NHS
Nottingham and Nottinghamshire
Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Annual Report and Accounts

1st April 2025 to March 31st 2026

About this report

This report explains what NHS Nottingham and Nottinghamshire Integrated Care Board did during 2025/26, how we performed, how we used public money and how we were governed. It is one of the main ways we are open and accountable to the people we serve.

The report follows NHS England and Department of Health and Social Care requirements and is divided into three main parts:

- **Performance Report** – this section explains what we do, what we planned to achieve, how we performed during the year, and where there were challenges.
  - **Performance Overview**, which introduces our organisation, our role, our main plans and our overall progress during the year.
  - **Performance Analysis**, which gives more detail on performance, finance, risk and how we met our main statutory duties.
- **Accountability Report** – this section explains how we met our legal and governance responsibilities and how decisions were overseen.
  - **Corporate Governance Report**, which explains how the organisation was governed and how governance supported delivery of our objectives.
  - **Remuneration and Staff Report**, which explains pay arrangements for senior leaders and provides information about our workforce.
  - **Parliamentary Accountability and Audit Report**, which brings together information supporting accountability, including audit reporting.
- **Annual Accounts** – this section contains our financial statements for the year.

If you need this document in large print or another language, please contact us:

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Foreword by Dr Kathy McLean OBE, Chair

It is my privilege to introduce this Annual Report for NHS Nottingham and Nottinghamshire Integrated Care Board (ICB), reflecting another year of progress, partnership and shared purpose across our Integrated Care System (ICS).

The year has been shaped by a challenging and evolving national landscape, with high expectations from Government, NHS England and the public we serve. Despite sustained operational and financial pressures, the system has demonstrated resilience and ambition, delivering care, transforming services and keeping people and communities at the heart of decision making. Over the past year, I have visited services across the area, including neighbourhood and primary care teams and voluntary, community and social enterprise organisations supporting vulnerable residents. These visits reinforce the importance of strong relationships and the dedication of our workforce and partners in driving improvement.

Throughout the year, the Board has maintained clear oversight of NHS delivery, including the quality and performance of commissioned services, alongside financial efficiency requirements. This has been essential as the need to restore quality, recover performance, improve productivity, and maintain public confidence has remained significant.

This year has also seen significant national reform and organisational change for ICBs, as signalled by the Ten-Year Health Plan for England. The introduction of management cost reduction requirements and a new ICB Operating Model have created a renewed opportunity to work differently. NHS Nottingham and Nottinghamshire ICB has established formal partnership arrangements with NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB, operating as an 'ICB Cluster', and I am now jointly appointed as Chair of the three ICBs. This closer working brings shared learning, consistency and resilience, while ensuring each organisation remains focused on its own population.

In parallel with organisational change, we have maintained our focus on the national ambition to shift care from hospital to community, from analogue to digital, and from treatment to prevention. This has been supported through the development of a new Five-Year Population Health Strategy and Five-Year Strategic Commissioning Plan, setting out a more joined-up approach to understanding need, targeting resources and shaping services in partnership. Work on integrated neighbourhood teams and population health management demonstrates how collaboration and innovation can translate ambition into better outcomes for local people.

The system has also shown leadership in neighbourhood working and inclusive service design, including progress in addressing health inequalities through place-based partnerships, support for people experiencing severe and multiple disadvantage, and integrated neighbourhood teams focused on frailty and prevention.

The Integrated Care Strategy continues to guide our priorities, complemented by the new Population Health Strategy and Strategic Commissioning Plan, and supported by constructive partnerships with local authorities, the voluntary sector and regional partners, including the East Midlands Combined County Authority and Mayor.

I would like to thank all members of the Board for their leadership, challenge and support during the year, and acknowledge colleagues who left the Board during the year. I also extend my sincere thanks to executive colleagues, partners and staff, whose professionalism and dedication underpin everything we do. As we look ahead, challenges remain, but so do significant opportunities to work together, with ambition and purpose, to build a healthier and fairer future for our communities.

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

Performance Report

Signed:

Amanda Sullivan
Accountable Officer

16 June 2026

Performance Overview

Statement from our Chief Executive

As we publish our Annual Report and Accounts for 2025/26, I reflect on a year of significant transition for the NHS, both locally and nationally. Leading NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) during this period has required sustained focus, resilience and professionalism across our Integrated Care System (ICS), as we have worked together to maintain services, respond to national reform and improve outcomes for our population.

Over the course of the year, we have maintained a clear focus on service delivery and outcomes, working closely with partners to deliver the priorities set out in our Joint Forward Plan and Operational Plan against a backdrop of sustained system pressure. Performance against several national standards has remained challenging, particularly in urgent and emergency care, but progress has been made in improving access to primary care, strengthening community-based alternatives to admission and reducing the longest waits. Access to mental health services has continued to improve, alongside further progress in supporting people with a learning disability and autistic people in community settings. Although significant challenges remain, the commitment and determination of staff across our system has been central to maintaining services and driving improvement.

Quality and safety have remained a central focus. Following the tragic events in Nottingham in June 2023, we have continued robust scrutiny, in collaboration with NHS England, of the quality and coordination of mental health services provided by Nottinghamshire Healthcare NHS Foundation Trust. In parallel, the independent review of maternity services at Nottingham University Hospitals NHS Trust has continued. Our priority has been to drive the required improvements and to ensure that learning from both the Independent Maternity Review and the Nottingham Inquiry is reflected in future services.

Our financial position has continued to require strong system leadership and careful financial management. We maintained a clear focus on financial recovery, strengthening governance and ensuring that resources were used as effectively as possible, supported by close and constructive working across system partners. However, we did not achieve financial breakeven for the year, and the need to restore financial sustainability remains a key priority.

Nationally, the NHS is undergoing a period of major reform, following the publication of the Government's Ten Year Health Plan for England. In response, formal joint working arrangements have been established between NHS Nottingham and Nottinghamshire ICB, NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB. These ICB clustering arrangements support a more consistent and sustainable approach to strategic commissioning, while ensuring that each ICB remains focused on meeting the needs of its local population. This has required a significant programme of organisational change to ensure the ICB is structured and prepared for its future role. I recognise that this has been a challenging period for colleagues, and I would like to thank our staff for their continued professionalism, resilience and commitment. While this report focuses on the activities and performance of NHS Nottingham and Nottinghamshire ICB, an increasing proportion of our work has been delivered within this broader collaborative context.

Looking ahead, we will continue to focus on commissioning high-quality, safe and sustainable services, while playing our part in shaping the future of the NHS. We remain committed to working with partners, staff and local communities to deliver meaningful and lasting benefits for the people we serve.

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

About us

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

We have four overarching aims:

- To improve outcomes in population health and healthcare.
- To tackle inequalities in outcomes, experience and access.
- To enhance productivity and value for money.
- To help the NHS support broader social and economic development.

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

- Most planned hospital care for the diagnosis and treatment of illness (including responsibility for 59 specialised acute services and 12 specialised mental health and learning disabilities services delegated to us by NHS England since 1 April 2024 and 1 April 2025 respectively).
- Urgent and emergency care (including out of hours services, accident and emergency services, ambulance services and NHS 111 services).
- Mental health services (including psychological therapies).
- Services for people with learning disabilities and autism.
- Maternity and new-born services.
- Children's healthcare services (mental and physical health).
- Most community health services.
- Rehabilitative care.
- Palliative care.
- NHS continuing healthcare.
- GP services (responsibility delegated to us by NHS England since 1 July 2022).
- Pharmacy, optometry and dental services (responsibility delegated to us by NHS England since 1 April 2023).

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

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

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

We also work in partnership with local NHS organisations, local authorities and wider system partners to support workforce and cultural development, enable digital transformation, advance environmental sustainability and promote effective use of the NHS estate.

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.

The Ten Year Health Plan for England, published on 3 July 2025, signals changes to the role, scale and operating model of ICBs. In line with this, we

have established formal partnership arrangements with NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB, operating as an 'ICB Cluster' to harness economies of scale and to strengthen resilience, capability and financial sustainability. Through this model, the three ICBs retain their statutory accountability and local duties and relationships, while working collectively across a wider footprint to share leadership capacity, governance infrastructure and enabling functions.

As of 31 March 2026, our organisational structure includes six core directorates:

- Our Chief Executive is responsible for the ICB's corporate leadership arrangements and oversees the effective management and performance of the organisation as a whole. This includes corporate governance and probity arrangements, information governance, legal and corporate administration, and freedom to speak up arrangements. The Chief Executive also leads on the ICB's operating model, organisational development and workforce matters, supported temporarily by an Executive Director of Transition, who is responsible for leading the organisational change process.
- Our Commissioning Directorate is responsible for strategic commissioning and system oversight, including service planning, market management, and contract performance, using data, analytics and intelligence to support improved population health outcomes. The Directorate also holds responsibility for emergency preparedness, resilience and response arrangements.
- Our Finance Directorate is responsible for financial stewardship and sustainability, value for money, financial planning, procurement and contracting, payment mechanisms, and demand and capacity management to support delivery of statutory financial duties. The Directorate also leads business and operational planning, audit and counter fraud arrangements, estates management, and digital transformation.
- Our Quality (Nursing) Directorate leads the ICB's approach to quality, safety and continuous improvement in commissioned services. Its responsibilities include clinical governance, patient safety, patient experience and complaints, safeguarding, infection prevention and control, continuing healthcare, and equality, diversity and inclusion.
- Our Outcomes (Medical) Directorate is responsible for clinical leadership to improve health outcomes and reduce unwarranted variation. It is responsible for population health management, clinical prioritisation, prevention and early intervention, medicines optimisation, and care pathway optimisation. The Directorate also leads on research and innovation activity.
- Our Strategy and Citizen Experience Directorate leads on population health strategy and long-term planning, ensuring that services are shaped around local needs, experiences and outcomes. Responsibilities include citizen engagement, stakeholder and partnership working, market and provider development, and internal and external communications.

As of 31 March 2026, 645 people worked for the ICB (including staff, clinical and professional advisors, and Board members). This includes a team of staff that we have hosted since 1 July 2023, who work on behalf of our ICB and the other four ICBs across the East Midlands (NHS Derby and Derbyshire ICB, NHS Leicester, Leicestershire and Rutland ICB, NHS Lincolnshire ICB and NHS Northamptonshire ICB) to commission pharmacy, optometry, and dental services. The ICB has also hosted the East Midlands Cancer Alliance Team since 1 April 2024, who work on behalf of NHS England and the five ICBs across the East Midlands to improve cancer care.

Our integrated care system

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

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

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

Our ICS structure includes:

- An Integrated Care Partnership (ICP), which is a statutory committee jointly formed between the ICB and the Nottingham City and Nottinghamshire County Councils. The ICP brings together a broad alliance of partners concerned with improving the care, health and wellbeing of the population. The ICP is the 'guiding mind' of our local health and care system, and it is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population we serve (see the next section on 'Our strategies and plans' for further details).
- Four place-based partnerships to lead the detailed design and delivery of integrated services across their localities and neighbourhoods. The partnerships involve the NHS, GP practices, local councils, community and voluntary organisations, local residents, people who use services, their carers and representatives and other community partners with a role in supporting the health and wellbeing of the population.
- 24 Primary Care Networks (PCNs), which are partnerships between General Practice surgeries who care for neighbourhoods of between 20,000 to 100,000 people. They work together to provide services designed for the specific needs of their communities. A key focus of our PCNs is helping residents to look after their own health, empowering people to live well by supporting them to achieve personal health and wellbeing goals.
- A provider collaborative at scale that brings local statutory NHS providers together to achieve the benefits of working at scale across multiple places, to improve quality, efficiency and outcomes and address unwarranted variation and inequalities in access and experience across different providers.

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

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

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

We are also an active strategic partner in the Universities for Nottingham Civic Agreement[1], which sets out a commitment to enhance the economic, social, and cultural life, and the health and wellbeing for the people and place of Nottingham and Nottinghamshire. The shared mission described within the Civic Agreement covers economic prosperity, education partnership, skills and employment, environmental sustainability, health and wellbeing, and community connections. You can read more about our role as an anchor organisation and our contribution to the Government's Health and Work priority in the Performance Analysis section of this report.

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

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, ethnicity, disability, and levels of deprivation. You can read more about the demographics and health needs of our population at https://www.nottinghaminsight.org.uk/ and https://www.nottinghamshireinsight.org.uk/.

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

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

The Strategy builds on existing system strategies, including the Joint Local Health and Wellbeing Strategies for Nottingham and Nottinghamshire, and sets out our system's priorities to improve life expectancy and healthy life expectancy and to reduce health inequalities for the people of Nottingham and Nottinghamshire.

Further information about the Integrated Care Strategy can be found at: https://healthandcarenotts.co.uk/integrated-care-strategy/.

The ICB and its NHS Trust and NHS Foundation Trust partners have developed a Joint Forward Plan that describes how the local NHS organisations will implement the NHS Mandate, tackle key issues and contribute to the delivery of the Integrated Care Strategy and the Joint Local Health and Wellbeing Strategies. Guided by the principles of prevention, integration and equity, the Plan focuses on four key areas:

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

During the year, delivery of these strategies and plans continued through partnership working across the system. You can read more about key achievements in delivery of the Joint Forward Plan during 2025/26 in the Performance Analysis section of this Annual Report.

During the year, in line with the NHS England Medium Term Planning Framework, the Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire ICBs have developed a joint Five-Year Population Health Strategy and a joint Five-Year Strategic Commissioning Plan (with the Strategic Commissioning Plan encompassing the statutory requirement for a Joint Forward Plan). Together, these will support delivery of the ambitions set out within the Ten Year Health Plan for England, focused on improving outcomes, reducing inequalities and supporting more preventative and neighbourhood-based models of care, while recognising the distinct needs and characteristics of each ICB's population.

Further information about our strategies and plans can be found on the ICB's website at https://notts.icb.nhs.uk/about-us/our-priorities/our-strategies-and-plans/.

Our performance

Service delivery

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

Urgent and emergency care services have continued to experience significant pressure during the year, driven by high demand, increased patient acuity and challenges with hospital flow and discharge. This has resulted in prolonged waits in Emergency Departments and ongoing pressure on bed capacity. However, progress has been made in strengthening alternatives to hospital admission, including Same Day Emergency Care, Urgent Treatment Centres and community-based responses. Improvements have also been seen in ambulance handover processes, supported by additional capacity and closer system-wide working.

During the year, we have continued to make progress in improving access to primary care, with increased delivery of GP appointments and sustained performance against access standards. We have also continued to address backlogs in elective and diagnostic care. While significant reductions have been achieved in the longest waits, performance has remained below planned levels, reflecting ongoing capacity challenges and demand pressures. The expansion of diagnostic capacity represents an important step towards supporting longer-term recovery.

In cancer services, performance against national waiting time standards has remained challenging, although sustained focus has been placed on reducing long waits and improving pathway performance. At the same time, continued progress has been made in earlier diagnosis, including through screening and targeted case-finding initiatives. Improving performance against the Faster Diagnosis Standard remains a key priority.

Access to mental health services has continued to improve, with the ICB exceeding planned levels of access for children and young people and consistently meeting national waiting time standards for talking therapies. Dementia diagnosis rates have exceeded the national target, and progress has continued in reducing inappropriate adult acute out-of-area placements, although further improvement is required. Ongoing quality and safety challenges at Nottinghamshire Healthcare NHS Foundation Trust have necessitated continued enhanced oversight.

Progress has continued in supporting children and young people with a learning disability and autistic people to remain in the community, reducing the need for inpatient care, and in strengthening access to annual health checks. While targets for children and young people have been achieved, reducing inpatient numbers for adults remains an area for further improvement.

Through the Local Maternity and Neonatal System, improvement activity has continued to strengthen the quality, safety and equity of maternity and neonatal services, informed by learning from reviews and regulatory scrutiny, including the Independent Review into maternity services at Nottingham University Hospitals NHS Trust.

Across all service areas, we have continued to work closely with our health and social care partners to deliver recovery plans and improvement activity, recognising that sustained system-wide collaboration remains essential to improving outcomes and reducing health inequalities for our population.

Financial performance

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

In 2025/26, the ICB spent more than the funding it received and therefore did not break even. NHS organisations are required by law to balance their income and spending each year (a financial breakeven duty). Because this did not happen, the ICB did not meet its legal financial duty for the year and under the National Health Service Act 2006,

has not discharged its financial duties under sections 223BG to 223N.

Further detail on the factors contributing to the financial outturn is provided in the Performance Analysis section of this Annual Report. For full details of our financial statements please see the Annual Accounts section of this Annual Report.

Going concern

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

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. If services will continue to be provided in the public sector the financial statements should be prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2026, on a going concern basis.

Our principal risks

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

The main risks identified and monitored through the Operational Risk Register during the reporting period related to operational pressures across urgent and emergency care, discharge, elective recovery, cancer and mental health services; maintaining the quality and safety of commissioned services, including maternity, mental health and primary care; ensuring appropriate support for people with learning disabilities and autistic people; workforce resilience; financial sustainability; digital and cyber security; and the delivery of organisational change associated with transition to formal ICB clustering arrangements.

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

Performance Analysis

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

How we measure our performance

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

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

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

Performance review

During 2025/26, the Nottingham and Nottinghamshire system has continued to operate in a highly pressured environment, with sustained demand across all parts of the health and care system. Despite this challenging context, progress has been made in several areas, supported by strengthened collaboration with partners, enhanced oversight arrangements and a continued focus on delivery of recovery actions. Throughout the year we have worked hard with our partners to deliver the ambitions we set out in our Joint Forward Plan and Integrated Care Strategy to improve outcomes for our local population. Our focus has been on the three system strategic principles of promoting prevention, equity and integration to improve outcomes for people of Nottingham and Nottinghamshire.

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

Primary care

Our Primary Care Strategy was published in June 2025 and sets out our vision and roadmap for the future of Primary Care in Nottingham and Nottinghamshire over the next five years. It is our intention to rapidly improve General Practice, Community Pharmacy, Community Optometry and Dental services to meet the needs of our patients. The strategy is underpinned by three transformational themes which are: creating resilient and sustainable services, improving quality and outcomes and enhancing partnership working and integration.

Improving access to Primary Care Services has continued to be a focus for us in 2025/2026 and is a key priority area in our Primary Care Strategy. During the year, our focus has been on making it easier for people to contact their GP practice, with the aim of ensuring that everyone who needs an appointment gets one within two weeks, and those who contact their practice urgently are assessed the same or next day according to clinical need. The target for appointments offered in two weeks is 85%, and in Nottingham and Nottinghamshire during March 2026 we achieved 86.5%. Our performance against this standard has been consistently above target since June 2025. As of March 2026, 61.9% of total appointments were held face to face, 44.7% were same day appointments, and 6.5% were next day appointments. In 2025/26, Nottingham and

Nottinghamshire GP practices have delivered 86,871 more appointments than the equivalent period in 2024/25.

During 2025/26 the performance standards for adult and children seen as routine dental appointments has been achieved and as of March 2026, 89% of the contracted units of dental activity were delivered. This is expected to increase further in 2026/27 as additional units of dental activity are commissioned across Nottinghamshire. Urgent dental care provision has been expanded in line with the national initiative announced in February 2025, which requires Integrated Care Boards to commission additional urgent appointments as part of the Government's commitment to deliver 700,000 extra urgent dental appointments across England. Currently, urgent dental appointments are below target; however, measures are being implemented to enhance urgent dental provision by extending contracts with core providers, developing proposals to secure a provider in Bassetlaw, and enhancing public awareness campaigns regarding appointment availability.

During 2025/26, we have continued to support and encourage the implementation of the expanded community pharmacy services to relieve pressure on General Practice by enabling patients with simpler conditions and requirements to be assessed and treated by pharmacists, including the ability to get certain prescription medications directly from a pharmacy, without a GP appointment. Our Pharmacy First service enables the supply of appropriate medicines for seven common conditions including earaches, sore throats, and urinary tract infections, and as of March 2026, 158 community pharmacies across Nottingham and Nottinghamshire (approximately 71.2%) were registered to provide the service, completing over 71,000 consultations between April 2025 and March 2026 which is an increase of 26% in comparison to the same period in 2024/25. During this period, the largest number of Pharmacy First consultations were for sore throats and uncomplicated urinary tract infections.

Some community pharmacies also provide blood pressure services, and as of March 2026, over 58,000 blood pressure checks had been undertaken. In addition, 93% of community pharmacies provide oral contraception services (both initiation and continuation of oral contraception) and have delivered over 32,000 consultations which continues to increase.

Locally we have commissioned four Community Pharmacy independent prescribing pathfinder sites as part of an NHS England pilot site to evaluate the use of independent prescribing in Community Pharmacy. These sites undertook 1,647 consultations between April 2025 and March 2026 for a wide range of on the day illnesses. Due to the success of the pilot, we have extended the service in three sites, helping to reduce demand for GP appointments.

Modernising general practice through digital initiatives is a key priority within our Primary Care Strategy. Nottingham and Nottinghamshire is the highest performing Midlands system for online registration enrolment at 100%. Support is being provided to boost digital sign-ups and encourage more practices to enable auto-registration. We also remain national leaders in the rollout of the NHS App; by January 2026, 98% of GP practices had patients using the NHS App to access their health records, with 67% of the population aged 13 and over registered. In addition, 97% of GP practices report that patients are using the NHS App to manage their prescriptions.

In July 2025, the Nottinghamshire Care Record was officially launched, bringing together health and social care information into a single shared record to support more joined-up care. Building on this strong foundation, we have ambitious plans to further expand digital innovation across primary care during 2026/27.

