Nottingham and Nottinghamshire
Integrated Care Board

Annual Report and Accounts

1 July 2022 – 31 March 2023

Foreword by the ICB Chair

I am delighted to present this first Annual Report for NHS Nottingham and Nottinghamshire Integrated Care Board (ICB). Our journey began, as a new organisation, on 1 July 2022 building on the work we had been doing as partners across the system for several years. I knew that the change represented by the establishment of ICBs across the country made real the opportunity I have been hoping would happen for many years. We have made considerable progress both as an organisation on our own priorities and also through the delivery of activity in support of the system since that date. I continue to have very high aspirations for our system and the last twelve months have shown what we can achieve when we aim to be the very best we can be for our population.

A key part of how we are ensuring that the ICB is stepping into its system leadership role is through a programme of development and support for our Board members. As a collection of experienced leaders, the Board members are fully expected to be able to deliver but as a new unitary Board coming together for the first time it has been important to place deliberate focus on our collective growth and understanding.

Some of key interactions for the Board have included sessions dedicated to team building and providing an overview of the ICB's functions and key projects. These sessions included, getting to know each other, and understanding the role and functions of the ICB, including those functions new to the ICB and those conferred from CCGs. The sessions also reviewed the differing roles of Board members and discussed the ICB's vision, values and behaviours.

Discrete sessions were held on new areas of ICB functions, including understanding in greater details the operation of the NHS Provider Selection Regime and People and Culture, which explored the national policy context, the ICB's role, a system diagnostic, future requirements and how the system could add value as a system. A session also discussed Clinical transformation, providing an overview of the work of the Clinical Design Authority and System Analytics and Intelligence Unit on clinical prioritisation and how this will support the system to deliver intelligence-based clinical transformation.

Other externally facilitated sessions included interactive sessions on the principles for conflicts of interest management, practical scenarios to explore Board decision-making, and consideration of the ICB's risk appetite.

One of the first roles of the ICB was to set up, with the two Local Authorities, a joint committee, the Integrated Care Partnership (ICP), which I chair. The two Councillors from Nottinghamshire County Council and Nottingham City Council, who chair the Health and Wellbeing Boards are Vice Chairs of the ICP. I am pleased with our diverse and engaged membership of the ICP, including leaders from the voluntary sector, the education sector and social care providers. It is great to see partnership working across our system leading to the publication in March 2023 of an excellent

Integrated Care Strategy. The role of the ICB will be to lead the delivery of the aims in the Integrated Care Strategy for the NHS through our Joint Forward Plan.

Through the NHS Joint Forward Plan we will be able to sharpen and embed our focus on our three principles within the Integrated Care Strategy: those of Prevention, Equity and Integration. The ICB's focus on prevention and a determination to make a difference in this space includes the establishment of a dedicated fund, ensuring our commitment to this agenda is backed up with appropriate resources and action. Delivery on our ambitions on Equity will require similar prioritisation of investments and transformation activities and careful work to rebalance focus away from areas where less support is needed. Integration will continue to be our watchword, and through our work within the System and also with neighbouring systems in the East Midlands we will fund ways to be more joined up and coherent for our citizens, staff and stakeholders.

The ICB is but one part of the complex and adaptive system that we operate within, and I continue to be of the firm view that it sits at the very bottom of our 'inverted pyramid' – with our population at the top, driving our priorities and ambitions, flowing through our Places and other collaborative forums and only then reaching the ICB. We serve our population, not the other way around. But any pyramid, inverted or otherwise, needs to have firm foundations and I believe that the ICB has established those foundations in its first year of operation. There is much still to do but we should be proud of our first twelve months and look forward with positive anticipation to the year ahead.

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

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 2022). Integrated Care Boards (ICB) 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:

- The ***Performance Report*** – which includes a ***performance overview*** and a more detailed ***performance analysis*** of the reporting period.
- The ***Accountability Report*** – which describes how we have met key accountability requirements and embodied best practice to comply with corporate governance norms and regulations. It comprises three sections:
  - The ***Corporate Governance Report***;
  - The ***Remuneration and Staff Report***; and
  - The ***Parliamentary Accountability and Audit Report***.
- The ***Annual Accounts*** – This section presents the ICB's 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:

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Performance Report

Signed:

Dr Amanda Sullivan
Chief Executive

28 June 2023

Performance Overview

This section of the annual report provides an overview of our organisation, describing who we are, what we do and summarises how we have performed during the period 1 July 2022 (when the ICB was established) to 31 March 2023.

Statement from our Chief Executive

I am very proud of what the ICB's teams have achieved in our first nine months and I would like to thank the teams that led the legal establishment of our new organisation, while managing the safe closure and transfer of assets and liabilities from the former clinical commissioning groups (CCG): NHS Nottingham and Nottinghamshire CCG and NHS Bassetlaw CCG. But more than the safe transfer, I am especially pleased that we have created four new directorates for our organisation – Medical, Quality and Nursing, Integration and Finance. We have four key Executive Directors leading these teams and steering the overall development of the organisation. The establishment of any new organisation is a challenge: creating a new culture, setting priorities, managing the transfer of people and other assets. These factors combined with the operational context in which ICBs were brought into life, have provided a number of challenges during the ICB's first year. This annual report talks more about some of these challenges, as well as describing our achievements and how we have exercised our functions over the period.

Almost from the start of our time as an ICB the pressures on the health and care system have been considerable – driven by a combination of staff absences, extreme weather (both hot and cold) and issues with flow through and out of our hospitals. This has meant a series of critical incidents being declared across the system which required the ICB and its teams to support the safe management of the risks these presented. Towards the end of the period this report covers we also experienced the impact of the national industrial action by nurses and doctors. Working closely with colleagues in our NHS provider organisations, our local authority partners and our communities and wider civil society, we have been able to navigate these challenges together. The ICB intends in the coming year to find a sustainable solution to the issues of demand, capacity and flow through our emergency care services as this is not a sustainable position but in the absence of this longer-term plan, I am proud of the way our teams collectively rose to the challenges presented.

Listening carefully to our population and their aspirations and needs for their health and care services is a critical part of our work as an ICB. It has been pleasing therefore to see the ICB's citizen intelligence and co-production strategies really start to move into their stride this year. The establishment and flourishing of the Citizen Intelligence Advisory Group with a clear link into the ICB's committee structure is a really positive step forward. The work of this Group along with the wider Practitioners Forum for the whole system means that we have a strong governance of the

listening, involvement and engagement activities across the system which will inform our strategic transformation projects as well as day-to-day service delivery. We are also working closely with the voluntary, community and social enterprise (VCSE) sector, with a VCSE Alliance Group now well established. Finally, the organisation is committed to co-production and the establishment of the Strategic Co-production Group means that we now have a group with majority lived-experience membership to help shape our approach to detailed service design.

Alongside this comprehensive approach to listening to and working with people and communities, we are also making strong progress as an ICB in using data and intelligence more systematically. The ongoing success of the System Analytics and Intelligence Unit (SAIU) means that we have a single version of the truth when it comes to key information about waiting lists, discharge, demand and capacity and much more. Our ICB is on a journey, moving from an organisation that is data heavy to an organisation that is intelligence rich. The SAIU's aim is to give users within the system self-service access to population intelligence as well as bespoke reporting that proactively supports decision making. We have been working collaboratively with system colleagues to develop a number of products that help to put intelligence at the heart of decision making.

As we look forward to the year ahead and the implementation of our Integrated Care Strategy, not least through the development of the ICB's Joint Forward Plan, we will remain agile and responsive as an organisation. The Government has asked us to find efficiencies in our overheads and running costs for the ICB and we are using this as an opportunity to transform the ICB into the organisation we need it be for the future. This will mean some change for our teams and possibly the movement of some roles into other organisations or into joint teams. All of this will mean that the need for us all to work differently will be more important than ever. The Review published in April 2023 by the Rt Hon Patricia Hewitt gives us some helpful pointers for the future and I look forward with optimism to the developments the next year will bring to the way health and care is delivered across our local area. We are still in an important and exciting period in the further development of integrated care, and I am looking forward to playing a part in driving this forward, alongside system partners from the NHS, Local Authorities and the voluntary, community and social enterprise sector.

Dr Amanda Sullivan
Chief Executive of the 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 are responsible for developing a plan to meet the health needs of our population, managing the NHS budget for our area, and arranging for the provision of the following health services in line with our plan:

- Most planned hospital care for the diagnosis and treatment of illness
- 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
- GP services (responsibility delegated to us by NHS England)
- Rehabilitative care
- Palliative care
- NHS continuing healthcare

We are also responsible for making certain that the healthcare provided is of a high standard, delivers quality improvements and offers value for money, and that systems are in place to make sure people are looked after in the best way possible. Patients are at the heart of everything we do, and we actively encourage people living in Nottingham and Nottinghamshire to get involved and help us shape our plans. You can read more about our approach to public and patient involvement in the *Statutory duties* section of this annual report.

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 2023, the ICB employed 568 staff. Our organisational structure is divided into four directorates:

- Our Integration Directorate is responsible for strategy development and strategic planning, integration of health, social care and health-related services, system development, commissioning of hospital and other health services, development of new care models, procurement and outcomes-based contracting, and emergency planning, resilience and response.
- Our Medical Directorate is responsible for health inequalities, clinical prioritisation and transformation, health needs assessments, population health management and system intelligence, data, digital and technology, clinical and care professional leadership and engagement, research, evidence and evaluation, and innovation.
- Our Quality and Nursing Directorate is responsible for quality improvement, infection prevention and control, safeguarding, continuing healthcare and personalisation, individual funding requests, people and culture, equality, diversity and inclusion, medicines management, corporate governance, risk management and assurance, and information governance.
- Our Finance Directorate is responsible for financial planning and stewardship, resource allocation, capital planning, operational planning, performance and system oversight arrangements, estates, social and economic development and environmental sustainability, and audit and counter fraud arrangements.

The ICB replaced two former clinical commissioning groups (CCGs); NHS Bassetlaw CCG and NHS Nottingham and Nottinghamshire CCG were abolished at the time of the ICB’s establishment and most of their statutory functions were conferred on the ICB. The former CCGs’ staff, assets and liabilities were also legally transferred at this time.

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.

The ICS has four 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.

By working together and collaborating as an ICS, our local health and care organisations are better able to tackle complex challenges, which includes: 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.

In addition to the ICB, 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.
- 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.
- 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.

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 Integrated Care Partnership has used this information, along with other evidence and data, to develop an Integrated Care Strategy (2023 to 2027) 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 designed to deliver the four aims of the ICS and 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.
- 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.
- 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'.

You can read the full strategy here: https://healthandcarenotts.co.uk/wp-content/uploads/2021/05/Integrated-Care-Strategy-2023_27.pdf

The Integrated Care Strategy builds on existing system strategies, including the Joint Health and Wellbeing Strategies for Nottingham and Nottinghamshire.

At the time of producing this annual report, the ICB and its NHS Trust and NHS Foundation Trust partners are developing a Joint Forward Plan that will describe how our local NHS organisations will implement the NHS Mandate, tackle key issues and contribute to the delivery of the Integrated Care Strategy.

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 a challenging period for the ICB in delivering against our national targets. Urgent and emergency care services have been impacted by high levels of demand and difficulties in discharging patients, leading to bed pressures through the hospital and longer waits in emergency departments or for ambulances.

Planned care continues to be affected by the significant increase in waiting lists caused by the pause of services during the Covid-19 period in 2020/21. Services have had difficulty in stepping back up to pre-Covid levels due to ongoing challenges with staffing levels because of vacancies or sickness absence, bed availability during times of heightened urgent care pressures, and periodic impacts from the industrial

action being undertaken. The level of demand for cancer services has been around 20% higher than seen during 2019/20, which when combined with periods of constrained activity delivery, such as during critical incidents or during industrial action, has been challenging for services. However, we have seen reductions in the volume of patients that are waiting for cancer services over 62 days.

The ICB has performed well across its mental health targets; with increases seen in the numbers of patients with referrals for talking therapies, community mental health services, perinatal care, individual placement support and children and young people's services. During 2022/23, access to children and young people's services has exceeded the expected plan each month, with an additional 4,000 contacts being in place.

We continue to work closely with our partners across the health and social care community 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, as well as to invest in securing the delivery of continuous improvements in the quality of services provided for our patients and citizens. Many factors can influence how much we have to spend, for example, the national economy, a major incident, unexpected increased demand for local health services, or projects taking longer than planned. It is therefore important that we have contingency plans in place to ensure that we can flex our finances accordingly.

The ICB achieved all its statutory financial duties for the reporting period, and you can read more about these and other key statutory duties in the *Performance Analysis* section of this annual report. For full details of our accounts please see the *Annual Accounts* section of this annual report.

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 the organisation will identify, manage and monitor its 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.

The main risks identified by the ICB and monitored through the Operational Risk Register during the reporting period related to the potential impacts of under-achieving areas of service delivery, such as an increased risk of harm to patients and the impact on health outcomes; the risk of patient harm and poor patient experience at some of our main healthcare providers, with specific reference to local maternity services; and the potential for non-delivery of our financial duties. Workforce capacity issues across general practice and other areas of the system have also been under review, which included the potential impacts of industrial action on services. At the time of finalising this report, we have also identified a risk in relation to the publication of the outcome report of the Nottinghamshire County Council Joint Local Area Ofsted and Care Quality Commission Inspection for Special educational needs and disabilities (SEND).

For more information on these risks and how we manage risk within the ICB, see the *Governance statement* contained within 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 the ICB has discharged its key statutory duties.

Monitoring 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. As an ICB we are also responsible for overseeing the performance of the NHS providers within Nottingham and Nottinghamshire. As the NHS has continued to recover from the impact of the pandemic, additional metrics to focus upon recovery of services have been introduced by NHS England, while some of the established requirements have continued to be paused during this time. These are expected to be re-established during 2023/24.

During 2022/23, a key priority has been to recover elective care services which were paused during the initial phase of Covid during 2020/21, and for which a return to pre-Covid levels has proved difficult, with the impacts of Covid still being presented through increased staff absences and increased vacancies, increased lengths of stay for patients for whom recovery is taking longer than pre-Covid, difficulties with being able to move patients out of hospital following their episode of acute care and a particularly challenging winter with the resurgence of peak flu levels and increases in Covid cases. In addition, the recent industrial action has also had an impact on the ability to flow patients through the urgent and planned care pathways, as well as mental health services.

Whilst performance requirements and required activity levels are included within service contracts held by the ICB with local health organisations providing NHS services, it is recognised locally that we can only make the progress necessary by working together to tackle the complex system issues. To respond collectively as a local health system to the ongoing challenges from the post-pandemic impacts, staffing levels and urgent care pressures, several wider system forums have been established to deliver the progress required and to have oversight of the achievement of national and jointly agreed local and NHS England measures. This approach has enabled focused problem-solving system discussions to ensure services improve and perform well and that organisations provide cross organisational support to each other to meet the health needs of our patients and people.

The responsibility for performance management ultimately sits with the Board; however, this duty has been delegated to our Quality and People Committee, and Finance and Performance Committee to ensure consistent scrutiny and challenge, with any issues escalated to the Board as necessary.

Areas that are under performing receive additional focus by the Quality and People, or Finance and Performance Committees, which includes reviewing the underlying causal factors and remedial actions in place, the potential impact of underperformance on the quality of services and delivery of recovery plans through system collaboration.

The Integrated Performance Reports to our Board set out the ICB's performance against all required standards and are available on our website at www.notts.icb.nhs.uk. The Integrated Performance Report focuses on the five areas of performance across the ICB, which are quality, finance, people, service delivery and health inequalities. This supports the emphasis of interdependency between all the component parts of the system, for the system to perform well and deliver quality services for our patients.

NHS England has a statutory duty to undertake performance assessments of ICBs in respect of each financial year and to publish a summary of these assessments. In undertaking this assessment, NHS England will consider how successfully the ICB has: led the NHS within its ICS; contributed to each of the four aims of the ICS; performed its statutory functions; and delivered on any guidance set out for it by NHS England or the Secretary of State for Health and Social Care regarding its functions. The outcome of these assessments will be published in NHS England's Annual Report 2022/23, which will be available on its website at www.england.nhs.uk.

Urgent and Emergency Care

Historically, the most challenging performance targets for the system have been the NHS Constitution targets for urgent and emergency care. The pressures across urgent and emergency care have continued, with high levels of demand, peak flu season, continued impacts from covid and difficulties in discharging patients from their acute episode of care leading to bed pressures through the hospital and longer waits in emergency departments and ambulances.

Most residents use the Accident and Emergency Department at Nottingham University Hospitals NHS Trust (NUH) or Sherwood Forest Hospitals NHS Foundation Trust (SFH) when they need to access urgent and emergency care. However, some of these services are also delivered at the Urgent Care Centre within Nottingham City and at Newark Hospital, and residents in the north of the ICB are more likely to use Doncaster and Bassetlaw services at Worksop.

The national standard requires that 95% of attending patients have a maximum 4-hour wait in the Accident and Emergency Department from arrival to admission, transfer or discharge; however, this has been paused since 2021/22 due to the impacts from Covid and the additional infection prevention control measures required to be put in place. NUH was also part of national trials being conducted pre-

pandemic and so have not been reporting against the 4-hour target in recent years. This waiting time standard will be reintroduced for all providers in 2023/24.

The focus for the period of the pandemic has been on minimising the number of patients waiting over 12 hours following a decision to admit into the hospital setting, as well as aiming to receive patients into the hospital from ambulances as quickly as possible, to support ambulances being available for other patients. There have been several instances where patients have been waiting longer for services than is considered acceptable. The system undertakes a full incident review in each case to assess for any potential harm and works collectively to address these delays as a whole urgent care pathway to ensure patients reach the right services at the right time wherever possible.

Considerable work has been undertaken across the system to focus on improving discharges. A new service model with additional resource was agreed during 2022/23 across acute, community and local authority services, to increase the number of supported discharges. This commenced in November 2022 to provide additional support moving into the winter period. This has had some success in increasing discharge numbers, however there is work to be undertaken to improve this further by embedding good practice and working within a Community Discharge Hub model.

The ICS Urgent and Emergency Care Board covers both Nottinghamshire providers, and includes Doncaster and Bassetlaw Hospitals as well, to ensure a collaborative system forum. This Board has responsibility for oversight of the urgent and emergency care pathway, with a clear aim of improving performance against the national Accident and Emergency waiting time standard, as well as being responsive to the changing pressures upon the system. The Board has been established in line with national guidance and its membership includes senior leaders from across the health and social care community. The Board is currently chaired by the ICB's Chief Executive.

East Midlands Ambulance Services NHS Trust (EMAS) provides all ambulance services within Nottingham and Nottinghamshire and has been significantly impacted by the scale of demand for services since the pandemic. The data reporting enables focus on how the service has responded to different levels of need: Category 1 calls are those for people with life-threatening illnesses or injuries; category 2 relates to emergency calls; category 3 relates to urgent calls; and category 4 relates to less urgent calls.

