declared interests for all individuals with ICB decision-making authority are published on the ICB's website.

The ICB is mindful that conflicts of interest can potentially arise in our day to day working. We have therefore embedded robust systems and processes for identifying and managing these in our key business activities, such as in our Board and committee meeting arrangements and during procurement exercises.

Data quality

The ICB recognises that good quality data is essential for the effective commissioning of services and underpins the delivery of high-quality patient care. Data quality is central to the organisation's ongoing ability to meet its statutory, legal and financial responsibilities.

The ICB has established a Data Quality Policy which sets out roles and responsibilities, along with the required approach to data quality within the organisation, including validation processes to ensure data is complete, accurate, relevant and timely.

All committees and sub-committees of the Board are also responsible for assuring themselves of the quality of data informing their decisions, and this duty is built into their respective terms of reference. This includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.

No issues have been raised by the Board or its committees regarding the quality of data received during the reporting period.

Information governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by a Data Security and Protection Toolkit, which for 2024/25 has been updated to align with the National Cyber Security Centre's Cyber Assessment Framework. An annual assessment against the toolkit's requirements provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework, which is underpinned by a comprehensive suite of information governance policies that outline the mechanisms in place to ensure that risks to confidentiality and data security are effectively managed and controlled.

The roles of Senior Information Risk Owner (SIRO) and Caldicott Guardian have been assigned to appropriate members of the organisation's Executive Team. The ICB also has a designated Data Protection Officer (DPO) in line with the requirements of the UK General Data Protection Regulation (GDPR). Our Audit and Risk Committee is responsible for scrutinising the ICB's compliance with legislative and regulatory requirements relating to information governance and the extent to which associated systems and processes are effective and embedded. The Committee is supported in the achievement of these duties by an Information Governance Steering Group which has been established to operationally drive forward the information governance agenda.

All staff are required to undertake the latest annual information governance training, which is supplemented by further specific role-based training and awareness raising activities in line with the ICB's Staff Training, Awareness and Communications Plan.

Staff are issued with an Information Governance Handbook on their induction to the ICB and in-house expertise is also available to support and guide staff in relation to confidentiality, data protection and information security. We have well-established arrangements and processes for information risk management and incident reporting and investigation of serious information incidents.

The ICB is anticipating full compliance with the requirements of the Data Security and Protection Toolkit by the submission deadline of 30 June 2025. Monthly progress is monitored by the Information Governance Steering Group, which is periodically overseen by the Audit and Risk Committee.

Business critical models

In line with the best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models, I can confirm that the ICB has an appropriate framework and environment in place to provide quality assurance of business-critical models.

Third party assurances

I also receive assurance through reports from audits performed on other organisations that provide services to the ICB. During the year, the ICB has received reports relating to:

- Arden and Greater East Midlands Commissioning Support Unit – payroll services
- NHS Shared Business Services – employment services
- NHS Shared Business Services – financial and accounting services
- NHS Business Services Authority – prescription payments
- NHS Business Services Authority – dental payments
- Capita – GP payment services
- NHS ESR – electronic staff records system

In reviewing the above reports, I have noted that most of the services have received unqualified audit opinions, indicating that appropriate controls are in place, with only minor or no exceptions noted. Three services (payroll, finance and accounting services and GP payment services) received qualified opinions due to a small number of control weaknesses; such as delayed removal of user access, lack of validation checks or insufficient evidence of appropriate approvals. However, it is important to note that one of these qualifications related to a particular element of the service not procured by the ICB. In all cases, an appropriate management response has been provided to address the exceptions identified, and I am satisfied with this response.

Control issues

There have been no significant control issues identified during the period 1 April 2024 to 31 March 2025.

Review of economy, efficiency, and effectiveness of the use of resources

The ICB's Board has oversight of the appropriateness of the organisation's arrangements to exercise its functions effectively, efficiently and economically, and as Accountable

Officer, I have overall executive responsibility for the use of resources. The following key processes and review and assurance mechanisms have been established within the organisation to ensure that we meet our statutory duty to act effectively, efficiently and economically:

- Clear Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions have been set out to ensure proper stewardship of public money and assets. The ICB also has clear policies in relation to the required standards of business conduct.
- A Procurement and Provider Selection Policy is in place, which reflects the requirements of the NHS Provider Selection Regime. The Policy sets out the organisation's approach for establishing contracts that provide value for money in line with the principles of good procurement practice, and clearly requires the ICB to ensure the delivery of improved efficiency and effectiveness in the provision of healthcare and non-healthcare services. The Audit and Risk Committee oversees compliance with the requirements of the NHS Provider Selection Regime, which includes oversight of annual reporting requirements, oversight of the ICB's monitoring and publication arrangements, and retrospective reporting of all provider representations received in relation to procurement and contract award decisions for healthcare services. The Committee also scrutinises all instances where requirements for formal competitive tendering or competitive quotations have been waived.
- The ICB has developed a strategic decision-making framework and service change review process, which ensures the robust evaluation of business case proposals for new investments, recurrent funding allocations and decommissioning and disinvestment of services in several areas, including clinical and cost effectiveness, productivity and value for money, affordability, anticipated health benefits (improved health outcomes and reduced health inequalities).
- Robust financial procedures and controls and effective financial management and financial planning arrangements have also been established, which are set out within the organisation's Standing Financial Instructions. These cover the management of resource allocations for healthcare services and running cost allowances to cover the ICB's management costs and costs of commissioning support. The Director of Finance provides reports to every meeting of the Board on financial performance, including performance against the organisation's statutory financial duties and the delivery of required efficiencies.
- The Remuneration and Human Resources Committee is in place with responsibility for reviewing the remuneration and terms of service for key senior leaders within the ICB. Suitable arrangements have been established to ensure that no member of the Committee participates in discussions and decisions about their own remuneration.
- The ICB has clear internal audit, external audit and counter fraud arrangements, which provide independent assurance to the organisation on a range of systems and processes that are designed to deliver economy, efficiency and effectiveness, including the organisation's annual accounts and reporting process.

Commissioning of delegated specialised services

The ICB signed a delegation agreement (DA) with NHS England and held full commissioning responsibilities for delegated services during the 2024/25 reporting period.

To the best of ICB leadership's knowledge, the commissioning of all delegated services has been compliant with the ten core commissioning requirements – as set out in the 2024/25 Delegated Commissioning Assurance Guidance, published by NHS England – including the requirement that all conditions set out in the DA are being met.

Where there were known compliance issues, the ICB leadership has engaged with NHS England's regional leadership to notify and address such issues in a timely manner.

The ICB leadership is able to provide the necessary evidence of core commissioning requirements compliance, should NHS England or a third party ask for such evidence.

Delegation of functions

The ICB is party to several section 75 partnership arrangements (under section 75 of the National Health Service Act 2006), which allow health and social care commissioners to take decisions in a collaborative way and ensure that both parties implement the decisions taken. Four such arrangements are in place with Nottingham City Council, relating to the Better Care Fund, Domestic Violence, Tier 2 Child and Adolescent Mental Health Services and Infection Prevention and Control (IPC), and two arrangements are in place with Nottinghamshire County Council, relating to the Better Care Fund and the Integrated Community Equipment Loan Service. For all section 75 partnership arrangements, the relevant Council acts as host, with overall strategic responsibility sitting with the Nottingham City and Nottinghamshire County Health and Wellbeing Boards. Oversight of the ICB's partnership arrangements is performed by the Strategic Planning and Integration Committee. No issues have been raised during the reporting period.

Counter fraud arrangements

The ICB has established arrangements to prevent fraud, bribery and corruption, and to deal with it should it occur. An accredited Counter Fraud Specialist (CFS) is contracted to undertake counter fraud work proportionate to the ICB's identified risks. This work is delivered through the production and implementation of an organisational fraud, bribery and corruption risk assessment and work plan, developed in line with national standards.

The ICB's Director of Finance has executive responsibility for the organisation's counter fraud arrangements, with the Audit and Risk Committee taking an oversight and scrutiny role in this area.

NHS organisations are required to demonstrate their compliance across 13 key counter fraud requirements through the annual self-assessment process the Government Functional Standard 013: Counter Fraud. The ICB have achieved an overall 'Green' rating for 2024/25.

Head of internal audit opinion

Following completion of the planned audit work for the period 1 April 2024 to 31 March 2025 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control. The Head of Internal Audit opinion stated:

"I am providing an opinion of significant assurance that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and controls are generally being applied consistently.

My opinion takes into account third party assurances received by the organisation".