Urgent and emergency care

The national four-hour Emergency Department standard states that 78% of patients should be admitted, transferred, or discharged within four hours of arrival. However, in Nottingham and Nottinghamshire, this target was not consistently met during 2025/26. As of March 2026, 70.6% of patients were seen within four hours (this represents the combined performance of Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS Foundation Trust).

During 2025/26, some patients have experienced waits of more than 12 hours in the Emergency Department following a decision to admit. While a

zero-tolerance position remains the ambition, a recovery target has been in place for this to affect no more than 10% of Emergency Department attendances during the year. Performance has been variable and has generally exceeded this threshold, with the position for March 2026 at 12.2%. Harm reviews and thematic reviews are undertaken for all patients affected by prolonged waits, with a focus on limiting corridor care.

A number of factors continue to impact performance against emergency care standards. Demand remains slightly under plan in volume terms, but timing and clustering of patient presentations, combined with high bed occupancy and discharge delays, continue to generate crowding and prolonged waits. Recovery plans are in place to focus on improving flow and reducing waiting times. During the year, we have expanded Same Day Emergency Care and Urgent Treatment Centre provision, which will enable the Urgent Treatment Centre to manage up to 220 attendances per day, diverting appropriate patients away from the Emergency Department. Ongoing pathway development is taking place at both Nottingham University Hospitals and Sherwood Forest Hospitals to shift activity away from Emergency Departments.

Ambulance handover performance remains challenging, with continued increases in total handover delays. In March 2026, 2,667 hours were lost due to ambulances waiting to hand over patients. Both Nottingham University Hospitals and Sherwood Forest Hospitals have created additional capacity to support ambulance offloads, with further improvement actions planned. Joint working continues with the East Midlands Ambulance Services NHS Trust to improve handover flow and reduce delays.

The Urgent Care Coordination Hub (UCCH) was introduced in 2024/25 to support patients to receive care in the community and avoid unnecessary hospital attendance. Activity has increased significantly throughout 2025/26, with the UCCH handling an average of 84 calls per day. Of these, 63% have been managed without the need for an ambulance response or Emergency Department referral, and a further 20% have been supported through self-care advice.

We are performing well with our Urgent Care Response service, which provides rapid, clinical assessment and treatment in the community. We consistently remain above the 70% standard for patients seen within two hours, achieving an average of 98%. This is the highest in the Midlands and exceeding the national average of 84%.

During 2025/26, our System Coordination Centre has operated daily from 8am to 6pm, providing us with comprehensive oversight of operational pressures and risks among providers and system partners. The System Coordination Centre facilitates a coordinated system-wide response to daily challenges by collaborating with partners to determine and implement actions to improve operational performance.

Diagnostics and elective care

Throughout the year, we have remained focused on reducing elective care waiting times and enhancing diagnostic services. Although fewer patients are now waiting over 65 and 52 weeks, these figures still exceed our planned targets. As of March 2026, there were 49 patients waiting more than 65 weeks. A key objective in our Joint Forward Plan is to eliminate waits longer than 65 weeks. Efforts are currently underway to further address this issue by working collaboratively and increasing the utilisation of the independent sector and out of area NHS providers.

The system-wide Elective Hub continues to provide oversight of long patient waits across local NHS Trusts and independent sector providers. Through the Hub, emerging specialty-level pressures are identified early, enabling proactive engagement with providers to understand underlying issues, agree improvement actions, and explore opportunities for mutual aid where appropriate.

Diagnostic delays persisted during 2025/26, with 27.1% of patients waiting more than six weeks for a diagnostic test in March 2026, compared to a planned level of 10.2%. Capacity challenges at Nottingham University Hospitals, particularly for MRI scans, contributed to a continued growth in the diagnostic backlog despite mitigating actions that included extended scanning hours and the use of third-party providers. As set out in our Joint Forward Plan, the phased implementation of Community Diagnostic Centres represents a key strategic objective to increase diagnostic capacity and improve timeliness. The opening of the

Mansfield Community Diagnostic Centre in April 2026, followed by a further centre in Nottingham in April 2027, will significantly expand capacity for key diagnostics, including CT and MRI scans and endoscopies, supporting recovery trajectories and improved performance. In advance of these developments, temporary and mobile diagnostic capacity has been deployed to help reduce the backlog and mitigate ongoing delays.

Cancer care

The Faster Diagnosis Standard for cancer was introduced to support timely diagnosis for people referred with suspected cancer, helping to ensure that treatment can begin as early as possible where cancer is confirmed and providing reassurance more quickly for those where cancer is ruled out. The standard aims for 75% of patients urgently referred by their GP to receive a diagnosis or have cancer excluded within 28 days. During 2025/26, performance in Nottingham and Nottinghamshire has remained below this ambition, with achievement at 73.1% in March 2026; however, sustained focus has been placed on improving diagnostic capacity and pathway performance to support progress toward the standard. The Faster Diagnosis Standard operates alongside the cancer referral-to-treatment waiting time standards (31-day and 62-day). Nottingham and Nottinghamshire remains off track against these standards and did not achieve the planned trajectory in January 2026. Joint work between Nottingham University Hospitals and Sherwood Forest Hospitals to expand the oncology footprint at King's Mill Hospital is underway and will increase capacity for clinics and treatments, supporting improvement in 62-day performance. At Nottingham University Hospitals, an improvement plan is in place to mobilise actions to improve performance against the 62-day standard. During 2025/26, a continued focus has been placed on reducing the backlog of patients waiting more than 62 days for treatment. While the backlog is gradually reducing, it remains above plan, with 464 patients waiting as of March 2026 compared to a planned level of 418 (combined position across both Trusts). Weekly oversight meetings are held with both Trusts, and recovery actions include additional insourced capacity, targeted funding, and pathway transformation work, with a particular focus on addressing bottleneck in the urology pathway.

Alongside recovery activity, work has continued to strengthen faster cancer diagnosis initiatives. The Lung Cancer Screening Programme, which is a key priority for us in our Joint Forward Plan, has been expanded across Nottingham and Nottinghamshire, resulting in over 400 cancers diagnosed, with more than 71% identified at an early stage. In addition, the Pancreatic Cancer Case-Finding Pilot has been launched in Nottinghamshire, targeting individuals aged 60 and over with new-onset diabetes and unexplained weight loss. Through proactive case-finding, 262 patient records have been reviewed, with 148 eligible patients identified via monthly searches and offered timely diagnostic investigations.

Funding has also been secured for an East Midlands oesophageal cancer detection initiative. The pilot, which will run for two years, will see Pharmacists helping to spot potential undiagnosed cases by identifying patients who are regularly using over-the-counter medications to ease their heartburn or reflux symptoms, but who have not come forward to their GP; aiming to spot early changes in the lining of the oesophagus that otherwise may have been missed.

Maternity and neonatal care

During 2025/26, work has continued across Nottingham and Nottinghamshire to deliver sustained improvement in maternity and neonatal care, aligned to the NHS Three Year Delivery Plan for maternity and neonatal services. This remains a system priority, particularly in the context of the ongoing Independent Review into maternity services at Nottingham University Hospitals NHS Trust.

Maternity and neonatal services are coordinated through the Nottingham and Nottinghamshire Local Maternity and Neonatal System (LMNS), bringing together providers, commissioners, public health colleagues and service user representatives to oversee quality, safety, performance and improvement activity.

Governance and assurance arrangements were strengthened during the year. Perinatal surveillance structures were streamlined to provide a more integrated view of risks, safety concerns

and improvement actions across providers, supporting clearer escalation and more consistent reporting. Learning from incidents, reviews and regulatory activity continues to inform system oversight, with risks actively monitored and managed through established governance processes.

Throughout 2025/26, the LMNS has continued to work collaboratively with providers, women and families, and wider system partners to deliver targeted improvement activity. A sustained focus has remained on addressing inequalities in outcomes and experience, recognising the ongoing impact of ethnicity, deprivation and access to services. Actions to address this have been outlined in the revised LMNS Equity Strategy.

The voices of women, birthing people and families remain central to improvement. The Maternity and Neonatal Voices Partnership is now embedded across both Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS Foundation Trust, informing service improvement, assurance processes and system decision-making.

Key areas of progress during the year include:

- Continued equity-focused improvement, including targeted support for those facing the greatest barriers to access and delivery of cultural competency training.
- Embedding of digital systems to support safer, more personalised care, including a shared digital maternity record across both trusts and enhanced dashboards to support performance monitoring, including through a health inequalities lens.
- Progression of service improvements to support better outcomes, including preterm birth optimisation pathways and embedding of perinatal pelvic health services.
- Continued action to address health inequalities for women and families whose first language is not English, with support secured through an additional year of the CardMedic pilot, enabling ongoing access to digital interpretation and translation support within maternity and neonatal services.

Quality and safety remained central to maternity and neonatal oversight during 2025/26. Both Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS Foundation Trust demonstrated strong compliance with version 3.2 of the Saving Babies' Lives Care Bundle, supported by routine review through LMNS governance. Both providers improved further during the year, achieving full compliance in several elements of the Care Bundle, with targeted improvement continuing in priority areas. This gave assurance that evidence-based approaches to reducing perinatal mortality remained embedded in practice.

In parallel, both Trusts achieved full compliance with the safety actions set out in the NHS Resolution Maternity Incentive Scheme.

Additional improvement work has continued, including a focus on reducing postpartum haemorrhage and severe perineal trauma through structured quality improvement initiatives. Together, this reflects a more mature and coordinated system approach to improvement, with clearer alignment of activity to improved outcomes and experience.

Recognising that workforce capability and sustainability are critical to safe maternity and neonatal services, system partners continued to prioritise workforce development during 2025/26. This included investment to expand access to neonatal life support training and strengthen local instructor capacity, supporting resilience and timely response to neonatal emergencies. These initiatives complement wider workforce development through the LMNS, including funded secondments and apprenticeships at Nottingham University Hospitals NHS Trust for maternity support workers, contributing to skills development and more sustainable service delivery.

While progress has been made, challenges remain, particularly in relation to maternity services in Nottinghamshire. These include continued workforce pressures, the need to sustain pace and consistency of improvement, and ongoing regulatory scrutiny, including the Independent Maternity Review. These are being addressed through strengthened system oversight, targeted support from NHS England, focused improvement programmes, and continued engagement with women, families and staff. Improvement activity is supported by clearer governance, enhanced safety surveillance, and a continued commitment to learning from incidents, reviews and lived

experience to drive sustained improvement over time.

Mental health services

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

Over the course of 2025/26, we have made progress in improving access to perinatal mental health services. Although current performance remains below the target access rate of 10%, it is still ahead of the forecasted trajectory. Throughout the year, targeted engagement has been carried out with various patient groups to boost awareness and accessibility among both GPs and patients.

As of March 2026, 20,980 children and young people were recorded as having at least one contact with mental health services in the preceding 12 month period, exceeding our plan of 20,475. It is a key ambition in our Joint Forward Plan to expand Mental Health Support Teams in Schools. These teams play an important role in providing early intervention for children and young people, thereby reducing the likelihood of future reliance on specialist mental health services. During 2025/26, we have expanded coverage to 56.3% across Nottingham and Nottinghamshire, and we intend to expand this further by mobilising two more teams in 2026/27. Our ambition is to reach 100% coverage by 2030.

Getting a dementia diagnosis is key to unlocking access to personalised care and support, as well as accessing treatments that can help to control symptoms; however, around 40% of those aged 65 or over thought to be living with dementia do not have a diagnosis. During 2025/26, we have focused on recovery of our dementia diagnosis rates, and as of March 2026, we have achieved 69.9%, which is in excess of the national target of 66.7%.

People with a Severe Mental Illness (SMI) such as schizophrenia, bipolar or other psychoses, often experience poor physical health and undiagnosed/untreated physical health conditions because of the focus on their mental health needs. During 2025/26, we have continued to support people with a SMI to receive a physical health check, and we have achieved our target of 60% throughout the year.

Talking therapies, or psychological therapies, are effective treatments to support people struggling with feelings of depression, excessive worry, social anxiety or post-traumatic stress disorder (PTSD). Examples of talking therapies include guided self-help, cognitive behavioural therapy (CBT) and counselling. As of February 2026, 1,150 adults and older adults completed talking therapies, compared to the planned target of 1,241. Our performance has improved during the latter part of the year; however, a recovery action plan has been requested to maintain performance standards. During February 2026 we achieved the national waiting time standards, with 93% against the 75% 6-week standard and 100% against the 95% 18-week standard. The 50% recovery standard has also been achieved at 51%.

During 2025/26, we have also been working towards eliminating inappropriate adult acute out of area placements. An ‘out of area placement’ for acute mental health inpatient care happens when a person with assessed acute mental health needs who requires adult mental health acute inpatient care, is admitted to a unit that does not form part of their usual local network of services. By this, we mean an inpatient unit that does not usually admit people living in the catchment of the person’s local community mental health service and where the person cannot be visited regularly by their care co-ordinator to ensure continuity of care and effective discharge planning. Patients should be treated in a location that helps them to retain the contact they want to maintain with family, carers, and friends, and to feel as familiar as possible with the local environment.

As of March 2026, there were ten out-of-area placements, exceeding the target of zero. Improvement plans have been implemented to decrease dependency on independent sector beds, optimise demand through enhanced community support, and enact measures to improve bed flow across all mental health services.

Services for people with a learning disability and/or autism

People with a learning disability often have poorer physical and mental health than other people, and on average, people with a learning disability will

die 20 years earlier than the general population. The completion of annual health checks can improve people's health by spotting problems earlier, in turn reducing the health inequalities that this group of people face. For 2025/26, we were set a target of ensuring that 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by year-end. As of March 2026, we are below plan for annual health checks completed; however, 96% are recorded to have a health action plan. During the year, work commenced on quality audits and standardisation, ensuring health checks consistently lead to meaningful health action plans.

Throughout the year, we remained committed to decreasing the number of people with learning disabilities and/or autism in inpatient facilities, while enhancing community-based services. For 2025/26, we were set targets of no more than 32 adults, and no more than three children and young people (under 18s), being cared for in an inpatient unit by March 2026. As of March 2026, we have achieved our target for children and young people; however, we have ended the year in excess of our target for adults, having 36 adult inpatients. While we still have more to do to address this, we continue to see successful admission avoidance through strengthened community support. This is mainly due to the embedding of key services and specialist roles to support people effectively within the community, and through successful implementation of the Dynamic Support Register, which identifies people at imminent risk of admission into adult services. In addition, there has been a sustained system focus on reducing new inpatient admissions, supported by tightened gatekeeping, regular oversight meetings and strengthened discharge planning.

The ICB continues to have a dedicated team that is responsible for coordinating a programme of work to learn from the lives and deaths of people with learning disabilities and autism (the LeDeR programme is a national initiative that aims to improve care for people with learning disabilities and autism). The LeDeR programme has continued to improve this year, with a fully established team in place with enhanced quality reviews leading to clearer, more practical learning. Strong governance and improved follow-up mean providers are responding more consistently to recommendations. Performance against national key performance indicators has also improved and LeDeR is now well embedded and playing a key role in improving care and safety for people with a learning disability and autistic people. Our future ambitions include an increased focussing on prevention, early identification, and working with underrepresented groups. We publish an annual report each year setting out the progress and impact of the LeDeR programme in Nottingham and Nottinghamshire, highlighting key achievements and areas where further improvement and development is needed. The reports are available in the 'Safeguarding' section of our website at https://notts.icb.nhs.uk.

The Oliver McGowan Mandatory Training on Learning Disability and Autism is now a statutory requirement following confirmation of the Code of Practice in September 2025. We have successfully delivered a system wide pilot of the Oliver McGowan mandatory training and have established governance, infrastructure, and a co-produced delivery model required to meet statutory expectations. Key learning from the pilot has informed next steps, with responsibility for ongoing delivery transitioning to providers, with Trusts now working collaboratively to develop a sustainable, provider-led model.

Preventative care and management of long-term conditions

Effective preventative care and long-term condition management is fundamental to improving the health outcomes for our population. It is also critical in helping to address the increasing demands on our health and social care services by preventing illness and disease. As such, we have focused our work in the following areas during the year, in line with our Joint forward Plan commitments:

- We have increased skill levels in relation to diabetes care in primary care, implemented continuous glucose monitoring and increased uptake of the Healthier You Diabetes Prevention and Type 2 Path to Remission programmes. We have also successfully implemented the NICE Technology Appraisal for Hybrid Closed Loop, which provides life changing technology to people living with Type 1 Diabetes.

- Our Best Years Hubs, first established in Newark and Sherwood, were successfully expanded during 2025/26 to Ashfield, Gedling, Rushcliffe and Broxtowe, widening access for older people across Mid Nottinghamshire. The Hubs have supported over 6,500 attendances, helping people stay active, independent and connected through activities such as falls prevention, exercise sessions, digital support, and benefits advice. In Bassetlaw, improvements in frailty assessment, vaccination uptake and advance care planning have strengthened care at home and end-of-life support, enabling earlier intervention, better coordination and more personalised care for older people.
- Integrated Neighbourhood Teams have focused on ageing well, particularly supporting older people living alone with moderate to severe frailty. A total of 310 older people received support, with improvements in identifying frailty, reducing falls risk, and providing care earlier. This has helped people stay well and reduced the need for urgent GP and crisis services.
- Best Start+ supported families from pregnancy through to early childhood, focusing on the wider factors that influence children's health. Breastfeeding rates improved, with 141 parents attending support groups. Of those who attended, 97% reported feeling more confident and were able to breastfeed for longer. Baby Week 2025 in Mansfield supported around 100 families and helped shape the new Your Notts Directory, making local support easier to access. Targeted work continued to improve childhood vaccination uptake and support families facing cost-of-living pressures. In Bassetlaw, proactive case finding has resulted in 1,731 children and young people being contacted and offered support. Early mental health support for children and young people has improved wellbeing and reduced the need for crisis or specialist care.
- During 2025/26, there was a strong focus on preventing long-term illness and identifying health problems earlier. Community spirometry clinics across Ashfield and Newark booked 612 patients, with 77% receiving a test, helping to identify previously undiagnosed lung conditions and support earlier treatment across 56 GP Practices. Targeted smoking cessation outreach helped identify people not previously engaged with services, with over 3,200 text messages leading to new referrals, quit attempts, and successful quits at both four and 12 weeks. In Newark, Healthy Hearts community events enabled 66 residents to receive blood pressure and cholesterol checks and access onward support for weight management, stopping smoking, diabetes prevention, and helping identify cardiovascular risk earlier.
- Throughout the year, we have continued to develop and improve respiratory services for our local population. The Respiratory Integrated Neighbourhood Team (INT), led by Sherwood Forest Hospitals NHS Foundation Trust, brings specialist respiratory expertise into community and primary care to support people with respiratory conditions closer to home. The INT launched in November 2025 across Mid Nottinghamshire. Providing personalised, proactive support to identified high risk patients and helping to reduce reliance on reactive and hospital-based care. In addition, we have expanded a respiratory pilot into Ashfield North Primary Care Network, an area with high health needs and deprivation. Using population health data, 107 people at highest risk were identified, and all received a personalised clinical review. Many were supported through wider multidisciplinary discussions or signposted to services such as social prescribing and smoking cessation. Alongside meeting clinical needs, the pilot supported people with wider factors affecting their health and wellbeing, aligned to the Building Blocks of Health.
- During 2025/26, Nottingham City's Integrated Neighbourhood Working Programme strengthened heart health through local, preventative care. 1,386 people received blood pressure checks during Know Your Numbers activity, an increase of 254 on previous years, alongside targeted work to improve hypertension detection in black male communities. Over 4,300 residents used new digital health stations to check blood pressure, body mass index, and heart age, supporting earlier identification of cardiovascular risk. The city also launched its first community-based Phase 4 cardiac rehabilitation programme, helping people recovering from cardiac events

to safely return to regular activity outside clinical settings. In addition, targeted childhood and seasonal vaccination programmes improved access and uptake in priority communities. Strong partnership working has been central to reducing inequalities and supporting care closer to home.

- In Bassetlaw, targeted community prevention supported residents with financial, housing and wellbeing issues through local, multi-agency outreach, helping prevent problems escalating into health crises.

Safeguarding children and young people

The ICB is committed to safeguarding and promoting the welfare of children and young people who access services within Nottingham and Nottinghamshire. While the ICB has specific statutory responsibilities in relation to safeguarding, effective safeguarding relies on strong partnership working across health, local authority, police and commissioned provider organisations. The ICB therefore works closely with partner agencies and providers to strengthen systems, improve practice and ensure effective oversight and assurance.

The ICB is a statutory safeguarding partner within both the Nottingham City Safeguarding Children Partnership and the Nottinghamshire Safeguarding Children Partnership, alongside local authorities and Nottinghamshire Police. These partnerships provide the formal safeguarding arrangements through which agencies work together to safeguard and promote the welfare of children, in line with the requirements set out in Working Together to Safeguard Children. The strategic aims of the ICB align closely with the safeguarding priorities of both partnerships. The published safeguarding arrangements and the most recent annual safeguarding partnership reports are available on the Nottingham City Council and Nottinghamshire County Council websites.

Local safeguarding partnership arrangements are supported by a number of established system safeguarding groups, which strengthen multi agency working, information sharing, oversight and assurance. The ICB's Safeguarding Team remains actively involved in all child safeguarding practice reviews and rapid reviews, and learning from national and local reviews and independent inquiries is routinely considered through safeguarding partnership governance. In addition, the Nottingham and Nottinghamshire Child Death Overview Panel continues to meet on a regular basis to review child death cases across the system, identifying themes, learning and opportunities for improvement.