Below is a table summarising performance in these areas for 2022/23 based on the latest information, indicating where the plan or target has been achieved or not. The table shows movement in position since the inception of the ICB on 1 July 2022, as it was handed over from the previous CCG organisations at the end of June. Where relevant, recovery actions are in place, which are being continually reviewed and updated to improve performance.

National Indicator	Q1 2022/23 (CCG)		Q4 2022/23 (ICB)		
	Target	Actual	Target	Actual	Commentary
A&E waiting time					
Percentage of patients who spent four hours or less in A&E	>95%	79.10%	>95%	77.68%	*The figures reported are at Trust level and are for June 2022 and March 2023 – SFHT only as NUH were not reporting in 2022-23.*
Number of A&E waits for admission from decision to admit to admission over 12 hours	0	617	0	883	*The figures reported are at Trust level and are for June 2022 and March 2023*
Ambulance clinical quality					
Ambulance Handover Times Over 60 Minutes	0	389	0	607	*The figures reported are at Trust level and are for June 2022 and March 2023*
Category 1 Average Response Time	<00:07:00	00:08:31	<00:07:00	00:08:06	
Category 1 90th Centile Response Time	<00:15:00	00:14:57	<00:15:00	00:13:34	
Category 2 Average Response Time	<00:18:00	00:52:32	<00:18:00	00:41:54	*The figures reported are at Trust level and are for June 2022 and March 2023*
Category 2 90th Centile Response Time	<00:40:00	01:53:04	<00:40:00	01:21:11	
Category 3 90th Centile Response Time	<02:00:00	09:08:23	<02:00:00	07:01:44	
Category 4 90th Centile Response Time	<03:00:00	08:14:38	<03:00:00	08:40:31	

Planned Care – Access to Treatment

During the Covid period of 2020/21, waiting lists increased significantly as planned care services were paused initially, and then capacity constraints continued with additional infection prevention control measures. During 2022/23, services have had difficulty in stepping back up to pre-Covid levels due to ongoing challenges with staffing levels due to vacancies or sickness absence, bed availability during times of heightened urgent care pressures, and periodic impacts from the industrial action being undertaken. This has led to fewer patients being treated than had been originally planned, and as such the system has not seen the reductions in waiting lists as was intended. However, the system has focused on those patients who have been waiting the longest for treatment as well as those patients with a greater clinical priority, including those waiting for cancer treatments. The patients waiting longest have been treated and numbers have been reducing, as can been seen in the table below.

Nottingham University Hospitals NHS Trust (NUH) and Sherwood Forest Hospitals NHS Foundation Trust (SFHT) are our main providers of acute services. To recover the elective position the system has collectively sought to utilise all available capacity including independent sector providers to ensure patients with highest clinical need and longest waits were treated first.

Below is a table summarising the ICB's performance in 2022/23 since its inception on 1 July, the position of the former CCGs as they closed in June 2022 is provided for comparison. Recovery priorities for planned care relate to waiting times for diagnostic tests and planned treatment. Performance is measured at ICB level and indicates where plan or target positions have been achieved or not.

NHS Constitution Standard	Q1 2022/23 (CCG)		Q4 2022/23 (ICB)		
	Target	Actual	Target	Actual	Commentary
Referral to treatment pathways					
Percentage incomplete patients <18 weeks	>92%	66.78%	>92%	62.63%	*These figures illustrate the difference between June 2022 and March 2023.*
Waiting list	-	106,424	-	114,733	*These figures illustrate the difference between June 2022 and March 2023.*
104 week waits	0	67	0	6	
78 week waits	-	795	-	150	*Targets are at provider level. The position for the population is tracked weekly to ensure progress towards national standard of zero by March 2023.*
RTT Activity level	-	24,969	-	27,043	*These figures illustrate the difference between June 2022 and March 2023.*
Diagnostic Tests					
Percentage of patients waiting six weeks or more for a diagnostic test	<1%	39.69%	<1%	36.02%	*These figures illustrate the difference between June 2022 and March 2023.*
The volume of patients waiting for a diagnostic test (Key 15 tests)	-	30,191	-	29,375	*These figures illustrate the difference between June 2022 and March 2023.*
Cancelled operations					
Number of cancelled operations rebooked beyond 28 days	0	51	0	62	*The figure reported is for Quarter 1 2022/23 and Quarter 4 22/23 and is at Trust level.*

Cancer Care – Access to Treatment

There are a range of waiting time indicators for access to cancer treatment, depending on the access route, stage of illness and the treatment needed.

Cancer diagnostics and treatment is primarily provided by Nottingham University Hospitals NHS Trust (NUH); however, services are also delivered through Sherwood Forest Hospitals NHS Foundation Trust (SFHT) as well as utilisation of independent sector for less complex cases. NUH is a regional cancer centre offering specialist cancer diagnostic and treatment services, and as such, it receives a relatively high number of tertiary referrals from surrounding areas, which can in some instances impact on the Trust's performance. The level of demand for cancer services has been around 20% higher than seen during 2019/20, which when combined with periods of constrained activity delivery such as during critical incidents or during

industrial action has been challenging for services. However, within the system there have been reductions in the volume of patients that are waiting for cancer services over 62 days, which has reduced from 497 at the end of Q1 2022/23 to 372 at the end of Q4 2022/23.

The system conducts weekly cancer prioritisation discussions to identify patients with greatest clinical need, and system providers conduct routine communication and support to patients who are waiting longer than expected.

Below is a table summarising performance against these cancer indicators and where targets or plans are being achieved or not. The periods are measured at the point the ICB was established (Q1 2022/23) to the end of the financial year (Q4 2022/23), and as can be seen improvements are being made across all areas. Where relevant, recovery actions are in place, which are being continually reviewed and updated to improve performance.

NHS Constitution Standard	Q1 2022/23 (CCG)		Q4 2022/23 (ICB)		
	Target	Actual	Target	Actual	Commentary
Cancer two week waits					
All cancer two week wait	>93%	70.16%	>93%	92.25%	
Two week wait for breast symptoms (where cancer was not initially suspected)	>93%	59.62%	>93%	89.71%	*Figures reported are for June 2022 and for March 2023*
No. 1st OP (referrals)	-	3,856	-	4,454	*Figures reported are for June 2022 and for March 2023*
No 1st treatment	-	3,824	-	628	*Figures reported are for June 2022 and for March 2023*
Cancer Waits					
Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis	>96%	82.28%	>96%	90.08%	
62-day wait for first treatment following an urgent GP referral	>85%	47.90%	>85%	67.49%	*Figures reported are for June 2022 and for March 2023*
Faster diagnosis 28 day	>75%	76.43%	>75%	76.10%	

Mental Health

Targets to improve access to mental health services for adults and children and young people are set nationally. Below is a table summarising the ICB's performance across the range of these areas for quarter 1 of 2022/23 as the close of the CCG, and then the latest position available as the ICB for 2022/23. Performance against

these indicators is measured at ICB level and is derived from a range of providers including Nottinghamshire Healthcare NHS Foundation Trust.

The ICB performs well across the mental health targets, with increases seen in the numbers of patients with referrals for talking therapies, community mental health services, perinatal care, individual placement support and children and young people's services. During 2022/23, access to children and young people's services has exceeded the expected plan each month, with an additional 4,000 contacts being in place over planned levels.

Where services are under more pressure, recovery action plans are in place. These are continually reviewed and updated to ensure an improvement in performance. These include areas such as the volumes of patients entering treatment for talking therapies, which has had difficulties with the capacity available to see patients due to preparations to change the main provider in April 2023. The improvements needed are included in the new provider contract arrangements.

The need to place patients out of the ICB's area due to capacity constraints and increased demand locally for inpatient mental health services, has reduced during the last three quarters of 2022/23 as Nottinghamshire Healthcare NHS Trust opened a new facility 'Sherwood Oaks' in November 2022, which has supported local provision. Continued demand for the services has meant that this has not fully enabled all patients to be placed locally, however plans are in place for 2023/24 to improve this further.

	Q1 2022/23		Q4 2022/23		
National Indicator	**Target**	**Actual**	**Target**	**2021/22**	**Commentary**
Estimated diagnosis rate for people with dementia					
Dementia diagnosis rate		68.90%		70.00%	*The figure reported is the end of period position as at June 2022 and end of March 2023.*
Improved Access to Psychological Therapy (IAPT)					
NHS Talking Therapies - Entering Treatment (3mth) (Previously IAPT)	>8984	8,110	9,648	6,735	*Performance is measured on a rolling three-month basis and the figures shown are at June 2022 and February 2023.*
NHS Talking Therapies- Recovery Rate (3mth Rolling) (Previously IAPT)	>50%	51.70%	>50%	50.12%	*Performance is measured on a rolling three-month basis and the figures shown are at June 2022 and February 2023.*
NHS Talking Therapies - Percentage of people that wait six weeks or less from referral to first treatment (Previously IAPT)	>75%	77.00%	>75%	94.10%	*The figure reported is the end of period position as at June 2022 and February 2023.*
NHS Talking Therapies - Percentage of people that wait 18 weeks or less from referral to first treatment (Previously IAPT)	>95%	100.00%	>95%	99.70%	*The figure reported is the end of period position as at June 2022 and February 2023.*
CYP Access					

National Indicator	Q1 2022/23 Target	Q1 2022/23 Actual	Q4 2022/23 Target	Q4 2022/23 2021/22	Commentary
Children & Young People Increasing Access (1+ Contact)	**13,300**	**17,880**	**13,559**	**18,030**	*The figure reported is the end of period position as at February 2023.*
Out of Area Placements					
Out of Area Occupied Bed Days	**0**	**385**	**0**	**125**	*The figure reported is the end of period position as at February 2023.*
Perinatal Mental Health Services					
Percentage of women with moderate/complex to severe Perinatal Mental Health difficulties that access care and support in the community	**9.30%**	**7.10%**	**10.00%**	**8.50%**	*The figure reported is the end of period position as at February 2023.*
Early Intervention in Psychosis Waiting Times					
Percentage of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral	**>60%**	**70.00%**	**>60%**	**86.50%**	*The figure reported is the end of period position as at February 2023.*

Primary Care

Across Nottingham and Nottinghamshire there are 131 GP Practices which deliver primary medical services to their local populations. The ICB is responsible for making the necessary contractual arrangements with the individual GP practices to deliver these services, ensuring appropriate contract monitoring is undertaken as well as overseeing quality assurance of those practices. This is undertaken through the ICB Primary Care Contracting Sub-Committee, which is a Sub-Committee of the ICB Strategic Planning and Integration Committee.

At a system level, through the Finance and Performance Committee, the overall access availability for the total population is monitored, as part of recovery and expansion of primary care services across Nottingham and Nottinghamshire. During November 2022 NHS Digital commenced publishing of individual GP data (General Practice Appointment Data) which will enable the ICB to monitor performance at an individual practice level and address variation across practices.

The total number of appointments available across Nottingham and Nottinghamshire has increased over the year as services have recovered, as well as being supported through the expansion of the Additional Roles Reimbursement Scheme across primary care services.

Below is a table summarising performance against these primary care access indicators and where targets or plans are being achieved or not, where relevant. The periods are measured at the point the ICB was established (Q1 2022/23) to the end of the financial year (Q4 2022/23), and as can be seen improvements are being made across all areas, in terms over overall volumes of activity.

National Indicator	Q1 2022/23 Target	Q1 2022/23 Actual	Q4 2022/23 Target	Q4 2022/23 2021/22	Commentary
Appointments - Access					
Total Number of GP Appointments	**527,046**	**537,509**	**602,676**	**663,959**	*The figure reported is the end of period position as at June 2022 and end of March 2023.*
Appointments per 10,000 population	**4,239**	**4,323**	**4,264**	**4,781**	-
Appointments - Timeliness					
Appointments on the same day	**Jun-22**	**43.11%**	**Mar-23**	**42.78%**	*Although the % has decreased, as the overall number of appointments has increased this represents an increase of 52,329 appointments on the same day.*
Appointments - Mode					
Appointments held Face-to-Face	**Jun-22**	**67.00%**	**Mar-23**	**70.35%**	*This represents an increase of 106,968 appointments being held face to face.*

Financial Review

The ICB has a responsibility to carefully manage the finances it has. This includes making sure we can deliver on our everyday commitments, as well as investing to secure the delivery of continuous improvements in the quality of services provided to our patients and citizens. Many factors influence how we can spend, for example, the national economy, unexpected increases in demand for local health services, or projects taking longer than planned.

During the reporting period, the ICB has established aligned financial plans, budgets, and reporting arrangements. At the same time the ICB managed the impact of elective recovery in the Nottingham and Nottinghamshire system following the Covid pandemic, the impact of a Covid and flu surge on non-elective activity during winter, and the impact of inflationary pressures, especially on continuing healthcare, and prescribing areas of spend.

2022/23 saw the continuation of fixed value (block) contract arrangements with NHS contracts, which mitigated risk of variation within system finances. At the same time there was variation in financial values in its non-NHS contracts that the ICB had to manage.

The ICB delivered against its key financial targets despite the challenges it has faced during its first year of operation. We have also worked closely with our system partners and minimised the overall financial impact of the risks highlighted which arose in the period.

The following tables set out the ICB's financial performance for the reporting period, including an analysis of total expenditure. As this is the first period of operation, there are no prior period comparatives.

Table 1: Financial performance

Duty	Target (£000)	Target (%)	Actual (£000)	Actual (%)	Achieved
Income and expenditure: Expenditure not to exceed income	Breakeven	-	7 surplus	-	✓
Cash balance: Remain below allowed cash balance	2,250	-	3	-	✓
Running costs: Remain within running cost allowance	19.565	-	16,249	-	✓
Better payment practice code: Pay NHS invoices by value within 30 days	-	95%	-	99.99%	✓
Pay NHS invoices by number within 30 days	-	95%	-	99.16%	✓
Pay non-NHS invoices by value within 30 days	-	95%	-	99.87%	✓
Pay non-NHS invoices by number within 30 days	-	95%	-	99.83%	✓
Mental health investment standard: Deliver the minimum mental health investment	190,665	-	190,692	-	✓

Table 2: Analysis of total spend

Category of expenditure	Total spend (£000)
Acute (hospital) care	950,099
Community care	149,240
Mental health care	188,616
Primary care	184,790
Prescribing	146,995
Continuing care	113,788
Other non-healthcare	66,733
Corporate running costs	16,249
Total	**1,816,510**

Mental Health Investment Standard

The Mental Health Investment Standard (MHIS), set by NHS England, was introduced as a requirement for CCGs to increase investment in Mental Health services in line with their overall increase in budget allocation each year. This remains a requirement for ICBs, which have also assumed responsibility for reporting MHIS performance for their former CCG organisations for the period 1 April – 30 June 2022 (their last three months of operations). Therefore, the table below sets out the amount and proportion of expenditure incurred in total for 2022/23:

Financial Years	2021/22	2022/23
Mental Health Spend	178,153	190,691
ICB Programme Allocation	2,021,092	2,122,730

Financial Years	2021/22	2022/23
Mental Health Spend as a proportion of ICB Programme Allocation	8.81%	8.98%

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. Further assurance is provided through our Board Assurance Framework, which identifies high-level risks with the potential to impact on the delivery of strategic objectives and statutory duties. It also details the controls and actions in place to mitigate such risks.

The following sections focus specifically on how we are meeting some of these duties.

Quality Improvement

Section 14Z34 of the National Health Service Act 2006 (as amended) requires ICBs 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. The ICB places quality at the heart of its functions, and organisations that we commission services from must meet essential standards of quality and safety as defined by the Care Quality Commission (CQC).

Continuous quality improvement is promoted and encouraged through a range of mechanisms, which includes the completion of equality and 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 system relationships. This includes regular attendance at the internal quality oversight and assurance meetings of system partners to be able to understand internal conversations and assurance processes. This approach utilises both qualitative and quantitative intelligence which supports quality oversight, assurance and planning, as well as highlighting early any emerging concerns that may be identified on either a theme, partner or system basis.

Our System Quality Strategy 2022/23 reflects the shared quality principles and values across our ICS and maintains our shared commitment to continually improving the quality of our services, in a way that makes a real difference to our local population. The ICB continues to work with system partners to develop shared insights and embed the National Quality Board's national guidance. Our priority is to

ensure that high-quality care is demonstrated through effective arrangements for quality oversight, quality assurance and risk response, with escalation where appropriate.

Our collaboration with system partners as part of the Nottingham and Nottinghamshire ICS has been strengthened with the establishment of the ICB in July 2022. This year has seen a renewed focus on the evolution of system quality architecture, and we have actively worked with partners to develop and deliver against a core set of principles to address three core components: quality planning, quality improvement, and quality control. A system-wide quality framework for 2023/24 is currently being co-created which will reflect these components, whilst encompassing the ICB's current delivery plan which remains focused on the recovery and restoration of services, reducing health inequalities and increasing engagement.

We have worked closely with our partners throughout the year to ensure that standards are met, enabling challenge and support so that patient care can be improved and positive experience prioritised. We recognise that there have been services where quality standards have not been met during the year and the improvements needed have not been made. In these cases, we have worked with regulators, services and our system partners to put robust oversight and support arrangements in place in accordance with national frameworks.

Continued focus remains on Nottingham University Hospitals NHS Trust (NUH) in relation to organisational culture, patient safety, patient experience and leadership. Scrutiny has focused on maternity services alongside wider organisation issues. The ICB continues to offer support to NUH and continues to work closely with NHS England and regulators to sustain improvements made.

The Board has delegated responsibility for a range of quality functions, including the requirement to improve the quality of commissioned services, to its Quality and People Committee. You can read more about the work of the Quality and People Committee (and our other committees) in the *Governance Statement* section of this annual report.

Children and Young People (CYP) Safeguarding

The ICB's safeguarding and looked after children's oversight has evolved during the year and ICS Assurance Groups have been established to support oversight in new system arrangements. These are the:

- ICS Safeguarding and Public Protection Assurance Group
- ICS Looked After Children Assurance Group, and
- ICS Health SEND Assurance Group.

We have continued to be a partner in the safeguarding arrangements for both Nottinghamshire and Nottingham local safeguarding children's and adults' partnerships, chairing both partnerships in the last year. The strategic aims for the ICB safeguarding teams align with local safeguarding partners' priorities and map through into our strategic plans.

The ICB's Safeguarding teams continue to be engaged and participate in all the child safeguarding practice rapid reviews and reviews; none of which have met the criteria for a national review.

The Nottinghamshire Safeguarding Children Partnership has published two child safeguarding practice reviews in year. It has also commissioned a review of the Multi Agency Safeguarding Hub (MASH). The ICB currently hosts the health element of the MASH and will use the findings from this review as well as internal audits to refresh the MASH Health model.

The Nottingham and Nottinghamshire Child Death Overview Panel continue to meet regularly to review the child death cases. In year, there has been over 70 child deaths with the majority being neonatal deaths, which is similar to previous years. The number of deaths reviewed in year has increased which is thought to be an impact of the post-Covid recovery plan.