During the year, Internal Audit issued the following audit reports:

Audit	Level of assurance
Data Quality (2324/NNICB/13)	Significant
Data Security and Protection Toolkit (2425/NNICB/01)	Substantial[34]
Delivering the People Plan (2425/NNICB/02)	Moderate
Delivering Digital Transformation (2425/NNICB/03)	Significant
Financial Systems (2425/NNICB/04)	Significant
Board Assurance Framework (2425/NNICB/05)	Significant
Provider Selection Regime (2425/NNICB/06)	Significant
Governance (2425/NNICB/07)	Substantial
Budgetary Control and Budget Management (2425/NNICB/09)	Significant
Framework for Clinical and Care Professional Leadership (2425/NNICB/10)	Moderate
Patient Safety and Incident Reporting Framework (2425/NNICB/12)	Moderate

Two further advisory reports have been issued, both of which were undertaken with NHS system partners: System-wide Discharge Arrangements and System Governance. No opinion was provided for these reports; however, areas of learning were

[34] Opinion in line with the DSPT Independent Assessment Framework

highlighted, and actions were suggested to enhance existing arrangements.

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive directors and senior managers within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review has also been informed by comments made by the external auditors in their annual audit letter and other reports.

The Board Assurance Framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its strategic objectives have been reviewed.

I have been advised on the implications of the result of my review by the Board, the Audit and Risk Committee and other committees as necessary and plans to address any weaknesses and to ensure continuous improvement of the system are in place.

Previous sections of this Governance Statement set out our approach to reviewing the ongoing effectiveness of the system of internal control, particularly in relation to the role of the Board and its committees. I have also been informed by the broad range of internal and external assurances received by the ICB during the year, as set out within the Board Assurance Framework.

Conclusion

My review of the effectiveness of governance, risk management and internal control has confirmed that the ICB has a generally sound system of internal control that supports the achievement of its policies, aims and objectives, and that there have been no significant control issues during the period 1 April 2024 to 31 March 2025.

Remuneration and Staff Report

Remuneration report

The Remuneration and Human Resources Committee

Our Remuneration and Human Resources Committee's membership is comprised entirely of Non-Executive Directors from our Board. Members of the Committee during the period 1 April 2024 to 31 March 2025 were as follows:

- Jon Towler (Chair of the Committee until 31 December 2024)
- Mehrunnisa Lalani (Chair of the Committee from 1 January 2025, when membership commenced)
- Dr Kathy McLean
- Stephen Jackson (membership ceased 31 October 2024)
- Professor Marios Adamou (membership ceased 31 December 2024)

We have also established a Non-Executive Director Remuneration Panel to agree the salaries of the ICB's Non-Executive Directors. Members of the Panel are the ICB's Chair (whose salary is determined by NHS England), the ICB's Director of Corporate Affairs and a Partner Member of the Board (who is not remunerated by the ICB).

Further details on the work of the Remuneration and Human Resources Committee and the Non-Executive Director Remuneration Panel during the reporting period are provided in the Governance statement contained within this Annual Report.

Policy on the remuneration of senior managers

For the purpose of this Remuneration report, senior managers are defined as being 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the ICB'. This means those who influence the decisions of the organisation as a whole, rather than the decisions of individual directorates or departments. As such, where this report discusses senior managers, we are referring to the members of our Board.

The remuneration of our Executive Directors and other Very Senior Managers is approved by the Remuneration and Human Resources Committee. Remuneration levels are determined in line with the national ICB Executive Pay Framework and benchmarking data. The Committee is responsible for reviewing senior managers' pay in terms of both basic pay awards and cost of living increases.

The remuneration of the ICB's Non-Executive Directors is set in line with the national framework for ICB non-executive member remuneration and is approved by our Non-Executive Director Remuneration Panel. The remuneration of the ICB's Chair is set by NHS England.

Legislation allows for the Partner Members of the Board to be remunerated where relevant, recognising that what is appropriate may vary for different members, depending on their circumstances. However, national guidance is clear that no members should be paid twice for the same time by different organisations. In line with this, the ICB has determined that the NHS Trust and Foundation Trust Partner Members and the Local Authority Partner Members are unremunerated appointments. The Primary Care Partner Member will be required to commit time to the ICB in relation to their appointment for which they will not be remunerated by their practice. As such, this role is remunerated at a standard sessional rate, calculated based on backfill costs.

The ICB does not operate any performance-related pay arrangements.

Standard contracts have been established for all senior manager posts, which differ depending on whether the post is appointed for a term of office (as is the case for some Board roles, such as our Non-Executive Directors and Partner Members) or is an employed position (as is the case for our Executive Directors and other Very Senior Managers). Standard notice periods are three months for both the employer and employee.

Remuneration of Very Senior Managers

Four Very Senior Managers are paid more than £150,000 per annum pro rata (2024/25: Five VSMs were paid more than £150,000). The ICB has

satisfied itself that this remuneration is reasonable via the Remuneration and Human Resources Committee, which has assured itself that the remuneration is in line with the ICB's policy on the remuneration of senior managers (see above).

Percentage change in remuneration of highest paid director (subject to audit)

2024/25	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	5.0%	-
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	6.8%	-

2023/24	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	5.0%	-
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	3.6%	-

During 2024/25, the ICB's Remuneration and Human Resources Committee approved a 5% pay uplift to all Very Senior Managers' salaries in line with the Government's acceptance of the pay recommendations of the Review Body on Senior Salaries for Senior Leaders in the NHS in England.

Pay ratio information (subject to audit)

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director/member in their organisation against the twenty-fifth percentile, median and seventy-fifth percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the twenty-fifth percentile, median and seventy-fifth percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director/member in NHS Nottingham and Nottinghamshire ICB in the reporting period 1 April 2024 to 31 March 2025 was £215,000 to £220,000 (2023/24: £205,000 to £210,000). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2024/25	25th percentile	Median pay ratio	75th percentile
Total remuneration	£37,339	£52,809	£66,247
Salary component of total remuneration	£37,339	£52,809	£66,247
Pay ratio information	5.83	4.12	3.28

2023/24	25th percentile	Median pay ratio	75th percentile
Total remuneration	£35,392	£45,996	£58,972
Salary component of total remuneration	£35,392	£45,996	£58,972
Pay ratio information	5.86	4.51	3.52

The differential pay uplifts to salaries for staff and Very Senior Managers during 2024/25 accounts for the change in ratio information from 2023/24.

During the reporting period 2024/25, no employees received remuneration in excess of the highest-paid director/member (2023/24: 0).

Remuneration ranged from £16,000 to £215,759 (2023/24: £13,738 to £205,485).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Compensation on early retirement or for loss of office (subject to audit)

There were no payments for early retirement or loss of office made in 2024/25 (2023/24: 0)

Payments to past directors (subject to audit)

There were no payments to past directors made in 2024/25 (2023/24: 0).

Senior manager remuneration, including salary and pension entitlements (subject to audit)