During 2025/26, the ICB has continued to prioritise safeguarding within its planning and commissioning responsibilities. Building on the Joint Forward Plan, key areas of focus during the year have included:

- Strengthening Section 47 and Multi Agency Safeguarding Hub coordination and information sharing arrangements.
- Improving health pathways and assurance for looked after children and care leavers.
- Supporting integrated safeguarding responses for unaccompanied asylum seeking children.
- Supporting implementation and appropriate use of the Child Protection Information System across health services.
- Promoting compliance with the Female Genital Mutilation Information Sharing System.
- Reviewing and strengthening health responses for children experiencing domestic abuse.
- Embedding the Voice of the Child across safeguarding activity through delivery of the Child Voice Strategy.

The ICB continues to embed the Voice of the Child across its safeguarding workstreams, ensuring that children's lived experience informs service improvement, assurance and learning. Partnership work to review and improve the health offer for children in care has remained a priority, led through the Designated Nurse for Looked After Children and supported by wider system partners.

The ICB is responsible for ensuring that its statutory safeguarding responsibilities are embedded within the services it commissions. Providers are expected to operate in line with national legislation, statutory guidance and local safeguarding arrangements. The ICB's Safeguarding Policy describes how these responsibilities are discharged and is published on the ICB's website.

Assurance on safeguarding arrangements is obtained through a range of mechanisms, including self-assessment against Section 11 of the Children Act 2004 and compliance with the National Health Service England Safeguarding Children, Young People and Adults at Risk – Safeguarding Accountability and Assurance Framework. These arrangements are supported by expert advice and challenge from the ICB's multidisciplinary Safeguarding Team, which includes nurses and doctors, and by routine reporting and escalation through established quality governance structures.

The ICB confirms that it has followed the statutory assurance processes set out in the Safeguarding Accountability and Assurance Framework and continues to meet its duties under Working Together to Safeguard Children. This assurance is reflected through safeguarding partnership reporting, ICB business planning, and routine quality and risk oversight.

Further information is available on the 'Safeguarding' section of our website at https://notts.icb.nhs.uk.

Special Educational Needs and Disabilities (SEND)

The ICB is responsible for arranging health provision and contributing to improved outcomes for children and young people with Special Educational Needs and Disabilities (SEND), working with partners to ensure access to appropriate health services and effective contributions to Education, Health and Care Plans (EHCPs).

The ICB recognises that the national SEND reform programme is placing increasing focus on the role, accountability and leadership of health partners within local SEND systems. For ICBs, this includes a strong emphasis on the quality, timeliness and consistency of health advice into EHCPs, effective commissioning and quality oversight of SEND health services, and active leadership within joint governance and improvement arrangements. The ICB is therefore continuing to align its SEND responsibilities and improvement activity to this direction of travel, with a focus on improving outcomes and experiences for children and young people, supporting earlier and more coordinated intervention, and reducing reliance on fragmented processes.

SEND is recognised by the ICB as a priority area, as timely and effective support in childhood is foundational to long-term health, wellbeing and life chances. The ICB therefore places strong emphasis on early intervention, partnership working across health, education and care, and improving the experience and outcomes of children, young people and their families.

The ICB undertakes its SEND responsibilities set out in the Children and Families Act 2014, supported by SEND Code of Practice and NHS England guidance for ICBs, and through joint arrangements evaluated against the Ofsted and Care Quality Commission Area SEND inspection framework.

Demand for SEND-related support remains high across Nottingham and Nottinghamshire, particularly in relation to EHCP processes and neurodevelopmental and speech communication and language pathways. Performance within EHCP processes has remained challenging during the year, reflecting increased demand, workforce capacity constraints and the complexity of delivery across both Nottingham and Nottinghamshire.

Neurodevelopmental pathways for autism and ADHD have continued to experience sustained growth in referrals, contributing to ongoing pressure on access and timeliness in parts of the system.

SEND performance and improvement activity is overseen through established SEND and CYP governance arrangements, with scrutiny and assurance at the ICB provided through our Joint Quality and Service Improvement Committee. These arrangements support coordinated system oversight and alignment of SEND improvement activity and help the ICB meet its responsibilities as a health partner within the local SEND system, including those reflected in the Area SEND inspection framework.

Improvement actions and progress during the year include:

- Additional time-limited ICB support has been agreed to strengthen delivery capacity within Nottingham City SEND. This includes funding for additional administrative and programme management resource, alongside executive

support to the Designated Clinical Officer, to improve coordination, pace and oversight.

- Both Nottingham City and Nottinghamshire have developed annual delivery plans aligned to their respective SEND strategies and refreshed governance arrangements, supporting clearer ownership of improvement actions and improved performance visibility.
- SEND tribunal and extended appeal activity continues to be overseen jointly with local authorities. Work is underway to strengthen arrangements and ensure learning from appeals is used to inform improvement priorities and commissioning decisions.
- A system-wide review of neurodevelopmental pathways is progressing to address access, variation and long-term sustainability. Alongside longer-term pathway redesign, actions have been taken to maintain continuity of early support during transition periods. SEND health services are aligned with wider CYP mental health and learning disability programmes to support more joined-up care.
- Work has continued to strengthen the consistency and quality of SEND performance reporting across commissioned providers. During the year, the Nottinghamshire SEND partnership received national recognition for innovation in data and improvement, including an HSJ Patient Safety Award for a pioneering outcomes-based dashboard[1] for children and young people with SEND. The dashboard combines health, education and social care data to support system-wide oversight, learning and improvement.

The ICB's ongoing focus is on improving experience and assessment timeliness across health pathways and EHCP responsibilities strengthening workforce sustainability, completing neurodevelopmental pathway transformation and progressing recovery plans for speech, communication and language needs, including exploring more integrated and sustainable models of support across the system. Embedding refreshed governance arrangements will support continued assurance and oversight of these priorities.

This work will continue to be taken forward in the context of the national SEND reform programme. The ICB will maintain close partnership working with the local authorities and providers, strengthen its contribution to joint accountability arrangements, and ensure SEND commissioning, quality oversight and performance arrangements remain aligned to emerging national expectations and inspection frameworks providing confidence that statutory responsibilities are being discharged effectively.

Supporting local economic development and contributing to the Health and Work priority

The ICB recognises that good health and meaningful work are closely linked, and that employment is a key wider determinant of health. In fulfilling its role as a strategic commissioner, the ICB contributes to the Government's Health and Work priority by ensuring that commissioning decisions and service models take account of the wider social and economic factors that influence population health.

The Get East Midlands Working plan aligns with the national Get Britain Working priorities, adapting them to the East Midlands economic context. Developed by the East Midlands Combined County Authority (EMCCA) in partnership with the Department for Work and Pensions (DWP) and the two NHS Integrated Care Boards, the plan sets out a shared ambition to support more people across Derby, Derbyshire, Nottingham and Nottinghamshire to access good work, improve their health, and enhance quality of life.

The plan focuses on three priorities:

- Priority 1: Effective training and employment support: We will connect residents to sustainable jobs through easy-to-access, targeted health and employment support and jobs-focused skills development so that everyone can get into work and progress.
- Priority 2: A joined-up system: We will work better together as partners to ensure clear leadership, coordinated action and accountable delivery across the employment, health and skills system.

[1] https://notts.icb.nhs.uk/2025/02/12/data-dashboard-gains-national-recognition/

- Priority 3: Overcoming wider barriers: We will tackle structural barriers that stop people getting into work, including transport, housing and health access.

During 2025/26, the ICB supported the piloting of an integrated health and work triage service within Rosewood Primary Care Network in Mansfield. The pilot brought together expert information, advice and guidance on employment and skills with PCN social prescribing teams to create an Employment and Skills 'triage' approach, enabling access to a wide range of employment support programmes. Learning from the pilot demonstrated that while primary care teams recognise the value of good employment and skills development for patients' physical and mental wellbeing, education alone is not sufficient. Instead, a "no wrong door" referral system with broad inclusion criteria is more effective in connecting people to appropriate support.

Learning from the pilot is informing the ICB's approach to the development of health and work support in 2026/27, aligning with the national WorkWell programme. Subject to funding arrangements, WorkWell is intended to support a more integrated, early-intervention work, health and skills model, providing personalised assessment of barriers to employment and coordinated support.

The ICB's commissioning approach places a strong emphasis on prevention, early intervention and neighbourhood-based models of care, with neighbourhood health services being designed to support independence and reduce avoidable deterioration through improved access to community-based support, proactive care and coordinated interventions for people with long-term conditions and complex needs. These models include stronger links with community assets and wider public-sector support, including employment and voluntary sector organisations.

The ICB also contributes to local economic development through its stewardship of workforce development across the health and care system. During the year, commissioning decisions considered through Joint Commissioning Executive Group arrangements included investment in service capacity and training models to improve skills utilisation and strengthen workforce sustainability, supporting a resilient local health and care labour market.

Partnership working underpins this approach. Through Integrated Care Partnership arrangements, the ICB works with local authorities and system partners to align healthcare commissioning with wider strategies addressing social, environmental and economic conditions. While the ICB does not directly deliver employment or economic development programmes, it plays an enabling role by embedding health considerations into place-based decision-making and commissioning services that support independence, resilience and participation in everyday life, including work where appropriate.

The ICB also participated in the development of the EMCCA Inclusive Growth Plan and will continue to engage during 2026/27 to consider how the NHS can contribute to delivery of the plan as a local anchor institution, including opportunities to support wider social and economic development.

Financial review

The ICB is responsible for managing the NHS funding allocated to it, ensuring that daily commitments are fulfilled, and investments are made to improve the quality of services provided to our patients and population, and address health inequalities. Several factors impact our ability to spend and manage within the financial allocations provided to us, including national economic conditions, unexpected increases or surges in demand for local health services and project delays.

The ICB and its wider NHS system partners have continued to face another challenging year financially during 2025/26, despite working collectively throughout the financial year to deliver efficiencies. The ICB delivered a deficit of £6.2 million against a planned target of breakeven. This deficit is entirely due to the non-receipt of the ICB component of NHS England Deficit Support Funding for the second half of the year, which was withheld due to the financial performance of our NHS system partners being lower than planned. This resulted in the ICB failing to meet its financial breakeven duty (expenditure being no more than allocations) in 2025/26; therefore, under the National Health Service Act 2006, the ICB has not discharged its duties under sections 223GB to 223N (financial duties).

During the financial year, the ICB faced a number of demand-led financial pressures. Acute services were particularly affected by higher than planned levels of Independent Sector hospital activity. Mental health services also experienced sustained growth in demand, resulting in additional cost pressures, most notably in relation to Section 117 aftercare packages and increased activity within neurodivergent services following their expansion to the wider market. These pressures were managed through the implementation of non-recurrent mitigations, including balance sheet releases and the prudent management of planned investment slippage, enabling the ICB to maintain overall financial control.

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

Duty	Target (£m's)	Actual (£m's)
Income and expenditure (ICB): Expenditure not to exceed income	3,434.2	3,440.4
Income and expenditure (NHS system): Expenditure not to exceed income	3,434.2	3,603.7
Running costs (ICB): Remain within running cost allowance	32.2	28.7

Category of expenditure	Total 2025/26 spend (£m's)	Total 2024/25 spend (£m's)
Acute (hospital) care	1,582.8	1,533.4
Specialised acute (hospital) care	353.2	277.7
Community care	294.7	303.1
Mental health care	316.9	294.5
Primary care	435.9	398.8
Prescribing	206.6	205.7
Continuing care	166.9	175.9
Other non-healthcare	54.7	36.3
Corporate running costs	28.7	21.0
Total	**3,440.4**	**3.246.4**

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

The ICB was established on 1 July 2022, and resources and spend have increased in each subsequent year, as shown in the table below.

This reflects the commissioning delegations for pharmacy, dental and ophthalmic services from NHS England as of 1 April 2023, and for specialised acute and mental health and learning disabilities services 1 April 2024 and 1 April 2025. Inflationary uplifts have also had an impact on both resources and operating costs.

Category of expenditure	Total 2025/26 spend (£m's)	Total 2024/25 spend (£m's)	Total 2023/24 spend (£m's)	Total 2022/23[1] spend (£m's)
Total Resources	(3,434.3)	(3,246.4)	(2,652.4)	(1,822.5)
Gross Operating Costs	3,440.4	3,246.4	2,667.1	1,816.5

Mental Health Expenditure

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

In 2025/26, the proportion of mental health spend as a percentage of the ICB's overall expenditure increased by 1.94%. On a like-for-like basis, using 2024/25 definitions, this represents an increase of 0.05%.

There have also been two changes to mental health financial reporting in 2025/26 which affect comparability with previous years:

- Service Development Funding: The MHIS target scope was amended by NHS England to include Service Development Funding expenditure that has now become baseline funding, increasing the proportion of reported mental health spend by 0.51%.
- Delegation of specialised mental health services: From 1 April 2025, responsibility for commissioning specialised mental health services transferred from NHS England to the ICB. As a result, this expenditure is now

[1] The ICB was established on 1 July 2022; therefore, 2022/23 was a nine-month reporting period.

included within the MHIS target, increasing the reported proportion of mental health spend by 1.38%.

The table below sets out the amount and proportion of expenditure incurred on mental health services in 2025/26 compared to 2024/25.

Mental health expenditure	2025/26	2024/25
Minimum expenditure in mental health services to meet the Mental Health Investment Standard as notified by NHS England (£000)	302,973	223,290
Eligible mental health expenditure (£000)	303,403	223,495
Mental health expenditure above/(below) minimum investment required (£000)	430	205
Mental health expenditure as a proportion of total expenditure (%)	8.82%	6.88%

Joint Capital Resource Use Plan

Each year, the ICB and its NHS Trust and Foundation Trust partners are required to develop and publish a Joint Capital Resource Use Plan. The aim of the joint plan is to provide transparency for local residents, patients, NHS staff, and other stakeholders on how capital funding is prioritised and used to support the delivery of strategic objectives across the system.

During 2025/26, capital resources across Nottingham and Nottinghamshire were managed collaboratively with partner organisations, including Sherwood Forest Hospitals NHS Foundation Trust, Nottinghamshire Healthcare NHS Foundation Trust, and Nottingham University Hospitals NHS Trust. Capital funding was prioritised in line with national guidance and within the agreed system capital envelope.

Capital expenditure during 2025/26 was as follows:

Capital expenditure	Final Plan (£m)	Actual (£m)	Variance (£m)
Provider organisations	103.1	102.9	0.2
ICB	3.9	3.8	0.1
Total capital spend	107.0	106.7	0.3

In year capital expenditure was primarily focused on operational and infrastructure priorities, including equipment replacement, information technology upgrades, backlog maintenance and minor General Practice premises improvements.

The system envelope also supported the completion of a new build Magnetic Resonance Imaging scanner.

In addition to core capital allocations, the system continued to benefit from national capital funding to support major programmes aligned to national and local priorities. These investments included Electronic Patient Records, Eradication of Mental Health Dormitories, and Community Diagnostic Centres. In addition, the system was allocated capital funding supporting Return to Constitution Standards and to address Critical Infrastructure Risk.

Governance arrangements were in place throughout the year to oversee capital planning and expenditure, ensuring that capital resources were used appropriately and in line with statutory financial duties and system priorities.

Our statutory duties

Responsibility for discharging our key statutory duties rests with the Board. During the year, the Board has operated a robust reporting and assurance framework, which has continued to evolve to reflect updated governance arrangements. Through this framework, the Board ensures that timely and appropriate assurances are received on the delivery of its key statutory responsibilities.

Oversight, scrutiny and assurance in relation to these duties are delegated to the Board's committees, in line with their approved terms of reference. The following sections set out how the ICB has met selected statutory duties during the year, and further detail on the work of the Board and its committees is provided in the Governance Statement section of this Annual Report.

Quality improvement

ICBs are legally required to exercise their functions with a view to securing continuous improvement in the quality of services provided for the prevention, diagnosis or treatment of illness. The ICB remains committed to ensuring that quality is central to all its statutory functions and commissioning responsibilities, and that organisations from which healthcare services are commissioned meet

essential standards of quality and safety as defined by the Care Quality Commission.

The ICB promotes and delivers continuous quality improvement through a range of mechanisms, including the use of quality impact assessments as a core requirement of decision-making. Robust arrangements are also in place to monitor quality standards, with oversight informed by serious incident reporting, patient and staff feedback, infection prevention and control assurance, safeguarding information, regulatory findings and clinical outcomes.

These arrangements are strengthened through wider intelligence gathering across the Integrated Care System and close partnership working with system partners. The ICB operates a system quality architecture aligned to National Quality Board guidance, with a clear focus on quality oversight, quality assurance and proportionate escalation. This supports consistent approaches to monitoring quality, managing risk and identifying improvement priorities across commissioned services. Where quality standards are not being met, proportionate escalation routes are applied, including regulatory engagement where concerns are serious or complex.

We have robust Board and committee oversight arrangements in relation to the quality of services commissioned by the ICB, with routine scrutiny of system-wide quality governance, patient safety and the effectiveness of improvement arrangements. Further detail on the work of the Board and its committees is provided in the Governance Statement section of this Annual Report.

During 2025/26, our quality improvement activity has been shaped by ongoing quality and safety challenges within a small number of providers and care pathways, requiring enhanced oversight, regulatory engagement and sustained improvement support.

Within Nottingham and Nottinghamshire, the most significant and persistent quality concerns have remained focused on Nottingham University Hospitals NHS Trust and Nottinghamshire Healthcare NHS Foundation Trust, both of which continue to be subject to enhanced national oversight.

Nottingham University Hospitals NHS Trust has continued to be subject to heightened scrutiny, particularly in relation to maternity services, urgent and emergency care pressures, leadership and organisational culture. The Trust remains within the highest segment of the NHS Oversight Framework, reflecting concerns about the pace and sustainability of improvement following Care Quality Commission inspections and wider regulatory reviews. The ICB has continued quality insight visits and oversight arrangements to support delivery of improvement plans and monitor progress.

Nottinghamshire Healthcare NHS Foundation Trust has remained under enhanced oversight due to long-standing quality and safety concerns across a number of services, including inpatient mental health and learning disability services. Following publication of the Independent Mental Health Homicide Review in January 2025 and the announcement of a judge-led inquiry, the Trust has continued to operate under sustained national and local scrutiny. The ICB has worked closely with the Trust to oversee delivery of agreed improvement actions and ensure that the learning from reviews and regulatory findings informs quality improvement at both organisational and system level.

In addition to provider-specific concerns, a number of system-wide quality challenges have continued during the year, including in relation to access, capacity and the delivery of timely care across some priority pathways. This has included challenges affecting services for children and young people, where increasing demand and system pressures have required enhanced oversight, strengthened partnership working and a sustained focus on improvement. These matters are managed through established quality governance and assurance arrangements. Further detail on the ICB's statutory responsibilities, performance and improvement activity in relation to children and young people with Special Educational Needs and Disabilities is set out in the Performance review section of this Annual Report.

These quality issues and associated risks are kept under regular review through established quality governance structures and are reflected within the ICB's risk management and assurance processes. Further detail on the most significant quality risks is set out in the Governance Statement section of this Annual Report.

The NHS Nottingham and Nottinghamshire ICB's Executive Director of Quality (Nursing) is the named executive lead for quality and has explicit responsibility for the following population groups:

- Children and young people (aged 0 to 25).
- Children and young people with Special Educational Needs and Disabilities (aged 0 to 25).
- Safeguarding (all-age).
- Learning disability and autism (all-age).
- Down syndrome (all-age).

This role provides clear Board-level accountability for quality and patient safety, with a particular focus on populations with higher levels of vulnerability and statutory protection. It also ensures that statutory duties relating to safeguarding and SEND receive sufficient executive oversight and are embedded within quality improvement, commissioning and assurance arrangements.

During 2025/26, the ICB has continued to embed the Patient Safety Incident Response Framework (PSIRF) and oversee its implementation across NHS system partners. This has included assurance that providers have appropriate patient safety governance arrangements in place, aligned to national PSIRF expectations.

Clear governance routes for patient safety oversight are in place, enabling consistent monitoring of patient safety themes, emerging risks and improvement activity across commissioned services. This supports a system-wide focus on learning and improvement rather than process compliance, aligned to the NHS Patient Safety Strategy.

During the year, the ICB has ensured that key staff, including Patient Safety Specialists, have undertaken training aligned to the National Patient Safety Syllabus, and that patient safety capability continues to be strengthened. Patient Safety Partners are also being embedded within governance arrangements, providing independent challenge and ensuring that the patient voice informs patient safety improvement work.

As part of its PSIRF oversight role, the ICB continues to monitor the maturity and impact of patient safety improvement activity, with NHS partners using early PSIRF learning to strengthen plans and improvement activity and maintain a clear focus on measurable improvement.

Working with people and communities

The ICB works with people and communities to understand what matters to local residents and to ensure that services are informed by the experiences, needs and priorities of the people who use them. This supports more effective planning and improvement of services, contributes to improved health and wellbeing, and helps the ICB respond to the diverse needs of its population.

Our citizen intelligence and coproduction strategies continue to provide the foundation for this work. Together, these strategies guide how the ICB gathers, understands and uses the views and experiences of local people to inform priorities, service development and transformation. The ICB works jointly with system partners, including local authorities, the voluntary, community and social enterprise sector, and Healthwatch Nottingham and Nottinghamshire, to ensure that people with lived experience help shape this work.