We are actively engaged and proactively participating to safeguarding and promote the health and wellbeing for children and young people in several workstreams including:

- Neglect
- Female Genital Mutilation
- Child Protection Information Sharing
- Children as victims of domestic abuse
- Unaccompanied Asylum-Seeking Children
- Ensuring the voice and lived experience of children and families

The Named Safeguarding Professional for General Practice has reviewed the GP Safeguarding Self-Assessment Assurance Framework. Overall the practices have reported good compliance. When there are concerns about compliance the team agree a plan of support and a mitigation plan.

Our Safeguarding teams are working with partners to ensure that the system is meeting its new statutory duty in relation to the Serious Violence Duty and Domestic Abuse Act by being integral members of the Violence Reduction Partnership and Domestic abuse forums.

The ICB is a member of the Strategic Multi-agency Public Protection Arrangements (MAPPA) Board and contributes to robust safety management plans. We have followed the statutory assurance processes set out in the 'Safeguarding Accountability and Assurance Framework' and met the duties set out in Working

Together to Safeguarding Children (2018). Further information can be found on the safeguarding pages of our website: Safeguarding - NHS Nottingham and Nottinghamshire ICB.

Engaging 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 therefore commission services that will deliver the most benefit to the population.

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 sector, Healthwatch Nottingham and Nottinghamshire and other organisations within our area to deliver on the aims of our ICS. This means that whilst much of the work described in this section relates to the work of the ICB, it also has a bearing on and relevance to the wider work of our system.

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. We involve people and communities in our work in several ways including:

- By undertaking targeted programmes of engagement and formal public consultations when there is a substantial variation or development in a service.
- Through patient participation groups which involve patients about the range and quality of services provided by their GP practice and how commissioners plan services.
- Through community engagement events and our social media channels.
- Through our Citizen's Panel, a consultative body of local residents; and our Citizen Intelligence Advisory Group, which ensures that citizen intelligence and insight informs the commissioning of health and care services.
- Through co-production, ensuring that all proposals to change and improve local healthcare services are developed with sufficient citizen and service use involvement.

The ICB's aspiration is to embed co-production within all elements of system design and delivery; including transformational activity, commissioning activity, service/system redesign and quality improvement. We want to empower and enable people to be involved in the co-design and co commissioning of our system and services in a meaningful way, as a powerful voice alongside those of professionals in the system.

We have developed our 'Working with People and Communities Strategy' which sets out our approach for involving local people in our commissioning activity together with our engagement platforms and governance structures. Our vision for working

with people and communities contains two key elements – that of Citizen Intelligence and for Co-production. Our strategy and further information can be found on our website at www.notts.icb.nhs.uk

We have formed the ICB's Citizen Intelligence Advisory Group, which brings together Healthwatch Nottingham and Nottinghamshire, representatives from our four Places, local authorities and the Voluntary, Community and Social Enterprise sector; to ensure citizen intelligence and insight informs the commissioning of health and care services.

An ICS Engagement Practitioners Forum has been established with 35 members from across various organisations in operating in the health and care space across Nottingham and Nottinghamshire. Representatives of the forum include Healthwatch Nottingham and Nottinghamshire, NHS Trusts, Local Authorities, universities, Community and Voluntary sector and Place Based Partnerships. This forum provides a platform for all system partners working with people and communities to work collaboratively and avoid duplication, share resources, knowledge and expertise and maximise existing knowledge and insights.

The Voluntary, Community and Social Enterprise Alliance has quickly become a powerful body representing various organisations across Nottingham and Nottinghamshire. All representatives have an equal voice, and the Alliance is a formal part of our ICS, enabling liaison with commissioners and other stakeholders and encouraging partnership working. with the aim of putting the voice of people and communities at the heart of what we do.

The ICB's Engagement Team continue to work closely with key stakeholders such as Nottingham Community and Voluntary Service, Healthwatch Nottingham and Nottinghamshire, Nottingham Trent University, University of Nottingham Business School, CityCare, NUH and other Place representatives to embed our Citizens Panel, a consultative body of Nottingham City residents.

The development of Nottingham and Nottinghamshire's Integrated Care Strategy has been one of the earliest testing grounds for our refreshed and enhanced approach to working with people and communities. Using a two-step approach, first a desktop research exercise was undertaken to understand the needs of our citizens and how these can be met, people and communities who are not to understand who we need to involve, and gaps in our knowledge that could form the basis of our involvement work.

The second stage involved a number of listening activities to test the findings from the desk research, explore gaps in our knowledge, test the emerging content of the Integrated Care Strategy and test the Vision and purpose for our ICS. A key principle of these activities was to allow citizens the opportunities to shape and inform the strategy and that we did not ask for citizen intelligence that we already have.

The ICS Assembly was a core mechanism for involving people and communities in the development of the Integrated Care Strategy, which was attended by 161

partners from across our ICS, including representation from NHS, Local Authority, Voluntary, Community and Social Enterprise, citizens and patients.

This was complemented by:

- One virtual and three in-person briefings to MPs and councillors
- Two virtual public events
- Development of an online survey, which was shared with the Citizens' Panel
- Attendance at the Nottinghamshire County Council Shadow event (targeted engagement with children and young people)
- Listening to feedback from members of our VCSE Alliance
- Working with the ICS Engagement Practitioners Forum to identify existing events and opportunities to hear from our citizens

The work undertaken with people and communities in the development of our Strategy has been a flagship piece of work, identified as an exemplar by the Department of Health and Social Care.

Our co-production work builds upon best practice from across our local health, local authority, and voluntary sector partners, and through co-production with people with lived experience in an equal partnership. Throughout 2022, the ICB was one of ten sites to develop and embed co-production through the NHS England 'Experience of Care' Team programme, and the work builds upon this national learning. We also celebrated our approach being a finalist in the NHS England and Academic Health Science Network's Innovation Awards 2022.

A full copy of our Working with People and Communities Annual Report can be found on our website at www.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 (NHS Long Term Plan, 2019).

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 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 the local community.
- 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.

We have recognised health equity (the ability for all individuals to attain their full potential for health and well-being) as a core principle to further build on and support the delivery of the health inequalities duty, which has been fundamental in championing the ICB's commitment to delivering equity in access and experience across our system. This is alongside the adoption of the NHS England Core20plus5 approach, which has provided a framework for our system's Health Inequalities Plan. This approach defines a target population cohort and identifies five focus clinical areas requiring accelerated improvement. These areas and plans we have progressed over the year are shown as follows:

- Maternity – we have carried out an equity review and developed plans for local maternity support workers dedicated to specific communities and population groups.
- Severe mental illness – we have expanded the role of the Health Improvement Workers carrying out 'reasonable adjustments' to support uptake for health checks.
- Chronic respiratory disease– we have combined efforts across flu, pneumonia and COVID vaccination programmes to target those with COPD, as one of the most clinically vulnerable groups, with the aim of increasing uptake in pulmonary rehabilitation.
- Early cancer diagnosis– we have implemented Lung Health Checks in both Nottingham City and Mansfield; in addition to undertaking a pilot for a Lung Cancer Hotline in a community with low referral rates and high smoking prevalence.
- Hypertension case-finding – we have implemented proactive care programmes across Primary Care Networks and community pharmacies.

In recognising the importance of integration, the Health Inequalities Plan is underpinned by the Nottingham City and Nottinghamshire County Health and Wellbeing Strategies and forms part of a wider response to addressing inequalities across our system, that responds to both national policy and our individual organisational responsibilities. The development of Places and Neighbourhoods continue to be fundamental in ensuring delivery of the plan, as we recognise that its success will come from really understanding our populations and the barriers and enablers to health that we will impact on both met and unmet need. The Health Inequalities Plan is available on the ICS website at www.healthandcarenotts.co.uk.

As part of the Nottingham and Nottinghamshire Integrated Care Partnership, we are able to further demonstrate our commitment in tackling inequalities in health outcomes, experiences and access. Working with our partner organisations from across health and care, we have developed our Integrated Care Strategy using the best available evidence and data and addressing the wider determinants of health and wellbeing.

The ICB's first year of operation has seen us drive forward several key enablers in addressing health inequalities. These include comprehensive reviews of our populations, allowing for a clear understanding of the opportunities for integration targeted to population need and work performed through our System Analytical Intelligence Unit to develop a health inequalities dashboard. This dashboard forms part of the ICB's Integrated Performance Report, which is overseen by the ICB's Finance and Performance Committee.

Equality, Diversity and Inclusion

The Public Sector Equality Duty (PSED) of the Equality Act 2010 requires us to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity and foster good relations. These are often referred to as the three general aims of the PSED. Having due regard requires the ICB to consider removing or minimising disadvantages, take steps to meet people's needs, tackling prejudice, and promoting understanding.

The ICB recognises and values the diverse needs of the population we serve, and we are committed to reducing health inequalities and improving the equality of health outcomes for local people. We are committed to embedding equality and diversity considerations into all aspects of our work, including policy development, commissioning processes and employment practices. 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 (JSNA) chapters consider all protected characteristic and other disadvantaged groups to accurately inform equality considerations in our commissioning intentions.
- Public engagement and communications – We engage with people from all protected characteristic and other disadvantaged groups in our population, particularly those whose voices may not be routinely heard, through a range of different mechanisms 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 targeted and tailored messaging that reaches the right people more 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 (EQIAs) that also incorporate wider quality considerations (patient safety, patient experience and clinical effectiveness). EQIAs are treated as 'live' documents and are revisited at key stages of scheme development and implementation, particularly following the conclusion of any patient and public engagement and consultation activities, 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 and we use the national NHS Standard Contract, which in its full-length version 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). A range of assurances on compliance with these requirements are incorporated within our routine quality and performance monitoring processes.
- Recruitment, selection and the working environment – We operate a fair, inclusive and transparent recruitment and selection process and maintain relevant workforce accreditations to help demonstrate that we promote equality of opportunity. We implement the NHS Workforce Race Equality Standard (WRES) and work to the requirements of the NHS Workforce Disability Equality Standard (WDES) and our working environment aims to promote the health and wellbeing of the whole workforce through a suite of human resources policies, which have been assessed from an equality perspective.

Our Annual Equality, Diversity and Inclusion Assurance Report describes the work we have done over the last year in more detail and is available on our website at Home - NHS Nottingham and Nottinghamshire ICB.

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.

In line with this duty, we are active members of the Nottingham City and Nottinghamshire County Health and Wellbeing Boards; 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 and NHS Improvement, local NHS Trusts and representatives from the voluntary sector.

The Health and Wellbeing Boards are statutorily responsible for producing joint strategic needs assessments (JSNAs) for their local populations. The JSNAs are the means by which a range of information (including local and national data) is utilised to identify the current health and wellbeing needs of local communities and to highlight health inequalities. This information is then used to inform the development of the city and county health and wellbeing strategies to address these specific factors.

The joint health and wellbeing strategies for both Nottingham City and Nottinghamshire set out the ambitions and priority areas for the next several years. and can be found on the councils' websites, at www.nottinghamshire.gov.uk and www.nottinghamcity.gov.uk.

Through well-established system working arrangements, the Chairs of the Health and Wellbeing Boards have been actively engaged in relation to the ICB's contribution to the joint local health and wellbeing strategies.

Environmental Matters

Sustainable development is recognised at a national level as an integral part of healthcare; climate change is not only a major threat to our planet, but to our health as well. The ICB is committed to contributing to the NHS England aim for the NHS to be the world's first 'net zero' national health service and in doing all we can to reduce our impact on the environment. This involves taking action around our NHS Carbon Footprint (emissions we control directly) and our NHS Carbon Footprint Plus (emissions we can influence).

Our strategy for tackling climate change is set out in our ICS Green Plan. This plan documents how we will work with our system partners to achieve carbon net zero on or before 2040 and deliver against the NHS target of 80% carbon net zero by 2028. It describes the specific actions and priority interventions we need to take to achieve carbon net zero and lay the foundation to deliver carbon emission reductions through the delivery of sustainable health and care services. This work has involved extensive collaboration across all of our system partners; building on individual commitments already made to support this agenda to define the necessary actions to help meet the carbon emission reductions as defined by the NHS Carbon

Footprint Plus for our local area. The Plan is lead executively by the ICB's Director of Finance, with a programme management approach in place to support delivery.

In January 2022, the national NHS England Green Programme created a dashboard of 15 key areas that will help move organisations on to carbon net zero. These areas include purchasing 100% of electricity from renewable sources, having a long-term climate change adaptation plan and travel-related targets such as working more closely with local transport partners. A system-wide action plan has been developed to ensure the achievement of all targets.

As the NHS continues its journey to becoming Net Zero by 2045, it's important to recognise that we all as individuals and as teams have a vital role to play in reaching our targets. To help staff in the ICB to understand how we build a Net Zero NHS, we promote utilising national training available on building a Net Zero NHS. We are also establishing a Green Champions Network, which our staff have been invited to participate in.

With regard to our estates and facilities, the former CCG organisations of the ICB were able to advance plans to rationalise its physical footprint as a result of the Covid pandemic; which saw a move to hybrid working and the availability of premises lease contract break clauses, which enabled us to reduce the properties our staff occupied. The carbon benefits of this are assumed to be reductions in energy usage, water usage, business travel and paper consumption. We have paper recycling bins across all of our sites and only purchase 100% recycled paper.

Presently, our Headquarters are leased from Nottinghamshire County Council. The ICB is charged a flat rate for its occupancy, with no breakdown of use or costs for energy, water and waste, which presents significant obstacles when evaluating our carbon emissions. Work is planned with the Council to understand if and how we can appropriately apportion carbon emissions from the building in order to evaluate our performance.

The ICB promotes active travel to its staff and offers a number of staff discounts for public transport. We are able to access the relevant facilities (such as secure cycle storage) at most of our sites. We also offer a salary sacrifice scheme for Ultra Low Emissions Vehicles and Electric Vehicles.

The ICB's Procurement Team is working with strategic procurement colleagues from our partner organisations to develop a joint 'net zero strategy' for the goods and services we buy across our system. This will be aligned to the national net zero supplier roadmap. Work is also underway to agree a joint procurement social value strategy for the system by March 2024; with the aim of gaining efficiencies from our combined purchasing power and supporting sustainability and social value in our communities. In addition, we are currently working with partners to implement new software that will enable us to identify opportunities to join up procurement activity, which will support the delivery of reduced carbon emissions.

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 system-wide digital strategy. 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. 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.

We are currently in the process of working with our system partners and stakeholders to refresh our ICS Data, Analytics, Information and Technology (DAIT) Strategy in line with the Framework; ensuring alignment to our key priorities which include public facing digital services (for example, providing individuals with access to their digital health and care record), supporting provider digitalisation (including utilising state of the art automation technologies to reduce burdensome processes) and supporting intelligent decision-making (using data to better understand the health and care needs of our population).

An ICS Digital Executive Group has been established comprising of relevant leads for our system partners to ensure operational ownership of the Strategy's planning and delivery. This group is supported by a number of fora that provide digital, clinical and operational input into the digital agenda. Assurance around delivery of the strategy and in meeting the ICB's specific digital responsibilities sits with our Finance and Performance Committee.

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 and the use in the health service of evidence obtained from research. We have put in place infrastructure and a programme of activities to meet these statutory duties going forwards.

The ICB's Executive Lead for Research is Dr Dave Briggs, Medical Director. We have a Research Strategy Group to oversee arrangements for the strategic development of research activity, capacity and culture within the ICB, Primary Care Networks (PCN) and GP practices. The Chair is the Research Lead at the University of Nottingham Health Service and the Primary Care National Specialty Lead for the National Institute for Health and Care Research (NIHR) Clinical Research Network

(CRN). The group has representatives from ICB teams, research active GP practices and other partner organisations including public health, academic primary care and the local NHS knowledge and library service.

We facilitate and promote primary care research capacity, capability and culture building through utilisation of our NIHR Research Capability Funding. This year we funded two Primary Care Research Champions (a GP and Practice Manager) working across the ICB area and a Primary Care Research Lead for Mid Nottinghamshire where historically there have been fewer research opportunities for people. These research leaders have engaged with primary care, PCNs and wider stakeholders to promote, advise, support and provide mentorship to integrate primary care research into everyday practice. They are focusing on equity of access to research opportunities for people and the workforce, promoting and supporting research being delivered where population need is greatest and increasing the diversity of people participating in research studies.

To support the ICB's statutory duty to facilitate or otherwise promote the use in the health service of evidence obtained from research, we commission an NHS Knowledge and Library Service provided by Sherwood Forest Hospitals NHS Foundation Trust. The Knowledge and Library Team conduct evidence searches and summaries and provide evidence update bulletins to support evidence informed decision making for strategic planning and transformation programmes.

In addition, the ICB is leading on system working through an Integrated Care System (ICS) Research Partners Group which has been convened and is chaired by the ICB's Head of Research and Evidence. This brings together senior representatives from the NHS providers, ICB, the two Local Authorities, the two Universities and the NIHR CRN East Midlands. The group was established in 2021/22 with the purpose of developing a system wide collaborative approach to health and care research across the ICS. Key aims of the group are to increase participation in research at the organisation, place and population level, enable equity of access to research opportunities and generate impact in health and care pathways.

In 2022/23 the group mapped health and care research activity, expertise, interests, NIHR and other research infrastructure in the constituent organisations. This has enabled the ICS to understand the breadth and depth of its research capabilities, strengths, expertise, areas of synergy and opportunities for future research collaborations that align to its needs, priorities and strategy. It has also led to agreed priorities for future development and collaboration, recognising that organisations are at different stages of research development. The ICS Research Partners Group and mapping exercise are cited as a best practice case study in the NHS England guidance for Integrated Care Systems on Maximising the Benefits of Research published in March 2023. A priority for 2023/24 is the development of an ICS Research Strategy.

In the context of integration with system partners, plus taking a targeted approach to health inequalities, during 2022/23 the ICB continued to take a joint approach to

commissioning research. We jointly funded with partners, an exploratory research study relating to the experience of Severe and Multiple Disadvantage (SMD) in ethnically diverse communities in Nottingham City. Therefore, using the benefits of research to target a priority relevant to Core20+5 and evidence generation to inform a greater understanding of health inequalities for this important inclusion health group. The research study is being conducted by a partnership between the University of Nottingham and Al-Hurraya, a Nottingham based peer led charity who work with and provide culturally sensitive interventions to ethnically diverse people experiencing SMD. The research study will report in the Autumn of 2023 and will inform the Changing Futures Programme in Nottingham City and strategic planning for personalised and integrated models of care for this population.

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. The ICB and our NHS Trust and NHS Foundation Trust partners are developing a Joint Forward Plan that will describe how our local NHS organisations 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.

More information about our approach to tackling inequalities can be found in the *Reducing health inequalities* section of this Annual Report.

Promoting Patient Involvement

ICBs must promote the involvement of patients, and their carers and representatives (if any), 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 developed a collaborative approach 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 make informed decisions and choices when their health changes. We have been recognised nationally as a leader in shared decision-making 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.