	1 April 2024 to 31 March 2025:						1 April 2023 to 31 March 2024:					
Name and title	**(a) Salary** *(bands of £5,000)*	**(b) Expense payments (taxable)** *(to nearest £100[35])*	**(c) Performance pay and bonuses** *(bands of £5,000)*	**(d) Long term performance pay and bonuses** *(bands of £5,000)*	**(e) All pension-related benefits** *(bands of £2,500)*	**(f) TOTAL (a to e)** *(bands of £5,000)*	**(a) Salary** *(bands of £5,000)*	**(b) Expense payments (taxable)** *(to nearest £100[1])*	**(c) Performance pay and bonuses** *(bands of £5,000)*	**(d) Long term performance pay and bonuses** *(bands of £5,000)*	**(e) All pension-related benefits** *(bands of £2,500)*	**(f) TOTAL (a to e)** *(bands of £5,000)*
Professor Marios Adamou, Non-Executive Director	15-20	0	0	0	0	15-20	15-20	0	0	0	0	15-20
Dr Dave Briggs, Medical Director	160-165	0	0	0	42.5-45	205-210	155-160	0	0	0	0	155-160
Gary Brown, Non-Executive Director[36]	0-5	0	0	0	0	0-5	-	-	-	-	-	-
Lucy Dadge, Director of Integration[37]	70-75	0	0	0	0	70-75	150-155	0	0	0	0	150-155
Stephen Jackson, Non-Executive Director	15-20	0	0	0	0	15-20	15-20	0	0	0	0	15-20
Mehrunnisa Lalani, Non-Executive Director[38]	0-5	0	0	0	0	0-5	-	-	-	-	-	-
Dr Kelvin Lim, Primary Care Partner Member	15-20	0	0	0	0	15-20	15-20	0	0	0	0	15-20
Ifti Majid, NHS Trust Partner Member	0	0	0	0	0	0	0	0	0	0	0	0
Caroline Maley, Non-Executive Director[39]	5-10	0	0	0	0	5-10	15-20	0	0	0	0	15-20
Victoria McGregor-Riley, Acting Director of Strategy and System Development[40]	70-75	0	0	0	50-52.5	125-130	0	0	0	0	0	0
Dr Kathy McLean, Chair	60-65	0	0	0	0	60-65	60-65	0	0	0	0	60-65
Vicky Murphy, Local Authority Partner Member	60-65	0	0	0	0	0	0	0	0	0	0	0
Stuart Poynor, Director of Finance[41]	45-50	0	0	0	0	45-50	165-170	0	0	0	0	165-170
Marcus Pratt, Acting Director of Finance[42]	110-115	0	0	0	72.5-75	185-190	0	0	0	0	0	0
Maria Principe, Acting Director of Delivery and Operations[43]	70-75	0	0	0	32.5-35	105-110	0	0	0	0	0	0
Paul Robinson, NHS Trust Partner Member	0	0	0	0	0	0	0	0	0	0	0	0
Amanda Sullivan, Chief Executive	215-220	0	0	0	0	215-220	205-210	0	0	0	0	205-210
Jon Towler, Non-Executive Director	15-20	0	0	0	0	15-20	15-20	0	0	0	0	15-20
Catherine Underwood, Local Authority Partner Member	0	0	0	0	0	0	0	0	0	0	0	0
Rosa Waddingham, Director of Nursing	155-160	0	0	0	25-27.5	185-190	150-155	0	0	0	37.5-40	190-195
Melanie Williams, Local Authority Partner Member	0	0	0	0	0	0	0	0	0	0	0	0

[35] Taxable expenses and benefits in kind are expressed to the nearest £100.
[36] Full year equivalent salary is £15,000-£20,000.
[37] Full year equivalent salary is £140,000-£145,000.
[38] Full year equivalent salary is £15,000-£20,000.
[39] Full year equivalent salary is £15,000-£20,000.
[40] Full year equivalent salary is £140,000-£145,000.
[41] Full year equivalent salary is £170,000-£175,000.
[42] Full year equivalent salary is £150,000-£155,000.
[43] Full year equivalent salary is £140,000-£145,000.

Pension benefits (subject to audit)

2024/25 Name and title	(a) Real increase in pension at pension age *(bands of £2,500)*	(b) Real increase in pension lump sum at pension age *(bands of £2,500)*	(c) Total accrued pension at pension age at 31 March 2025 *(bands of £5,000)*	(d) Lump sum at pension age related to accrued pension at 31 March 2025 *(bands of £5,000)*	(e) Cash Equivalent Transfer Value[44] at 1 April 2024	(f) Real Increase in Cash Equivalent Transfer Value[45]	(g) Cash Equivalent Transfer Value at 31 March 2025	(h) Employers Contribution to partnership pension
Dr Dave Briggs, Medical Director	2.5-5	0	35-40	75-80	650	37	751	0
Lucy Dadge, Director of Integration	0	0	5-10	0-5	95	4	126	0
Victoria McGregor-Riley, Acting Director of Strategy and System Development	2.5-5	5-7.5	35-40	90-95	667	54	853	0
Stuart Poynor, Director of Finance	0	0	0	0	0	0	0	0
Marcus Pratt, Acting Director of Finance	2.5-5	5-7.5	35-40	90-95	606	64	754	0
Maria Principe, Acting Director of Delivery and Operations	0-2.5	2.5-5	40-45	95-100	723	34	873	0
Amanda Sullivan, Chief Executive	0	0	0	0	0	0	0	0
Rosa Waddingham, Director of Nursing [46]	0-2.5	0	55-60	0-5	769	24	864	0

2023/24 Name and title	(a) Real increase in pension at pension age *(bands of £2,500)*	(b) Real increase in pension lump sum at pension age *(bands of £2,500)*	(c) Total accrued pension at pension age at 31 March 2024 *(bands of £5,000)*	(d) Lump sum at pension age related to accrued pension at 31 March 2024 *(bands of £5,000)*	(e) Cash Equivalent Transfer Value at 1 April 2023	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2024	(h) Employers Contribution to partnership pension
Dr Dave Briggs, Medical Director	0	25-27.5	30-35	70-75	505	74	650	0
Lucy Dadge, Director of Integration	0	17.5-20	35-40	100-105	807	0	95	0
Stuart Poynor, Director of Finance	0	0	0	0	0	0	0	0
Amanda Sullivan, Chief Executive	0	0	0	0	0	0	0	0
Rosa Waddingham, Director of Nursing	2.5-5	0	20-25	0-5	185	61	285	0

Note: Individuals named above may be affected by the public service pensions remedy, which may mean that their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995 to 2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

[44] **Cash Equivalent Transfer Value:** A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

[45] **Real increase in CETV:** This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

[46] The figure for Rosa Waddingham's Cash Equivalent Transfer Value, at 31 March 2024 within 2023/24 reporting and 1 April 2024 within 2024/25 reporting, has seen an adjustment between the reporting periods. This is due to a revision in the information received from the pension's agency in 2024/25, for the period of 2023/24.

Staff report

Number of senior managers and staff composition

The following table provides a breakdown of our workforce by pay band and gender as of 31 March 2025:

Pay band	Female	Male	Number
Band 1	0	0	0
Band 2	0	0	0
Band 3	24	4	28
Band 4	45	7	52
Band 5	61	3	64
Band 6	87	27	114
Band 7	82	30	112
Band 8a	72	23	95
Band 8b	47	18	65
Band 8c	27	7	34
Band 8d	18	9	27
Band 9	11	5	16
Very senior managers (non-Board members)	2	8	10
Any other spot salary (non-Board members)	9	11	20
Board members	8	8	16
Totals	**493**	**160**	**649**

Sickness absence data

Sickness absence data for the ICB for the period January to December 2024 has been provided by NHS England:

Total days lost (whole-time equivalent)	7687.75
Total days available (whole-time equivalent)	205,937
Average working days lost due to sickness absence (per whole-time equivalent)	**8.4**

Staff turnover percentages

The ICB's staff turnover rate (staff leaving the organisation) during the reporting period was 9.6% (on a whole-time equivalent basis)

Staff engagement percentages

The ICB participated in the 2024 NHS Staff Survey. We had a response rate of 74%, which is in line with the average response rate for the ICB benchmark group (74%).

The survey results showed good progress in some key areas, including appraisal uptake, flexible working and access to learning and development. However, the results also highlighted a number of areas where actions are required, including the need to improve the quality of appraisals, address work-related stress, and explore career progression opportunities. Reports of bullying and harassment have increased slightly from the previous year, with 12% of staff reporting they have experiencing this from managers (up from 8% in 2023) and 13% from colleagues (12% in 2023).

The ICB's Executive Team is now working with staff to develop an action plan focused on making improvements in these areas. Once finalised, our Executive Human Resources Steering Group, which is led by our Chief Executive, will be responsible for ensuring delivery of the plan, which will be overseen by our Remuneration and Human Resources Committee on behalf of the Board.

Staff policies and other employee matters

The ICB has policies in place to provide guidance to all employees. We are committed to being a fair and inclusive employer, and continually strive to maintain a working environment that promotes the health and wellbeing of our employees. We have therefore taken positive steps to ensure that our policies deal with equality implications relating to recruitment and selection, pay and benefits, flexible working hours, training and development, and that we have policies around managing employees and protecting employees from harassment, victimisation and discrimination. This includes working to the requirements of the NHS Workforce Race Equality Standard (WRES) and the NHS Workforce Disability Equality Standard (WDES), which aim to ensure that employees from black and minority ethnic backgrounds and those that identify as disabled have equal access to career opportunities and receive fair treatment in the workplace.

We are accredited under the Disability Confident employer scheme, which encourages us to think differently about disability and take action to improve how we recruit, retain and develop disabled people. As part of this, we operate a Guaranteed Interview Scheme, which ensures an interview for any candidate with a disclosed disability whose application meets all of the essential criteria for the post.