During 2025/26, this approach included:

- Continued use of our Citizens' Panel to gather views from local residents on service priorities and service change, providing an ongoing mechanism for capturing citizen insight to inform planning and improvement.
- Coordination of engagement activity across partners through the ICS Engagement Practitioners Forum, bringing together over 60 engagement professionals from across health, care and the voluntary sector to share insight, reduce duplication and strengthen the use of citizen intelligence across the system.
- Delivery of targeted engagement with children, young people and families, working with partners such as the Youth Service and community organisations to gather feedback on health and care services and ensure that younger voices inform service development.
- Investment in community-led engagement through initiatives such as the Bassetlaw VCSE Community Grants programme, enabling local voluntary and community organisations to engage with underserved groups and bring

forward insight from communities whose voices are less often heard.

- Involvement of people with lived experience through established coproduction networks, including mental health, learning disability and autism programmes, ensuring lived experience continued to inform service design, transformation activity and governance.
- Ongoing engagement through the Maternity and Neonatal Voices Partnership, enabling women, families and carers to feed back on their experiences and support improvements in maternity and neonatal services.
- Use of engagement and insight to inform specific service developments, including work to support programmes such as lung cancer screening and the refresh of the ICB's co-production approach

These activities supported the strengthening of citizen insight and coproduction and helped ensure that the voices of people and communities remained central to service improvement and transformation. Further detail on activity undertaken during the year, including examples of how the ICB has worked with people and communities, is set out in the published Working with People and Communities Annual Report which is available at https://notts.icb.nhs.uk/get-involved/.

Reducing health inequalities

Health inequalities are the unfair and avoidable differences in health experienced by individuals and communities, including differences in access to health services and the outcomes achieved. A person's chance of enjoying good health and a longer life is influenced by the social, economic and environmental conditions in which they are born, grow, live, work and age, as well as by how health and care services are planned and delivered. ICBs are statutorily required to have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved from those services. This requires health inequalities to be actively and systematically considered as part of how the ICB plans services, allocates resources and takes decisions on behalf of its population.

The ICB discharges this duty by ensuring that the consideration of health inequalities is firmly embedded within its strategic planning and core business activities. In practice, this includes:

- Ensuring that strategies and plans are informed by an understanding of population need, variation and inequality, drawing on population health management and system intelligence.
- Ensuring that approaches to engagement, insight and involvement are inclusive and enable the views and experiences of people and communities experiencing the greatest health inequalities to inform planning and decision-making.
- Following a clear approach to identifying barriers to access, experience and outcomes for Core20PLUS5 and other underserved groups.
- Applying a consistent, system-wide decision-making framework so that investment, disinvestment and service change proposals are informed by evidence and explicitly consider their impact on health inequalities.
- Requiring proposals to change, redesign or remove services, policies or functions to assess and clearly articulate their impact on inequalities in access, experience and outcomes, and how any adverse impacts will be mitigated.
- Ensuring appropriate oversight and scrutiny of arrangements to reduce health inequalities through shared governance and assurance processes.

Health inequalities are closely linked to differences in life expectancy and rates of avoidable mortality. Avoidable mortality, defined as deaths that could be prevented through effective public health interventions or treated with timely and appropriate healthcare, is recognised as a key system-level indicator and forms part of the Integrated Care System Outcomes Framework. Variation in avoidable mortality rates between population groups and places provides insight into where preventative action and targeted improvement may be most needed. The ICB uses population health intelligence, including information on avoidable mortality, to identify unwarranted variation in outcomes and support targeted action. Trends in avoidable mortality are considered as part of

routine Board-level oversight, alongside learning from deaths, quality improvement intelligence and wider population health reporting. This informs strategic priorities and longer-term system planning, helping to align commissioning and service transformation activity with areas of greatest population health need and to support a preventative, outcomes-focused approach. This work is underpinned by system intelligence and population health management analysis provided by the ICB's Strategic Analytics and Intelligence Unit (SAIU), which operates across the Integrated Care System. The SAIU supports a shared understanding of population need and patterns of inequality, including variation in access and outcomes, enabling evidence-based planning and effective oversight of progress in reducing health inequalities.

Health equity is a core principle of our Integrated Care Strategy and is reflected in our Joint Forward Plan, which sets out how the NHS, working with partners, will improve outcomes, tackle inequalities and strengthen prevention across the system. During the year, the Board also approved a Five-Year Population Health Strategy, developed jointly across the Integrated Care System, which provides a shared strategic framework for improving population health and reducing health inequalities. The Strategy is informed by population need and adopts a proportionate approach to addressing inequalities, guiding future commissioning and service transformation.

During 2025/26, the ICB played a central leadership role in progressing action on health inequalities, particularly through NHS commissioning, primary care transformation, data and outcomes leadership, and targeted intervention for underserved groups. This included:

- Significant ICB-led improvements for people with severe mental illness (SMI) and learning disabilities through delivery of the SMI Local Enhanced Service (LES) in primary care, which contributed to an increase in the proportion of SMI patients receiving all six physical health checks from 37.2% to 58.1%. The proportion of people with a learning disability receiving an annual health check also increased from 68.3% to 74.4%, reflecting sustained ICB focus on proactive uptake through general practice and system oversight of delivery. These improvements represent important ICB-led action to address long-standing inequalities in premature mortality and unmet physical health needs.
- Roll-out of Integrated Neighbourhood Teams, with nine teams live by early 2026 and further teams planned. This model has strengthened access to coordinated care for populations with complex needs, including those living with frailty, long-term conditions and social vulnerability, contributing to more equitable access to community-based support. In parallel, the ICB supported primary care transformation through record levels of general practice access, with over eight million appointments delivered during 2025, supporting earlier contact and prevention in deprived communities.
- Collaborative delivery of a system-wide Making Every Contact Count (MECC) training offer, co-designed across health and social care, with new e-learning and a trained cohort of MECC trainers across NHS, local authority and voluntary sector organisations. This strengthened the NHS workforce's ability to address inequalities through routine preventative conversations.
- Improvements in children and young people's outcomes through continued expansion of Mental Health Support Teams in Schools, contributing to access for over 21,000 children and young people in the rolling 12 month period.
- Alignment of NHS services with refreshed Children and Young People's Mental Health and Wellbeing Plans, ensuring targeted early intervention for children most at risk of poor long-term outcomes.

As part of national annual reporting requirements, the ICB publishes a separate statutory statement setting out how it is meeting its duty to reduce health inequalities. The statement is published alongside this Annual Report on our website at https://notts.icb.nhs.uk in the 'Annual Reports and Accounts' section.

Equality, diversity and inclusion

The ICB recognises the diversity of the population it serves and the workforce it employs, and is

committed to embedding equality, diversity and inclusion across all aspects of its work. As a public body, the ICB is subject to the Public Sector Equality Duty under the Equality Act 2010 (PSED). This requires the ICB, in the exercise of its functions, to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people who share a protected characteristic and those who do not.

The ICB discharges this duty through its commissioning responsibilities, workforce policies and practices, service redesign, public engagement, and formal governance and assurance arrangements. This includes both ongoing equality improvement activity and the application of equality principles during a significant period of organisational change.

In discharging its equality duties, the ICB is committed to:

- Embedding equality, diversity and inclusion within commissioning, policy development and decision-making.
- Reducing inequality in access, experience and outcomes for people with protected characteristics and underserved groups.
- Fostering a respectful, inclusive and supportive workplace for all staff.
- Ensuring that equality considerations are integral to organisational change and formal consultation activity.
- Maintaining transparency through public reporting and governance assurance.

The ICB recognises that inequality can affect people differently depending on their circumstances and protected characteristics, including age, disability, sex, race, pregnancy and maternity, religion or belief, sexual orientation, gender reassignment, and marriage and civil partnership. While not all activity is specific to individual characteristics, due regard is demonstrated through inclusive commissioning, equality impact assessments, accessible communication, workforce equality standards, and targeted action where inequalities are identified.

The ICB embeds equality, diversity and inclusion across its core business activities by:

- Using data and intelligence to understand variation in access, experience and outcomes.
- Involving under-represented groups in service development and engagement activity.
- Undertaking integrated equality, quality and inequality impact assessments when planning, changing or removing services, policies or functions, to help identify and mitigate potential impacts on protected characteristics and inclusion health groups as part of decision-making.
- Building equality requirements into procurement and contract management.

A particularly important aspect of the ICB's equality work this year related to organisational change. As the ICB moved through a significant period of transition associated with the creation of the Derbyshire, Lincolnshire and Nottinghamshire ICB Cluster, ensuring that change was delivered lawfully, fairly and inclusively was a major focus.

Organisational change was overseen through formal governance arrangements, with consultation processes used to ensure affected staff were informed about proposals and able to raise questions, concerns and feedback before decisions were finalised. Equality impact assessments were completed and reviewed to identify potential impacts on staff with protected characteristics and to inform mitigating action where required. This was supported by training on fairness, equity and inclusion in organisational change, alongside leadership and committee-level oversight.

Oversight of equality, diversity and inclusion is embedded within the ICB's governance framework through executive leadership responsibility, routine reporting, statutory workforce equality standards and the Equality Delivery System. During 2025/26, the Board received an Annual Equality Assurance Report, which provided assurance on how the ICB, working with NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB, discharged its Public Sector Equality Duty through equality impact assessments, engagement with underserved groups, data-informed commissioning, workforce practices and governance oversight.

The ICB remains committed to transparency in how it discharges its equality duties, with further information on equality performance published

through statutory reporting and supporting public documentation.

Health and wellbeing strategies

Section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007 requires us to have regard to joint health and wellbeing strategies when exercising our functions. The Nottingham City and Nottinghamshire County Health and Wellbeing Boards are statutory partnerships established to lead and advise on work to improve the health and wellbeing of the populations of Nottingham City and Nottinghamshire County and specifically to reduce health inequalities experienced by citizens.

These Boards bring partners together to address city and county-wide issues where collaborative approaches between partners are essential. In addition to the ICB and City and County Councils, the Boards' memberships include a range of local partners, including Nottinghamshire Police, Nottinghamshire Fire and Rescue Service, Healthwatch Nottingham and Nottinghamshire, NHS England, local NHS Trusts and representatives from the voluntary sector.

We are active members of the Nottingham City and Nottinghamshire County Health and Wellbeing Boards, and our NHS Joint Forward Plan describes how the ICB, together with the NHS organisations within our ICS, will contribute to the delivery of the Nottingham City and Nottinghamshire County Joint Local Health and Wellbeing Strategies and the Nottingham and Nottinghamshire Integrated Care Strategy, produced by our Integrated Care Partnership (of which the two Health and Wellbeing Board Chairs are joint vice-chairs). Both Health and Wellbeing Boards were engaged in developing the content of this Annual Report and throughout the development of our Joint Forward Plan; they have provided positive statements of support for the Plan, confirming that it clearly articulates the ICB's commitment and contribution to the delivery of their Joint Local Health and Wellbeing Strategies.

The Nottingham and Nottinghamshire Integrated Care Partnership monitors delivery of the Integrated Care Strategy through reports setting out progress in delivery of the Joint Local Health and Wellbeing Strategies and NHS Joint Forward Plan. The Integrated Care Strategy annual Report for 2025/26 demonstrated good progress against all key priorities and metrics, covering healthy life expectancy, improved life expectancy and health inequalities.

Environmental matters

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

Our strategy for tackling climate change is set out in our ICS Green Plan 2025-28, which has been developed in collaboration with system partners. The plan outlines how we will work across health and care in our system to support NHS England's net zero ambitions. The ICB leads coordination of the Plan's delivery, with operational oversight through system arrangements supporting sustainability and net zero activity. The ICB also continues to reduce its own environmental footprint through measures including hybrid working, estate consolidation and application of the NHS Net Zero Supplier Roadmap.

Taskforce on Climate-related Financial Disclosures (TCFD)

The Department of Health and Social Care group accounting manual set out a phased approach to incorporating the recommended TCFD, as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports.

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

TCFD recommended disclosures, as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements.

The phased approach incorporates the disclosure requirements of the following 'pillars': governance, strategy, risk management, and metrics and targets. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in this Annual Report.

Governance

The ICB operates within established governance arrangements, with oversight of sustainability and climate-related matters exercised through these arrangements, alongside wider strategic, operational, and financial decision-making. Further details on the ICB's governance arrangements during 2025/26 are set out in the Governance Statement of this Annual Report.

The ICB applies a mandatory minimum weighting of 10% on net zero and social value in procurements and requires suppliers bidding for contracts to have a Carbon Reduction Plan in place. Climate-related considerations are also reflected in business case development and supporting planning processes.

Management responsibility for assessing and managing climate-related matters sits within established executive and operational arrangements, supporting delivery of the Green Plan, ICS Infrastructure Strategy, procurement, estates planning and business case development. This includes coordination with system partners and provider organisations, together with relevant supporting functions involved in sustainability, estates, planning, transformation, and resilience.

Strategy

The ICB recognises that climate change presents risks and opportunities for population health, service resilience, estates, workforce and the wider health and care system. Climate-related risks and opportunities are considered through a range of existing information sources and planning processes, including Green Plan development, estates and infrastructure planning, business continuity and emergency preparedness arrangements, public health intelligence, and engagement with provider organisations and wider system partners. Opportunities include supporting more sustainable service models, reducing environmental impact through procurement and estate decisions, and strengthening partnership working across the system.

Climate-related risks and opportunities have implications for the ICB's operations, strategy, and financial planning, including through estates and infrastructure planning, commissioning, procurement, business continuity, emergency preparedness, and wider service transformation activity. The ICB's Green Plan and infrastructure strategy support this work, alongside broader partnership arrangements across the system.

Risk management

Climate-related considerations are identified, assessed, and managed through the ICB's corporate governance and risk management framework, drawing on information from partner organisations, estates, emergency preparedness and resilience processes, business continuity planning, procurement, and wider system intelligence, with delivery supported through the Green Plan and related system planning arrangements. Further details on the ICB's risk management arrangements during 2025/26 are set out in the Governance Statement of this Annual Report.

Metrics and targets

Performance against environmental objectives is monitored primarily through the NHS Greener Dashboard, which provides a consistent national framework for tracking progress across NHS Trusts and Integrated Care Systems. For Nottingham and Nottinghamshire, this draws predominantly on provider-submitted data to NHS England and includes information relating to estates and facilities, anaesthetic and medical gases, inhaler emissions, fleet and travel, and procurement. Given that the majority of direct emissions sit within NHS provider organisations, much of the quantitative environmental performance information is derived from provider returns submitted to NHS England. The ICB uses this information to monitor system-wide performance, identify areas of risk or under-performance, inform assurance reporting to the Board and relevant committees, and help prioritise future investment and system-level interventions.

The Green Plan focuses on nine priority areas, including estates and facilities, clinical care, medicines, travel and transport, procurement and supply chain, and adaptation to climate change. Progress against these priorities is tracked through system-level outcomes, key performance

indicators, and delivery milestones. The ICB monitors progress against the objectives and commitments set out in its Green Plan, alongside relevant national NHS net zero ambitions and wider sustainability requirements.

Promoting patient involvement

ICBs must promote the involvement of patients, and their carers and representatives, in decisions that relate to the prevention or diagnosis of illness, or in patients' care or treatment. The ICB recognises that a 'one-size-fits-all' approach cannot meet the complexity of people's needs, and that personalised care supports individuals to have greater choice and control over how their care is planned and delivered, and to be actively involved in decisions about what matters most to them.

In line with the national Comprehensive Model of Personalised Care, the ICB has continued to work with system partners during 2025/26 to support a whole-population approach to personalised care. This includes maintaining arrangements that help people of all ages, and their carers, to manage their physical and mental health and wellbeing, build resilience, and make informed choices when their health needs change.

Throughout the year, expectations around patient involvement and co-production have been embedded within the ICB's commissioning and decision-making processes. Commissioning proposals considered by the Joint Commissioning Executive Group routinely include assessment of patient experience, engagement, co-production and personalised care impacts, ensuring that the perspectives of patients and communities are considered as part of service development and change.

The ICB has continued to support the application of personalised care through established Personal Health Budget and Care and Support Planning arrangements, underpinned by defined governance and assurance processes. In addition, collaborative work with people with lived experience has continued in priority areas such as mental health, including through the implementation of the Integrated Mental Health Pathway Strategic Plan, which was developed jointly with system partners and people with lived experience.

The ICB's approach to patient involvement and personalised care aligns with its wider work on digital transformation and service accessibility, supporting people to access information, engage with services and manage aspects of their care in ways that reflect individual needs. Further detail on digital developments is set out later in this Annual Report under the heading 'Promoting innovation'.

More information on personalised care can be found on the 'Personalised Care' section of our website at https://notts.icb.nhs.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 remains implicit within the ICB's established commissioning and contracting arrangements. The ICB commissions healthcare services (in line with its commissioning responsibilities, as described in the About us section of this Annual Report) from a range of NHS and independent sector providers, ensuring that these are made known to patients at the point of referral via the contracts held with primary care providers.

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

Patients can make a choice of mental health provider and team for a consultant-led assessment and subsequent treatment. This applies from the point of referral from a GP and options can be discussed with GPs in the first instance to ensure that the patient's choice is clinically appropriate, and that care can continue to be delivered in an integrated way to ensure that their needs continue to be met. Some exclusions to patient choice apply, including the use of urgent, emergency or

crisis services, where a patient is detained under the Mental Health Act 1983, or where the patient is already receiving care and treatment for the condition.

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

We also operate a formal Accreditation Process for providers seeking to be awarded an NHS Standard Contract by the ICB for services to which patient choice applies. This supports patient choice by enabling new providers to enter the NHS market or existing providers to deliver additional services, in line with national patient choice regulations.

During the year, we have continued to support the use of digital solutions to offer patients more choice in how they access care – by increasing the use of digital correspondence, improving patient access to services through the use of the NHS App, and expanding patient self-referral routes. These approaches help patients to understand available options and exercise choice where appropriate. Further detail on system performance and digital developments is set out in the Performance Analysis section of this Annual Report.

Obtaining appropriate advice

All ICBs have a statutory duty to obtain appropriate advice from people who, collectively, have a broad range of professional expertise in relation to the prevention, diagnosis or treatment of illness, and the protection or improvement of public health. We recognise that this duty enables us to discharge our functions effectively and we place great importance on clinical and care professional leadership and engagement.

We have a dedicated clinical leadership function and employ a range of healthcare professionals who, as part of their roles, provide expert advice to support decision-making. This includes executive medical and nurse leadership, supported by senior clinical leaders and professional advisers, together with specialist input across areas such as primary care, proactive and community-based care, mental health, learning disability and autism, planned care, urgent and emergency care, children and young people's services, quality and clinical safety, medicines optimisation, population health management and research. These clinical leaders also support the embedding of wider system clinical partnership working within the ICB's commissioning arrangements and its statutory partnership forums.

We have also established an ICS Collaborative Clinical and Care Leadership and Transformation Group, comprising senior clinical and care leaders from across system partner organisations and place-based partnerships, to support the development of clinical policy and inform clinical transformation activity. The Group is supported by a broader assembly of clinical and care professionals who contribute to pathway development and clinical and care model design, and this work informs the ICB's formal decision-making arrangements.

The Board has ensured that it has access to the skills, knowledge and experience required to operate effectively, including securing expert public health advice as required. The Board also ensures that the memberships of its key decision-making and assurance committees include appropriate professional expertise, and it may co-opt subject matter experts to advise members when discharging their responsibilities. Further information about the Board and its committees is set out in the Members' Report and Governance Statement sections of this Annual Report

Promoting innovation

ICBs are statutorily required to promote innovation in the provision of health services in the exercise of its functions; an example of which can be demonstrated by our approach to ensuring the innovative use of technology as part of our Digital, Data and Technology (DDaT) Strategy[1]. Our system is supported by an established digital health and care community, underpinned by appropriate infrastructure and a system-wide

[1] https://prezi.com/view/WAlBPVywyhc231fdWMlx/.

digital charter that sets out shared principles and responsibilities for working together.

Nationally, the over-arching digital aspiration is set out within the 'What Good Looks Like' (WGLL) Framework[1]. 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. The ICB's DDaT Strategy is aligned to this framework and supports the appropriate adoption of digital approaches across the health and care system. The Strategy is underpinned by five programmes:

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

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

During 2025/26, the ICB also promoted innovation through its commissioning decision-making and governance arrangements, which included the following:

- Digitally enabled mental health support – the ICB provided commissioning oversight and funding assurance for NottAlone, a co-produced digital mental health platform offering locally tailored information, self-help resources and service signposting for children, young people, adults and professionals across Nottingham and Nottinghamshire. The platform was supported as a core system resource to enable early understanding, self-management and access to support.
- Governance of clinically led digital service models – the ICB considered proposals for digitally enabled mental health service models, particularly for children and young people, ensuring appropriate clinical oversight, digital alignment and system integration were in place prior to progression. This supported the safe and effective development of innovative approaches to care.
- Population-health-led, digitally enabled commissioning – commissioning proposals considered during 2025/26 demonstrated the use of shared intelligence, data and digital tools to support more proactive, targeted and integrated models of care. These approaches combined digital and face-to-face delivery and represented a shift away from traditional referral-only models towards population-health-led commissioning.
- Creating the conditions for innovation – the ICB promoted innovation by overseeing commissioning decisions that maintained and optimised the digital infrastructure required to support modern models of care, ensuring continuity, safety and resilience in digital service delivery across the system. This supported the system's ongoing ability to adopt and scale innovative approaches in line with national expectations.