We have established an ICS Personalised Care Strategic Oversight Group, which provides operational ownership across system partners for the personalised care agenda and locally, assurance on the delivery of the ICB's specific duties are the responsibility of our Quality and People Committee.

More information on personalised care can be found on in the Personalised Care section of our website at www.notts.icb.uk.

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 health care services (in line with our commissioning responsibilities, as described in the *Performance Summary* 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. More recently, we have established a process for qualifying providers to ensure that we do not restrict providers from inclusion.

In practice, this means that patients requiring planned 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. Patients are able to make a choice of mental health provider and team including where they require integrated packages of care involving social care. Exclusions do apply, for example when accessing urgent or emergency (crisis) care or inpatient care whilst detained under the Mental Health Act 1983. In these services, the ICB focuses on

improving outcomes for people experiencing mental health crisis, to ensure they can access the support they need, when they need it.

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.

Going into 2023/24, NHS England has set out a number of actions and activities required of ICBs and primary care and secondary care organisations to enable greater patient choice. For ICBs, this includes ensuring a system level plan is in place to raise the profile of patient choice. Further information on this can be found at www.england.nhs.uk .

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, five 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 Clinical and Care Professional Leadership 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 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 and within the ICB's Governance Handbook which can be found here: [Our Constitution - NHS Nottingham and Nottinghamshire ICB](#).

Promoting Education and Training

When exercising our functions, the ICB has 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 Culture Plan, which 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.

Within the Nottingham and Nottinghamshire ICS, we recognise that a key factor to successfully delivering our Integrated Care Strategy will be to support our workforce, taking a 'one workforce' approach to making our health and care system a better place to work, inclusive of all staff involved in supporting local people's health and wellbeing. This will enable us to make the most of skills and talent across our system, building integrated teams with the adaptability and capacity to support prevention and deliver person-centred care.

In 2023/24, we will review our People and Culture Plan to ensure that it meets the ambitions of the Integrated Care Strategy. This will see a renewed 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. We also aim to expand our CARE4Notts Health and Care Careers Academy to support people into work. CARE4Notts provides a single point of access to promote health and care careers, delivering information, advice and guidance,

focusing on schools and colleges, young people and growing the future talent pipeline to ensure our teams reflect the diversity of our local population.

We have established an ICS People and Culture Group, which is comprised of relevant colleagues from all system partners and has operational ownership of planning and delivery. Our Quality and People Committee ensures that the ICB is developing robust arrangements with partners to support the 'one workforce' approach by leading system development and takes an assurance role regarding implementation of the ICS People and Culture Plan.

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.

When establishing the 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.

The Board's membership is comprised of the ICB's Chair and Chief Executive, four Non-Executive Directors, the ICB's Director of Finance, Director of Nursing, Medical Director and Director of Integration, and five Partner Members nominated by our system partner organisations.

An exercise has been completed to explicitly allocate executive accountability for each of the ICB's functions and duties. The 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 at www.nnicb.

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: [Our Board - NHS Nottingham and Nottinghamshire ICB].

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.

During course of the first seven months of the ICB's establishment, the Chair and wider Board members have kept these arrangements under review. Initial Board development sessions and a governance stock-take exercise have confirmed that roles and responsibilities are well understood and actions are being taken forward to further strengthen the voice of people and communities and our voluntary, community or social enterprise sector within the work of the Board. A more detailed self-assessment of the ICB's governance and partnership arrangements will be completed during 2023/24.

More information about how the Board secures the right professional expert advice can be found in the *Obtaining appropriate advice* section of this Annual Report.

Promoting Integration

Our ambition is to achieve the vision of integrated health and care within the ICS, joining up strategic leadership and the transformation of health and care to improve outcomes for our population; ensuring decision making is led and integrated at the appropriate population level, with an emphasis on subsidiarity. The ICB, Nottingham City Council and Nottinghamshire County Council are committed to planning and commissioning services together where that improves outcomes for citizens, ensures the care and support we offer is more effective and where this provides opportunities to maximise value in our services.

A Collaborative Planning and Commissioning Framework has been developed that sets out our approach to commissioning and planning services in partnership. The framework sets out the principles for how the organisations will work together to improve outcomes and reduce health inequalities for the population through integrated care. This provides an indication of the maturity of collaborative planning within the ICS.

A Collaborative Commissioning Oversight Group has been established to oversee a joint work programme of collaborative commissioning priority areas. The group includes commissioners from the ICB, Nottingham City Council and Nottinghamshire County Council (with additional place representation as required). This includes health, social care and public health commissioning. The Group is responsible for:

- Providing leadership for new ways of planning and commissioning in the ICS
- Delivering against the principles of the Collaborative Planning and Commissioning Framework
- Defining what good integration looks like

- Identifying opportunities for collaborative planning and commissioning to unlock demand management and achieve the 'left shift'
- Oversight of all programmes of collaborative commissioning, for problem solving and supporting progress
- Supporting alignment of commissioning resource where appropriate.

One of the key achievements supporting integration in 2022/23 was the development of an ICS joint strategy for unpaid carers that recognised the inequalities experience by people with a caring responsibility. A single procurement approach will be undertaken in 2023/24 to put in place services such as advice, information, support and respite care for unpaid carers.

Emergency Preparedness, Resilience and Response

The NHS needs 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 the community or the delivery of patient care. The Civil Contingencies Act (2004) and the NHS Emergency Preparedness, Resilience and Response (EPRR) Framework requires NHS organisations and providers of NHS-funded care to have plans and arrangements in place to respond to such incidents while maintaining services to patients.

ICBs are classed as 'Category 1' responders, which are at the core of an emergency response. We are subject to the full set of civil protection duties and required to:

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

In addition to meeting our legal requirements, the ICB is also required to comply with national guidance issued by NHS England and the ISO standards for business continuity.

The ICB's Accountable Emergency Officer (AEO) is the Director of Integration and therefore holds the required level of authority and responsibility for ensuring that the ICB complies with legal and policy requirements. The AEO takes a lead role in relation to legal duties to ensure preparedness to respond and to maintain the public's protection and maximise the NHS response.

The ICB is a member of the Local Resilience Forum (LRF). This includes supporting LRF planning and our attendance at relevant sub-groups including the Resilience

Working Group, LRF Risk Group and Local Health Resilience Partnership (LHRP). The LHRP is the strategic forum for Nottingham and Nottinghamshire healthcare organisations to facilitate preparedness and planning for health emergencies at a suitable system and LRF level.

In line with the NHS EPRR Framework, the ICB has the appropriate structures in place in relation to organisational incidents. This includes alert systems and ensuring a tactical and organisational response and system wide response. We operate a two tier on-call system which provides 24/7 response and local health leadership to emergencies and issues affecting Nottingham and Nottinghamshire's health system.

During the year, the ICB has led the response on a number of challenging incidents; including industrial action, system pressures and a Met Office Red Alert for Extreme Heat. The ICB has also managed the response to Monkey Pox and Avian Flu outbreaks.

We complete an annual EPRR self-assessment, which provides assurance that NHS organisations are working to meet the NHS EPRR Core Standards. For 2022/23, the ICB was assessed as partially compliant with the Core Standards and actions were agreed with NHS England to address the areas requiring improvement. An internal audit review undertaken of the ICB's EPRR arrangements (March 2023) provided significant assurance that the actions were being progressed towards full compliance.

Accountability Report

Signed:

Dr Amanda Sullivan
Chief Executive

28 June 2023

Introduction

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

The Accountability Report comprises three sections:

- The ***Corporate Governance Report*** sets out how we have governed the organisation during year, including membership and organisation of our governance structures and how they supported the achievement of our objectives.
- The ***Remuneration and Staff Report*** 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.
- The ***Parliamentary Accountability and Audit Report*** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

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.

Our Chair is Dr Kathy McLean, OBE and the Board's membership also includes our Chief Executive and the ICB's Director of Finance, Medical Director, Director of Nursing and Director of Integration. The Board's membership is also comprised of four Non-Executive Directors, one of which is the ICB's Vice-Chair, and five Partner Members from our system partner organisations

The Board's full membership for the period 1 July 2022 to 31 March 2023 is as follows:

- Dr Kathy McLean – Chair
- Dr Amanda Sullivan – Chief Executive
- Stuart Poynor – Director of Finance
- Dr Dave Briggs – Medical Director
- Rosa Waddingham – Director of Nursing
- Lucy Dadge – Director of Integration
- Jon Towler – Non-Executive Director and Vice-Chair

- Caroline Maley – Non-Executive Director
- Stephen Jackson – Non-Executive Director
- Professor Marios Adamou – Non-Executive Director
- Dr John Brewin – NHS Trust/Foundation Trust Partner Member (until 31 August 2022)
- Ifti Majid – NHS Trust/Foundation Trust Partner Member (from 8 January 2023)
- Paul Robinson – NHS Trust/Foundation Trust Partner Member
- Dr Kelvin Lim – Primary Care Partner Member
- Catherine Underwood – Local Authority Partner Member
- Melanie Williams – Local Authority Partner Member

Full biographies of our Board members are available in the '*About us*' section of our website at www.notts.icb.nhs.uk. You can read more about the work of the Board and its committee structure in the *Governance Statement* contained within this report.

Audit and Risk Committee

The following Non-Executive Directors were members of the Audit and Risk Committee during the period 1 July 2022 to 31 March 2023 and up to the signing of our annual report and accounts:

- Caroline Maley (Chair)
- Stephen Jackson
- Professor Marios Adamou

Other committee memberships

The *Governance Statement* contained within this annual report provides further details on all the Board's committees and sub-committees, including the composition of their memberships. Details regarding the ICB's Remuneration Committee can also be found in the *Remuneration Report* section of this 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 has a publicly available Register of Declared Interests that captures the declared interests of all members and attendees of the Board and its committees, along with all other employees of the ICB. The register can be found in the *'About us'* section of our website at www.notts.icb.nhs.uk. Further details on how we manage conflicts of interest are detailed in the *Governance Statement* contained within this report.

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 has been one serious incident that required external reporting during the reporting period, as prescribed by national guidance: Guide to the Notification of Data Security and Protection Incidents. This was due to two emails being sent with the recipients' personal email addresses included in the 'To' function, rather than the 'BCC' (blind carbon copy) function. The email topic implied recipients' general involvement with a matter of a sensitive nature. No further action was taken by the Information Commissioner's Office who was satisfied with the ICB's initial incident response and follow up actions. This included sending the recipients an explanation and apology as soon as the error had been noted.

There were eighteen personal data related incidents and a further three near misses during the reporting period; however, these were not rated as serious in nature and were managed in line with the ICB's incident reporting and management procedures.

Complaints

As an organisation we welcome complaints as a valuable source of learning and recognise that lessons learnt as a result of complaint investigations give us an opportunity to maximise service development, make changes where required to systems and processes, and improve future experiences for everybody. The complaints we receive are about the services we commission, but sometimes the ICB leads on a complaint investigation because the complaint involves a number of different local health providers. All complaints are handled in line with the statutory NHS Complaint Handling Guidelines.

Between 1 July 2022 and 31 March 2023, we received 266 complaints and three Parliamentary and Health Service Ombudsman (PHSO) cases. As at the time of signing this report, one PHSO complaint has been confirmed as not being upheld, one was not investigated by the PHSO as no complaint was made to the ICB and we are awaiting further information on the remaining case.

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 2023 is published on our website at www.notts.icb.nhs.uk.

Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board 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 Nottingham and Nottinghamshire Integrated Care Board (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; and,
- Prepare the accounts on a going concern basis; and
- 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 Dr Amanda Sullivan to be the Accountable Officer of NHS Nottingham and Nottinghamshire 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 Integrated Care Board 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 Integrated Care Board ("the ICB") is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended by the Health and Care Act 2022).

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 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. The ICB also has full delegated responsibility from NHS England for commissioning primary medical services for the people of Nottingham and Nottinghamshire.

Between 1 July 2022 and 31 March 2023, 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).

The Nottingham and Nottinghamshire Integrated Care System ("the ICS" or "the system") is a partnership of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in the 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. More information on the structure of the ICS can be found in the *About us* section of this annual report.

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 and sub-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 (SoRD), 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 sub-committees, and functions and decisions delegated to another body or bodies or to be exercised jointly with another body or bodies[1]

The ICB has also 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, hospitality and sponsorship) and its Raising Concerns (Whistleblowing) 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

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[1] *A summarised version of the SoRD can be viewed on the ICB's Functions and Decisions Map, available on the ICB's website at www.notts.icb.nhs.uk.*

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 the ICB's governing documents and policies are available in the '*About us'* section of our website at www.notts.icb.nhs.uk.

The Board

The main function of the ICB's Board is 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 also 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 is comprised of the ICB's Chair and Chief Executive, four Non-Executive Directors, the ICB's Director of Finance, Director of Nursing, Medical Director and Director of Integration, 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 and human resources.

The members of the Board are named within the *Members Report* section of this annual report.

The Board held its inaugural meeting on its first day of establishment (1 July 2022) and has met on a further four occasions during 2022/23. At these meetings, the Board:

- Established its committee and sub-committee structure and approved the ICB's Governance Handbook, including term of reference for all committees and sub-committees, the Standing Financial Instructions and the Scheme of Reservation and Delegation. The Board also adopted a suite of organisational policies and approved the appointment of the ICB's external auditor, following a recommendation from its Auditor Panel.
- Received regular updates, via the Chair's report and Chief Executive's report, on the production of key strategies and plans; most notably the first Integrated Care Strategy for Nottingham and Nottinghamshire, which was published in March 2023 and the ICB's first Joint Forward Plan, being produced with NHS Trust and NHS Foundation Trust partners. The Board also approved the ICB's joint Operational and Financial Plans with NHS Trust and NHS Foundation Trust partners for 2023/24.
- Received delivery and transformation updates on a range of priority areas including urgent and emergency care, elective care, mental health services, children and young people's services, primary medical services, community services and personalised care. The reports focused on actions being taken to support system resilience, tackle inequalities, improve outcomes and integrate services, using citizen stories to highlight health improvements for local people.
- Received reports on the development of partnership working arrangements, including updates from the leaders of two Place-Based Partnerships to demonstrate the early impact of new ways of working to achieve transformational change in areas of identified local need, in line with the principle of subsidiarity.
- Received assurance reports regarding progress in delivery of the ICS Digital Strategy and ICS Green Plan.
- Received integrated performance reports relating to finance, quality standards, service delivery targets, health inequalities and workforce indicators. These highlighted areas of improvement and areas of concern, along with actions and recovery timelines.
- Received highlight reports from each of its committees, providing assurance that delegated responsibilities were being effectively discharged. This included being advised of any decisions made and updates on the high and extreme operational risks being oversighted by the committees.
- Received regular updates in relation to the development and management of the ICB's strategic risks, via its Board Assurance Framework.

All meetings were quorate in accordance with the ICB's Standing Orders, except for one which was due to unforeseen circumstances. At this meeting, the ICB's Chair and Chief Executive used the Board's emergency decision-making powers, as permitted by the Standing Orders, to make the required decisions. Most Board members were present for these items, giving their unanimous support for the decisions made, which were subsequently ratified at the following Board meeting. Members achieved an average attendance of 86%.

In addition to its formal meetings, the Board also held six development sessions, two of which were held in June 2022, immediately prior to the ICB being formally established. These sessions provided members with the ability to further discuss the developing role of the new ICB, the responsibilities of Board and the vision and

values of the organisation. Other sessions focussed on new ways of working between system partners, exploring the ICB's risk appetite and looking in more detail at evolving areas of work, such as the development of the ICB's people and culture function.

Committees and Sub-Committees of the Board

The ICB Board has established several committees and sub-committees to assist it with the discharge of its functions. Some committees are statutory requirements, whilst others are established 'by design' taking into account 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 and sub-committees. All committees routinely report to the Board through the submission of highlight reports and other appropriate updates, as necessary. Sub-committees report directly into their respective 'parent' committee, which will then forward on any matters requiring the Board's attention.

As newly established forums, all committees held development sessions early in the year and before proceeding to full business meetings. This provided the time and space for members to fully explore the responsibilities and objectives of their respective committees and to consider ways in which they could work best going forward.

Memberships of committees and sub-committees consist of non-executive director members of the Board, executive directors and other senior leaders and clinical members (as appropriate to the remit of the committee). For our key assurance committees (the Quality and People Committee and the Finance and Performance Committee) we have also appointed non-executive directors from our partner NHS Trusts and NHS Foundation Trusts. Whilst these roles bring the knowledge and perspective of providers within our system, enriching the committees' discussions and adding further scrutiny to the ICB's activities; they are full committee members and not in attendance to represent their respective organisations.

A governance 'stock-take' exercise was undertaken one hundred days post-establishment of the ICB, which confirmed that the ICB's structures were fit for purpose and arrangements were working well in practice. Towards the end of the reporting period, a review of committee effectiveness was completed; an annual requirement for all committees and sub-committees stipulated within their terms of reference. This work considered how committees and sub-committees have operated since their establishment and whether any actions are needed to further support them in discharging their delegated duties. In completing this work, it was recognised that 2022/23 has been an atypical year in which the Board and its committees are still maturing. Therefore a pragmatic approach has been taken, which has focussed on the fundamental elements of committee effectiveness; such

as planning and preparation for meetings, the quality of papers and presentations received and behaviours and etiquette. This review has also considered the annual work programmes of the committees and sub-committees; ensuring that the progress made by each to develop comprehensive reporting arrangements during the year can be built upon and enhanced going in to 2023/24. Following discussion and feedback on the outcome of the review with Committee Chairs and members, a full outcome report and action plan has been developed for presentation to the Audit and Risk Committee at its first scheduled meeting in 2023/24, with the Committee assuming responsibility for the oversight of actions until their completion.

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 of the Board; 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 four times during 2022/23. All formal meetings were quorate in line with the Committee's terms of reference and its members achieved an average of 92% attendance at meetings. The members of the Committee are named within the *Members Report* section of this annual report.

Of note this year has been the Committee's role in continuing to oversee the actions required following a comprehensive due diligence process undertaken by the two former CCG organisations. This process was necessary to ensure the safe transfer of staff and property to the ICB; to preserve corporate memory and to inform the new organisation of any liabilities (or potential liabilities) it would inherit following disestablishment of the CCGs. The Committee was presented with the outcome of this work at its inaugural meeting in September 2022, which included an update on the status of any residual issues and actions. A final update on this work was provided to the Committee in March, which assured members that any ongoing issues had been successfully transferred to the appropriate ICB committee or responsible person and had been clearly embedded within the ICB's own oversight and management processes.