Our Sickness Absence Policy supports disabled employees and states that in cases where the employee is disabled within the meaning of the

Equality Act 2010, or where employees become disabled and wish to remain in employment, every effort will be made to make reasonable adjustments or find an alternative post. We continue to support a number of our employees with complex health conditions, and in undertaking neurodiversity assessments, to support them in the workplace. As a result of these assessments, some staff have been recognised as having a disability as described within the Equality Act 2010.

Our Equality Improvement Plan includes specific workforce objectives to ensure that we are a diverse and inclusive organisation and that our workforce, at all levels, is representative of the communities, neighbourhoods and diverse cultures within Nottingham and Nottinghamshire. The ICB continues to monitor the profile of our workforce and has a number of action plans relating to WRES, WDES and the NHS Equality Delivery System.

We have a number of staff networks in place, including our Staff Engagement Group, our LGBTQ+ Staff Network, our Staff Disability and Wellbeing Network (DAWN), and our Race Equity Staff Network, each with an Executive sponsor. The networks provide a safe space for staff to discuss their lived experiences, or those of their family, friends or wider communities and networks, with the aim of ensuring an inclusive and diverse working environment for all staff, with no fear of discrimination or disrespect. The staff networks are seen as key advisory forums to support the work of the ICB as an employer, but also as a commissioner of health services, through the provision of shared insights, constructive challenge to existing ways of working, and through the co-production of equality initiatives and improvement plans.

As with all employers, we are required to comply with health, safety and fire legislation. We are committed to a culture of health and safety awareness in our organisation and in providing a secure and healthy environment for our employees and any other individual who may come into contact with the organisation's activities. We ensure this by having robust arrangements in place for the delivery of all statutory and mandatory requirements in relation to health, safety and fire and by ensuring that all staff are sufficiently trained and instructed in these areas. This includes the relevant policies and procedures for staff who are working from home.

To support the wellbeing of our staff, we have an occupational health service and employee assistance programme in place. This is supported by regular communications to staff on health and wellbeing and an online wellbeing portal.

Staff are actively encouraged to speak up about any matters that concern them and whilst we foster positive relationships across our organisation to enable individuals to do so, we also understand this may not always be an approach that individuals wish to take forward. We have a Freedom to Speak Up (FTSU) Policy, aligned to NHS England guidance, that sets out our arrangements for staff who wish to raise any issues in confidence and to ensure that the organisation is meeting its legal requirements with regard to the Public Interest Disclosure Act 1998 (PIDA). As part of our arrangements, we have an employed FTSU Guardian, with executive leadership of FTSU provided by our Director of Nursing. Independent support for the arrangements is available via a Board appointed Non-Executive Director, which enables an objective perspective to be provided on arrangements. The effectiveness of our FTSU arrangements is overseen by the ICB's Audit and Risk Committee, with evaluation provided through insights gained from our annual staff survey results and case data monitoring. As concerns can often be remedied at an early stage (for example, with the individual's line manager) and remain confidential, it is difficult to fully assess the effectiveness of our arrangements. However, no specific concerns regarding the ability to speak up were raised as part of this year's staff survey results and we are not aware of any external disclosures being made to a prescribed body during 2024/25.

Trade union facility time reporting requirements

Table 1: Trade union facility time

Number of relevant union officials during 1 April 2023 to 31 March 2024	2
Whole-time equivalent employee number	2.0
Percentage of time spent on facility time	0%

Table 2: Percentage of pay bill spent on facility time

Total cost of facility time	£0
Total pay bill	££40,020,110
Percentage of total pay bill spent on facility time	0%

Table 3: Paid trade union activities

Time spent on trade union activities as a percentage of paid facility time	0%

Expenditure on consultancy

Expenditure on consultancy for the period 1 April 2024 to 31 March 2025 totalled £1,039,724, which is an increase of £966,552 since the previous reporting period (2023/24: £73,172).

This increase relates to nationally required consultancy support to aid delivery of the 2024/25 financial plan. Although the contract was managed and funded upfront by the ICB, the work was undertaken across NHS system partners, who were subsequently recharged £585,600 of the total cost.

Off-payroll engagements

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as at 31 March 2025, for more than £245[47] per day:

	Number
Number of existing engagements as of 31 March 2025	4
Of which, the number that have existed:	
For less than one year at the time of reporting	4
For between one and two years at the time of reporting	0
For between two and three years at the time of reporting	0
For between three and four years at the time of reporting	0
For four or more years at the time of reporting	0

Existing off-payroll engagements have been subject to a risk-based assessment to ascertain whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2024 and 31 March 2025, for more than £245 per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2024 to 31 March 2025	4
Of which:	
Number not subject to off-payroll legislation[48]	4
Number subject to off-payroll legislation and determined as in-scope of IR35[33]	0
Number subject to off-payroll legislation and determined as out of scope of IR35[33]	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2024 to 31 March 2025:

	2024/25
Number of off-payroll engagements of Board members, and/or senior officers with significant financial responsibility, during reporting period	0
Total number of individuals on payroll and off-payroll that have been deemed "Board members, and/or senior officials with significant financial responsibility", during the reporting period. This figure should include both on payroll and off-payroll engagements	21

[47] The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.
[48] A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Staff numbers and costs (subject to audit)

The following table shows the average number and costs of whole time equivalent (WTE) staff employed by the ICB across the financial year:

2024/25	Number (WTE)	Salary and wages (£000)	Social security costs (£000)	NHS Pension costs (£000)	Other pensions costs (£000)	Termination benefits (£000)	Less: recoveries in respect of outward secondments (£000)	Total Costs (£000)
Permanent	507.18	28,563	3,220	6,360	4	0	0	38,148
Other	22.35	1,872	0	0	0	0	0	1,872
Total	**529.53**	**30,435**	**3,220**	**6,360**	**4**	**0**	**0**	**40,020**

2023/24	Number (WTE)	Salary and wages (£000)	Social security costs (£000)	NHS Pension costs (£000)	Other pensions costs (£000)	Termination benefits (£000)	Less: recoveries in respect of outward secondments (£000)	Total Costs (£000)
Permanent	528.21	25,924	2,910	4,928	4	35	-136	33,665
Other	23.93	1,532	5	4	0	0	0	1,540
Total	**552.14**	**27,456**	**2,915**	**4,932**	**4**	**35**	**-136**	**35,205**

Exit packages, including special (non-contractual) payments (subject to audit)

2024/25 Exit Package cost band (including any special payment element)	Number of compulsory redundancies (Whole numbers only)	Cost of compulsory redundancies (£)	Number of other agreed departures (Whole numbers only)	Cost of other agreed departures (£)	Total number of exit packages (Whole numbers only)	Total cost of exit packages (£)	Number of departures where special payments have been made (Whole numbers only)	Cost of special payment element included in exit packages (£)
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 to £25,000	0	0	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0	0	0
Greater than £200,000	0	0	0	0	0	0	0	0
Totals	**0**	**0**	**0**	**0**	0	0	0	0

2023/24 Exit Package cost band (including any special payment element)	Number of compulsory redundancies (Whole numbers only)	Cost of compulsory redundancies (£)	Number of other agreed departures (Whole numbers only)	Cost of other agreed departures (£)	Total number of exit packages (Whole numbers only)	Total cost of exit packages (£)	Number of departures where special payments have been made (Whole numbers only)	Cost of special payment element included in exit packages (£)
Less than £10,000	1	4,735	0	0	1	4,735	0	0
£10,000 to £25,000	0	0	0	0	0	0	0	0
£25,001 to £50,000	1	30,292	0	0	1	30,292	0	0
£50,001 to £100,000	0	0	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0	0	0
Greater than £200,000	0	0	0	0	0	0	0	0
Totals	**2**	**35,027**	**0**	**0**	2	35,027	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of NHS Agenda for Change Terms and Conditions of Service. Exit costs in this note are accounted for in full in the year of departure. Where NHS Nottingham and Nottinghamshire ICB has agreed early retirements, the additional costs are met by NHS Nottingham and Nottinghamshire ICB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Analysis of Other Departures

The ICB agreed no departures where special payments have been made during the reporting period.

Parliamentary Accountability and Audit Report

NHS Nottingham and Nottinghamshire ICB is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report from 71. An audit certificate and report is also included in this Annual Report at page 93.