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

Promoting research

ICBs have a statutory duty under the Health and Care Act 2022 to facilitate or otherwise promote research on matters relevant to the health service, and to promote the use in the health service of

[1] https://transform.england.nhs.uk/digitise-connect-transform/what-good-looks-like/what-good-looks-like-publication/.

evidence obtained from research. We recognise that research leads to improvements in clinical and care practice, reduces the cost of health and care, supports a healthier population and contributes to a skilled and engaged workforce. Research-driven commissioning is a key enabler in improving outcomes, reducing inequalities and strengthening access to high-quality care across the system.

During 2025/26, the ICB continued to deliver its approved Nottingham and Nottinghamshire Research Strategy collaboratively with system partners, in line with the agreed delivery plan. The Strategy is framed around four priorities:

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

Key achievements during the year include:

- Delivery of the first ICS Engage, Enthuse, Empower Research Conference in June 2025, jointly organised by Nottingham University Hospitals NHS Trust and the ICB, bringing together colleagues from health, social care, academia, the National Institute for Health and Care Research (NIHR) and research volunteers to promote research and innovation across the system.
- Establishment of an ICS Research and Evidence Community of Practice, supported by National Institute for Health and Care Research (NIHR) funding, to connect practitioners, grow skills, share learning and promote evidence-based practice across clinical, public health and social care settings.
- Continued development of the Research Engagement Network, working with voluntary and community sector partners to improve inclusion and representation of diverse and underserved communities in health and care research.
- Delivery of the Foundation Research Training Programme by the University of Lincoln and Lincolnshire ICB, supporting research capability development across NHS organisations, local authorities and the voluntary sector.
- Continuation of the ICS Thought Lab series, delivered in collaboration with the University of Nottingham and Nottingham Trent University, to promote the use of research and evidence in service transformation, including integrated neighbourhood working.

As part of the ICB's system leadership role, a robust research governance infrastructure is in place, including an ICS Research Leaders Group and an ICS Research Partners Group, bringing together senior representatives from NHS providers, local authorities, universities and NIHR infrastructure to oversee delivery of the Strategy.

Primary care research capacity continues to be a key focus. The ICB operates a Primary Care Settings Research Strategy Group and has utilised NIHR Research Capability Funding to support Primary Care Research Champions and leadership roles. During 2025/26, 60% of GP practices were part of the NIHR East Midlands Regional Research Delivery Network Research Site Initiative Scheme, an increase from 44% in the previous year. In each of the four Places, more GP practices were participating in the scheme than were not, demonstrating increasing engagement with research activity across primary care.

During the year, 12,166 people in Nottingham and Nottinghamshire participated in 457 unique NIHR research studies, with recruitment taking place across acute, community and primary care settings. Through these arrangements, the ICB has facilitated research activity at scale, strengthened workforce and system capability, and promoted the routine use of research evidence to inform service design and commissioning.

Promoting education and training

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

We satisfy this duty through our system leadership role in developing and delivering our ICS People and Workforce Plan, which can be found on the 'Strategies and Plans' section of our website at https://notts.icb.nhs.uk.

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

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

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

Further details on key education and training activities during 2025/26 are set out within the Performance review section of this Annual Report.. These include workforce development activity linked to quality improvement, patient safety, prevention and population health, digital transformation and research, as well as targeted training to support statutory and mandatory requirements within commissioned services

Promoting integration

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

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

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

During 2025/26, this has continued to be reflected in a range of established and developing partnership arrangements across Nottingham and Nottinghamshire, including the following examples:

- Working jointly with Nottingham City Council and Nottinghamshire County Council, the ICB continued delivery of the ICS Carers Strategy, which was co-produced with carers, health and care partners and VCSE organisations. Through joint commissioning arrangements, this included a single point of access Carers Hub providing advice, assessments and coordinated support with social care; a flexible offer of respite and breaks to support carers' wellbeing; and a single point of access Young Carers Hub offering advice, information and family-focused support for children and young people aged 18 and under.
- The ICB continued to work with Nottingham City Council, Nottinghamshire County Council and the Office of the Police and Crime Commissioner to support the Sexual Violence

Hub and therapy service provided by Nottinghamshire Sexual Violence Support Services. The service provides integrated, trauma-informed support for survivors of sexual violence and assault and acts as a gateway to wider services. A delivery partnership with Nottinghamshire Healthcare NHS Foundation Trust is in place, including the secondment of a Mental Health Practitioner into the service to strengthen links with secondary mental health services and support survivors to access the right care at the right time.

- Integrated neighbourhood working, supported through the development of Integrated Neighbourhood Teams, underpinned the ICB's approach to neighbourhood-level delivery during 2025/26. This approach brings together partners across health, local government and the voluntary, community and social enterprise sector at neighbourhood level, informed by population health data and local insight, and was reflected within strategic commissioning intentions and population health planning. Delivery followed a phased approach, recognising variation in local readiness and the need to align emerging neighbourhood models with developing national guidance, with the ICB working towards embedding a more consistent approach across all Primary Care Networks to support a longer-term shift towards preventative, community-based and more joined-up care.

Through these partnerships and delivery approaches, the ICB continued to promote integration across health, social care and wider services during 2025/26, supporting more coordinated, person-centred care and contributing to improved outcomes and reduced inequalities for the population of Nottingham and Nottinghamshire.

Having regard to the wider effects of decisions

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

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

Across our ICS, we are aligned around a common set of aims and guiding principles, which are described within our Integrated Care Strategy. We have also developed a Joint Forward Plan with our NHS Trust and NHS Foundation Trust partners that describes how our local NHS organisations 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 Joint Strategic Commissioning Committee has a key role in exercising the ICB's commissioning functions and ensures the robustness of decision-making in line with relevant statutory duties and the aims of the ICS. You can read more about the work of this committee in the Governance Statement section of this Annual Report.

Skills, knowledge and experience of members

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

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

and experience that is appropriate for the organisation.

Since the ICB's establishment the Chair and wider Board members have kept these arrangements under review, and during 2025/26 the Board's membership has been amended to align it with the Board memberships of ICB Cluster partners, enabling joint appointments to be made across the three ICBs where permissible. The knowledge skills and experience of members was an explicit consideration in this process. The Board's membership is now comprised of the ICB's Chair and Chief Executive, six Non-Executive Directors, the ICB's Executive Director of Commissioning, Executive Director of Finance, Executive Director of Outcomes (Medical), Executive Director of Quality (Nursing), and Executive Director of Strategy and Citizen Experience, an Ordinary Member for Mental Health, and three Partner Members nominated by our system partner organisations.

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

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

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 Committee Chair is a qualified accountant).

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

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

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

Accountability Report

Signed:

Amanda Sullivan
Accountable Officer

16 June 2026

Corporate Governance Report

Members Report

Composition of the Board

The composition of NHS Nottingham and Nottinghamshire ICB's Board was revised during the year in line with the establishment of formal partnership arrangements with NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB, with the three ICBs operating as an 'ICB Cluster' from 1 November 2025.

The Board's full membership for the period 1 April 2025 to 31 March 2026 is as follows:

Name	Role
Professor Marios Adamou	Non-Executive Director (to 31 October 2025)
Dr Dave Briggs	Medical Director (to 31 October 2025) and Executive Director of Outcomes (from 1 November 2025)
Gary Brown	Non-Executive Director (to 31 October 2025)
John Dunstan	Non-Executive Director (from 1 November 2025)
Margaret Gildea	Non-Executive Director (from 1 November 2025)
Stephen Jackson	Non-Executive Director
Mehrunnisa Lalani	Non-Executive Director
Dr Kelvin Lim	Primary Care Partner Member
Ifti Majid	NHS Trust/Foundation Trust Partner Member (to 31 October 2025)
Victoria McGregor-Riley	Acting Director of Strategy and System Development (to 31 October 2025)
Dr Kathy McLean	Chair
Jon Melbourne	NHS Trust/Foundation Trust Partner Member (from 1 November 2025)
Vicky Murphy	Local Authority Partner Member (to 11 September 2025)
Mark Powell	Ordinary Member for Mental Health (from 1 November 2025)
Maria Principe	Acting Director of Delivery and Operations (to 31 October 2025) and Executive Director of Commissioning (from 1 November 2025)
Clair Raybould	Executive Director of Strategy and Citizen Experience (from 1 November 2025)
Sharon Robson	Non-Executive Director (from 1 November 2025)
Bill Shields	Executive Director of Finance
Adrian Smith	Local Authority Partner Member (from 1 December 2025)
Amanda Sullivan	Chief Executive
Jon Towler	Non-Executive Director (Deputy Chair and Senior Non-Executive member)
Rosa Waddingham	Director of Nursing (to 31 October 2025) and Executive Director of Quality (from 1 November 2025)
Melanie Williams	Local Authority Partner Member (to 31 August 2025)

You can read more about the role of the Board and its work during the year in the Governance Statement contained within this Annual Report.

Member profiles

Full biographies of our Board members are available at https://notts.icb.nhs.uk/about-us/our-icb-board/.

Each director knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware. They have taken all the steps that they ought to have taken to make themselves aware of any such information and to establish that the auditors are aware of it.

Audit and Risk Committee and Audit Committee

The following Non-Executive Directors were members of the Audit and Risk Committee during the period 1 April to 31 October 2025:

- Gary Brown (Chair)
- Marios Adamou
- Stephen Jackson

The following Non-Executive Directors were members of the Audit Committee during the period 1 November 2025 to 31 March 2026, and up to the date of signing the Annual Report and Accounts:

- John Dunstan (Chair)
- Stephen Jackson
- Sharon Robson

The Governance Statement contained within this Annual Report provides further details on all

committees of the Board, including details of their memberships. Details regarding the ICB's Remuneration and Human Resource Committee can also be found in the Remuneration Report section of this Annual Report.

Register of interests

We are committed to ensuring that our organisation inspires confidence and trust, avoiding any potential situations of undue bias or influence in decision-making and protecting the NHS, the ICB, and the individuals involved from any appearance of impropriety.

The ICB maintains appropriate records of declared interests in line with national policy, and the declared interests of all Board members are published at notts.icb.nhs.uk/about-us/our-lists-and-registers.

Further details on how we manage conflicts of interest are detailed in the Governance Statement contained within this Annual 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.

During the year, 26 personal data related incidents and three near-miss incidents were reported. None were classified as serious, and all were managed in line with the ICB's incident reporting and management procedures. There have been no data protection breaches that have required reporting to the Information Commissioner's Office during 2025/26.

Further details of the ICB's Information Governance arrangements can be found within the Governance Statement contained within this Annual Report.

Modern Slavery Act

Our 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 2026 is published on the 'Equality, Inclusion and Human Rights' section of our website at https://notts.icb.nhs.uk.

Statement of Accountable Officer's Responsibilities

Under the NHS 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 NHS Nottingham and Nottinghamshire ICB and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

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

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

The NHS 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 appointed 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 NHS 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 NHS Nottingham and Nottinghamshire ICB's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Governance Statement

Introduction and context

NHS Nottingham and Nottinghamshire ICB is a corporate body established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended). The ICB's statutory functions are set out under the National Health Service Act 2006 (as amended).

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

Upon its establishment, the ICB was delegated responsibility from NHS England for commissioning primary medical services for the people of Nottingham and Nottinghamshire. After this, the ICB took on delegated responsibility from NHS England for commissioning primary dental services and prescribed dental services, primary ophthalmic services and pharmaceutical services and local pharmaceutical services from 1 April 2023, and responsibility for commissioning 71 specialised services (59 specialised acute services from 1 April 2024 and a further 12 specialised mental health and learning disabilities services from 1 April 2025).

Between 1 April 2025 and 31 March 2026, the ICB was not subject to any directions from NHS England issued in accordance with Section 14Z61 of the NHS Act 2006 (as amended).

The Ten Year Health Plan for England, published on 3 July 2025, signals changes to the role, scale and operating model of ICBs. The Plan requires ICBs to refocus on their core role as strategic commissioners, and to operate within substantially reduced running cost allowances. As such, 2025/26 has been a year of significant change for the ICB as the organisation transitions to meet these requirements, ahead of anticipated legislative changes.

During the year, NHS Nottingham and Nottinghamshire ICB has established formal partnership arrangements with NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB, operating as an 'ICB Cluster' in order to harness economies of scale and to strengthen resilience, capability and financial sustainability. Through this model, the three ICBs retain their statutory accountability and local duties and relationships, while working collectively across a wider footprint to share leadership capacity, governance infrastructure and enabling functions.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of NHS Nottingham and Nottinghamshire 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.

On 1 October 2025, I was also appointed as Accountable Officer for NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB. The following sections describe how NHS Nottingham and Nottinghamshire ICB has continued to discharge its own statutory duties and responsibilities, whilst implementing robust governance and assurance arrangements as part of the ICB Cluster.

Governance arrangements and effectiveness

The ICB has a Constitution that sets out the statutory framework within which we operate. The Constitution 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 interest, 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, which sets out functions and decisions that are reserved to the Board, functions and decisions that have been delegated to individuals or to committees, and functions and decisions delegated to another body or bodies or to be exercised jointly with another body or bodies.

The ICB's governing documents, which have all been updated during the year in line with the move to ICB clustering arrangements, are available in the 'About us' section of our website at https://notts.icb.nhs.uk.

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

The Board

The main functions of the Board are to ensure that the ICB has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and in accordance 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.

The Board's membership has changed in year as a result of the formal partnership arrangements established between NHS Nottingham and Nottinghamshire ICB, NHS Derby and Derbyshire ICB, and NHS Lincolnshire ICB, with the three ICBs working together as an ICB Cluster from 1

November 2025. Memberships of the three ICBs' Boards have been aligned, and all Board members other than the Partner Members (which are required to remain as individual ICB appointments) have now been jointly appointed by the three ICBs.

As of 31 March 2026, the Board's membership is comprised of 17 members; the Chair and Chief Executive, six Non-Executive Directors, five Executive Directors, an Ordinary Member for Mental Health, and three Partner Members nominated by system partners. The Partner Members bring knowledge and a perspective from their relevant sectors to the work of the Board; these cover hospital, urgent and emergency care, primary care, and social care. The Board also co-opts a number of participants with speaking rights to attend meetings as required to advise members when discharging their responsibilities; this includes subject matter experts on public health, the voluntary, community and social enterprise sector, governance and organisational change.

The NHS Fit and Proper Person Test Framework applies to all Board members in line with national requirements, and all individuals appointed as Board members during the reporting period satisfied the relevant fitness and propriety requirements.

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

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.

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

The Board meets formally every two months, with extraordinary meeting scheduled as necessary.

Since November 2025, the Boards of NHS Nottingham and Nottinghamshire ICB, NHS Derby and Derbyshire ICB, and NHS Lincolnshire ICB have met in common, facilitating single discussions and providing a single strategic direction for the three clustering ICBs. However, each Board, retained the authority to make decisions independently in accordance with its Constitution and statutory responsibilities.

All meetings during 2025/26 were quorate in accordance with the ICB's Standing Orders and members achieved an average annual attendance of 83%.

During 2025/26, the Board maintained strong oversight of the ICB's statutory responsibilities during a period of significant change, financial constraint and sustained service pressures. A central and recurring focus was the transition to formal ICB clustering arrangements with NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB. The Board received regular assurance on the development and implementation of aligned governance, leadership and operating arrangements, while ensuring that accountability for local statutory duties was preserved. Strategic direction for the ICB Cluster was set through approval of a Five-Year Population Health Strategy, a Five-Year Strategic Commissioning Plan, and a Three-Year Operational Plan, aimed at improving outcomes, reducing inequalities and ensuring equitable access through an increased focus on prevention, strengthened neighbourhood services, digital enablement, and productivity improvements.

The Board also gave sustained attention to the financial position of the ICB and local NHS providers, and to the quality and performance of commissioned services. It scrutinised efficiency requirements, workforce and cost pressures, and delivery against national standards, particularly in relation to urgent and emergency care, elective recovery, mental health services and primary care access, maintaining oversight of providers requiring enhanced support. Citizen stories remained a core feature of Board meetings, reinforcing a consistent focus on lived experience and the impact of decisions on local communities. In parallel, the Board strengthened governance, risk management and assurance arrangements, including regular review of the Board Assurance Framework and strategic risks, ensuring effective

governance, transparency and robust decision-making as the ICB transitioned towards a more strategic commissioning model.

In addition to its formal meetings, the Board also held five development sessions during the year to support continuous improvement in Board effectiveness and collective leadership. These sessions focused on: developing the governance arrangements for the ICB Cluster and understanding the new operating landscape; development of the Five-Year Population Health Strategy, alongside the emerging commissioning intentions and planning priorities for 2026/27; and developing and embedding integrated neighbourhood working, including the ambition for working with voluntary, community and social enterprise partners.

Committees of the Board

Throughout 2025/26, the Board has been supported by a range of committees to discharge its statutory responsibilities and maintain oversight of key areas. All committees are accountable to the Board through agreed terms of reference and routine reporting arrangements. The Board approves and keeps under review the terms of reference for all committees and receives assurance through highlight reports, activity updates and escalation of key risks and decisions.

At its meeting on 20 November 2025 (held in common with meetings of the Boards of NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB), the Board approved a revised committee structure in line with the agreement for the three ICBs to operate under formal partnership arrangements as an ICB Cluster. The new committee structure, which replaced the former committees in place within the individual ICBs, is largely comprised of joint committees of the three Boards, while maintaining separate ICB-specific Audit Committees and Auditor Panels (in line with statutory requirements) that meet in common. Appropriate procedures were followed to transition to the new committee structure and ensure the safe close-down of previous ICB-specific committees. A committee review session was held on 5 March 2026 to support a structured and reflective assessment of the new committee arrangements, focusing on their effectiveness, clarity of purpose and contribution to the ICB Cluster's governance framework. The session enabled Non-Executive and Executive members to articulate the characteristics of high-performing committees, evaluate current strengths and areas for improvement, and agree clear actions to strengthen committee relationships, ways of working and impact. This formed part of the ICB's ongoing approach to assuring itself that its committee structures remain fit for purpose, support effective decision-making, and continue to evolve in line with best practice.

The following sections summarise the committee arrangements in place during 2025/26, including those operating prior to the commencement of ICB clustering arrangements and those established as part of the revised governance model from 20 November 2025. Within these sections, committee membership is described by role rather than by named postholder. During the year, some executive portfolios and job titles changed as part of the ICB clustering arrangements; however, this did not alter the functional basis of membership, and equivalent role holders continued to participate under the revised arrangements in line with the relevant terms of reference.

During the year, all committees operated in accordance with their approved terms of reference, and all meetings were quorate.

Audit and Risk Committee (1 April to 19 November 2025) and Audit Committee (20 November 2025 to 31 March 2026)

Until 19 November 2025, the Audit and Risk Committee provided assurance to the Board on the effectiveness of the ICB's systems of governance, risk management and internal control. From 20 November 2025, these responsibilities were assumed by the Audit Committee, which met in common with the Audit Committees of NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB as part of the revised cluster governance arrangements. A formal handover report supported the transition between the two committees, ensuring continuity of oversight and clear ownership of ongoing priorities, including internal audit actions and risk management arrangements.

Memberships of both Committees were comprised solely of Non-Executive Directors, with the Committees' Chairs having recent and relevant financial experience. Meetings were routinely

attended by the Executive Director of Finance, governance leads, internal and external audit representatives, and the Local Counter Fraud Specialist as required.

The former Audit and Risk Committee met three times and the Audit Committee met twice, with average attendance across the year of 93%. The Committees' key activities during the year included: oversight of the Annual Report and Accounts process; scrutiny of financial stewardship arrangements, including oversight of the implementation of the new ISFE2 financial ledger; approval of internal and external audit plans and review of associated reports; approval of counter fraud plans and monitoring of associated activity; and monitoring of compliance with governing documents. The Committees also oversaw arrangements for risk management, information governance and cyber security, health and safety, emergency preparedness, resilience and response, and standards of business conduct.

Remuneration and Human Resource Committee (1 April to 19 November 2025) and Joint Remuneration and Human Resource Committee (20 November 2025 to 31 March 2026)

Until 19 November 2025, the Remuneration and Human Resource Committee provided assurance to the Board on Very Senior Manager remuneration and succession planning, ICB human resource management, and organisational development. From 20 November 2025, these responsibilities were carried forward by the Joint Remuneration and Human Resource Committee, established jointly by NHS Nottingham and Nottinghamshire ICB, NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB as part of ICB clustering arrangements. A formal handover report supported the transition between the two committees, ensuring continuity of oversight and alignment of work programmes.

Both Committees' memberships were comprised solely of Non-Executive Directors; however, the Committees were supported by relevant subject matter experts and governance leads.

The former Committee met six times with an average attendance of 89%, and the Joint Committee met four times with 100% attendance. The Committees' key areas of focus during the year included: oversight of the ICB's organisational change and staff support processes, including approval of workforce consultations on revised staffing structures and oversight of arrangements for voluntary redundancies; approval of Very Senior Manager remuneration and contractual arrangements; scrutiny of workforce reports, including metrics relating to sickness absence, turnover, and staff wellbeing; oversight of staff communication and engagement mechanisms; and oversight of equality, diversity and inclusion objectives and reporting requirements. The Committees also maintained oversight of actions to mitigate the key operational risks relevant to their remits.