During the reporting period, the Committee also:

- Scrutinised reports from the ICB's internal and external auditors, which culminated in the receipt of year-end opinions and conclusions
- Approved the ICB's Annual Report and Accounts for the period 1 July 2022 to 31 March 2023 and the Annual Reports and Accounts of the two former CCGs for the period 1 April 2022 to 30 June 2022, as the ICB assumed responsibility for these following the disestablishment of the two organisations. Robust assurances to enable members to do this have been provided.
- Scrutinised the ICB's Register of Tender Waivers, which sets out all contracts that have been awarded without a competitive tender. The Committee has been assured that all waivers were appropriate.
- Received assurance reports demonstrating the arrangements in place for operational and strategic risk management. This has included oversight of the further development of the ICB's Risk Management Policy and focused reviews of all strategic risks on the ICB's Board Assurance Framework.
- Received updates from the ICB's counter fraud service on progress in achieving the NHS Counter Fraud Authority Standards for NHS commissioners and reviewed the ICB's Fraud Risk Register, which provided assurance that risks on the ICB's Fraud Risk Register were being actively managed. The Committee approved the Counter Fraud Plans for 2022/23 and 2023/24.
- Maintained oversight of the ICB's key financial stewardship arrangements, including continued focus of off payroll arrangements and procurement card usage. The outputs of an NHS England mandated self-assessment, based on a Healthcare Financial Management Association (HFMA) financial sustainability checklist, was also kept under review.
- Received assurance reports on the implementation of the ICB's Standards of Business Conduct Policy; in particular, scrutinising the arrangements established for the management of conflicts of interest. Its update in March 2023 confirmed that an organisation-wide assurance exercise of the ICB's Register of Declared Interests had been undertaken to confirm the Register's accuracy.
- Received assurance in relation to implementation of the ICB's policy management framework and scrutinised compliance with the ICB's statutory and mandatory training and health and safety requirements, and compliance with legislative and regulatory requirements relating to information governance.
- Received a comprehensive report on the ICB's Emergency Preparedness, Resilience and Response (EPRR) responsibilities, receiving assurance that robust structures were in place to respond to known system pressures.
- Considered the relevant factors affecting the ICB's risks reported in the 2022/23 External Audit Plan.
- Maintained constant focus on the internal audit plan to ensure that the plan gave sufficient focus on key areas of scrutiny to produce the end of year Head of Internal Audit Opinion. The Committee has also approved the Internal Audit Plans for 2022/23 and 2023/24.

Finance and Performance Committee

The Finance and Performance Committee exists to scrutinise 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 scrutinising actions

to tackle heath inequalities, deliver improved health outcomes, and address 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 oversights non-healthcare contracts; making decisions on investments and contract awards in line with the SoRD. The Committee's remit incorporates the relevant requirements set out within the Delegation Agreement between NHS England and the ICB (Primary Medical Services), insofar as they relate to finance, performance and estates.

The Committee's membership is comprised of two Non-Executive Directors of the Board, two Non-Executive Director members nominated from NHS Trust and NHS Foundation Trust partners and the ICB's Director of Finance and its Medical Director. The Committee met seven times during the reporting period and achieved an average attendance of 83%.

During the reporting period, the Committee:

- Reviewed and endorsed the ICB 2022/23 capital funding and capital expenditure plans for onward submission to the Board. The Committee also scrutinised and approved a capital planning and prioritisation process for future capital schemes and monitored progress against these plans throughout the course of the year and sought assurance on actions being taken to address slippage as and when necessary.
- Reviewed and endorsed the 2022/23 Financial Plans and opening budgets in advance of submission to the Board, noting that these covered the full financial year and therefore included detail specific to the two former CCG organisations (where relevant). The Committee also monitored progress against the 2022/23 Financial Plans, seeking assurance regarding actions being taken by the ICB and its NHS Trust and NHS Foundation Trust partners to recover their respective positions against areas of slippage.
- Oversaw the development of the ICB's joint Operational and Financial Plans with NHS Trust and NHS Foundation Trust partners for 2023/24.
- Scrutinised monthly performance reports containing service delivery scorecards (covering key metrics in urgent care, planned care, mental health, primary and community care) and monitored highlighted exceptions and progress with actions being taken to address areas of concern. This led to more detailed examinations of the operational oversight arrangements established across the system relevant to planned care, mental health and urgent care.
- Scrutinised progress to date in delivering the ICS Green Plan, noting actions being taken across the ICS to achieve the NHS goal of reaching net zero carbon emissions by the year 2040.
- Scrutinised progress in delivery of the ICS Digital Strategy, noting actions being taken to mitigate digital risks and work to develop an updated strategy.
- Considered and approved proposals relating to primary care estates, noting the need to ensure there is sustainable infrastructure across the primary care landscape to cope with population growth.
- Received a standing operational risk report, which included risks aligned to the Committee's responsibilities, with particular focus on areas of high and extreme risk.

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 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 management 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 (Primary Medical Services), insofar as they relate to quality and people.

The Committee's membership is comprised of two Non-Executive Directors of the Board, two Non-Executive Director members nominated from NHS Trust and NHS Foundation Trust partners and the ICB's Director of Nursing and its Director of Integration. The Committee met six times during the reporting period and achieved an average attendance of 86%.

During the reporting period, the Committee:

- Scrutinised progress in delivery of the twelve priorities set out within the 2022/23 ICS Quality Strategy, noting that moving into 2023/24, the priorities would remain broadly the same but be presented as a system quality framework.
- Scrutinised regular reports providing assurance that the ICB is discharging its statutory duties in relation to quality. These reports highlighted key issues, challenges, and improvements, whilst also articulating risks to delivery. This led to more detailed examination in several areas, including Learning Disabilities and Autism, Looked After Children, the Local Maternity Neonatal Service. The committee also scrutinised the actions underway to promote safety and improve patient flow across the system to address risk and reduce patient harm.
- Scrutinised monthly performance reports containing quality improvement indicators, facilitating a particular focus on areas of transformation.
- Approved the ICB's commentary to be included within the Quality Accounts of the ICB's main provider organisations.
- Oversaw development and delivery of the ICS People Plan, which included a focus on turnover, sickness absence, recruitment and spending on agency and bank staff.
- Reviewed and endorsed the annual equality assurance report setting out the ICB's compliance with the Public Sector Equality Duty and commitment to equality, diversity, inclusion, and human rights.
- Received a standing operational risk report, which included risks aligned to the Committee's responsibilities, with particular focus on areas of high and extreme risk.

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 compliance with the general duties of ICBs, public sector equality duties, social value duties, and the rules set out in NHS Procurement, Patient Choice and Competition Regulations 2013. 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 and applications to NHS England for further delegated functions.

The Committee's membership is comprised of three Non-Executive Directors of the Board, the Chief Executive, Director of Integration, Medical Director and other senior nursing and finance leads. The Committee met seven times during the reporting period, achieving an average attendance of 79%.

During the reporting period, the Committee:

- Scrutinised the development of several key strategic plans; including the development of the Joint Forward Plan, the Primary Care Strategy and the Health Inequalities Plan. The Committee also reviewed progress in several key system transformation areas; including the community care and mental health transformation programmes.
- Scrutinised the progress of system development activities; including those relevant to Place-Based Partnerships, Primary Care Networks and the provider collaborative at scale, and reviewed the impact of the ICS approach to Population Health Management on health outcomes and inequalities.
- Oversaw the pre-delegation work required ahead of taking on delegated commissioning responsibility from NHS England for Pharmacy, Optometry and Dental (POD) Services and Specialised Services.
- Oversaw the development of the Tomorrow's NUH Pre-Consultation Business Case in line with national requirements.
- Endorsed a decision-making framework for the ICB to provide the basis for decisions on all proposed service changes to support the Committee's decision-making arrangements through the robust peer review and quality assurance of service change proposals. In line with its delegated authority, the Committee also approved several healthcare investments and contract awards, which covered community gynaecology services, termination of pregnancy services, acute respiratory hubs, anticipatory care pilots, community crisis support services, unpaid carer support services, discharge support services and community ophthalmology services.
- Reviewed the progress made regarding the alignment of the commissioning policies of the former CCG organisations.
- Received a standing operational risk report, which included risks aligned to the Committee's responsibilities, with particular focus on areas of high and extreme risk.

Primary Care Contracting Sub-Committee

The Primary Care Contracting Sub-Committee has been established by the Strategic Planning and Integration Committee to exercise requirements set out within the Delegation Agreement between NHS England and the ICB (Primary Medical Services), insofar as they relate to contract management.

Membership of the Sub-Committee is comprised of primary care contracting, medical, nursing and finance leads, along with senior representatives from the four Place-Based Partnerships. The Sub-Committee met six times during the reporting period, achieving average attendance of 63%.

During the reporting period, the Sub-Committee:

- Received updates at each meeting regarding contractual issues relating to the 132 GP Practices within Nottingham and Nottinghamshire. In line with its delegated authority, the Sub-Committee approved one practice merger, one patient list closure, one amendment to practice opening hours, one practice boundary change and one contract amendment to remove a branch from a medical group's contract. The Sub-Committee also oversaw the development and implementation of a resilience support package offered to general practice during the winter period.
- Received routine reports regarding GP practice performance, including early warning indicators where improvements may be needed and an overview of Care Quality Commission (CQC) inspections and outcomes. The Sub-Committee also analysed the General Practice Appointment Data (GPAD), which became publicly available during November 2022.
- Monitored implementation of the Network Direct Enhanced Service (DES) Enhanced Access Primary Care Network (PCN) Plans, which commenced 1 October 2022.

Remuneration Committee

The main purpose of the Remuneration 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). 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 NED Remuneration Panel respectively).

The Committee's membership consists of four Non-Executive Directors of the Board, which includes the Chair of the ICB. The Committee met four times during the year, achieving an average attendance of 94%.

The Committee held its inaugural meeting on the first day of the ICB's establishment, during which it formally approved the terms of appointment and remuneration of the Chief Executive, Executive Directors and other Very Senior Managers. During the reporting period, the Committee also:

- Received a handover report from the two former CCGs to the ICB, which described a small number of ongoing human resource matters (related to the Committee's responsibilities) that had

transferred into the ICB as potential liabilities. Members continued to receive progress updates on these matters at its subsequent meetings.

- Set the remuneration for key appointments to the ICB, including the Chief People Officer, Chief Digital Officer and Deputy Medical Director roles and for individuals engaged by the ICB on a contract for services basis.

NED Remuneration Panel

The Non-Executive Director (NED) Remuneration Panel exists 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 Associate Director of Governance and one of the Partner Members of the Board.

The Panel met once during the reporting period, which was on the ICB's first day of establishment, to discuss and agree the proposed remuneration and terms of appointment for the non-executive members of the Board.

Human Resources Sub-Committee

The Human Resources Sub-Committee has been established to ensure that rigorous and transparent employee policies, procedures and systems are in place and kept under review for all staff employed by the ICB.

The Sub-Committee's membership is comprised of the ICB's Executive Management Team, with the Board agreeing in March to extend this to include the ICB's Chief People Officer from 1 April 2023. Open invitations to meetings are also made to the ICB's staff network groups, with the aim of providing the staff voice in discussions. The Sub-Committee met twice during the reporting period, achieving an average attendance of 90%.

During the reporting period, the Sub-Committee:

- Oversaw the development of an ICB Workforce Dashboard to support it in monitoring performance against a set of key workforce indicators, including turnover, retention and recruitment data and workforce demographics.
- Monitored progress in delivery of actions identified in response to the NHS Staff survey, covering health and wellbeing, workforce planning and talent management, equality, diversity and inclusion, training and education.
- Received a standing operational risk report, which included risks aligned to the Sub-Committee's responsibilities.

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.

The Panel met once during the reporting period, which was on 1 July 2022 to review a proposal to appoint KPMG as the ICB's external auditor. The proposal was endorsed by members and subsequently approved by the Board.

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.

Further information can be found in the *Our statutory duties* section of this annual report.

Risk management arrangements and effectiveness

A fundamental aspect of the ICB's governance structure is the establishment and implementation of sound risk management arrangements. Effective risk management ensures processes are in place to proactively identify, understand, monitor and address current and future risks; both operationally and strategically.

The ICB's Risk Management Policy clearly sets out the processes in place to ensure the systematic identification, assessment, evaluation and control of risks, including arrangements for the Operational Risk Register and Board Assurance Framework.

The following key elements are explicitly identified within the ICB's Risk Management Policy, which support the embedment of a risk aware culture:

- The Board's commitment to, and leadership of, the total risk management function – This is demonstrated by the Board's approval and ownership of the Risk Management Policy and the ongoing review of strategic and high and extreme operational risks through regular and consistent

Board reporting. During 2022/23, the Board held a focussed development session to review the ICB's risk appetite in the context of its developing operating framework and finalisation of the Nottingham and Nottinghamshire Integrated Care Strategy.

- Having defined individual roles and responsibilities in relation to risk management – As the Chief Executive, I am ultimately responsible for risk management within the ICB; however, all members of my Executive and Senior Leadership Team have a specific duty to ensure that appropriate mechanisms are in place within their areas of responsibility for identifying and highlighting new and emerging risks relating to the ICB or wider system priorities.
- Embedding proactive and reactive risk identification within business decision making processes – Risks are identified through an assortment of activities, such as horizon scanning, external and self-assessments (including internal and external audits), formal risk assessments and during committee, system forum 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.
- Having standardised mechanisms in place to systematically assess, control and minimise risk – All risks are assessed by defining qualitative measures of impact and likelihood, and scored methodically using the ICB's risk scoring matrix. Risks are then prioritised for management action dependent on the current (residual) risk score, in line with the ICB's risk appetite.
- Having effective reporting and scrutiny mechanisms for all risks, incidents and near misses – All committees of the Board are responsible for monitoring risks that relate to their terms of reference. All high and extreme operational risks are also 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.
- Ensuring the effectiveness of the Risk Management Policy – The Audit and Risk Committee has delegated responsibility for:
  - Reviewing the strategic and operational risk management processes across the ICB and satisfying itself that the overall system and processes in place are effective.
  - Reviewing the relevance and rigour of the Board Assurance Framework and Operational Risk Register and the arrangements that surround them.
  - Providing assurance to the Board in support of the annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework and the completeness and embedment of risk management in the organisation.

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 fundamental aspect of the policy is the defined risk appetite, which has been reviewed by the Board and has been considered from the following two perspectives:

- Risk taking – which acknowledges where the ICB has the resources, skills and control environment in place to be innovative and exploit opportunities; and
- Risk tolerance – which clearly sets out the boundaries of risk that the Board is willing to accept.

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. All strategic risks are owned by an Executive Director of the ICB, and the Board receives bi-annual updates.

Operational risks are current, 'live' risks that the organisation is facing; these 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 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 now 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.

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.

Risk Assessment

The high or extreme risks identified and monitored through the Operational Risk Register since the 1 July 2022, related to:

- The potential for patients to have extended lengths of stay in inappropriate care settings because of delayed discharges, patient flow challenges and demand outstripping capacity across urgent and emergency care services. Mitigations to this risk largely relate to the discharge to assess programme being undertaken collectively by system partners; overseen by the ICS Urgent and Emergency Care Transformation Board and its supporting governance structure. Mitigations also relate to the system-wide discharge planning work being undertaken, as well as working with Local Authority partners to increase funding and capacity across the care home and home care market. Driving improvement across the urgent and emergency care pathway will continue to be a key priority for 2023/24.
- The potential for harm to occur across the elective and non-elective pathways because of increasing levels of demand and increased waiting lists. Mitigations identified in relation to this risk relate to the clinical prioritisation work undertaken by the ICS Clinical and Care Professional Leadership Group and Acute providers within the system, to ensure that planned care is being delivered based on clinical need, as well as the system-wide admissions avoidance work undertaken to reduce Emergency Department attendances.
- The potential for mental health outcomes to worsen because of increased waiting times, particularly for children and young people given the level of demand for this demographic. Mitigations to this risk largely relate to the implementation of restoration and recovery plans by mental health providers and the utilisation of national funding to address local priorities. Improving access to mental health and support for children and young people is a key priority for the ICS for 2023/24.
- The potential for poor patient experience and patient safety concerns at Nottinghamshire Healthcare NHS Foundation Trust. This risk was originally identified following the outcome of a CQC inspection being published. The ICB identified a further risk relating to lack of assurance regarding the culture and leadership at the Trust in response to the issues identified. Assurance in relation to service quality and wider governance improvements has been provided via the ICB's Quality and People Committee during the year. Monitoring and support continued throughout 2022/23 and the delivery of high-quality services at the Trust continues to be a key priority for 2023/24.
- The potential for poor patient experience, clinical outcomes and patient safety concerns at Nottingham University Hospitals NHS Trust; specifically, in relation to the Trust's maternity services and workforce continued to be a significant risk area during 2022/23. Concerns were initially identified following the outcome of a CQC inspection; with further concerns being raised through local and national reviews. Routine updates regarding the Trust and its maternity services are provided to the ICB's Quality and People Committee and both ICB and system-led quality

assurance processes have been strengthened. Monitoring of the quality of services continues daily and the delivery of high-quality maternity services at the Trust continues to be a key priority for 2023/24.

- The potential for workforce capacity within General Practice to significantly reduce because of sickness, exhaustion and 'burn out', impacting the sustainability of some GP Practices. This has been further exacerbated by sustained levels of high demand; meaning that there continues to be a risk that the ICB's population access needs are not met, adversely impacting patient experience and/or outcomes. GP Practices have recognised the need to adapt workforce models to enable the sustained delivery of core services, whilst also ensuring sufficient capacity to deliver system and transformation requirements. Assurance updates in relation to primary care workforce and quality have been embedded across relevant ICB and system forums throughout 2022/23.
- The potential impact of loss of public confidence in local primary and secondary health services, because of national and local media reports and known quality issues, has been recognised as a key risk by the ICB in 2022/23. This may impact the extent to which people interface with health services, resulting in increased pressure on urgent and emergency care services if services are not accessed until a point of crisis. Mitigations to this risk largely relate to planning and prevention work, primary care transformation, as well as targeted work being undertaken by the ICB's Communication Team.
- The potential impact on the delivery of services across all partners within the system because of industrial action. Mitigations to this risk largely relate to system-led prioritisation of service delivery, training and upskilling staff, Trade Union engagement and communication plans; which are being overseen by the ICS Urgent and Emergency Care Transformation Board, ICS People and Culture Group and emergency preparedness, resilience and response (EPRR) arrangements.
- The potential impact of shortages in workforce capacity across key areas, such as theatres, maternity and home care, on the delivery of safe and effective health and social care. Mitigations to this risk largely relate to collective workforce planning and modelling and delivery of the ICS People Plan; both of which are overseen by the ICS People and Culture Group.
- The potential for non-delivery of the ICB's statutory financial duties for 2022/23, due to deterioration in the underlying positions of the former CCG organisations, the depletion of non-recurrent funds available and delays in planned 'cash releasing' efficiencies not materialising. Financial recovery processes have been in place throughout the year; however, continued reliance was placed on non-recurrent solutions. In response to the ICB forecasting to meet its statutory financial duties for 2022/23, the likelihood score of the risk reduced in the period up to year-end; at which time, a correlating new financial risk was identified for 2023/24.
- The potential that the ICB and its NHS Trust and NHS Foundation Trust partners, may not meet the collective year-end position outlined within the 2022/23 financial plan, due to deterioration in the underlying position of individual system partners, non-delivery of system-wide transformation programmes and increasing costs associated with Covid-19. This risk has been managed via the development of an ICS Finance Framework and the embedment of system finance governance arrangements. In response to system partners forecasting to meet an agreed collective financial position for 2022/23, the likelihood score of the risk reduced in the period up to year-end; at which time, a correlating new financial risk was identified for 2023/24.
- The potential for poor patient experience, adverse clinical outcomes and/or safety issues for children and young people with special educational needs and disabilities (SEND) in Nottingham and Nottinghamshire. This has been identified as a system-wide risk following the Nottinghamshire County Council Joint Local Area Ofsted and Care Quality Commission Inspection for SEND, which concluded on 3 February 2023. The outcome report (published 16 May 2023) identified widespread and/or systemic failings leading to significant concerns about the experiences and outcomes of children and young people with SEND, which the SEND Local Area Partnership must address urgently. The inspection identified issues that are across the

Nottingham and Nottinghamshire system and are mirrored within the SEND Local Area Partnership for Nottingham City Council.