Annual Accounts

Signed:

Amanda Sullivan
Accountable Officer

19 June 2025

Contents

Statement of Comprehensive Net Expenditure for the year ended 31 March 2025

	Note	2024-25 £'000	2023-24 £'000
Income from sale of goods and services	2	(36,899)	(43,949)
Other operating income	2	(1,967)	(4,731)
Total operating income		**(38,866)**	**(48,680)**
Staff costs	4	40,020	35,341
Purchase of goods and services	5	3,245,082	2,679,391
Depreciation and impairment charges	5	241	222
Provision expense	5	(612)	(73)
Other operating expenditure	5	561	808
Total operating expenditure		**3,285,292**	**2,715,689**
Net Operating Expenditure		**3,246,426**	**2,667,009**
Finance expense	10	11	12
Other Gains & Losses	9	-	89
Net expenditure for the Year		**3,246,437**	**2,667,110**
Total Net Expenditure for the Financial Year		**3,246,437**	**2,667,110**
Comprehensive Expenditure for the year		**3,246,437**	**2,667,110**

Statement of Financial Position as at 31 March 2025

	Note	2024-25 £'000	2023-24 £'000
Non-current assets:			
Property, plant and equipment	12	345	123
Right-of-use assets	13	996	1,211
Total non-current assets		**1,341**	**1,334**
Current assets:			
Trade and other receivables	17	24,764	28,584
Cash and cash equivalents	20	9	2
Total current assets		**24,773**	**28,586**
Total assets		**26,114**	**29,920**
Current liabilities			
Trade and other payables	23	(104,363)	(109,021)
Lease liabilities	13a	(384)	(305)
Provisions	30	(169)	(781)
Total current liabilities		**(104,916)**	**(110,107)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(78,802)**	**(80,187)**
Non-current liabilities			
Lease liabilities	13a	(795)	(1,010)
Total non-current liabilities		**(795)**	**(1,010)**
Assets less Liabilities		**(79,597)**	**(81,197)**
Financed by Taxpayers' Equity			
General fund		(79,597)	(81,197)
Total taxpayers' equity:		**(79,597)**	**(81,197)**

The notes on pages 71 to 92 form part of this statement.

The financial statements on pages 68 to 70 were approved by the Audit and Risk Committee on 18th June 2024 and signed on its behalf by:

Amanda Sullivan
Chief Accountable Officer

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2025

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2024-25		
Balance at 01 April 2024	(81,197)	**(81,197)**
Changes in NHS Integrated Care Board taxpayers' equity for 2024-25		
Net operating expenditure for the financial year	(3,246,438)	**(3,246,438)**
Net funding	3,248,038	**3,248,038**
Balance at 31 March 2025	**(79,597)**	**(79,597)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2023-24		
Balance at 01 April 2023	(89,273)	**(89,273)**
Changes in NHS Integrated Care Board taxpayers' equity for 2023-24		
Net operating costs for the financial year	(2,667,109)	**(2,667,109)**
Net funding	2,675,185	**2,675,185**
Balance at 31 March 2024	**(81,197)**	**(81,197)**

Statement of Cash Flows for the year ended 31 March 2025

	Note	2024-25 £'000	2023-24 £'000
Cash Flows from Operating Activities			
Net expenditure for the financial year		(3,246,438)	(2,667,110)
Depreciation and amortisation	5	241	222
Movement due to transfer by Modified Absorption		-	89
(Increase)/decrease in trade & other receivables	17	3,821	(7,478)
Increase/(decrease) in trade & other payables	23	(4,658)	(415)
Provisions utilised	30	-	(158)
Increase/(decrease) in provisions	30	(612)	(73)
Net Cash Inflow (Outflow) from Operating Activities		**(3,247,646)**	**(2,674,923)**
Cash Flows from Investing Activities			
Interest Paid/Received		10	-
(Payments) for property, plant and equipment		(248)	(110)
Proceeds from disposal of assets held for sale: property, plant and equipment		-	(89)
Net Cash Inflow (Outflow) from Investing Activities		**(238)**	**(199)**
Net Cash Inflow (Outflow) before Financing		**(3,247,884)**	**(2,675,122)**
Cash Flows from Financing Activities			
Net funding received		3,248,038	2,675,185
Payments in Respect of Finance Lease		(146)	(63)
Net Cash Inflow (Outflow) from Financing Activities		**3,247,892**	**2,675,122**
Net Increase (Decrease) in Cash & Cash Equivalents	20	**8**	**0**
Cash & Cash Equivalents at the Beginning of the Financial Year		**2**	2
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**10**	**2**

The notes on pages 71 to 92 form part of this statement

Notes to the Financial Statements

1 **Accounting Policies**

NHS England has directed that the financial statements of Integrated Care Boards (ICBS) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2024-25 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. If services will continue to be provided in the public sector the financial statements should be prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2025, on a going concern basis.

1.2 **Accounting Convention**

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 **Movement of Assets within the Department of Health and Social Care Group**

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 **Pooled Budgets**

The Integrated Care Board (ICBs) entered into a pooled budget arrangement for Integrated Community Equipment Schemes with Nottinghamshire County Council. Under the arrangements, funds are pooled under section 75 of the NHS Act for Integrated Community Equipment Scheme activities.

The Pool is hosted by Nottinghamshire County Council. As a Commissioner of Healthcare Services, the ICB makes contributions to the pool.

The second pooled budget is 'The Better Care Fund (BCF)' and is hosted by Nottingham City Council, and jointly commissions services to achieve national and local objectives to integrate health and social care services in Nottingham City. It is between the ICB and Nottingham City Council, and its aims are to improve the quality & efficiency of services.

The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement

1.5 **Operating Segments**

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the ICB.

1.6 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
- The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the ICBs is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.7.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.8 **Other Expenses**

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.9 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the ICB recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.10 **Property, Plant & Equipment**

1.10.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the ICB;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and
- The item has a cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.10.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are

measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.10.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11 **Intangible Assets**

1.11.1 **Recognition**

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the ICB's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the ICB;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.11.2 **Measurement**

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating . Internally developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.11.3 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the ICB expects to obtain economic benefits or service potential from the asset. This is specific to the ICB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the ICB checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.12 Leases

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.
The ICB assesses whether a contract is or contains a lease, at inception of the contract.

1.12.1 The ICB as Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease. The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.13 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

1.14 **Provisions**

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be

made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A nominal short-term rate of 4.03% (2023-24: 4.26%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date
- A nominal medium-term rate of 4.07% (2023-24: 4.03%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date
- A nominal long-term rate of 4.81% (2023-24: 4.72%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date
- A nominal very long-term rate of 4.55% (2023-24: 4.40%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably

A restructuring provision is recognised when the ICB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.15 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with ICB.

1.16 **Non-clinical Risk Pooling**

The ICB participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.17 **Contingent Liabilities and Contingent Assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.18 **Financial Assets**

Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.18.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.18.2 **Financial assets at fair value through other comprehensive income**

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the ICB elected to measure an equity instrument in this category on initial recognition.

1.18.3 **Financial assets at fair value through profit and loss**

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

1.18.4 **Impairment of financial assets**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets or assets measured at fair value through other comprehensive income, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.

The ICB adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the ICB does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.19 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.19.1 **Financial Liabilities at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the ICB's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.19.2 **Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.20 **Value Added Tax**

Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.21 **Foreign Currencies**

The ICB's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the ICB's surplus/deficit in the period in which they arise.

1.22 **Third Party Assets**
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the ICB has no beneficial interest in them.

1.23 **Losses & Special Payments**
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.24 **Critical accounting judgements and key sources of estimation uncertainty**
In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.24.1 **Critical accounting judgements in applying accounting policies**
The following are the judgements, apart from those involving estimations, that management has made in the process of applying the ICB's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

- Maternity Pathway
- Partially Completed Spells

Where amounts earned by NHS Providers from ICBs depends on units of activity, revenue related to spells that are partially completed at the financial year end should be allocated across financial years, applying the principles of performance obligations in IFRS15, where material. The ICB and providers have considered these to be not material, and as such neither are recognised in the preparation of these accounts.

1.24.2 **Sources of estimation uncertainty**
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

a) Healthcare contracts: based on the provisional costed activity data provided by the healthcare providers in conjunction with historic experience and using any additional intelligence available. The data is subject to final verification and validation;

b) Prescribing: calculated by applying the forecast expenditure profile provided by the NHS Business Services Authority, to the expenditure incurred during the first 11 months, or 10, if month 11 not provided in a timely manner, taking into account prior year expenditure. The extent to which any in-year changes to the costs of generic drugs have been reflected in the expenditure profile will be assessed and adjustments made as appropriate. The impact of increased costs due to concessions under the 'no cheaper stock obtainable' policy will be assessed and adjustments made as appropriate. The costs of influenza and pneumococcal vaccinations are recharged to NHS England and the level of recharge for March, and February if information not provided in a timely manner, will be calculated using the profile of such costs incurred in prior years;

c) Non-contracted activity: based on year to date costs invoiced and prior year expenditure;

d) Individual packages of care (including continuing healthcare): The primary source of information to estimate the forecast spend will be the lists of patients held for each type of package. An assessment will be made in respect of the likely number of cases and associated costs (based on known costs for the provider or an average cost for the type of care) where care is being provided but funding has not yet been agreed due to delays between assessment and panel/notification to the ICB or agreement of the level of costs.