Finance and Performance Committee (1 April to 19 November 2025) and Joint Finance and Performance Committee (20 November 2025 to 31 March 2026)

Until 19 November 2025, the Finance and Performance Committee provided assurance to the Board on the effective discharge of the ICB's statutory financial duties, financial planning, and in-year delivery of national and local health targets and performance standards. From 20 November 2025, these responsibilities were assumed by the Joint Finance and Performance Committee under the revised cluster governance arrangements. A formal handover report supported the transition, ensuring continuity of oversight and transfer of key issues into the Joint Committee's work programme.

Membership of both Committees comprised Non-Executive Directors together with the relevant Executive Directors and Senior Leaders responsible for finance, quality, delivery and operations, medical leadership, and strategy, in line with the applicable terms of reference. The Committees were also routinely supported by relevant subject matter experts and governance leads.

The former Committee met six times with an average attendance of 88%, and the Joint Committee met four times with average attendance of 83%. The Committees' key areas of focus during the year included: the development of financial and operational plans (including capital planning); monitoring delivery of the ICB's statutory financial duties, in-year financial

performance, and productivity and efficiency requirements; scrutiny of operational performance against national standards (including winter planning and performance across urgent and emergency care, elective recovery, diagnostics, cancer, mental health, community services and primary care access); and oversight of the delivery of estates, digital and environmental sustainability priorities. The Committees also maintained oversight of actions to mitigate the key operational risks relevant to their remits.

Quality and People Committee (1 April to 19 November 2025) and Joint Quality and Service Improvement Committee (20 November 2025 to 31 March 2026)

Until 19 November 2025, the Quality and People Committee provided assurance to the Board on quality improvement, clinical effectiveness, medicines optimisation, patient experience, safeguarding, and provider workforce transformation. From 20 November 2025, the core quality and service improvement responsibilities were carried forward by the Joint Quality and Service Improvement Committee under the revised governance arrangements. A formal handover report ensured continuity of oversight and transfer of key priorities into the successor committee.

Membership of both Committees comprised Non-Executive Directors and the relevant Executive Directors and Senior Leaders responsible for quality, medical leadership, delivery and operations, finance, and strategy, in line with the applicable terms of reference. The Committees were also routinely supported by relevant subject matter experts and governance leads.

The former Committee met six times with average attendance of 89%, and the Joint Committee met three times with the same attendance rate. The Committees' key areas of focus during the year included: development of quality improvement plans and priorities, with a focus on reducing inequalities; oversight of service quality, with particular focus on organisations in heightened oversight arrangements and areas subject to enhanced surveillance; scrutiny of patient safety and learning from incidents, complaints, patient experience, and mortality reviews; and monitoring of safeguarding, infection prevention and control, medicines optimisation, and immunisation and vaccination arrangements. The Committees also maintained oversight of actions to mitigate the key operational risks relevant to their remits.

Strategic Planning and Integration Committee (1 April to 19 November 2025) and Joint Strategic Commissioning Committee (20 November 2025 to 31 March 2026)

Until November 2025, the Strategic Planning and Integration Committee oversaw the ICB's strategic commissioning functions and service transformation priorities. From November 2025, these responsibilities were assumed by the Joint Strategic Commissioning Committee. Through these arrangements, the ICB has been able to discharge its responsibilities in relation to planning, service redesign, commissioning compliance and the improvement of population health outcomes. A formal handover report supported the transition between the two Committees and ensured continuity of oversight.

Membership of both Committees comprised Non-Executive Directors together with the Chief Executive and the relevant Executive Directors and Senior Leaders responsible for strategy and citizen engagement, commissioning, finance, and quality. The Committees were also routinely supported by relevant programme, governance and subject matter leads.

The former Committee met seven times and the Joint Committee met three times, with attendance rates of 82% and 92% respectively. The Committees' key areas of focus during the year included: development of the Five-Year Population Health Strategy and Five-Year Strategic Commissioning Plan; scrutiny of progress against major transformation and service redesign priorities, including neighbourhood health, prevention, acute services, urgent care, primary and community care, mental health services, learning disability and autism services, and the management of long-term conditions; monitoring delivery of inequalities priorities and health-equity approaches, including action to reduce disparities in access and outcomes for key population groups; and overseeing arrangements for public and patient involvement and research governance. The Committees also maintained oversight of actions to mitigate the key operational risks relevant to their remits.

Joint Commissioning Executive Group

As part of the transition to clustering arrangements between the three ICBs, the Joint Strategic Commissioning Committee also established the Joint Commissioning Executive Group as a sub-committee to provide a single point of executive-led decision-making relating to resource allocation, investment and disinvestment, and the award of healthcare and non-healthcare contracts.

The Group's membership is comprised of the ICB's Executive Directors and is chaired by the Chief Executive. The Group met on four occasions following its establishment, and average attendance by members was 82%. At these meetings, the Group considered a broad range of commissioning proposals to supported continuity of services and progression of pathway redesign and service transformation, while ensuring that proposals were supported by appropriate clinical, financial, quality and equality considerations and aligned to statutory duties, improved outcomes, reduced inequalities and value for money.

Joint Transition Committee

The Joint Transition Committee was established to oversee delivery of the ICB Cluster transition programme to develop and implement a fit-for-purpose operating model that meets revised national requirements, delivers efficiencies within the management cost envelope, and complies with relevant legal and governance requirements. The Committee will also oversee the safe transfer of ICB functions where required, the capability assessment against the Strategic Commissioning Framework, and preparations for any future merger or boundary change.

Membership comprised Non-Executive Directors, the Chief Executive, and Executive Directors responsible for finance and ICB transition. The Committee met thirteen times during the year, with average attendance of 88%. The Committee's key activities during the year included: development of transition plans, the ICB Cluster operating model, and management of changes processes; oversight of financial affordability and delivery of management cost reductions; and monitoring the impact of Commissioning Support Unit closures. The Committee also maintained oversight of actions to mitigate the key operational risks relevant to its remit.

Auditor Panel

The Auditor Panel exists to advise the Board on the selection and appointment of the organisation's external auditor, with membership comprised of three Non-Executive Directors of the Board.

The Panel met once during the reporting period, with 100% attendance, to consider options relating to the ICB's existing external audit contract.

Joint Non-Executive Remuneration Panel

During 2025/26, the ICB transitioned from its former Non-Executive Remuneration Panel to a new joint panel, established under the revised governance arrangements. The new Panel assumed responsibility for setting the remuneration, fees, allowances and other terms of appointment for Non-Executive members of the Board (excluding the ICB Chair, whose remuneration is determined by NHS England). Membership is comprised of the ICB's Chair and lead for governance.

The Joint Panel met once during the reporting period, with 100% attendance, to consider matters relating to non-executive remuneration.

Other Joint Committees

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

Integrated Care Partnership – Section 116ZA of the Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Care Act 2022), requires ICBs and upper tier Local Authorities to establish Integrated Care Partnerships (ICPs) as equal partners. In Nottingham and Nottinghamshire, an ICP has been established as a joint committee of Nottingham City Council, Nottinghamshire County Council and NHS Nottingham and Nottinghamshire ICB. The primary role of the ICP is to lead on creating an Integrated Care Strategy and Outcomes Framework to reduce health inequalities and improve health and care outcomes and experiences for the Nottingham and Nottinghamshire population. In doing so, the ICP acts as the 'guiding mind' of the local health and care system, providing a forum for NHS leaders and Local Authorities to come together with

important stakeholders from across the wider system and communities.

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

The ICP met once during the reporting period to maintain oversight of delivery against the Integrated Care Strategy.

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

The Committee met four times during the year. Matters considered included the strengthening of governance arrangements in anticipation of the full delegation of specialised services, updates and decisions relating to dental, pharmacy and optometry services, and regular assurance reports on quality, financial performance and service pressures.

UK Corporate Governance Code

NHS bodies are not required to comply with the UK Corporate Governance Code. However, we have reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the ICB.

This Governance Statement is intended to demonstrate how the ICB has regard to the principles set out in the Code considered appropriate for ICBs for the financial year ended 31 March 2026.

For the financial year ended 31 March 2026, and up to the date of signing this statement, the ICB had regard to the provisions set out in the Code. All aspects that the ICB must reference within this statement are fully compliant.

Discharge of Statutory Functions

The ICB has reviewed all of the statutory duties and powers conferred on it by the NHS Act 2006 (as amended) and other associated legislation and regulations. As a result, and as the Accountable Officer, 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, who have confirmed that their structures provide the necessary capability and capacity to undertake all of the ICB's statutory duties.

Risk Management Arrangements and Effectiveness

The ICB has established and maintains a comprehensive risk management framework designed to support the systematic identification, assessment, evaluation and control of risks that may affect the delivery of its statutory duties, strategic objectives and operational priorities. During 2025/26, these arrangements evolved as part of the transition to formal partnership working with NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB. From 20 November 2025, a joint Risk Management Policy was implemented across the three organisations to support a consistent and collaborative approach, while preserving each ICB's individual statutory responsibilities.

The framework distinguishes between strategic and operational risks. Strategic risks are managed through the Board Assurance Framework, which

enables the Board to identify principal risks to the achievement of strategic objectives and to assess the effectiveness of controls and assurances in place. The Board Assurance Framework operates as a continuous process, informing Board and committee work programmes and ensuring that appropriate assurance is obtained throughout the year. Each strategic risk is owned by an Executive Director and is subject to regular review and update.

Operational risks arising from day-to-day delivery are managed through the Operational Risk Register and are owned by members of the Senior Leadership Team. Risks are identified through routine management processes, audit activity, risk assessments, incident reporting and committee scrutiny. All risks are assessed using a consistent scoring methodology based on impact and likelihood, with mitigating actions identified, monitored and reviewed.

From November 2025, the introduction of a joint risk matrix, shared risk appetite statement and aligned risk classification strengthened consistency in risk assessment, reporting and escalation across the three ICBs. A separate fraud risk register is also maintained and reported to the Audit Committee (or equivalent) as part of the annual fraud risk assessment, with mitigating controls embedded within the wider system of internal control.

Capacity to Handle Risk

The ICB's capacity to manage risk is underpinned by clear leadership, defined accountabilities and effective governance and assurance arrangements. The Board retains overall responsibility for risk management and provides strategic leadership through oversight of the Board Assurance Framework, supported by its committees. The Audit Committee (or equivalent) has delegated responsibility for reviewing the adequacy and effectiveness of the ICB's risk management framework and internal control environment.

Executive Directors and Senior Leaders are accountable for managing risks within their respective portfolios, ensuring that risks are identified promptly, escalated appropriately and managed within the agreed risk appetite. Strategic risks are owned by Executive Directors, while operational risks are managed through established leadership and management structures, with regular reporting to relevant committees and escalation to the Board where required.

The ICB has established clear reporting lines and escalation routes to support timely and accurate visibility of risks affecting compliance with statutory obligations, service delivery, quality, workforce and financial sustainability. The revised joint arrangements introduced in November 2025 strengthened consistency and comparability of risk reporting across the three ICBs and supported more effective collective scrutiny through the aligned committee structure.

Risk management capability is supported through training, guidance and advice provided by officers with specialist governance and risk expertise. This promotes consistent application of the Risk Management Policy and supports staff and committees to understand and discharge their responsibilities. Consideration of the potential impact of risks on patients, the public and other stakeholders is embedded within risk assessment and management processes, supporting informed decision-making and transparent communication.

Risk Assessment

During 2025/26, the ICB undertook regular assessment and review of risks that could affect delivery of its statutory functions, service performance, quality of care and financial sustainability. The ICB's risk profile reflected significant operational pressures across health and care services, alongside risks associated with financial recovery, workforce resilience, digital transformation and the transition to aligned ICB cluster arrangements. Risks were reviewed through established governance and reporting arrangements, with mitigating actions in place and escalation where required.

The most significant operational risks during the year related to system capacity and flow, particularly within urgent and emergency care, hospital discharge, elective recovery, and cancer services. Sustained demand pressures and capacity constraints also affected mental health services, including access to community provision and availability of inpatient beds, with potential impacts on patient experience, outcomes and system costs.

Quality-related risks remained a key focus, including the need to sustain improvements within commissioned provider organisations and to maintain public confidence in services such as maternity, mental health and primary care. Risks affecting people with learning disabilities and autistic people were monitored closely, particularly where insufficient community-based support or accommodation could result in prolonged inpatient stays.

The risks relating to the wellbeing and resilience of the ICB's workforce were also monitored, recognising the potential impact of high workloads and staffing pressures on sickness absence, retention and productivity.

Financial risks remained significant, reflecting rising costs, delivery of efficiency requirements and the need to maintain financial sustainability while progressing transformation programmes.

Digital and cyber risks were assessed throughout the year, including risks associated with digital transformation capacity, implementation of new systems and the potential impact of cyber threats on service continuity and data security.

As part of its aligned governance arrangements, the ICB also shared a number of risks with NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB. These included risks associated with the planned closure of commissioning support services, delivery of ICB priorities during organisational change, workforce change affordability, and the effectiveness of communication during transition. These shared risks were subject to joint oversight and assurance arrangements, while maintaining accountability for local statutory responsibilities.

Across all risk areas, mitigating actions were monitored through the ICB's risk management framework, with progress reviewed by relevant committees and the Board. The ICB will continue to review its risk profile to ensure that emerging risks are identified promptly and managed effectively in line with its risk appetite.

Other Sources of Assurance:

Internal Control Framework

A system of internal control is the set of processes and procedures the ICB has in place to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise risks, including evaluation of the likelihood of those risks being realised and the impact should they be realised, and enables risks to be managed efficiently, effectively and economically.

The system of internal control also allows risks 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 management forums and the work of the Board and its committees. Of note is the role of the Audit Committee (or equivalent) in relation to the scrutiny of the ICB's integrated governance, risk management and internal control arrangements.

Management of Conflicts of Interest

The National Health Service Act 2006 (as amended) places specific duties on ICBs in relation to the management of conflicts of interest. NHS England guidance requires ICBs to have clear and well-communicated processes, defined roles and responsibilities, appropriate advice, training and support, and arrangements for maintaining and publishing registers of interests.

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

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

and committee meeting arrangements and during procurement exercises.

Data Quality

The ICB recognises that good quality data is essential for the effective commissioning of services and underpins the delivery of high-quality patient care. Data quality is central to the ICB'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 of the Board are also responsible for assuring themselves of the quality of data informing their decisions, and this duty is built into their respective terms of reference. This includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data. No issues have been raised by the Board or its committees regarding the quality of data received during the reporting period.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance 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 and procedures designed to ensure that risks to confidentiality and data security are effectively managed and controlled.

The roles of Senior Information Risk Owner and Caldicott Guardian have been assigned to appropriate members of the Executive Team. The ICB also has a designated Data Protection Officer in line with the requirements of the UK General Data Protection Regulation. The Audit Committee (or equivalent) is responsible for scrutinising the ICB's compliance with legislative and regulatory requirements relating to information governance, including data protection and cyber security, and the extent to which associated systems and processes are effective and embedded.

All staff are required to undertake annual information governance training, supplemented by role-specific training and awareness activity where appropriate. Staff are supported through induction materials, guidance and access to in-house expertise in relation to confidentiality, data protection and information security. Processes are in place for incident reporting and investigation of serious information incidents, and arrangements for information risk assessment and management continue to be developed and embedded across the organisation.

The ICB is anticipating full compliance with the requirements of the Data Security and Protection Toolkit by the submission deadline of 30 June 2026. Progress is monitored through operational management oversight arrangements and is periodically reported to the Audit Committee (or equivalent).

Business Critical Models

The ICB does not currently use any business-critical analytical models. However, it remains committed to applying the principles of the MacPherson Review and will ensure that any future models classified as business-critical are subject to appropriate quality assurance.

Third party assurances

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

- Arden and Greater East Midlands CSU – Payroll Services

- NHS Shared Business Services – Employment Services
- NHS Shared Business Services – Finance and Accounting Services
- NHS Business Services Authority – Prescription Payments
- Capita – GP Payment Services
- NHS Business Services Authority – Electronic Staff Record (ESR) system
- NHS Business Services Authority – Dental Payments

The majority of these reports resulted in unqualified audit opinions, with only a small number of minor control exceptions identified. These exceptions related to isolated instances of delays in processing, gaps in independent verification, and limited weaknesses in access controls and transactional approvals. These findings were not considered material to the overall control environment.

One report, relating to GP Payment Services (Capita), received a qualified opinion. This was due to isolated control weaknesses identified in relation to the accuracy of data updates within pension systems and the validation of bank detail changes. These matters are subject to ongoing monitoring and engagement with the service provider.

No control exceptions were identified in relation to prescription payments, the Electronic Staff Record (ESR) system, or dental payment services.

Control Issues

There have been no significant control issues identified during the period 1 April 2025 to 31 March 2026.

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

The ICB's Board has oversight of the appropriateness of the organisation's arrangements to exercise its functions effectively, efficiently and economically, and as Accountable Officer, I have overall executive responsibility for the use of resources. The following key processes and review and assurance mechanisms have been established within the organisation to ensure that we meet our statutory duty to act effectively, efficiently and economically:

- Clear Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions have been set out to ensure proper stewardship of public money and assets. The ICB also has clear policies in relation to the required standards of business conduct.
- A Procurement and Provider Selection Policy is in place, which reflects the requirements of the NHS Provider Selection Regime. The Policy sets out the organisation's approach for establishing contracts that provide value for money, in line with the principles of good procurement practice, and clearly requires the ICB to ensure the delivery of improved efficiency and effectiveness in the provision of healthcare and non-healthcare services. The Audit Committee (or equivalent) oversees compliance with the requirements of the NHS Provider Selection Regime relating to annual reporting, monitoring and publication arrangements, including review of all provider representations received in relation to procurement and contract award decisions for healthcare services. The Committee also scrutinises all instances where requirements for formal competitive tendering have been waived in relation to non-healthcare services.
- The ICB has a strategic decision-making framework and service review process, which ensure 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 Executive Director of Finance

provides reports to every meeting of the Board and the Joint Finance and Performance Committee (or equivalent) on financial performance, including performance against the organisation's statutory financial duties and the delivery of required efficiencies. As detailed in the Financial Review element of this report the ICB failed to meet its statutory financial breakeven duty in 2025/26. Therefore, under the National Health Service Act 2006, the ICB has not discharged its duties under sections 223GB to 223N (financial duties).

- The Joint Remuneration and Human Resource Committee (or equivalent) is in place with responsibility for reviewing the remuneration and terms of service for key senior leaders within the ICB. Suitable arrangements have been established to ensure that no member of the Committee participates in discussions and decisions about their own remuneration.
- The ICB has clear internal audit, external audit and counter fraud arrangements, which provide independent assurance to the organisation on a range of systems and processes that are designed to deliver economy, efficiency and effectiveness, including the organisation's annual accounts and reporting process.

Commissioning of delegated services (primary care services and specialised services)

The ICB signed a delegation agreement with NHS England and held full commissioning responsibilities for delegated services during the 2025/26 reporting period.

To the best of the ICB leadership's knowledge, all delegated services were commissioned in accordance with 2025/26 delegation agreements and national service specifications.

The ICB leadership is able to provide the necessary evidence of compliance with the delegation agreements, any associated developmental requirements and national service specifications, and to show how effectively the delegated functions are operating (either directly or via multi-ICB working arrangements) should NHS England or a third party ask for such evidence.

Delegation of ICB 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. Oversight of the ICB's partnership arrangements is performed by the Joint Strategic Commissioning Committee (or equivalent). No issues have been raised during the reporting period.

Counter Fraud Arrangements

The ICB has established arrangements to prevent and manage fraud, bribery and corruption. 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 Executive Director of Finance has executive responsibility for the ICB's counter fraud arrangements, with the Audit Committee (or equivalent) taking an oversight and scrutiny role in this area.

NHS organisations are required to demonstrate their compliance across 13 key counter fraud requirements through the annual self-assessment process the Government Functional Standard 013: Counter Fraud. The ICB has achieved an overall 'Green' rating for 2025/26.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 April 2025 to 31 March 2026 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control. The Head of Internal Audit Opinion 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". During the year, Internal Audit issued the following audit reports:

Audit	Level of assurance
Data Security and Protection Toolkit	Low risk/high confidence *(Opinion in line with the DSPT Independent Assessment Framework)*
Operational Risk Management	Significant
Fit and Proper Persons Test	Significant
Board Assurance Framework	Significant
Delivery of Operational Plans – Governance Review	Significant
Cost Improvement Plan Governance	Significant

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, and my review is also 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 this review by the Board, the Audit Committee (or equivalent) and other committees, and plans to address any weaknesses and to ensure continuous improvement are in place.

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

Conclusion

My review of the effectiveness of governance, risk management and internal control has confirmed that the ICB has a generally sound system of internal control that supports the achievement of its policies, aims and objectives, and that there have been no significant control issues during the period 1 April 2025 to 31 March 2026.

Remuneration and Staff Report

Remuneration report

The Remuneration and Human Resource Committee

Up until 19 November 2025, the Remuneration and Human Resource Committee operated as a committee of NHS Nottingham and Nottinghamshire ICB. During 2025/26, new governance arrangements were implemented to support formal partnership working across the Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire ICBs. From 20 November 2025, the Committee transitioned to operate as a Joint Remuneration and Human Resource Committee of the three ICBs.