Work has commenced on a SEND improvement action plan, which has been developed in conjunction with the Nottinghamshire Parent Carer Forum and local children and young people with SEND and their families. A Nottinghamshire SEND Partnership Improvement Board has been established to oversee the improvement actions needed. This Board will be chaired independently by a recognised sector expert, Dame Christine Lenehan, Director of the Council for Disabled Children.

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 statutory 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 these requirements. We maintain and publish a register of declared interests for all employees and appointees of the ICB and an annual assurance exercise is completed to confirm the completeness and accuracy of the register. Agendas for meetings of the ICB's Board and its committees and sub-committees also contain a standing item to ensure that members and attendees declare any interest relating specifically to the agenda items being considered and to ensure that the course of action is clearly documented

within the minutes. Where appropriate, action is taken in advance of the meetings (e.g. by excluding any individual with an identified conflict of interest from that section of the meeting and ensuring that they do not receive any related papers).

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 and sub-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 person-identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit (the Data Security and Protection Toolkit) and the annual submission process 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. Staff are issued with an Information Governance Handbook on their induction to the ICB and there are a series of briefings to ensure they are aware of their roles and responsibilities 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 (DSPT) by the submission deadline of 30 June 2023. Monthly progress is monitored by the Information Governance Steering Group, which is periodically overseen by the Audit and Risk Committee. An independent assessment of the ICB's self-assessed DSPT compliance is mandated by NHS England, and as such, has been included within the ICB's internal audit plan for 2023/24.

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. For 2022/23, 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 Process
- Capita – Primary Care Support
- NHS ESR – Electronic Staff Record Programme

In reviewing the above reports, I have noted that with the exception of the NHS Shared Business Services (Financial and Accounting Services) and Arden and Greater East Midlands Commissioning Support Unit, qualified opinions have been

provided by the service auditors. These opinions have been qualified on the basis of a small number of exceptions identified in the testing of controls. Overall, we are satisfied with the management responses in relation to these exceptions and the actions being taken to address them.

Control issues

There have been no significant control issues identified during the period 1 July 2022 to 31 March 2023.

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 Policy is in place, which sets out the organisation's approach for establishing contracts that provide value for money in line with the principles of good procurement practice. The policy 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 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.
- A Remuneration 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.

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. For the reporting period, the ICB assessed itself as being 'green' across all areas and the return was provided to the NHS Counter Fraud Authority by the deadline of 31 May 2023.

Head of internal audit opinion

Following completion of the planned audit work for the period 1 July 2022 to 31 March 2023 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 concluded that:

> *"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.*
>
> *In providing my opinion three main areas are considered:*
>
> - *Board Assurance Framework (BAF)*
> - *Individual assignments*
> - *Follow up of actions.*
>
> *I am providing an opinion of significant assurance for the BAF.*
> *I am providing an opinion of significant assurance for the outturn of individual audit assignments.*
> *I am providing an opinion of significant assurance for the follow up of actions."*

During the reporting period, internal audit issued the following audit reports:

Audit report	Audit objectives	Level of assurance
Review of HFMA Improving NHS financial sustainability checklist (2223/NNICB/01)	The purpose of this work was to conduct a review of the ICB's completed self-assessment against the HFMA checklist.	Not applicable[1]
Integrity of the Ledger and Financial Reporting (2223/NNICB/03)	The overall objective of the review was to assess the adequacy of controls over the ICB's general ledger and its financial reporting arrangements.	Significant
Governance (2223/NNICB/04)	The overall objective of the review was to provide independent assurance that the ICB has put in place robust high level governance arrangements which support effective performance management.	Significant
Business Continuity and Emergency Preparedness, Resilience and Response (EPRR) (2223/NNICB/06)	The overall aim of the review was to provide assurance in respect of the ICB's business continuity and EPRR arrangements.	Significant
Personal Health Budgets – Decision Making Process (2223/NNICB/07)	The objective of this review was to provide assurance on the control framework in place for the management and oversight of personal health budgets.	Limited (see paragraph below this table for further information)

Limited Opinion

The internal audit review of personal health budgets (PHBs) – decision making process, considered the information presented to the ICB's Personalised Care Panel meetings and whether this was sufficient to aid decision making and in ensuring consistency across similar applications. The review identified a number of factors

[1] *'Not applicable' refers to advisory audit reports where no formal opinion is provided.*

that required action; which include addressing gaps in our PHB Policy and developing clear terms of reference for our Panel, supported by robust documentation processes. All actions are now underway, with an expected completion date of 31 October 2023 (or sooner).

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 July 2022 to 31 March 2023.

Remuneration and Staff Report

Remuneration Report

The Remuneration Committee

The ICB's Remuneration Committee's membership is comprised entirely of Non-Executive Directors from our Board. Members of the Committee during the period 1 July 2022 to 31 March 2023 were as follows:

- Jon Towler (Chair)
- Dr Kathy McLean
- Professor Marios Adamou
- Stephen Jackson

We have also established a Non-Executive Director (NED) 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 Associate Director of Governance and a Partner Member of the Board (who is not remunerated by the ICB).

Further details on the work of the Remuneration Committee and the NED Remuneration Panel during the reporting period are provided in the *Governance Statement* contained within this annual report.

Percentage change in remuneration of highest paid director

ICBs are required to report:

- The percentage change from the previous financial year in respect of the highest paid director; and
- The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole

The ICB is not able to provide comparative information for the reporting period, as it is its first year of operation.

Pay ratio information (subject to audit)

Reporting bodies are required to disclose the relationship between the total remuneration of the highest paid director in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director in NHS Nottingham and Nottinghamshire ICB in the reporting period 1 July 2022 to 31 March 2023 was £195,000 to £200,000.

The relationship to the remuneration of the organisation's workforce is disclosed in the below table. A comparator to the previous year is not available, as this is the ICB’s first year of operation.

	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration	£34,943	£46,032	£57,061
Salary component of total remuneration	£34,943	£46,032	£57,061
Pay ratio information	5.65	4.29	3.46

During the reporting period, no employee received remuneration in excess of the highest paid director. Remuneration ranged from £3,250 to £195,700. 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.

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 (VSM) is approved by the Remuneration 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 ICB’s Partner Members 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 won't 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 Very Senior Managers). Standard notice periods are three months on either side.

Remuneration of Very Senior Managers

Two Very Senior Managers are paid more than £150,000 per annum pro rata. The ICB has satisfied itself that this remuneration is reasonable via the Remuneration Committee, which has assured itself that the remuneration is in line with the ICB's policy on the remuneration of senior managers (see above).

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

The following information is for the period 1 July 2022 to 31 March 2023. No comparator to the previous year is available, as this is the first year of the ICB's operation.

Name and Title	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100* £	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits (bands of £2,500) £000	(f) TOTAL (a to e) (bands of £5,000) £000
Professor Marios Adamou – Non-Executive Director[1]	10-15	0	0	0	0	10-15
Dr John Brewin – NHS Trust/Foundation Trust Partner Member	0	0	0	0	0	0
Dr Dave Briggs – Medical Director[2]	110-115	0	0	0	57.5-60	170-175
Lucy Dadge – Director of Integration[3]	110-115	0	0	0	45-47.5	155-160
Stephen Jackson – Non-Executive Director[4]	10-15	0	0	0	0	10-15
Dr Kelvin Lim – Primary Care Partner Member[5]	10-15	0	0	0	0	10-15
Ifti Majid – NHS Trust/Foundation Trust Partner Member	0	0	0	0	0	0
Caroline Maley – Non-Executive Director[6]	10-15	0	0	0	0	10-15
Dr Kathy McLean – Chair[7]	45-50	0	0	0	0	45-50
Stuart Poynor – Director of Finance[8]	120-125	0	0	0	0	120-125
Paul Robinson – NHS Trust/Foundation Trust Partner Member	0	0	0	0	0	0
Dr Amanda Sullivan – Chief Executive[9]	145-150	0	0	0	0	145-150
John Towler – Non-Executive Director[10]	10-15	0	0	0	0	10-15
Rosa Waddingham – Director of Nursing[11]	105-110	0	0	0	0	105-110
Melanie Williams – Local Authority Partner Member	0	0	0	0	0	0
Catherine Underwood – Local Authority Partner Member	0	0	0	0	0	0

**Note: Taxable expenses and benefits in kind are expressed to the nearest £100.*

The full annual salaries of the above posts are shown below:

[1] 15-20
[2] 110-115
[3] 140-145
[4] 15-20
[5] 10-15
[6] 15-20
[7] 60-65
[8] 155-160
[9] 195-200
[10] 20-25
[11] 140-145

Pension benefits (subject to audit)

The following information is for the period 1 July 2022 to 31 March 2023. No comparator to the previous year is available, as this is the first year of the ICB's operation.

Name and Title	(a) Real increase in pension at pension age (bands of £2,500) £000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £000	(c) Total accrued pension at pension age at 31 March 2023 (bands of £5,000) £000	(d) Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000) £000	(e) Cash Equivalent Transfer Value at 1 July 2023 £000	(f) Real Increase in Cash Equivalent Transfer Value £000	(g) Cash Equivalent Transfer Value at 31 March 2023 £000	(h) Employers Contribution to stakeholder pension £000
Dr Dave Briggs – Medical Director	2.5-5	0-2.5	30-35	40-45	432	29	505	0
Lucy Dadge – Director of Integration	2.5-5	0-2.5	25-30	55-60	526	49	606	0
Stuart Poynor – Director of Finance	0	0	0	0	0	0	0	0
Dr Amanda Sullivan – Chief Executive	0	0	0	0	0	0	0	0
Rosa Waddingham – Director of Nursing	0	0	10-15	0-5	451	0	139	0

Cash equivalent transfer values

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.

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).

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

There were no payments to past members made during the period 1 July 2022 to 31 March 2023.

Payments to past directors (subject to audit)

There were no payments made to past directors during the period 1 July 2022 to 31 March 2023.

Staff Report

Number of senior managers and staff composition

The following table provides a breakdown of our workforce by pay band and gender as at 31 March 2023:

Pay band	Female	Male	Number
Band 1	0	0	0
Band 2	1	2	3
Band 3	27	4	31
Band 4	34	1	35
Band 5	59	8	67
Band 6	60	21	81
Band 7	82	23	105
Band 8a	77	16	93
Band 8b	33	13	46
Band 8c	24	6	30
Band 8d	13	3	16
Band 9	11	5	16
Very senior managers (non-Board members)	2	6	8
Any other spot salary (non-Board members)	12	14	26
Board members	5	6	11
Totals	**440**	**128**	**568**

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:

	Number (WTE)	Salary and wages (£'000)	Social security costs (£'000)	NHS Pension costs (£'000)	Other pensions costs (£'000)	Less: recoveries in respect of outward secondments (£'000)	Total Costs (£'000)
Permanent	478.98	19,112	2,211	3,297	3	0	24,623
Other	10.05	873	0	1	0	0	874
Total	**489.03**	**19,985**	**2,211**	**3,298**	**3**	**0**	**25,497**

Sickness absence data

Sickness absence data for the reporting period has been calculated in accordance with guidance from the Department of Health and Social Care:

1 July 2022 – 31 March 2023	
Total days lost (WTE)	3825.2
Total days available (WTE)	131912.8
Average working days lost due to sickness absence[i] (per WTE)	**6.5%**

Staff turnover percentages

The ICB's staff turnover rate (staff leaving the organisation) during the reporting period was 13.53% (on a WTE basis).

[i] The average has been estimated by dividing the estimated number of FTE days sick by the average FTE days available and multiplying by 225 (the typical number of working days per year).

Staff engagement percentages

The ICB participated in the 2022 NHS Staff Survey. We had a response rate of 77%, which is above the average for the ICB benchmark group (73%). A small number of areas were highlighted where actions are required during 2023 to improve staff experiences. Working in partnership with our staff networks, the ICB is developing an action plan aligned to the NHS People Promise to help address this.

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, as well as maintaining 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. We also have Mindful Employer status, which demonstrates our commitment to supporting mental wellbeing at work. These accreditations help to ensure that specific needs of employees are identified and addressed, whilst promoting positive attitudes towards people with physical, sensory and mental impairments.

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 are not aware of any of our employees becoming disabled during 2022/23 but are continuing to support a number of employees with complex health conditions.

We have developed an overarching Equality Improvement Plan which includes two specific equality objectives for our organisation:

- To improve workforce diversity at all levels within the ICB to be reflective of the population we serve, with a specific focus on ethnicity, disability and sexual orientation; and

- To improve the cultural competence of our workforce and empower our staff to support us in improving equality acceptance and inclusion in our organisation.

These objectives are being supported through use of the NHS Employers 'Measuring Up' Tool to help us understand where we have underrepresentation in our workforce when compared to our population demographics; and the utilisation of our Staff Survey results and feedback from our staff groups. As part of the plan, we have identified a number of actions that are needed to help achieve these objectives and defined the desired outcome for each.

Responsibility for monitoring the ICB's equality performance in relation to its role as an employer sits with our Human Resources Sub-Committee. This includes monitoring the delivery of plan in relation to recruitment, training and development, cultural competence and staff experience.

Three Staff Networks have also been established: a BAME Staff Network, a LGBTQ+ Staff Network and a Staff Disability and Wellbeing Network (DAWN), each with an Executive sponsor. These networks are staff-led, and they shape their own agendas, with support from the Head of Equality, Diversity and Inclusion. They 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 ICB 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 online wellbeing portal.

Trade Union Facility Time Reporting Requirements

The ICB continues to recognise and work in partnership with Trade Union colleagues. The ICB is working on a formal recognition agreement, to build professional practice and foster good employment relations. The Recognition

Agreement will acknowledge the recognised Trade Unions to support, represent and bargain for its members.

Time off for Trade Union duties and activities is detailed in the ICB's Special Leave Policy. For members of a recognised Trade Union, Trade Union activities are unpaid. For Trade Union duties, training or acting as a Learning Representative, payment is made in line with ACAS Code of Practice. To date, we have only been asked to recognise one employee as a representative for Managers in Partnership Trade Union.

Expenditure on Consultancy

Expenditure on consultancy for the period 1 July 2022 to 31 March 2023 totalled £258,000.

Off-payroll engagements:

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

For all off-payroll engagements as at 31 March 2023, for more than £245[i] per day:

	Number
Number of existing engagements as of 31 March 2023	**1**
Of which, the number that have existed:	
For less than one year at the time of reporting	1
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 July 2022 and 31 March 2023, for more than £245[i] per day:

	Number
No. of temporary off-payroll workers engaged between 1 July 2022 and 31 March 2023	6
Of which:	
No. not subject to off-payroll legislation[ii]	5
No. subject to off-payroll legislation and determined as in-scope of IR35 [ii]	0
No. subject to off-payroll legislation and determined as out of scope of IR35 [ii]	1
The number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: No. of engagements that saw a change to IR35 status following review	0

[i] *The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant*

[ii] *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.*

Table 3: Off-payroll engagements/senior official engagements

For any off-payroll engagements of Board members and/or senior officials with significant financial responsibility:

	Number
Number of off-payroll engagements of Board members and/or senior officials with significant financial responsibility, during the 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 includes both on-payroll and off-payroll engagements.	15

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

Table 1: Exit Packages

Exit Package cost band (including any special payment element)	Number of Compulsory Redundancies Whole Numbers only	Cost of Compulsory redundancies £s	Number of other agreed departures Whole Numbers only	Cost of other agreed departures £s	Total number of exit packages Whole Numbers only	Total cost of exit packages £s	Number of departures where special payments have been made Whole Numbers only	Cost of special payment element included in exit packages £s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	1	69,000	0	0	1	69,000	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	1	160,000	0	0	1	160,000	0	0
>£200,000	0	0	0	0	0	0	0	0
Totals	**2**	**229,000**	**0**	**0**	**2**	**229,000**	**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.

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 page 82. An audit certificate and report is also included in this Annual Report at page 115.