Payments for non-contracted activity during 2024/25 have been restricted to those to other ICBs, providers in the devolved authorities (Scotland, Wales & Northern Ireland) and non-NHS providers.

1.25 **Gifts**
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.26 **New and revised IFRS Standards in issue but not yet effective**

- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted
- IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted
- IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted

2 Other Operating Revenue

	2024-25 Admin £'000	2024-25 Programme £'000	2024-25 Total £'000	2023-24 Total £'000
Income from sale of goods and services (contracts)				
Non-patient care services to other bodies	871	1,687	**2,558**	8,350
Prescription fees and charges	-	15,448	**15,448**	14,704
Dental fees and charges	-	18,416	**18,416**	16,569
Other Contract income	31	446	**477**	4,190
Recoveries in respect of employee benefits	-	-	**-**	136
Total Income from sale of goods and services	**902**	**35,997**	**36,899**	**43,949**
Other operating income				
Other non contract revenue	5	1,962	**1,967**	4,731
Total Other operating income	**5**	**1,962**	**1,967**	**4,731**
Total Operating Income	**907**	**37,959**	**38,866**	**48,680**

3.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Source of Revenue					
NHS	2,227	-	-	151	-
Non NHS	332	15,448	18,416	326	-
Total	**2,559**	**15,448**	**18,416**	**477**	**-**

	£'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Timing of Revenue					
Point in time	-	-	-	-	-
Over time	2,559	15,448	18,416	477	-
Total	**2,559**	**15,448**	**18,416**	**477**	**-**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Admin			Programme			Total		2024-25
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits									
Salaries and wages	11,797	448	**12,245**	16,766	1,425	**18,190**	28,563	1,872	**30,435**
Social security costs	1,394	-	**1,394**	1,827	-	**1,827**	3,220	-	**3,220**
Employer contributions to the NHS Pension Scheme	4,236	-	**4,236**	2,125	-	**2,125**	6,360	-	**6,360**
Other pension costs	1	-	**1**	3	-	**3**	4	-	**4**
Termination benefits	-	-	**-**	-	-	**-**	-	-	**-**
Gross employee benefits expenditure	**17,428**	**448**	**17,876**	**20,720**	**1,425**	**22,144**	**38,148**	**1,872**	**40,020**
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	**-**	-	-	**-**	-	-	**-**
Total - Net admin employee benefits including capitalised costs	**17,428**	**448**	**17,876**	**20,720**	**1,425**	**22,144**	**38,148**	**1,872**	**40,020**
Less: Employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**
Net employee benefits excluding capitalised costs	**17,428**	**448**	**17,876**	**20,720**	**1,425**	**22,144**	**38,148**	**1,872**	**40,020**

4.1.1 Employee benefits

	Admin			Programme			Total		2023-24
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits									
Salaries and wages	11,895	525	**12,420**	14,029	1,007	**15,036**	25,924	1,532	**27,456**
Social security costs	1,400	5	**1,405**	1,510	-	**1,510**	2,910	5	**2,915**
Employer contributions to the NHS Pension Scheme	3,147	4	**3,151**	1,781	-	**1,781**	4,928	4	**4,932**
Other pension costs	1	-	**1**	3	-	**3**	4	-	**4**
Termination benefits	35	-	**35**	-	-	**-**	35	-	**35**
Gross employee benefits expenditure	**16,478**	**534**	**17,012**	**17,323**	**1,007**	**18,330**	**33,801**	**1,541**	**35,342**
Less recoveries in respect of employee benefits (note 4.1.2)	(90)	-	**(90)**	(46)	-	**(46)**	(136)	-	**(136)**
Total - Net admin employee benefits including capitalised costs	**16,388**	**534**	**16,922**	**17,277**	**1,007**	**18,284**	**33,665**	**1,541**	**35,206**
Less: Employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**
Net employee benefits excluding capitalised costs	**16,388**	**534**	**16,922**	**17,277**	**1,007**	**18,284**	**33,665**	**1,541**	**35,206**

4.2 Average number of people employed

	2024-25 Permanently employed Number	2024-25 Other Number	2024-25 Total Number	2023-24 Permanently employed Number	2023-24 Other Number	2023-24 Total Number
Total	**507.18**	**22.35**	**529.53**	**528.21**	**23.93**	**552.14**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.4 Exit packages agreed in the financial year

	2024-25 Compulsory redundancies Number	2024-25 Compulsory redundancies £	2024-25 Other agreed departures Number	2024-25 Other agreed departures £	2024-25 Total Number	2024-25 Total £
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**

	2023-24 Compulsory redundancies Number	2023-24 Compulsory redundancies £	2023-24 Other agreed departures Number	2023-24 Other agreed departures £	2023-24 Total Number	2023-24 Total £
Less than £10,000	1	4,735	-	-	1	4,735
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	1	30,292	-	-	1	30,292
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**2**	**35,027**	**-**	**-**	**2**	**35,027**

	2024-25 Departures where special payments have been made Number	2024-25 Departures where special payments have been made £	2023-24 Departures where special payments have been made Number	2023-24 Departures where special payments have been made £
Less than £10,000	-	-	-	-
£10,001 to £25,000	-	-	-	-
£25,001 to £50,000	-	-	-	-
£50,001 to £100,000	-	-	-	-
£100,001 to £150,000	-	-	-	-
£150,001 to £200,000	-	-	-	-
Over £200,001	-	-	-	-
Total	**-**	**-**	**-**	**-**

Analysis of Other Agreed Departures

	2024-25 Other agreed departures Number	2024-25 Other agreed departures £	2023-24 Other agreed departures Number	2023-24 Other agreed departures £
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**-**	**-**	**-**	**-**

4.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

5. Operating expenses

	2024-25 Total £'000	2023-24 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	1,873	1,557
Services from foundation trusts	956,412	823,887
Services from other NHS trusts	1,171,938	811,871
Provider Sustainability Fund	-	-
Services from Other WGA bodies	1	1
Purchase of healthcare from non-NHS bodies	429,879	458,645
Purchase of social care	51,856	-
General Dental services and personal dental services	76,482	62,382
Prescribing costs	205,579	205,538
Pharmaceutical services	43,783	41,581
General Ophthalmic services	12,461	12,358
GPMS/APMS and PCTMS	255,829	220,877
Supplies and services – clinical	494	522
Supplies and services – general	9,196	12,257
Consultancy services	1,079	73
Establishment	2,848	2,845
Transport	9,085	9,007
Premises	14,756	14,749
Audit fees	230	225
Other non-statutory audit expenditure		
· Internal audit services		-
· Other services	18	15
Other professional fees	376	194
Legal fees	448	418
Education, training and conferences	459	389
MPET Training Expenditure	-	-
Funding to group bodies	-	-
Non cash apprenticeship training grants	-	-
Total Purchase of goods and services	**3,245,082**	**2,679,391**
Depreciation and impairment charges		
Depreciation	241	222
Total Depreciation and impairment charges	**241**	**222**
Provision expense		
Change in discount rate	-	-
Provisions	(612)	(73)
Total Provision expense	**(612)**	**(73)**
Other Operating Expenditure		
Chair and Non-Executive Members	151	179
Grants to Other bodies		350
Clinical negligence		-
Research and development (excluding staff costs)	315	268
Expected credit loss on receivables	16	11
Other expenditure	79	0
Total Other Operating Expenditure	**561**	**808**
Total operating expenditure	**3,245,272**	**2,680,348**

6 Payment Compliance Reporting

6.1 Better Payment Practice Code

Measure of compliance	2024-25 Number	2024-25 £'000	2023-24 Number	2023-24 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	52,369	811,077	51,079	752,427
Total Non-NHS Trade Invoices paid within target	52,324	808,955	51,001	751,248
Percentage of Non-NHS Trade invoices paid within target	**99.91%**	**99.74%**	**99.85%**	**99.84%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,502	2,138,332	2,027	1,627,914
Total NHS Trade Invoices Paid within target	2,493	2,137,878	2,000	1,627,530
Percentage of NHS Trade Invoices paid within target	**99.64%**	**99.98%**	**98.67%**	**99.98%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2024-25 £'000	2023-24 £'000
Amounts included in finance costs from claims made under this legislation	1	0
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	**1**	**0**

7 Income Generation Activities

The following provides details of income generation activities whose full cost exceeded £1m or was otherwise material:

	2024-25 Income £'000	2024-25 Full Cost £'000	2024-25 Surplus/ (deficit) £'000	2023-24 Income £'000	2023-24 Full Cost £'000	2023-24 Surplus/ (deficit) £'000
Prescription fees and charges	15,448	249,362	(233,914)	14,704	247,119	(232,415)
Dental fees and charges	18,416	76,482	(58,066)	16,569	62,382	(45,813)
Total fees and charges	**33,864**	**325,844**	**(291,980)**	**31,273**	**309,501**	**(278,228)**

The fees and charges information in this note is provided in accordance with section 6.7.1 of the Government Financial Reporting Manual. It is provided for fees and charges purposes and not for International Financial Reporting Standards (IFRS) 8 purposes.