Our Remuneration and Human Resource Committee's membership is comprised entirely of Non-Executive Directors from our Board. The following Non-Executive Directors were members of the Remuneration and Human Resources Committee during the period 1 April to 19 November 2025:

- Mehrunnisa Lalani (Chair)
- Dr Kathy McLean
- Jon Towler
- Professor Marios Adamou

The following Non-Executive Directors were members of the Joint Remuneration and Human Resource Committee during the period 20 November 2025 to 31 March 2026, and up to the date of signing the Annual Report and Accounts:

- Margaret Gildea (Chair)
- Dr Kathy McLean
- Jon Towler
- Mehrunnisa Lalani

We have also established a Non-Executive Director Remuneration Panel to agree the salaries of the ICB's Non-Executive Directors. Members of the Panel are the ICB's Chair (whose salary is determined by NHS England) and the ICB's Director of Corporate Governance and Assurance.

Further details on the work of the Remuneration and Human Resource Committee and the Non-Executive Director 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 (subject to audit)

2025/26	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	25.29%	-
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	2.80%	-

2024/25	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	5.00%	-
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	6.75%	-

During 2025/26, employees were awarded a 3.6% (2024/25: 5.5%) pay uplift under the Governments' Agenda for Change pay award. The ICB's Very Senior Managers received an uplift of 3.25%.

As part of this restructuring, the ICB has partnered with NHS Derby and Derbyshire ICB and Lincolnshire ICB resulting in increased salaries for the Executive Team, which is reflected in the highest paid director change above.

Pay ratio information (subject to audit)

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director/member in their organisation against the 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/member in the ICB in the reporting period 1 April 2025 to 31 March 2026 was £270,000 to £275,000 (2024-25: £215,000 to £220,000). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

The calculation of the 25th percentile, median, and 75th percentile remuneration of the workforce includes the remuneration of members of the Board but excludes the highest paid director/member.

The tables below show the relationship between the remuneration of the highest-paid director in their organisation against the 25th percentile, median, and 75th percentile of remuneration of the organisation's workforce as of 31 March 2026 and 31 March 2025.

2025/26	25th percentile	Median pay ratio	75th percentile
Total remuneration (£)	£38,383	£54,288	£68,101
Salary component of total remuneration (£)	£38,383	£54,288	£68,101
Pay ratio information	7.10:1	5.02:1	4.00:1

2024/25	25th percentile	Median pay ratio	75th percentile
Total remuneration (£)	£37,378	£52,809	£66,247
Salary component of total remuneration (£)	£37,378	£52,809	£66,247
Pay ratio information	5.83:1	4.12:1	3.28:1

During the reporting period 2025/26, no employees received remuneration in excess of the highest-paid director/member (2024/25: nil).

Remuneration ranged from £16,000 to £271,032 (2024/25: £16,000 to £215,759). 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 and Executive Management Team.

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

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

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

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

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

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

	1 April 2025 to 31 March 2026:						1 April 2024 to 31 March 2025:					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100[1]	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100[1]	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
Name and title	**£000**	**£**	**£000**	**£000**	**£000**	**£000**	**£000**	**£**	**£000**	**£000**	**£000**	**£000**
Professor Marios Adamou, Non-Executive Director	5-10	0	0-0	0-0	0-0	5-10	15-20	0	0	0	0	15-20
Dr Dave Briggs, Executive Director of Outcomes (Medical)	125-130	0	0-0	0-0	22.5-25	150-155	160-165	0	0	0	42.5-45	205-210
Gary Brown, Non-Executive Director	5-10	100	0-0	0-0	0-0	5-10	0-5	0	0	0	0	0-5
Lucy Dadge, Director of Integration	-	-	-	-	-	-	70-75	0	0	0	0	70-75
Helen Dillistone, Executive Director of Transition	25-30	0	0-0	0-0	10-12.5	35-40	-	-	-	-	-	-
John Dunstan, Non-Executive Director	0-5	0	0-0	0-0	0-0	0-5	-	-	-	-	-	-
Margaret Gildea, Non-Executive Director	0-5	0	0-0	0-0	0-0	0-5	-	-	-	-	-	-
Stephen Jackson, Non-Executive Director	10-15	0	0-0	0-0	0-0	10-15	15-20	0	0	0	0	15-20
Mehrunnisa Lalani, Non-Executive Director	15-20	0	0-0	0-0	0-0	15-20	0-5	0	0	0	0	0-5
Dr Kelvin Lim, Primary Care Partner Member	25-30	0	0-0	0-0	0-0	25-30	15-20	0	0	0	0	15-20
Ifti Majid, NHS Trust/Foundation Trust Partner Member	0	0	0	0	0	0	0	0	0	0	0	0
Caroline Maley, Non-Executive Director	-	-	-	-	-	-	5-10	0	0	0	0	5-10
Victoria McGregor Riley, Executive Director of Strategy and System Development	85-90	0	0-0	0-0	35-37.5	120-125	70-75	0	0	0	117.5-120	190-195
Dr Kathy McLean, Chair	45-50	300	0-0	0-0	0-0	45-50	60-65	0	0	0	0	60-65
Jon Melbourne, NHS Trust/Foundation Trust Partner Member	0	0	0	0	0	0	-	-	-	-	-	-
Vicky Murphy, Local Authority Partner Member	0	0	0	0	0	0	0	0	0	0	0	0
Mark Powell, Ordinary Member for Mental Health	0	0	0	0	0	0	-	-	-	-	-	-
Stuart Poynor, Director of Finance	-	-	-	-	-	-	45-50	0	0	0	0	45-50
Marcus Pratt, Director of Finance	-	-	-	-	-	-	110-115	0	0	0	102.5-105	215-220
Maria Principe, Executive Director of Commissioning	110-115	0	0-0	0-0	80-82.5	190-195	70-75	0	0	0	85-87.5	160-165
Clair Raybould, Executive Director of Strategy and Citizen Experience	25-30	0	0-0	0-0	25-27.5	50-55	-	-	-	-	-	-
Paul Robinson, NHS Trust/Foundation Trust Partner Member	-	-	-	-	-	-	0	0	0	0	0	0
Sharon Robson, Non-Executive Director	0-5	0	0-0	0-0	0-0	0-5	-	-	-	-	-	-
Bill Shields, Executive Director of Finance	100-105	0	0-0	0-0	560-562.5	660-665	-	-	-	-	-	-
Adrian Smith, Local Authority Partner Member	0	-	0	0	0	0	-	-	-	-	-	-

[1] Taxable expenses and benefits in kind are expressed to the nearest £100

	1 April 2025 to 31 March 2026:						1 April 2024 to 31 March 2025:					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100[1]	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100[1]	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
Name and title	**£000**	**£**	**£000**	**£000**	**£000**	**£000**	**£000**	**£**	**£000**	**£000**	**£000**	**£000**
Amanda Sullivan, Chief Executive	155-160	0	0-0	0-0	0-0	155-160	215-220	0	0	0	0	215-220
John Towler, Non-Executive Director	10-15	0	0-0	0-0	0-0	10-15	15-20	0	0	0	0	15-20
Rosa Waddingham, Executive Director of Quality (Nursing)	120-125	0	0-0	0-0	55-57.5	175-180	155-160	0	0	0	25-27.5	185-190
Catherine Underwood, Local Authority Partner Member	-	-	-	-	-	-	0	0	0	0	0	0
Melanie Williams, Local Authority Partner Member	0	0	0	0	0	0	0	0	0	0	0	0

Notes

1. Due the national restructuring of the NHS, there have been a number of changes to the members of the Board, due to the ICB entering into a formal partnership arrangement with NHS Derby and Derbyshire ICB and Lincolnshire ICB.
2. Victoria McGregor-Riley, Professor Marios Adamou, and Gary Brown ceased in role on 31 October 2025.
3. The following became members of the Board for NHS Nottingham and Nottinghamshire ICB on 1 November 2025, and are jointly appointed as Board members of NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB:
   - John Dunstan (Full year equivalent remuneration is £15,000 to £20,000).
   - Margaret Gildea (Full year equivalent remuneration is £15,000 to £20,000).
   - Clair Raybould (Full year equivalent remuneration is £165,000 to £170,000).
   - Sharon Robson (Full year equivalent remuneration is £20,000 to £25,000).

   The table above includes the share of their remuneration and expense payments for NHS Nottingham and Nottinghamshire ICB only, based on population size.
4. Dr Kathy McLean maintained her Board membership with NHS Nottingham and Nottinghamshire ICB throughout the year. Her remuneration and expense payments from 1 April to 30 September 2025 are wholly reported within NHS Nottingham and Nottinghamshire ICB values above. However, from 1 October 2025 to 31 March 2026, she was jointly appointed with NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB and the table above includes the share of her remuneration for this period for NHS Nottingham and Nottinghamshire ICB only, based on population size. Full year equivalent remuneration is £110,000 to £115,000.
5. Bill Shields maintained his Board membership with NHS Nottingham and Nottinghamshire ICB throughout the year. From 1 April to 30 September 2025, he was jointly appointed with NHS Derby and Derbyshire ICB and the table above includes the share of his remuneration for this period for NHS Nottingham and Nottinghamshire ICB only, based on population size. From 1 October 2025 to 31 March 2026, he was jointly appointed with NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB and the table above includes the share of his remuneration for this period for NHS Nottingham and Nottinghamshire ICB only, based on population size. Full year equivalent remuneration is £225,000 to £230,000.
6. Amanda Sullivan maintained her Board membership with NHS Nottingham and Nottinghamshire ICB throughout the year. Her remuneration and expense payments from 1 April to 30 September 2025 are wholly reported within NHS Nottingham and Nottinghamshire ICB values above. However, from 1 October 2025 to 31 March 2026, she was jointly appointed with NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB and the table above includes the share of her remuneration for this period for NHS Nottingham and Nottinghamshire ICB only, based on population size. Full year equivalent remuneration is £240,000 to £245,000.
7. The following maintained their Board membership with NHS Nottingham and Nottinghamshire ICB throughout the year; however, they were jointly appointed with NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB from 1 November 2025:
   - Dr Dave Briggs (Full year equivalent remuneration is £170,000 to £175,000).
   - Stephen Jackson (Full year equivalent remuneration is £15,000 to £20,000).
   - Mehrunnisa Lalani (Full year equivalent remuneration is £20,000 to £25,000).
   - Maria Principe (Full year equivalent remuneration is £150,000 to £155,000).
   - Jon Towler (Full year equivalent remuneration is £15,000 to £20,000).
   - Rosa Waddingham (Full year equivalent remuneration is £165,000 to £170,000).

   Their remuneration and expense payments from 1 April to 31 October 2025 are wholly reported within NHS Nottingham and Nottinghamshire ICB values above. However, the values from 1 November 2025 to 31 March 2026 have been shared across NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB, based on population size, with the above table including the share for NHS Nottingham and Nottinghamshire only.
8. No payments were made to Partner Members from Local Authorities or NHS Trusts/Foundation Trusts, nor were recharges made by their employers.
9. Helen Dillistone was appointed as a member of NHS Nottingham and Nottinghamshire ICB's Executive Management Team on 1 November 2025, as a joint appointment with NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB. Her remuneration and expense payments from 1 November 2025 to 31 March 2026 have been shared across NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB, based on population size, with the above table including the share for NHS Nottingham and Nottinghamshire only. Full year equivalent remuneration is £150,000 to £155,000.
10. Bill Shields rejoined the NHS Pension Scheme during the year 2025/26. Due to a period of absence from the scheme, in addition to the ICB Executive salary received, the in-year pension benefit is significantly higher than the employer contributions made of £ £14,893.30.
11. The job titles shown in the remuneration tables reflect positions held as at 31 March 2026. Some individuals may have held different roles during the reporting period. Details of appointments, role changes and periods of office are provided in the Members' Report.

Pension benefits (subject to audit)

The information below is based on data provided by the NHS Business Services Authority.

The employer's contribution rate to pension benefits is set nationally and applied as a percentage of pensionable pay during the reporting period.

Pension figures included in the tables below are for senior managers and include their total NHS service, not just the pension benefits accrued during the year under disclosure.

Where an individual has been in post for only part of the year, their pension figures are time-apportioned to reflect their period in post.

Members of the NHS Pension Scheme are able to make additional voluntary contributions alongside their regular contributions.

The calculation of the real increase in Cash Equivalent Transfer Value (CETV) includes allowance for employee contributions. It should be noted that, on some occasions, a small proportion of employee contributions may relate to a previous financial year.

Pension benefits as at 31 March 2026	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2026 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2025	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2026	(h) Employers Contribution to partnership pension
Name and title	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Dr Dave Briggs, Executive Director of Outcomes	0-2.5	0-2.5	35-40	80-85	751	26	820	0
Helen Dillistone, Executive Director of Transition	0-2.5	0-2.5	50-55	120-125	1,000	11	1,106	0
Victoria McGregor Riley, Director of Strategy and System Development	0-2.5	0-2.5	40-45	95-100	853	37	950	0
Maria Principe, Executive Director of Commissioning	2.5-5	5-7.5	45-50	105-110	873	83	1,017	0
Clair Raybould, Executive Director of Strategy and Citizen Experience	0-2.5	2.5-5	45-50	110-115	850	27	1,047	0
Bill Shields, Executive Director of Finance	25-27.5	80-82.5	55-60	175-180	-	0	29	0
Rosa Waddingham, Executive Director of Quality	2.5-5	0-0	60-65	0-0	864	47	962	0

Pension benefits as at 31 March 2025	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2025 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2024	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2025	(h) Employers Contribution to partnership pension
Name and title	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Dr Dave Briggs, Medical Director	2.5-5	0	35-40	75-80	650	37	751	0
Lucy Dadge, Director of Integration	0	0	5-10	0	95	8	126	0
Rosa Waddingham, Director of Nursing	0-2.5	0	55-60	0	769	24	864	0
Victoria McGregor Riley, Director of Strategy and System Development	2.5-5	5-7.5	35-40	90-95	667	62	853	0
Marcus Pratt, Director of Finance	2.5-5	5-7.5	35-40	90-95	606	68	754	0
Maria Principe, Director of Delivery and Operations	0-2.5	2.5-5	40-45	95-100	723	43	873	0

Notes

1. The real increase in pension, real increase in pension lump sum and real increase in Cash Equivalent Transfer Value (CETV) are all shown as the amount apportioned to NHS Nottingham and Nottinghamshire ICB for the 2025/26 year, in line with the ICB's formal partnership arrangement with NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB, with amounts apportioned based on population size. The full real increases are:
   - Dr Dave Briggs: Full Increase in pension band: 2.5-5, full increase in lump sum band: 0.5-2.5, full increase in CETV: 34.
   - Helen Dillistone: Full Increase in pension band: 2.5-5, full increase in lump sum band: 2.5-5, full increase in CETV: 69.
   - Maria Principe: Full Increase in pension band: 5-7.5, full increase in lump sum band: 7.5-10, full increase in CETV: 110.
   - Clair Raybould: Full Increase in pension band: 7.5-10, full increase in lump sum band: 15-17.5, full increase in CETV: 163.
   - Bill Shields: Full Increase in pension band: 55-57.5, full increase in lump sum band: 177.5-180, full increase in CETV: 1.
   - Rosa Waddingham: Full Increase in pension band: 2.5-5, full increase in lump sum band: 0.0-0.0, full increase in CETV: 63.
2. The Department of Health and Social Care Group Accounting Manual confirms that where a senior manager has opted out of the pension arrangements for the whole of the year, no pension figures should be reported and this guidance has been applied. Amanda Sullivan opted out of the pension arrangements during the reporting period.

Cash equivalent transfer values (subject to audit)

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).

Pension disclosures for members affected by the public service pensions remedy

On 1 April 2015, the government made changes to public service pension schemes which treated members differently based on their age. The public service pensions remedy puts this right and removes the age discrimination for the remedy period, between 1 April 2015 and 31 March 2022. Part 1 of the remedy closed the 1995/2008 Scheme on 31 March 2022, with active members becoming members of the 2015 Scheme on 1 April 2022. For Part 2 of the remedy, eligible members had their membership during the remedy period in the 2015 Scheme moved back into the 1995/2008 Scheme on 1 October 2023.

Where members are affected by the Public Service Pensions Remedy, and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023, this is disclosed as a note to the Pension Benefits table.

Compensation on early retirement or for loss of office

No compensation payments on early retirement or for loss of office were made to Directors or Very Senior Managers during the year.

Payments to past directors

There were no payments made to past Directors during the year in respect of loss of office, redundancy, or other termination benefits.

Staff report

Number of senior managers and staff composition

The following table provides a breakdown of our workforce by pay band and gender as of 31 March 2026:

Pay band	Female	Male	Number
Band 1	0	0	0
Band 2	0	0	0
Band 3	25	3	28
Band 4	46	7	53
Band 5	63	4	67
Band 6	98	29	127
Band 7	94	29	123
Band 8a	71	23	94
Band 8b	43	14	57
Band 8c	26	8	34
Band 8d	16	8	24
Band 9	9	2	11
Very senior managers (non-Board members)	6	8	14
Any other spot salary (non-Board members)	4	4	8
Board members	3	2	5
Totals	**504**	**141**	**645**

Sickness absence data

Sickness absence data for the ICB for the period January to December 2025 has been provided by NHS England using the NHS Electronic Staff Record (ESR) system. While total days lost and available are based on whole-time equivalent staffing, the key measure is the average working days lost per employee, which was 7.6 days in 2025.

Total days lost (whole-time equivalent)	7248
Total days available (whole-time equivalent)	214,775
Average working days lost due to sickness absence (per whole-time equivalent)	**7.6**

Staff turnover percentages

The ICB's staff turnover rate (staff leaving the organisation) during the reporting period was 8.7% (on a whole-time equivalent basis).

Staff engagement percentages

The ICB participated in the 2025 NHS Staff Survey, published in March 2026. The survey provides insight into staff experience, engagement and wellbeing, and is structured around the NHS People Promise framework. The ICB achieved a response rate of 62%, which places it within the upper range of response rates across the ICBs participating in the survey.

The results highlighted a number of strengths, including positive and supportive relationships with line managers, respectful team working and inclusive behaviours at local team level. These themes were consistently identified across People Promise domains relating to compassionate leadership, team culture and inclusion.

The results also identified ongoing challenges, including pressures relating to workload, work-related stress and staff wellbeing, which mirror national NHS Staff Survey trends. Engagement and advocacy scores remain an important area of focus, particularly in the context of the organisational change and transition experienced during the year.

The ICB's Executive Team has reviewed the survey findings, which were also considered through established workforce governance arrangements, including consideration alongside wider staff experience, equality and wellbeing matters. Actions to respond to survey findings are being taken forward through existing workforce, wellbeing and inclusion programmes, with oversight through the Joint Remuneration and Human Resource Committee on behalf of the Board.

Staff policies and other employee matters

The ICB has policies in place to provide guidance to all employees. It remains committed to being a fair and inclusive employer and to maintaining a working environment that promotes the health, wellbeing and engagement of its workforce.

During 2025/26, the ICB operated through a period of planned organisational change as it transitioned to an ICB cluster operating model. This was managed through a formal Management of Change process, overseen through the transition programme and kept under regular review. Workforce change was delivered through a structured and phased approach intended to maintain delivery of statutory responsibilities while supporting staff through a period of significant change.

The process was supported by aligned human resource policies, including the cluster-wide Change Management and Pay Protection Policy, which provided a consistent framework for consultation, redeployment, pay protection and redundancy avoidance across all three ICBs. Developed in partnership with recognised trade unions, subject to Equality Impact Assessment, and approved through the appropriate governance arrangements, the policy informed all stages of workforce transition during 2025/26.

The Management of Change process was also informed throughout by consideration of staff impact, including regular reporting on workforce risks, capacity and wellbeing. The ICB sought to support staff through regular and transparent communication, including briefings and updates, access to human resource and organisational development advice, and a wellbeing offer adapted in response to emerging pressures. Arrangements were kept under review to ensure that the timing, sequencing and cumulative effect of change remained appropriate and proportionate.

The ICB promotes and delivers effective people management through a range of policies and procedures, including those relating to recruitment and selection, pay and benefits, flexible working, training and development, and the management of employee relations. Equality, diversity and inclusion considerations are embedded across policies and decision-making, including arrangements to protect employees from harassment, victimisation and discrimination. The ICB continues to work in line with the requirements of the NHS Workforce Race Equality Standard (WRES) and the NHS Workforce Disability Equality Standard (WDES), which support fair access to career opportunities and equitable treatment for staff from black and minority ethnic backgrounds and for staff who identify as disabled.

The ICB is accredited under the Disability Confident Employer Scheme, which supports inclusive recruitment and employment practice for disabled people. As part of this commitment, the organisation operates a Guaranteed Interview Scheme, offering an interview to applicants who declare a disability and meet all the essential criteria for a role.

The Sickness Absence Policy provides specific support for disabled employees and reflects the requirements of the Equality Act 2010. Where an employee is disabled within the meaning of the Act, or becomes disabled during employment, every effort is made to identify and implement reasonable adjustments or suitable alternative roles, where appropriate. During the year, the ICB has continued to support staff with complex health conditions and those undergoing neurodiversity assessments, enabling individuals to remain in employment and contribute effectively in the workplace. In some cases, these assessments have resulted in employees being recognised as disabled under the Equality Act 2010.

The ICB's Equality Improvement Plan includes workforce-focused objectives aimed at ensuring that the organisation is inclusive and that its workforce, at all levels, reflects the diverse communities it serves across Nottingham and Nottinghamshire. Workforce profile data continues to be monitored, alongside delivery of action plans arising from WRES, WDES and the NHS Equality Delivery System, with oversight through established governance arrangements.