Annual Accounts

Signed:

Dr Amanda Sullivan
Chief Executive

28 June 2023

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Statement of Comprehensive Net Expenditure for the period ended 31 March 2023

	Note	2022-23 £'000
Income from sale of goods and services	2	(12,071)
Other operating income	2	(8,804)
Total operating income		**(20,875)**
Staff costs	4	25,566
Purchase of goods and services	5	1,811,423
Depreciation and impairment charges	5	191
Provision expense	5	(100)
Other Operating Expenditure	5	383
Total operating expenditure		**1,837,463**
Net Operating Expenditure		**1,816,588**
Finance income		-
Finance expense		(78)
Net expenditure for the Period		**1,816,510**
Net (Gain)/Loss on Transfer by Absorption		-
Total Net Expenditure for the Financial Period		**1,816,510**
Other Comprehensive Expenditure		
Items which will not be reclassified to net operating costs		
Net (gain)/loss on revaluation of PPE		-
Net (gain)/loss on revaluation of right-of-use assets		-
Net (gain)/loss on revaluation of Intangibles		-
Net (gain)/loss on revaluation of Financial Assets		-
Net (gain)/loss on assets held for sale		-
Actuarial (gain)/loss in pension schemes		-
Impairments and reversals taken to Revaluation Reserve		-
Items that may be reclassified to Net Operating Costs		-
Net (gain)/loss on revaluation of other Financial Assets		-
Net gain/loss on revaluation of available for sale financial assets		-
Reclassification adjustment on disposal of available for sale financial assets		-
Total other comprehensive net expenditure		**-**
Comprehensive Expenditure for the Period		**1,816,510**

Statement of Financial Position as at period ended 31 March 2023

	Note	31 March 2023 £'000	1 July 2022 £'000
Non-current assets:			
Property, plant and equipment	13	19	-
Right-of-use assets	13	1,515	1,706
Total non-current assets		**1,534**	**1,706**
Current assets:			
Inventories	16	-	-
Trade and other receivables	17	21,105	7,722
Other financial assets	18	-	-
Other current assets	19	-	-
Cash and cash equivalents	20	2	18
Total current assets		**21,107**	**7,740**
Non-current assets held for sale	21	-	-
Total current assets		**21,107**	**7,740**
Total assets		**22,641**	**9,446**
Current liabilities			
Trade and other payables	23	(109,437)	(94,615)
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Lease liabilities	13a	(243)	(327)
Borrowings	26	-	-
Provisions	30	(1,011)	(1,304)
Total current liabilities		**(110,691)**	**(96,246)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(88,050)**	**(86,800)**
Non-current liabilities			
Trade and other payables	23	-	-
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Lease liabilities	13a	(1,223)	(1,381)
Borrowings	26	-	-
Provisions	30	-	-
Total non-current liabilities		**(1,223)**	**(1,381)**
Assets less Liabilities		**(89,273)**	**(88,181)**
Financed by Taxpayers' Equity			
General fund		(89,273)	(88,181)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	
Total taxpayers' equity:		**(89,273)**	**(88,181)**

The notes on pages 88 to 114 form part of this statement

The financial statements on pages 84 to 87 were approved by the Audit and Risk Committee on 13th June 2023 and signed on its behalf by:

Amanda Sullivan
Chief Executive

Statement of Changes In Taxpayers Equity for the period ended 31 March 2023

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2022-23				
Balance as at 01 July 2022	-	-	-	-
Transfer between reserves in respect of assets transferred from closed NHS bodies	-	-	-	-
Adjusted NHS Clinical Commissioning Group balance at 31 March 2023	-	-	-	-
				-
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2022-23				
Total transition adjustment for initial application of IFRS 16	-	-	-	-
Net operating expenditure for the financial year	(1,816,510)	-	-	**(1,816,510)**
Net gain/(loss) on revaluation of property, plant and equipment	-	-	-	-
Net gain/(loss) on revaluation of right-of-use assets	-	-	-	-
Net gain/(loss) on revaluation of intangible assets	-	-	-	-
Net gain/(loss) on revaluation of financial assets	-	-	-	-
Total revaluations against revaluation reserve		-		-
Net gain (loss) on available for sale financial assets	-	-	-	-
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)			-	-
Net gain (loss) on revaluation of assets held for sale	-	-	-	-
Impairments and reversals	-	-	-	-
Net actuarial gain (loss) on pensions	-	-	-	-
Movements in other reserves	-	-	-	-
Transfers between reserves	-	-	-	-
Release of reserves to the Statement of Comprehensive Net Expenditure	-	-	-	-
Reclassification adjustment on disposal of available for sale financial assets	-	-	-	-
Transfers by absorption to (from) other bodies	(88,192)	-	-	(88,192)
Reserves eliminated on dissolution	-	-	-	-
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial period	**(1,904,702)**	-	-	**(1,904,702)**
Net funding	1,815,428	-	-	**1,815,428**
Balance at 31 March 2023	**(89,273)**	-	-	**(89,273)**

The notes on pages 88 to 114 form part of this statement

Statement of Cash Flows for the period ended 31 March 2023

	Note	2022-23 £'000
Cash Flows from Operating Activities		
Net operating expenditure for the financial period		(1,816,510)
Depreciation and amortisation	5	191
Impairments and reversals	5	-
Non-cash movements arising on application of new accounting standards		-
Movement due to transfer by Modified Absorption		18
Other gains (losses) on foreign exchange		-
Donated assets received credited to revenue but non-cash		-
Government granted assets received credited to revenue but non-cash		-
Interest paid		-
Release of PFI deferred credit		-
Other Gains & Losses		(89)
Finance Costs		-
Unwinding of Discounts		-
(Increase)/decrease in inventories		-
(Increase)/decrease in trade & other receivables	17	(13,657)
(Increase)/decrease in other current assets		-
Increase/(decrease) in trade & other payables	23	15,095
Increase/(decrease) in other current liabilities		-
Provisions utilised	30	(191)
Increase/(decrease) in provisions	30	(100)
Net Cash Inflow (Outflow) from Operating Activities		**(1,815,243)**
Cash Flows from Investing Activities		
Interest received		-
(Payments) for property, plant and equipment		(19)
(Payments) for intangible assets		-
(Payments) for investments with the Department of Health		-
(Payments) for other financial assets		-
(Payments) for financial assets (LIFT)		-
Proceeds from disposal of assets held for sale: property, plant and equipment		89
Proceeds from disposal of assets held for sale: intangible assets		-
Proceeds from disposal of investments with the Department of Health		-
Proceeds from disposal of other financial assets		-
Proceeds from disposal of financial assets (LIFT)		-
Non-cash movements arising on application of new accounting standards		-
Loans made in respect of LIFT		-
Loans repaid in respect of LIFT		-
Rental revenue		-
Net Cash Inflow (Outflow) from Investing Activities		**70**
Net Cash Inflow (Outflow) before Financing		**(1,815,173)**
Cash Flows from Financing Activities		
Grant in Aid Funding Received		1,815,428
Other loans received		-
Other loans repaid		-
Repayment of lease liabilities		(253)
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		-
Capital grants and other capital receipts		-
Capital receipts surrendered		-
Non-cash movements arising on application of new accounting standards		-
Net Cash Inflow (Outflow) from Financing Activities		**1,815,175**
Net Increase (Decrease) in Cash & Cash Equivalents	20	**2**
Cash & Cash Equivalents at the Beginning of the Financial period		
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial period		**2**

The notes on pages 88 to 114 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed hat 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 2022-23 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 clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis

The Health and Social Care Act was introduced into the House of Commons on 6 July 2021. The Bill allowed for the establishment of Integrated Care Boards (ICB) across England and abolished Clinical Commissioning Groups (CCG). ICBs took on the commissioning functions of CCGs. The CCG functions, assets and liabilities were transferred to an ICB on 1 July 2022.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in he future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

When clinical commissioning group ceased to exist on 1 July 2022, the services con inued to be provided by ICBs (using he same assets, by another public sector entity). The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

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 liabili ies 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 Heal h 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 (ICB) 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 he 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 he activi ies 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 informa ion 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 he performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires he 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 he amount of the transaction price allocated to hat 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, Accoun ing for Government Grants. Where hese 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 he 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 he extent that employees are permitted to carry forward leave into the following period.

Notes to the financial statements

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**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

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 but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. 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.

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.

1.12 **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.

Notes to the financial statements

1.13 **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.

1.13.1 **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 HM Treasury incremental borrowing rate of 3.51% is applied for leases commencing, transitioning or being remeasured in the 2023 calendar year under FRS 16.
Lease payments included in the measurement of the lease liability comprise
-Fixed payments;
Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
-The amount expected to be payable under residual value guarantees;
-The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.
Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

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.
The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.
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.

1.14 **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.

1.15 **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 3.27% (2021-22: -0.47%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 3.20% (2021-22: 0.70%) 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 3.51% (2021-22 0.95%) 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 3.00% (2021-22: 0.66%) 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.

1.16 **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.

1.17 **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.

1.18 **Carbon Reduction Commitment Scheme**

The Carbon Reduction Commitment scheme is a mandatory cap and trade scheme for non-transport CO_2 emissions. The ICB is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO_2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO_2 emissions are made.
The carrying amount of the liability at the financial year end will therefore reflect the CO_2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.
The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.
Allowances acquired under the scheme are recognised as intangible assets.

1.19 **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.

Notes to the financial statements

1 20 **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 20.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are hose 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 he financial asset.

1 20.2 **Financial assets at fair value through other comprehensive income**

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1 20.3 **Financial assets at fair value through profit and loss**

Financial assets measure at fair value through profit and loss are hose that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1 20.4 **Impairment**

For all financial assets measured at amortised cost or at fair value through o her comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, 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 wi h 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 mon h 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 he 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 21 **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 21.1 **Financial Guarantee Contract Liabilities**

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1 21.2 **Financial Liabilities at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteris ics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value hrough 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 21.3 **Other Financial Liabilities**

After initial recognition, all o her 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 hat 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 22 **Value Added Tax**

Most of the ac ivities 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 23 **Foreign Currencies**

The ICB's func ional 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 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 24 **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 25 **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 wi h the generality of payments. They are divided into different categories, which govern the way hat 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 26 **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.

Notes to the financial statements

1 26.1 **Sources of estimation uncertainty**

The following are assumptions about he 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 wi hin the next financial year:

(a) Healthcare contracts: based on the provisional costed activity data provided by the healthcare providers in conjunc ion wi h 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 informa ion 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.

It should be noted that due to the COVID-19 pandemic, contracts for services and payments for non-contracted activity with NHS Trusts and Foundation Trusts have been replaced with block contract arrangements for 2022/23, significantly reducing the level of estimations required.

Payments for non-contracted activity during 2022/23 have been restricted to those to other ICBs, providers in the devolved authorities (Scotland, Wales & Northern Ireland) and non-NHS providers.

1 27 **Gifts**

Gifts are items that are voluntarily donated, with no precondi ions and without he 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 28 **New and revised IFRS Standards in issue but not yet effective**

● IFRS 14 Regulatory Deferral Accounts – Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.

● IFRS 17 Insurance Contracts – Applica ion 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.

2 Other Operating Revenue

	2022-23 Total £'000
Income from sale of goods and services (contracts)	
Education, training and research	-
Non-patient care services to other bodies	2,844
Patient transport services	-
Prescription fees and charges	4,245
Dental fees and charges	-
Income generation	-
Other Contract income	4,982
Recoveries in respect of employee benefits	-
Total Income from sale of goods and services	12,071
Other operating income	
Rental revenue from finance leases	-
Rental revenue from operating leases	-
Charitable and other contributions to revenue expenditure: NHS	-
Charitable and other contributions to revenue expenditure: non-NHS	-
Receipt of donations (capital/cash)	-
Receipt of Government grants for capital acquisitions	-
Continuing Health Care risk pool contributions	-
Non cash apprenticeship training grants revenue	-
Other non contract revenue	8,804
Total Other operating income	8,804
Total Operating Income	20,875

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

	Education, training and research	Non patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits	TOTAL
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£000
Source of Revenue									
NHS	-	725	-	-	-	-	616	-	1,341
Non NHS	-	2 119	-	4 245	-	-	4 366	-	10 730
Total		**2,844**		**4,245**			**4,982**		**12,071**

	Education, training and research	Non patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits	TOTAL
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£000
Timing of Revenue									
Point in time	-	-	-	-	-	-	-	-	-
Over time	-	2 844	-	4 245	-	-	4 982	-	12 071
Total		**2,844**		**4,245**			**4,982**		**12,071**

3.2 Transaction price to remaining contract performance obligations

Contract revenue expected to be recognised in the future periods related to contract performance obligations not

	Period ended 31st March 2023	Revenue expected from NHSE Bodies	Revenue expected from Other DHSC Group Bodies	Revenue expected from Non-DHSC Group Bodies	2021-22	Revenue expected from NHSE Bodies	Revenue expected from Other DHSC Group Bodies	Revenue expected from Non-DHSC Group Bodies	TOTAL
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000
Not later than 1 year	-	-	-	-	-	-	-	-	-
Later than 1 year, not later than 5 years	-	-	-	-	-	-	-	-	-
Later than 5 Years	-	-	-	-	-	-	-	-	-
Total									

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Admin			Programme			Total		2022-23
	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	10,010	224	**10,234**	9,102	650	**9,752**	19,112	874	**19,986**
Social security costs	1,232	-	**1,232**	978	-	**978**	2,210	-	**2,210**
Employer contributions to the NHS Pension Scheme	2,183	-	**2,183**	1,114	1	**1,115**	3,297	1	**3,298**
Other pension costs	1	-	**1**	2	-	**2**	3	-	**3**
Apprenticeship Levy	-	-	**-**	-	-	**-**	-	-	**-**
Other post-employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Other employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Termination benefits	69	-	**69**	-	-	**-**	69	-	**69**
Gross employee benefits expenditure	**13,495**	**224**	**13,719**	**11,196**	**651**	**11,847**	**24,691**	**875**	**25,566**
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	**-**	-	-	**-**	-	-	**-**
Total - Net admin employee benefits including capitalised costs	**13,495**	**224**	**13,719**	**11,196**	**651**	**11,847**	**24,691**	**875**	**25,566**
Less: Employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**
Net employee benefits excluding capitalised costs	**13,495**	**224**	**13,719**	**11,196**	**651**	**11,847**	**24,691**	**875**	**25,566**

4.2 Average number of people employed

	2022-23					
	Permanently employed Number	**Other Number**	**Total Number**			
Total	**478.98**	**10.05**	**489.03**			
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.4 Exit packages agreed in the financial year

	2022-23 Compulsory redundancies		2022-23 Other agreed departures		2022-23 Total	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	1	69,000	-	-	1	69,000
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	1	160,000	-	-	1	160,000
Over £200,001	-	-	-	-	-	-
Total	**2**	**229,000**	**-**	**-**	**2**	**229,000**

	2022-23 Departures where special payments have been made	
	Number	**£**
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

	2022-23 Other agreed departures	
	Number	**£**
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 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.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

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 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme 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 (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

5. Operating expenses

	2022-23 Total £'000
Purchase of goods and services	
Services from other ICBs, CCGs and NHS England	985
Services from foundation trusts	589,010
Services from other NHS trusts	565,752
Provider Sustainability Fund	-
Services from Other WGA bodies	2
Purchase of healthcare from non-NHS bodies	304,198
Purchase of social care	-
General Dental services and personal dental services	-
Prescribing costs	150,176
Pharmaceutical services	-
General Ophthalmic services	-
GPMS/APMS and PCTMS	166,659
Supplies and services – clinical	1,312
Supplies and services – general	9,316
Consultancy services	468
Establishment	2,725
Transport	7,194
Premises	11,394
Audit fees	285
Other non statutory audit expenditure	
· Internal audit services	-
· Other services	6
Other professional fees	45
Legal fees	280
Education, training and conferences	1,616
Funding to group bodies	-
CHC Risk Pool contr butions	-
Non cash apprenticeship training grants	-
Total Purchase of goods and services	**1,811,423**
Depreciation and impairment charges	
Depreciation	191
Amortisation	-
Impairments and reversals of property, plant and equipment	-
Impairments and reversals of right-of-use assets	-
Impairments and reversals of intangible assets	-
Impairments and reversals of financial assets	-
· Assets carried at amortised cost	-
· Assets carried at cost	-
· Available for sale financial assets	-
Impairments and reversals of non-current assets held for sale	-
Impairments and reversals of investment properties	-
Total Depreciation and impairment charges	**191**
Provision expense	
Change in discount rate	-
Provisions	(100)
Total Provision expense	**(100)**
Other Operating Expenditure	
Chair and Non Executive Members	279
Grants to Other bodies	-
Clinical negligence	-
Research and development (excluding staff costs)	40
Expected credit loss on receivables	64
Expected credit loss on other financial assets (stage 1 and 2 only)	-
Inventories written down	-
Inventories consumed	-
Other expenditure	-
Total Other Operating Expenditure	**383**
Total operating expenditure	**1,811,897**

6.1 Better Payment Practice Code

Measure of compliance	**2022-23 Number**	**2022-23 £'000**
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	34,431	487,770
Total Non-NHS Trade Invoices paid within target	34,374	487,135
Percentage of Non-NHS Trade invoices paid within target	**99.83%**	**99.87%**
NHS Payables		
Total NHS Trade Invoices Paid in the Year	1,308	1,174,702
Total NHS Trade Invoices Paid within target	1,297	1,174,534
Percentage of NHS Trade Invoices paid within target	**99.16%**	**99.99%**

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

	2022-23 £'000
Amounts included in finance costs from claims made under this legislation	0
Compensation paid to cover debt recovery costs under this legislation	-
Total	**0**

7 Income Generation Activities
There were no Income Generation Activities during the year.

8 Investment Income
There was no Investment Income during the year.

9 Other Gains and Losses

	2022-23 £'000
Gain/(loss) on disposal of property, plant and equipment assets other than by sale	(89)
	-
Total	**(89)**

10 Finance Costs

	2022-23 £'000
Interest on lease liabilities	11
	11

11. Net gain/(loss) on transfer by absorption

Transfers as part of a reorganisation fall to be accounted for by use of modified absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. 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. During the period 01 July 2022 to 31 March 2023, NHS England transferred the PUPOC liability to ICB, which totalled £11,000 for the ICB. This has been treated as Transfer by Absorption.

On 1 July 2022, the Clinical Commissioing Groups of NHS Bassetlaw and NHS Nottingham & Nottinghamshire ceased to exist, and NHS Nottingham and Nottinghamshire ICB was established.