The financial objective of prescription and dental charges is to collect charges only from those patients that are eligible to pay.

Prescription charges are a contribution to the cost of pharmaceutical services including the supply of drugs. In 2024/25, the NHS prescription charge for each medicine or appliance dispensed was £9.90 from 1 May 2024 (£9.65 in April 2024). However, the majority of prescription items are dispensed free each year where patients are exempt from charges. In addition, patients who were eligible to pay charges could purchase pre-payment certificates at £32.05 for 3 months from 1 May 2024 (£31.25 in April 2024), £114.50 for a year from 1 May 2024 (£111.60 in April 2024) or £19.80 from 1 May 2024 for Hormone Replacement Therapy (HRT)) for a year (£19.30 in April 2024). A number of other charges were payable for wigs and fabric supports.

Those who are not eligible for exemption are required to pay NHS dental charges which fall into 3 bands depending on the level and complexity of care provided. In 2024/25, the charge for Band 1 treatments was £26.80, for Band 2 was £73.50 and for Band 3 was £319.10.

8 Other Gains and Losses

	2024-25 £'000	2023-24 £'000
Gain/(loss) on disposal of property, plant and equipment assets other than by sale	-	89
	-	**89**

9 Finance Costs

	2024-25 £'000	2023-24 £'000
Interest on lease liabilities	11	**12**
	11	**12**

10 Net gain/(loss) on transfer by absorption

There were no Transfers By Absorption during the year.

11 Property, plant and equipment

2024-25	Information technology £'000	Total £'000
Cost or valuation at 01 April 2024	272	272
Additions purchased	248	248
Statement of Cash Flows for the year ended 31st March 2025	**520**	**520**
Depreciation 01 April 2024	149	149
Charged during the year	26	26
Depreciation at 31 March 2025	**175**	**175**
Net Book Value at 31 March 2025	**345**	**345**
Purchased	345	345
Total at 31 March 2025	**345**	**345**
Asset financing:		
Owned	345	345
Total at 31 March 2025	**345**	**345**

Economic Lives

	Minimum Life Years	Maximum Life Years
Information Technology	5	5

12 Leases

12.1 Right-of-use assets

2024-25	Buildings excluding dwellings £'000	Total £'000	Of which: leased from DHSC group bodies £'000
Cost or valuation at 01 April 2024	1,643	1,643	449
Statement of Cash Flows for the year ended 31st March 2025	**1,643**	**1,643**	**449**
Depreciation 01 April 2024	431	431	180
Charged during the year	215	215	89
Depreciation at 31 March 2025	**646**	**646**	**269**
Net Book Value at 31 March 2025	**997**	**997**	**180**
NBV by counterparty			
Leased from DHSC			180
Leased from Non-Departmental Public Bodies			816
Net Book Value at 31 March 2025			**996**

12.2 Lease liabilities

2024-25	2024-25 £'000	2023-24 £'000
Lease liabilities at 01 April 2024	(1,315)	(1,466)
Interest expense relating to lease liabilities	(10)	(12)
Repayment of lease liabilities (including interest)	146	63
Derecognition for early terminations	-	100
Lease liabilities at 31 March 2025	**(1,179)**	**(1,315)**

12.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2024-25 £'000	Of which: leased from DHSC group bodies £'000		2023-24 £'000	Of which: leased from DHSC group bodies £000
Within one year	(348)	(184)		(315)	(184)
Between one and five years	(616)	(92)		(708)	(184)
After five years	(197)			(328)	-
Balance at 31 March 2025	**(1,161)**	**(276)**		**(1,351)**	**(368)**
Balance by counterparty					
Leased from DHSC			(276)		(368)
Leased from Non-Departmental Public Bodies			(885)		(983)
Balance as at 31 March 2023			**(1,161)**		**(1,351)**

12.4 Amounts recognised in Statement of Comprehensive Net Expenditure

2024-25	2024-25 £'000	2023-24 £'000
Depreciation expense on right-of-use assets	215	215
Interest expense on lease liabilities	10	12

12.5 Amounts recognised in Statement of Cash Flows

	2024-25 £'000	2023-24 £'000
Total cash outflow on leases under IFRS 16	146	63

13.1 Trade and other receivables

	Current 2024-25 £'000	Non-current 2024-25 £'000	Current 2023-24 £'000	Non-current 2023-24 £'000
NHS receivables: Revenue	1,044	-	1,579	-
NHS prepayments	723	-	325	-
NHS accrued income	1,829	-	1,923	-
Non-NHS and Other WGA receivables: Revenue	1,156	-	1,903	-
Non-NHS and Other WGA prepayments	1,826	-	3,716	-
Non-NHS and Other WGA accrued income	5,289	-	3,463	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	12,226	-	15,219	-
Expected credit loss allowance-receivables	(34)	-	(42)	-
VAT	692	-	314	-
Other receivables and accruals	13	-	184	-
Total Trade & other receivables	**24,764**	**-**	**25,584**	**-**
Total current and non-current	**24,764**		**28,584**	
Included above:				
Prepaid pensions contributions	-		-	

13.2 Receivables past their due date but not impaired

	2024-25 DHSC Group Bodies £'000	2024-25 Non DHSC Group Bodies £'000	2023-24 DHSC Group Bodies £'000	2023-24 Non DHSC Group Bodies £'000
By up to three months	59	109	1,418	931
By three to six months	-	42	33	68
By more than six months	3	264	-	17
Total	**62**	**414**	**1,451**	**1,016**

13.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000	Other financial assets £'000	Total £'000
Balance at 01 April 2022	**(42)**	**-**	**(42)**
Lifetime expected credit losses on trade and other receivables-Stage 2	(16)	-	**(16)**
Amounts written off	24	-	**24**
Other changes	-	-	**-**
Total	**(34)**	**-**	**(34)**

14 Cash and cash equivalents

	2024-25 £'000	2023-24 £'000
Balance at 01 April 2024	2	2
Net change in year	8	-
Balance at 31 March 2025	**10**	**2**
Made up of:		
Cash with the Government Banking Service	10	2
Cash and cash equivalents as in statement of financial position	**10**	**2**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2025	**10**	**2**

15 Trade and other payables

	Current 2024-25 £'000	Non-current 2024-25 £'000	Current 2023-24 £'000	Non-current 2023-24 £'000
NHS payables: Revenue	1,014	-	9,289	-
NHS accruals	30,985	-	21,489	-
Non-NHS and Other WGA payables: Revenue	24,051	-	25,887	-
Non-NHS and Other WGA accruals	40,377	-	44,126	-
Social security costs	(166)	-	(44)	-
Tax	441	-	380	-
Other payables and accruals	7,662	-	7,896	-
Total Trade & Other Payables	**104,364**	**-**	**109,023**	**-**
Total current and non-current	**104,364**		**109,023**	

Other payables include £2,326k outstanding pension contributions at 31 March 2023

16 Provisions

	Current 2024-25 £'000	Non-current 2024-25 £'000	Current 2023-24 £'000	Non-current 2023-24 £'000
Continuing care	169	-	781	-
Other	-	-	-	-
Total	**169**	**-**	**781**	**-**
Total current and non-current	**169**		**781**	

	Continuing Care £'000
Balance at 01 April 2024	781
Reversed unused	(612)
Balance at 31 March 2025	**169**
Expected timing of cash flows:	
Within one year	169
Between one and five years	-
After five years	-
Balance at 31 March 2025	**169**

17 Commitments

17.1 Capital commitments

The ICB has no Capital Commitments at the year end.