The figures shown below represent the sum of the two CCGs

	2022-23			
	Total	NHS England Parent Entities	NHS England Group Entities (non parent)	Non NHSE Group
	£'000	**£'000**	**£'000**	**£'000**
Transfer of property plant and equipment	-	-	-	-
Transfer of Right of Use assets	1,706	-	1,706	-
Transfer of cash and cash equivalents	18	-	18	-
Transfer of receivables	7,722	-	7,722	-
Transfer of payables	(94,626)	(11)	(94,615)	-
Transfer of provisions	(1,304)	-	(1,304)	-
Transfer of Right Of Use liabilities	(1,708)	-	(1,708)	-
Net loss on transfers by absorption	**(88,192)**	**(11)**	**(88,181)**	**-**

12. Operating Leases - N/A covered under Note 13a

13 Property, plant and equipment

2022-23	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 July 2022	-	-	-	-	-	-	-	-	-
Addition of assets under construction and payments on account				-					-
Additions purchased	-	-	-	-	-	-	19	-	19
Additions donated	-	-	-	-	-	-	-	-	-
Additions government granted	-	-	-	-	-	-	-	-	-
Additions leased	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-	-	143	-	143
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Cost/Valuation at 31 March 2023	**-**	**-**	**-**	**-**	**-**	**-**	**162**	**-**	**162**
Depreciation 01 July 2022	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Charged during the year	-	-	-	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-	-	143	-	143
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Depreciation at 31 March 2023	**-**	**-**	**-**	**-**	**-**	**-**	**143**	**-**	**143**
Net Book Value at 31 March 2023	**-**	**-**	**-**	**-**	**-**	**-**	**19**	**-**	**19**
Purchased	-	-	-	-	-	-	19	-	19
Donated	-	-	-	-	-	-	-	-	-
Government Granted	-	-	-	-	-	-	-	-	-
Total at 31 March 2023	**-**	**-**	**-**	**-**	**-**	**-**	**19**	**-**	**19**
Asset financing:									
Owned	-	-	-	-	-	-	19	-	19
Held on finance lease	-	-	-	-	-	-	-	-	-
On-SOFP Lift contracts	-	-	-	-	-	-	-	-	-
PFI residual: interests	-	-	-	-	-	-	-	-	-
Total at 31 March 2023	**-**	**-**	**-**	**-**	**-**	**-**	**19**	**-**	**19**

13a Leases

13a.1 Right of use assets

2022 23	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000	Of which: leased from DHSC group bodies £000
Cost or valuation at 01 July 2022	-	-	-	-	-	-	-	-	-	
IFRS 16 Transition Adjustment	-	-	-	-	-	-	-	-	-	
Addition of assets under construction and payments on account				-					-	
Additions	-	-	-	-	-	-	-	-	-	
Reclassifications	-	-	-	-	-	-	-	-	-	
Upward revaluation gains	-	-	-	-	-	-	-	-	-	
Lease remeasurement	-	-	-	-	-	-	-	-	-	
Modifications	-	-	-	-	-	-	-	-	-	
Disposals on expiry of lease term	-	-	-	-	-	-	-	-	-	
Derecognition for early terminations	-	-	-	-	-	-	-	-	-	
Transfer (to) from other public sector body	-	1 790	-	-	-	-	-	-	1 790	597
Cost/Valuation at 31 March 2023		**1,790**							**1,790**	**597**
Depreciation 01 July 2022	-	-	-	-	-	-	-	-	-	
Charged during the year	-	191	-	-	-	-	-	-	191	97
Reclassifications	-	-	-	-	-	-	-	-	-	
Upward revaluation gains	-	-	-	-	-	-	-	-	-	
Impairments charged	-	-	-	-	-	-	-	-	-	
Reversal of impairments	-	-	-	-	-	-	-	-	-	
Disposals on expiry of lease term	-	-	-	-	-	-	-	-	-	
Derecognition for early terminations	-	-	-	-	-	-	-	-	-	
Transfer (to) from other public sector body	-	83	-	-	-	-	-	-	83	52
Depreciation at 31 March 2023		**274**							**274**	**149**
Net Book Value at 31 March 2023		**1,516**							**1,516**	**448**

NBV by counterparty

Leased from DHSC	448
Leased from the NHS England Group	0
Leased from NHS Providers	0
Leased from Executive Agencies	0
Leased from Non-Departmental Public Bodies	0
Leased from other group bodies	0
Net Book Value at 31 March 2023	**448**

13a Leases cont'd

13a.2 Lease liabilities

2022-23	**2022-23 £'000**
Lease liabilities at 01 July 2022	-
IFRS 16 Transition Adjustment	(1,790)
Addition of Assets under Construction & Payments on Account	-
Additions purchased	-
Reclassifications	-
Interest expense relating to lease liabilities	-
Repayment of lease liabilities (including interest)	(11)
Lease remeasurement	253
Modifications	-
Disposals on expiry of lease term	-
Derecognition for early terminations	-
Transfer (to) from other public sector body	-
Other	-
Lease liabilities at 31 March 2023	**(1,548)**

13a.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2022-23 £'000	**Of which leased from DHSC group bodies £000**
Within one year	(223)	(92)
Between one and five years	(800)	(276)
After five years	(459)	-
Balance at 31 March 2023	**(1,482)**	**(368)**
Effect of Discounting	(16)	
Included in		
Current lease liabilities	(244)	
Non-current lease liabilities	(1,223)	
Balance at 31 March 2023	**(1,467)**	

Balance by counterparty	**Leased from DHSC Group**
Leased from DHSC	-
Leased from the NHS England Group	-
Leased from NHS Providers	-
Leased from Executive Agencies	-
Leased from Non-Departmental Public Bodies	-
Leased from other group bodies	362
Balance as at 31 March 2023	**362**

13a Leases cont'd

13a.4 Amounts recognised in Statement of Comprehensive Net Expenditure

2022-23	**2022-23** **£'000**
Depreciation expense on right-of-use assets	191
Interest expense on lease liabilities	11
Expense relating to short-term leases	-
Expense relating to leases of low value assets	-
Expense relating to variable lease payments not included in the measurement of the lease liability	-
Income from sub-leasing right-of-use assets	-
Gain/(loss) from sale and leaseback transactions	-
Gain/(loss) resulting from COVID-19 related rent concessions	-

13a.5 Amounts recognised in Statement of Cash Flows

	2022-23 **£'000**
Total cash outflow on leases under IFRS 16	253
Total cash outflow for lease payments not included within the measurement of lease liabilities	-
Total cash inflows from sale and leaseback transactions	-

13a.6 Revaluation

There has been no revaluation in the year

14 Intengible Non Current Assets

The ICB has no Intangible Assets at the year end

15 Investment Property

The ICB has no Investment Property at the year end

16 Inventories

The ICB has no Inventories at the year end

17.1 Trade and other receivables

	Current 2022-23 £'000	Non-current 2022-23 £'000	1 July 2022 £'000	1 July 2022 £'000
NHS receivables: Revenue	3,673	-	489	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	-	-	-	-
NHS accrued income	2,252	-	29	-
NHS Contract Receivable not yet invoiced/non-invoice	-	-	-	-
NHS Non Contract trade receivable (i e pass through funding)	-	-	-	-
NHS Contract Assets	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	974	-	465	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	1,353	-	2,812	-
Non-NHS and Other WGA accrued income	12,516	-	3,334	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	-	-	-	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	-	-	-	-
Non-NHS Contract Assets	-	-	-	-
Expected credit loss allowance-receivables	(35)	-	(199)	-
VAT	358	-	766	-
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-	-	-
Interest receivables	-	-	-	-
Finance lease receivables	-	-	-	-
Operating lease receivables	-	-	-	-
Other receivables and accruals	14	-	27	-
Total Trade & other receivables	**21,105**	**-**	**7,723**	**-**
Total current and non current	**21,105**		**7,723**	
Included above:				
Prepaid pensions contributions	-		-	

17.2 Receivables past their due date but not impaired

	2022-23 DHSC Group Bodies £'000	2022-23 Non DHSC Group Bodies £'000	1 July 2022 DHSC Group Bodies £'000	1 July 2022 Non DHSC Group Bodies £'000
By up to three months	91	110	-	13
By three to six months	20	22	-	99
By more than six months	24	15	24	207
Total	**135**	**147**	**24**	**319**

17.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000	Other financial assets £'000	Total £'000
Balance at 30 June 2022	**(199)**	**-**	**(199)**
Lifetime expected credit loss on credit impaired financial assets	-	-	**-**
Lifetime expected credit losses on trade and other receivables-Stage 2	-	-	**-**
Lifetime expected credit losses on trade and other receivables-Stage 3	14	-	**14**
Credit losses recognised on purchase originated credit impaired financial assets	-	-	**-**
Amounts written off	78	-	**78**
Financial assets that have been derecognised	76	-	**76**
Changes due to modifications that did not result in derecognition	-	-	**-**
Transfer by Absorption from other entity	-	-	**-**
Other changes	(4)	-	**(4)**
Total	**(35)**	**-**	**(35)**

18 Other Financial Assets
The ICB has no Other Financial Assets at the year end

19 Other Current Assets
The ICB has no Other Current Assets at the year end

20 Cash and cash equivalents

	2022-23 £'000	1 July 2022 £'000
Balance at 01 April 2022		53
Net change in year	2	(35)
Balance at 31 March 2023	**2**	**18**
Made up of:		
Cash with the Government Banking Service	2	18
Cash with Commercial banks	-	-
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in statement of	**2**	**18**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2023	**2**	**18**

21 Non Current Assets Held for Sale
The ICB has no Non Current Assets Held for Sale at the period end.

22 Analysis of Impairments and Reversals
The ICB has no Impairments and Reversals at the period end

23 Trade and other payables	**Current 2022-23 £'000**	**Non-current 2022-23 £'000**	**Current 1 July 2022 £'000**	**Non-current 1 July 2022 £'000**
Interest payable	-	-	-	-
NHS payables: Revenue	2,823	-	1,527	-
NHS payables: Capital	-	-	-	-
NHS accruals	8,190	-	16,064	-
NHS deferred income	-	-	-	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	26,095	-	15,536	-
Non-NHS and Other WGA payables: Capital	-	-	-	-
Non-NHS and Other WGA accruals	42,727	-	37,682	-
Non-NHS and Other WGA deferred income	345	-	-	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	54	-	160	-
VAT	-	-		-
Tax	313	-	294	-
Payments received on account	-	-	-	-
Other payables and accruals	28,890	-	23,352	-
Total Trade & Other Payables	**109,437**	**-**	**94,615**	**-**
Total current and non-current	**109,437**		**94,615**	

Other payables include £1,849k outstanding pension contributions at 31 March 2023

24 Other financial liabilities
The ICB has no Other Financial Liabilities at the period end

25 Other liabilities
The ICB has no Other Liabilities at the period end

26 Borrowings
The ICB has no Borrowings at the period end

27 Private Finance Initiative, LIFT, and other Service concession arrangements
The ICB had no Private Financae Initiatives, LIFT of other Service concession arrangements at the period end

28 Finance Lease Obligations
The ICB has no Finance Lease obligations at the period end

29 Finance lease receivables
The ICB has no Finance Lease receivables at the period end

30 Provisions

	Current 2022-23 £'000	Non-current 2022-23 £'000	Current 2021-22 £'000	Non-current 2021-22 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	-	-	160	-
Redundancy	-	-	-	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	-	-	-	-
Continuing care	1,012	-	1,144	-
Other	-	-	-	-
Total	**1,012**	**-**	**1,304**	**-**
Total current and non-current	**1,012**		**1,304**	

	Pensions Relating to Former Directors £'000	Pensions Relating to Other Staff £'000	Restructuring £'000	Redundancy £'000	Agenda for Change £'000	Equal Pay £'000	Legal Claims £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 July 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Arising during the year	-	-	-	-	-	-	-	-	-	**-**
Utilised during the year	-	-	(160)	-	-	-	-	(31)	-	**(191)**
Reversed unused	-	-	-	-	-	-	-	(100)	-	**(100)**
Unwinding of discount	-	-	-	-	-	-	-	-	-	**-**
Change in discount rate	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body under absorption	-	-	160	-	-	-	-	1,144	-	**1,304**
Balance at 31 March 2023	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**1,013**	**-**	**1,013**
Expected timing of cash flows:										
Within one year	-	-	-	-	-	-	-	1,013	-	**1,013**
Between one and five years	-	-	-	-	-	-	-	-	-	**-**
After five years	-	-	-	-	-	-	-	-	-	**-**
Balance at 31 March 2023	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**1,013**	**-**	**1,013**

31 Contingencies

The ICB has no contingencies at the period end.

32 Commitments

32.1 Capital commitments

	2022-23 £'000
Property, plant and equipment	-
Intangible assets	-
Total	**-**

32.2 Other financial commitments

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

	2022-23 £'000
In not more than one year	91,477
In more than one year but not more than five years	-
In more than five years	-
Total	**91,477**

33 Financial instruments

33.1 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 the ICB 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 clinical commissioning group 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 ICB in undertaking its activities.

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

33.1.1 Currency risk

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

33.1.2 Interest rate risk

The ICB 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 ICB therefore has low exposure to interest rate fluctuations.

33.1.3 Credit risk

Because the majority of the ICB revenue comes parliamentary funding, the ICB group 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.

33.1.4 Liquidity risk

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

33.1.5 Financial Instruments

As the cash requirements of NHS England 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 England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

33 Financial instruments cont'd

33.2 Financial assets

	Financial Assets measured at amortised cost 2022-23 £'000	Equity Instruments designated at FVOCI 2022-23 £'000	Total 2022-23 £'000
Equity investment in group bodies		-	-
Equity investment in external bodies		-	-
Loans receivable with group bodies	-		-
Loans receivable with external bodies	-		-
Trade and other receivables with NHSE bodies	1,317		1,317
Trade and other receivables with other DHSC group bodies	7,575		7,575
Trade and other receivables with external bodies	10,537		10,537
Other financial assets	-		-
Cash and cash equivalents	2		2
Total at 31 March 2023	**19,431**	**-**	**19,431**

33.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2022-23 £'000	Other 2022-23 £'000	Total 2022-23 £'000
Loans with group bodies	-		**-**
Loans with external bodies	-		**-**
Trade and other payables with NHSE bodies	598		**598**
Trade and other payables with other DHSC group bodies	23,850		**23,850**
Trade and other payables with external bodies	86,018		**86,018**
Other financial liabilities	-		**-**
Private Finance Initiative and finance lease obligations	-		**-**
Total at 31 March 2023	**110,466**	**-**	**110,466**

34 Operating segments

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

35 Pooled budgets
The ICB 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 table below shows the full year detail of the pooled budget. The CCGs contibuted for the period 01 April 2022 to 30 June 2022. the ICB then contributed for the period 1 July 2022 to March 2023

	2022/23 **£'000**
Balance at 30 June	
Income	**1868**
Nottinghamshire County Council ASCH&PP	1,393
Nottinghamshire County Council CFCS	576
Nottinghamshire City Council ASCH & CYP	774
NHS Nottingham & Nottinghamshire ICB	7,054
Other income	45
TOTAL INCOME	**11,710**
Expenditure	
Partnership Management & Administration costs	1036
Contract delivery and collection costs	1397
ICES Equipment	7266
Minor Adaptations	117
Direct Payments	8
TOTAL EXPENDITURE	**9,824**
Balance at 31 March	**1,886**
Carry Forward by Partner	
Nottinghamshire City Council ASCH	546
Notts County Council - ASCH	1246
Notts County Council - CYPS	0
Notts County Council - PDSS/EY	18
ICELS Staffing reserves	5
NHS Nottingham & Nottinghamshire ICB	71
Balance at 31 March	**1,886**

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. The ICBs contibuted for the period 01 April 2022 to 30 June 2022. The ICB then contributed for the period 1 July 2022 to March 2023

Memorandum Account for Nottingham City Better Care Fund

	2022/23 **£'000**
Funding	
NHS Nottingham & Nottinghamshire ICB	20649
Nottingham City Council (Capital)	2076
Nottingham City Council	0
Nottingham City Council (Improved Better Care Fund)	12452
Total Funding	**35,177**
Expenditure	
Access & Navigation	1,613
Assistive Technology	353
Carers	536
Co-ordinated Care	12,452
Capital Grants	2,076
Independence Pathway	0
Programme Costs	0
Integrated Care	13,884
Primary Care	2,132
Facilitating Discharge	2,063
Housing Related Schemes	68
Total Expenditure	**35,177**
Balance Carried forward for all partners	**0**

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

	2022/23 **£'000**
Income	10,898
Expenditure	-10,898
TOTAL	**0**

36 NHS Lift investments
The ICB has no L FT investments at the year end

37 Related party transactions

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Eastwood Primary Care Centre	1,895	0	69	0
Primary Integrated Community Services	2,314	0	120	0
NEMS	10,059	0	453	0
Greater Nottingham Lift Co	72	0	56	0
Derby Health United Health Care CIC	67	0	4	0
Department of Health	0	30	0	0
NHS England	1,524	561	598	1,317
NHS Trusts	568,024	328	4,648	1,559
Foundation Trusts	591,974	468	5,767	3,023
Agencies	0	0	0	0
Health Education England	0	1,520	0	0
Special Health Authorities	16	0	0	0
Other Group Bodies	9,487	0	1,344	0
Nottingham City Council	34,086	437	5,184	76
Nottinghamshire County Council	10,889	62,311	8,946	12,915

38 Events After the Reporting Peiod
The ICB has no events After the Reporting Period

39 Third Party Assets
The ICB has no Third Pary Asseta at the year end.

40 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:

	2022-23 Target	2022-23 Performance
Expenditure not to exceed income	1,837,393	1,837,386
Capital resource use does not exceed the amount specified in Directions	60	19
Revenue resource use does not exceed the amount specified in Directions	1,816,517	1,816,510
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0
Revenue administration resource use does not exceed the amount specified in Directions	19,565	16,249

41 Analysis of charitable reserves
The ICB has no Charitable Reserves at the period end

42 Losses and special payments

Losses

The total number of ICB losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2022-23 Number	Total Value of Cases 2022-23 £'000
Administrative write-offs	4	78
Fruitless payments	-	-
Store losses	-	-
Book Keeping Losses	-	-
Constructive loss	-	-
Cash losses	-	-
Claims abandoned	-	-
Total	**4**	**78**

Special payments

	Total Number of Cases 2022-23 Number	Total Value of Cases 2022-23 £'000
Compensation payments	-	-
Compensation payments Treasury Approved	-	-
Extra Contractual Payments	-	-
Extra Contractual Payments Treasury Approved	-	-
Ex Gratia Payments	-	-
Ex Gratia Payments Treasury Approved	-	-
Extra Statutory Extra Regulatory Payments	-	-
Extra Statutory Extra Regulatory Payments Treasury Approved	-	-
Special Severance Payments Treasury Approved	-	-
Special Severance Payments	-	-
Total	**-**	**-**

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS NOTTINGHAM AND NOTTINGHAMSHIRE INTEGRATED CARE BOARD

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Nottingham and Nottinghamshire Integrated Care Board ("the ICB") for the nine month period ended 31 March 2023 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the ICB's affairs as at 31 March 2023 and of its income and expenditure for the nine month period then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State on 26 April 2023 as being relevant to ICBs in England and included in the Department of Health and Social Care Group Accounting Manual 2022/23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the ICB in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accountable Officer of the ICB ("the Accountable Officer") has prepared the financial statements on the going concern basis, as they have not been informed by the relevant national body of the intention to either cease the ICB's services or dissolve the ICB without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accountable Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the ICB over the going concern period.

Our conclusions based on this work:

- we consider that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified, and concur with the Accountable Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the ICB will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit and Risk Committee and internal audit and inspection of policy documentation as to the ICB's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the ICB's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported expenditure as a result of the need to achieve statutory targets delegated to the ICB by NHS England.
- Reading Board and Audit and Risk Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reading the ICB's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated statutory resource limits, we performed procedures to address the risk of management override of controls, in particular the risk that ICB management may be in a position to make inappropriate accounting entries and the risk of bias in accounting estimates and judgements such as accruals.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to the completeness and accuracy of year-end accruals.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the ICB, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity.

We also identified a fraud risk related to potential manipulation of accruals and expenditure recognition. This is also in response to possible pressures to meet delegated statutory resource limits.

We also performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included unexpected postings related to cash, unexpected expenditure journals posted near period end and material post close journal entries.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Inspecting a sample of transactions in the period after 31 March 2023 to verify that expenditure had been recognised in the correct accounting period.
- Evaluating accruals posted as at 31 March 2023, and performing sample testing to verify accruals are appropriate and accurately recorded.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Board and other management (as required by auditing standards), and from inspection of the ICB's regulatory and legal correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The ICB is subject to laws and regulations that directly affect the financial statements including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the ICB is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accountable Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial period is consistent with the financial statements.

Annual Governance Statement

We are required by the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022/23. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2022/23.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 45, the Accountable Officer of the ICB is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the ICB or dissolve the ICB without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 21(4) and (5) of the Local Audit and Accountability Act 2014.

In our opinion, in all material respects, the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Report on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the ICB to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 45, the Accountable Officer is responsible for ensuring that the ICB exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the ICB had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if we refer a matter to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in this respect.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Board of NHS Nottingham and Nottinghamshire Integrated Care Board, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Board of the ICB, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Board of the ICB, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of NHS Nottingham and Nottinghamshire ICB for the nine month period ended 31 March 2023 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Richard Walton
for and on behalf of KPMG LLP
Chartered Accountants
EastWest
Tollhouse Hill
Nottingham
NG1 5FS

30 June 2023