17.2 Other financial commitments

The NHS integrated care board has entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

	2024-25 £'000	2023-24 £'000
In not more than one year	102,736	95,437
In more than one year but not more than five years	3,698	-
In more than five years	-	-
Total	**106,434**	**95,437**

18 Financial instruments

18.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS integrated care board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS integrated care board has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS integrated care board in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS integrated care board standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS integrated care board and internal auditors.

18.1.1 Currency risk

The NHS integrated care board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS integrated care board has no overseas operations and therefore has low exposure to currency rate fluctuations.

18.1.2 Interest rate risk

The NHS integrated care board borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The NHS integrated care board therefore has low exposure to interest rate fluctuations.

18.1.3 Credit risk

Because the majority of the NHS integrated care board revenue comes parliamentary funding, NHS integrated care board has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

18.1.4 Liquidity risk

NHS integrated care board is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS integrated care board draws down cash to cover expenditure, as the need arises. The NHS integrated care board is not, therefore, exposed to significant liquidity risks.

18.1.5 Financial Instruments

As the cash requirements of NHS integrated care board are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS integrated care board's expected purchase and usage requirements and NHS integrated care board is therefore exposed to little credit, liquidity or market risk.

18 Financial instruments cont'd

18.2 Financial assets

	Financial Assets measured at amortised cost 2024-25 £'000	Total 2023-24 £'000
Trade and other receivables with NHSE bodies	2,086	1,896
Trade and other receivables with other DHSC group bodies	848	3,834
Trade and other receivables with external bodies	18,623	18,541
Cash and cash equivalents	9	2
Total at 31 March 2025	**21,566**	**24,273**

18.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2024-25 £'000	Total 2023-24 £'000
Trade and other payables with NHSE bodies	980	236
Trade and other payables with other DHSC group bodies	46,517	46,523
Trade and other payables with external bodies	56,593	63,242
Private Finance Initiative and finance lease obligations	1,179	-
Total at 31 March 2025	**105,269**	**110,001**

19 Operating segments

The ICB and consolidated group consider they have only one Operating Segment, Commissioning of Healthcare.

20 Pooled budgets

The NHS Integrated Care Board entered into a pooled budget arrangement for Integrated Community Equipment Schemes with Nottinghamshire County Council. Under the arrangements, funds are pooled under section 75 of the NHS Act for Integrated Community Equipment Scheme activities. The Pool is hosted by Nottinghamshire County Council. As a Commissioner of Healthcare Services, the NHS Integrated Care Board makes contributions to the pool. The table below shows the full year detail of the pooled budget.

	2024-25 £'000	2023-24 £'000
Balance at 31 March		
Income	**1,639**	**1,886**
Nottinghamshire County Council ASCH&PP	1,393	1,650
Nottinghamshire County Council CFCS	641	641
Nottinghamshire City Council ASCH & CYP	888	488
NHS Nottingham & Nottinghamshire ICB	8,596	7,587
Other income	111	31
TOTAL INCOME	**13,268**	**12,283**
Expenditure		
Partnership Management & Administration costs	1,369	1,182
Contract delivery and collection costs	1,423	1,307
ICES Equipment	8,815	7,843
Minor Adaptations	297	312
Direct Payments	0	0
TOTAL EXPENDITURE	**11,904**	**10,644**
Balance at 31 March	**1,364**	**1,639**
Carry Forward by Partner		
Nottinghamshire City Council ASCH	89	133
Notts County Council - ASCH	813	1,191
Notts County Council - CYPS	135	109
Notts County Council - PDSS/EY	75	41
ICELS Staffing reserves	12	0
NHS Nottingham & Nottinghamshire ICB	240	165
Balance at 31 March	**1,364**	**1,639**

The second pooled budget is 'The Better Care Fund (BCF)' and is hosted by Nottingham City Council, and jointly commissions services to achieve national and local objectives to integrate health and social care services in Nottingham City. It is between NHS Nottingham and Nottinghamshire ICB Nottingham City Council, and its aims are to improve the quality & efficiency of services. The table below shows the full year detail of the pooled budget.

Memorandum Account for Nottingham City Better Care Fund

	2024-25 £'000	2023-24 £'000
Funding		
NHS Nottingham & Nottinghamshire ICB	34,319	31,079
Nottingham City Council (Capital)	3,020	2,768
Nottingham City Council (Discharge Funding)	3,879	2,328
Nottingham City Council (Improved Better Care Fund)	16,603	16,603
Total Funding	**57,821**	**52,778**
Expenditure		
Access & Navigation	1,610	2,080
Assistive Technology	352	471
Carers	714	714
Co-ordinated Care	16,603	16,603
Capital Grants	3,020	2,768
Reablement / Discharge	7,462	4,317
Programme Costs	0	0
Integrated Care	21,767	19,847
Primary Care	3,173	3,003
Facilitating Discharge	3,043	2,880
Housing Related Schemes	77	95
Total Expenditure	**57,821**	**52,778**
Balance Carried forward for all partners	**0**	**0**

NHS Nottingham & Nottinghamshire ICBs's shares of the Income & expenditure handled by the pooled budget in the financial year was as below:

	2024-25 £'000	2023-24 £'000
Income	12,255	11,547
Expenditure	-12,255	-11,547
TOTAL	**0**	**0**

21 Related party transactions

2024-25	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Derby Health United Health Care CIC	10,641	0	0	0
NHS Confederation	55	0	0	0
NHS Professionals	0	3	0	0
Portland College	152	0	17	0
Specsavers Opticians	6,744	0	0	0
Florence Nightingale Foundation	1	0	0	0
Nottingham Trent University	84	0	0	0
Nottingham University Hospitals NHS Trust	1,081,424	83	10,581	5
Nottinghamshire Healthcare NHS Foundation Trust	348,030	568	12,347	487
Sherwood Forest Hospitals NHS Foundation Trust	446,934	289	7,507	257
Department of Health	0	25	0	0
NHS England	2,305	1,518	980	2,086
NHS Trusts	91,871	74	91	161
Foundation Trusts	167,535	18	493	599
Special Health Authorities	4	0	16	0
Other Group Bodies	13,706	0	1,862	0
Nottingham City Council	53,763	88	4,643	417
Nottinghamshire County Council	97,195	1,066	2,494	2,720
2023-24				
Eastwood Primary Care Centre	2,750	0	0	0
Primary Integrated Community Services	10,664	0	7	0
NEMS	15,559	0	0	0
Derby Health United Health Care CIC	7,414	0	1	0
Greater Nottingham Lift Co	99	0	0	0
North Nottingham Lift Co	7	0	0	0
NHS Confederation	31	0	0	0
NHS Professionals	82	3	0	0
Portland College	176	0	0	0
Specsavers Opticians	5,398	0	0	0
Florence Nightingale Foundation	1	0	0	0
Nottingham City Transport	1	0	0	0
Department of Health	0	91	0	0
NHS England	2,179	816	236	1,896
NHS Trusts	814,749	476	11,235	1,396
Foundation Trusts	829,826	324	19,306	535
Special Health Authorities	24	0	8	0
Other Group Bodies	14,857	0	4,023	0
Nottingham City Council	52,211	332	4,355	114
Nottinghamshire County Council	91,781	11,108	5,491	3,929

22 Events After the Reporting Period

On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged but they have been tasked with significant reductions in their cost base. Discussions are ongoing on the impact of these and the impact of staffing reductions, together with the costs and approvals of any exit arrangements. ICBs are currently being asked to implement any plans during quarter 3 of the 2025/26 financial year.

23 Financial performance targets

The ICB have a number of financial duties under the NHS Act 2006 (as amended). The ICB performance against those duties was as follows:

	Achievement Y/N	2024-25 Target	2024-25 Performance	2023-24 Target	2023-24 Performance
Expenditure not to exceed income	Y	3,285,318	3,285,305	2,708,994	2,715,789
Capital resource use does not exceed the amount specified in Directions	Y	248	248	110	110
Revenue resource use does not exceed the amount specified in Directions	Y	3,246,451	3,246,438	2,660,314	2,667,110
Revenue administration resource use does not exceed the amount specified in Directions	Y	22,487	20,980	24,743	19,205

Losses and special payments

Losses

The total number of NHS integrated care board losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2024-25 Number	Total Value of Cases 2024-25 £'000	Total Number of Cases 2023-24 Number	Total Value of Cases 2023-24 £'000
Administrative write-offs	4	24	1	3
Total	**4**	**24**	**1**	**3**