The ICB continues to support a number of staff networks, including the Staff Engagement Group, LGBTQ+ Staff Network, Staff Disability and Wellbeing Network, and Race Equity Staff Network, each with an Executive sponsor. These networks continued to play an important role during the Management of Change process, providing insight into staff experience and contributing to the organisation's understanding of the impact of change on different groups of employees.

As part of the transition programme, the ICB implemented a nationally approved Voluntary Redundancy Scheme during 2025/26, in line with NHS England requirements. The scheme was intended to minimise the need for compulsory redundancies and formed one element of the wider Management of Change approach. It was applied consistently and fairly, supported by consultation with staff and recognised trade unions, informed by an Equality Impact Assessment, and overseen through established governance arrangements. Human resource teams provided direct support to staff considering the scheme, alongside access to wellbeing support, recognising the personal impact of exit decisions.

The ICB meets its responsibilities under health, safety and fire legislation and remains committed to a culture of health and safety awareness.

Robust arrangements are in place to ensure compliance with statutory and mandatory requirements, including training and instruction for staff and clear policies and procedures for those working remotely or in hybrid roles.

To support staff wellbeing, the organisation provides access to an occupational health service and an employee assistance programme, alongside regular wellbeing communications and access to an online wellbeing portal. These arrangements were maintained and enhanced where necessary to support staff during organisational change.

Staff are encouraged to raise concerns where they arise. The ICB's Freedom to Speak Up Policy, aligned to NHS England guidance, sets out arrangements for staff to raise concerns confidentially and ensures compliance with the Public Interest Disclosure Act 1998. The organisation has an employed Freedom to Speak Up Guardian, with executive leadership provided by the Chief Executive, and independent oversight from a Board-appointed Non-Executive Director.

The effectiveness of Freedom to Speak Up arrangements is overseen by the Audit Committee, informed by routine case monitoring and insights from the annual NHS Staff Survey. During the year, Freedom to Speak Up arrangements were also reviewed to ensure they remained fit for purpose during the Management of Change process. As issues are often resolved confidentially and at an early stage, effectiveness can be difficult to quantify; however, no specific concerns regarding the ability to speak up were identified through the most recent staff survey, and the ICB is not aware of any external disclosures to prescribed bodies during 2025/26.

Expenditure on consultancy

The expenditure on consultancy for the year to 31 March 2026 was £1,617,017 (2024/25: £1,079,413). This includes costs that the ICB has paid on behalf of work carried out to support system providers.

Business consultancy is used sparingly by the ICB and only for limited periods where there is demonstrable cost-effectiveness. Consultancy assignments are used where specialist skills and knowledge do not exist within the permanent staff team and are required to address urgent matters.

Off-payroll engagements

In line with HM Treasury guidance the ICB is required to disclose information about 'Off payroll Engagements'.

The information relating to the ICB is provided in the following tables:

Length of all highly paid off-payroll engagements

For all off-payroll engagements as at 31 March 2026, for more than £245[1] per day:

	Number 2025/26	Number 2024/25
Number of existing engagements as of 31 March 2026	2	4
Of which, the number that have existed:		
For less than one year at the time of reporting	2	4
For between one and two years at the time of reporting	0	0
For between two and three years at the time of reporting	0	0
For between three and four years at the time of reporting	0	0
For four or more years at the time of reporting	0	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.

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

For all new off-payroll engagements between 1 April 2025 and 31 March 2026, for more than £245[7] per day:

	Number 2025/26	Number 2024/25
No. of temporary off-payroll workers engaged between 1 April 2025 to 31 March 2026	5	4
Of which:		
Number not subject to off-payroll legislation[2]	5	4

[1] The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.
[2] 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.

	Number 2025/26	Number 2024/25
Number subject to off-payroll legislation and determined as in-scope of IR35[8]	0	0
Number subject to off-payroll legislation and determined as out of scope of IR35[8]	0	0
Number of engagements reassessed for compliance or assurance purposes during the year	0	0
Of which: number of engagements that saw a change to IR35 status following review	0	0

Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2025 to 31 March 2026:

	2025/26	2024/25
Number of off-payroll engagements of Board members, and/or senior officers with significant financial responsibility, during reporting period[1]	0	0
Total number of individuals on payroll and off-payroll that have been deemed “Board members, and/or senior officials with significant financial responsibility”, during the reporting period. This figure should include both on payroll and off-payroll engagements[2]	23	21

[1] There should only be a very small number of off-payroll engagements of board members and/or senior officials with significant financial responsibility, permitted only in exceptional circumstances and for no more than six months.
[2] As both on payroll and off-payroll engagements are included in the total figure, no entries here should be blank or zero.

Staff numbers and costs (subject to audit)

Staff costs are shown in the table below. The national restructuring of the NHS across ICBs, Commissioning Support Units (CSUs), and NHS England has had a significant impact on staff costs. This includes termination benefits of £12,798k, the part-year effect of the transfer of some CSU staff into the ICB during the financial year, and a reduction in the usage of temporary staff. Other movements in staff costs reflect the national pay uplift of 3.6% and the changes to employer national rates and thresholds.

Employee Benefits 2025/26	Permanent Employees £000s	Other £000s	Total £000s	Employee Benefits 2024/25	Permanent Employees £000s	Other £000s	Total £000s
Salaries and wages	30,616	850	850	Salaries and wages	28,563	1,872	30,435
Social Security Costs	4,176	92	92	Social Security Costs	3,220	0	3,220
Employer NHS Pension Contributions	6,866	0	0	Employer NHS Pension Contributions	6,360	0	6,360
Other Pension Costs	26	0	0	Other Pension Costs	4	0	4
Apprenticeship Levy	0	0	0	Apprenticeship Levy	0	0	0
Termination Benefits	12,798	0	0	Termination Benefits	0	0	0
Gross Employee Benefits	**54,482**	**942**	**942**	**Gross Employee Benefits**	**38,148**	**1,872**	**40,020**
Less recoveries in respect of employee benefits	0	0	0	Less recoveries in respect of employee benefits	0	0	0
Total Net Employee Benefit Costs	**54,482**	**942**	**942**	**Total Net Employee Benefit Costs**	**38,148**	**1,872**	**40,020**

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

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure. Where entities have agreed early retirements, the additional costs are met by NHS Entities and not by the NHS Pension Scheme and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

Termination packages totalling £11,788,403 (2024/25: £0) were agreed for 161 (2024/25: 0) members of staff during the year. During the year to 31 March 2026, the ICB along with ICB partnering organisations NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB consulted on a staffing restructure. As a result, a number of exit packages have been agreed during the financial year and recognised in the annual accounts. Further provisions have been included in the Annual Accounts for anticipated redundancies, however, exit packages have not yet been agreed and hence are not included within this disclosure.

Exit packages 2025/26 Exit Package cost band (including any special payment element)	Number of compulsory redundancies (Whole numbers only)	Cost of compulsory redundancies (£)	Number of other agreed departures (Whole numbers only)	Cost of other agreed departures (£)	Total number of exit packages (Whole numbers only)	Total cost of exit packages (£)	Number of departures where special payments have been made (Whole numbers only)	Cost of special payment element included in exit packages (£)
Less than £10,000	0	0	2	7,914	2	7,914	0	0
£10,000 to £25,000	1	19,485	21	383,920	22	403,405	0	0
£25,001 to £50,000	0	0	37	1,385,814	37	1,385,814	0	0
£50,001 to £100,000	0	0	54	3,835,336	54	3,835,336	0	0
£100,001 to £150,000	1	146,677	29	3,483,660	30	3,630,327	0	0
£150,001 to £200,000	0	0	16	2,525,607	16	2,525,607	0	0
Greater than £200,000	0	0	0	0	0	0	0	0
Totals	**2**	**166,152**	**159**	**11,622,251**	**161**	**11,788,403**	**0**	**0**

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

Analysis of other departures

Analysis of other departures 2025/26	Agreements Number	Total value of agreements £000s
Voluntary redundancies including early retirement contractual costs	159	11,622
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	
Contractual payments in lieu of notice[1]	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
Total	**159**	**11,622**

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 4 which will be the number of individuals.

Nil non-contractual payments (£Nil) were made to individuals where the payment value was more than 12 months of their annual salary.

The Remuneration report includes disclosure of exit packages payable to individuals named in that report.

[1] Any non-contractual payments in lieu of notice are disclosed under “non-contracted payments requiring HMT approval” below

Parliamentary Accountability and Audit Report

NHS Nottingham and Nottinghamshire ICB is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report from 71. An audit certificate and report is also included in this Annual Report at page 104.

Annual Accounts

Signed:

Amanda Sullivan
Accountable Officer

16 June 2026

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2026

	Note	2025-26 £'000	2024-25 £'000
Income from sale of goods and services	2	(37,906)	(36,899)
Other operating income	2	(2,031)	(1,967)
Total operating income		**(39,937)**	**(38,866)**
Staff costs	4	55,424	40,020
Purchase of goods and services	5	3,419,778	3,245,082
Depreciation and impairment charges	5	291	241
Provision expense	5	3,289	(612)
Other operating expenditure	5	1,598	561
Total operating expenditure		**3,480,380**	**3,285,292**
Net Operating Expenditure		**3,440,443**	**3,246,426**
Finance expense	9	8	11
Other Gains & Losses	10	-	-
Net expenditure for the Year		**3,440,451**	**3,246,437**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**3,440,451**	**3,246,437**
Comprehensive Expenditure for the year		**3,440,451**	**3,246,437**

Statement of Financial Position as at 31 March 2026

	Note	2025-26 £'000	2024-25 £'000
Non-current assets:			
Property, plant and equipment	11	347	345
Right-of-use assets	12	781	996
Total non-current assets		**1,128**	**1,341**
Current assets:			
Trade and other receivables	13	12,983	24,764
Cash and cash equivalents	14	8	9
Total current assets		**12,991**	**24,773**
Total assets		**14,119**	**26,114**
Current liabilities			
Trade and other payables	15	(152,322)	(104,363)
Lease liabilities	12	(438)	(384)
Provisions	16	(3,037)	(169)
Total current liabilities		**(155,797)**	**(104,916)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(141,678)**	**(78,802)**
Non-current liabilities			
Lease liabilities	12	(579)	(795)
Total non-current liabilities		**(579)**	**(795)**
Assets less Liabilities		**(142,257)**	**(79,597)**
Financed by Taxpayers' Equity			
General fund		(142,257)	(79,597)
Total taxpayers' equity:		**(142,257)**	**(79,597)**

The notes on pages 77 to 103 form part of this statement

The financial statements on pages 73 to 76 were approved by the Audit Committee on 16 June 2026 and signed on its behalf by:

Amanda Sullivan
Chief Accountable Officer

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2026

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2025-26		
Balance at 01 April 2025	(79,597)	(79,597)
Changes in NHS Integrated Care Board taxpayers' equity for 2025-26		
Net operating expenditure for the financial year	(3,440,451)	(3,440,451)
Net funding	3,377,791	**3,377,791**
Balance at 31 March 2026	**(142,257)**	**(142,257)**

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

The notes on pages 77 to 103 form part of this statement

Statement of Cash Flows for the year ended 31 March 2026

	Note	2025-26 £'000	2024-25 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(3,440,451)	(3,246,438)
Depreciation and amortisation	5	291	241
Interest paid / received		8	-
(Increase)/decrease in trade & other receivables	13	11,781	3,821
Increase/(decrease) in trade & other payables	15	47,957	(4,658)
Provisions utilised	16	(420)	-
Increase/(decrease) in provisions	16	3,289	(612)
Net Cash Inflow (Outflow) from Operating Activities		**(3,377,545)**	**(3,247,646)**
Cash Flows from Investing Activities			
Interest paid / received		-	10
(Payments) for property, plant and equipment		(78)	(248)
Net Cash Inflow (Outflow) from Investing Activities		**(78)**	**(238)**
Net Cash Inflow (Outflow) before Financing		**(3,377,623)**	**(3,247,884)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		3,377,791	3,248,038
Repayment of lease liabilities		(170)	(146)
Net Cash Inflow (Outflow) from Financing Activities		**3,377,621**	**3,247,892**
Net Increase (Decrease) in Cash & Cash Equivalents	14	**(2)**	**8**
Cash & Cash Equivalents at the Beginning of the Financial Year		**10**	2
Effect of exchange rate changes on the balance of cash and cash equivalent		-	-
Cash & Cash Equivalents (including bank overdrafts) at the End of the F		**8**	10

The notes on pages 77 to 103 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards (ICBs) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2025-26 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern where the continued provision of services is expected, as evidenced by the inclusion of funding for those services in published plans.

In March 2025, the Government announced significant changes affecting the Department of Health and Social Care, NHS England and a number of other NHS organisations. In response, NHS England and ministers formally approved, in July 2025, the grouping of NHS Derby and Derbyshire Integrated Care Board, NHS Lincolnshire Integrated Care Board, and NHS Nottingham and Nottinghamshire Integrated Care Board into a new cluster. These ICBs will continue to operate while progressing towards a single merged organisation over the next 12 months, with the a merger date expected to be confirmed during 2026/27. Although the ICB will cease to exist at that point, its functions will continue to be delivered by the successor organisation.

In accordance with the Department of Health and Social Care Group Accounting Manual, the ongoing provision of healthcare services within the public sector supports the preparation of the accounts of NHS Nottingham and Nottinghamshire Integrated ICB on a going concern basis.

1.2 Accounting Convention

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

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

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

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

1.4 Pooled Budgets

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

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

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

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

1.5 Operating Segments

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

1.6 Revenue

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

- As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

- The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

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

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

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

Payment terms are standard reflecting cross government principles.

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

1.7 Employee Benefits

1.7.1 Short-term Employee Benefits

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

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

1.7.2 Retirement Benefit Costs

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

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

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

1.8 Other Expenses

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

1.9 Grants Payable

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

1.10 Property, Plant & Equipment

1.10.1 Recognition

Property, plant and equipment is capitalised if:

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

- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

1.10.2 **Measurement**

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

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

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

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

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

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use. IT equipment is depreciated over 5 years.

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

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

1.11.2 **Measurement**

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

From 1 April 2025, intangible assets are carried at cost. Where intangible assets have been carried historically under a revaluation approach following initial recognition, the carrying net amount as 31 March 2025 will be considered to be the deemed historic cost. In accordance with the GAM this change in valuation is being applied prospectively.

1.11.3 **Depreciation, Amortisation & Impairments**

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

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

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

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

1.12 **Leases**

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

1.12.1 **The ICB as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

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

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

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.

1.13 **Cash & Cash Equivalents**

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

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

1.14 **Provisions**

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

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

- A nominal short-term rate of 3.64% (2024-25: 4.03%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 4.22% (2024-25: 4.07%) 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 5.32% (2024-25: 4.81%) 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 5.07% (2024-25: 4.55%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

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

1.15 **Clinical Negligence Costs**

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

1.16 **Non-clinical Risk Pooling**

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

1.17 **Contingent liabilities and contingent assets**

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

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

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

1.18 **Financial Assets**

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

Financial assets are classified into the following categories:

- Financial assets at amortised cost;

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

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

1.18.1 **Financial Assets at Amortised cost**

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

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

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

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

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

1.18.4 **Impairment of financial assets**

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

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

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

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

1.19 **Financial Liabilities**

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

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

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

The ICB has irrevocably designated the following financial liabilities as measured at fair value through profit or loss in accordance with IFRS 9 paragraph 4.2.2:

1.19.2 **Other Financial Liabilities**

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

1.20 **Value Added Tax**

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

1.21 **Foreign Currencies**

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

1.22 **Third Party Assets**

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

1.23 **Losses & Special Payments**

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

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

1.24 **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.24.1 **Critical accounting judgements in applying accounting policies**

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

- Maternity Pathway
- Partially Completed Spells

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

1.24.2 **Sources of estimation uncertainty**

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

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

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

(c) 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.

(d) Restructure Costs: Redundancies (compulsory and voluntary), confirmed within the financial year, have been accrued. Redundancies assumed resulting from waves 2 and 3 published structures have been accounted for by a provision, calculated by way of average redundancy cost per full whole time equivalent (WTE) of remaining staff, mulitpled by anticipated WTE reduction. Where a decision has been deferred for specific teams, and no consultation has taken place during the financial year, a contingent liability has been included, based on those staff that have applied for voluntary redundancy.

1.25 **Gifts**

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

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

• IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

• IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

The application of IFRS 18 and IFRS19 would not a material impact on the accounts for 2025-26, were they applied in year.

2 Other Operating Revenue

	2025-26 Total	2024-25 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Education, training and research	**12**	-
Non-patient care services to other bodies	**1,581**	2,558
Prescription fees and charges	**15,492**	15,448
Dental fees and charges	**20,143**	18,416
Income generation	**86**	-
Other Contract income	**581**	477
Recoveries in respect of employee benefits	**10**	-
Total Income from sale of goods and services	**37,906**	**36,899**
Other operating income		
Other non contract revenue	**2,031**	1,967
Total Other operating income	**2,031**	**1,967**
Total Operating Income	**39,937**	**38,866**

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

	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000
Source of Revenue						
NHS	1,173	-	-	86	369	10
Non NHS	408	15,492	20,143	-	212	-
Total	**1,581**	**15,492**	**20,143**	**86**	**581**	**10**

	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000
Timing of Revenue						
Point in time	-	-	-	-	-	-
Over time	1,581	15,492	20,143	86	581	10
Total	**1,581**	**15,492**	**20,143**	**86**	**581**	**10**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Admin			Programme			Total			2025-26
	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	12,257	38	**12,296**	18,359	812	**19,171**	30,616	850	**31,466**	
Social security costs	1,702	91	**1,793**	2,474	1	**2,475**	4,176	92	**4,268**	
Employer contributions to the NHS Pensi	4,488	-	**4,488**	2,378	-	**2,378**	6,866	-	**6,866**	
Other pension costs	8	-	**8**	18	-	**18**	26	-	**26**	
Apprenticeship Levy	-	-	**-**	-	-	**-**	-	-	**-**	
Other post-employment benefits	-	-	**-**	-	-	**-**	-	-	**-**	
Other employment benefits	-	-	**-**	-	-	**-**	-	-	**-**	
Termination benefits	5,826	-	**5,826**	6,972	-	**6,972**	12,798	-	**12,798**	
Gross employee benefits expenditure	**24,281**	**130**	**24,410**	**30,201**	**813**	**31,014**	**54,482**	**942**	**55,424**	
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	**-**	-	-	**-**	-	-	**-**	
Total - Net admin employee benefits including capitalised costs	**24,281**	**130**	**24,410**	**30,201**	**813**	**31,014**	**54,482**	**942**	**55,424**	
Less: Employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**	
Net employee benefits excluding capitalised costs	**24,281**	**130**	**24,410**	**30,201**	**813**	**31,014**	**54,482**	**942**	**55,424**	

4.1.2 Employee benefits

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

4.2 Average number of people employed

	2025-26			2024-25		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**538.21**	**10.74**	**548.95**	**507.18**	**22.35**	**529.53**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.4 Exit packages agreed in the financial year

	2025-26 Compulsory redundancies		2025-26 Other agreed departures		2025-26 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	2	7,914	2	7,914
£10,001 to £25,000	1	19,485	21	383,920	22	403,405
£25,001 to £50,000	-	-	37	1,385,814	37	1,385,814
£50,001 to £100,000	-	-	54	3,835,336	54	3,835,336
£100,001 to £150,000	1	146,667	29	3,483,660	30	3,630,327
£150,001 to £200,000	-	-	16	2,525,607	16	2,525,607
Over £200,001	-	-	-	-	-	-
Total	**2**	**166,152**	**159**	**11,622,251**	**161**	**11,788,403**

	2024-25 Compulsory redundancies		2024-25 Other agreed departures		2024-25 Total	
	Number	£	Number	£	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	**-**	**-**	**-**	**-**	**-**	**-**

	2025-26 Departures where special payments have been made		2024-25 Departures where special payments have been made	
	Number	£	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

	2025-26 Other agreed departures		2024-25 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	159	11,622,251	-	-
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	**159**	**11,622,251**	**-**	**-**

4.5 Pension costs

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

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 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.5.2 Full actuarial (funding) valuation

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

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

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

5. Operating expenses

	2025-26 Admin £'000	2025-26 Programme £'000	2025-26 Total £'000	2024-25 Total £'000
Purchase of goods and services				
Services from other ICBs and NHS England	1,051	414	1,464	1,873
Services from foundation trusts	-	1,003,184	1,003,184	956,412
Services from other NHS trusts	-	1,215,465	1,215,465	1,171,938
Provider Sustainability Fund	-	-	-	-
Services from Other WGA bodies	-	8	8	1
Purchase of healthcare from non-NHS bodies	-	466,342	466,342	429,879
Purchase of social care	-	52,867	52,867	51,856
General Dental services and personal dental services	-	81,993	81,993	76,482
Prescribing costs	-	207,717	207,717	205,579
Pharmaceutical services	-	51,696	51,696	43,783
General Ophthalmic services	-	12,999	12,999	12,461
GPMS/APMS and PCTMS	0	279,571	279,571	255,829
Supplies and services – clinical	-	876	876	494
Supplies and services – general	167	13,659	13,825	9,196
Consultancy services	(137)	1,754	1,617	1,079
Establishment	406	2,711	3,117	2,848
Transport	9	9,096	9,105	9,085
Premises	(43)	16,393	16,350	14,756
Audit fees	240	-	240	230
Other non statutory audit expenditure				
· Internal audit services	-	-	-	
· Other services	18	123	141	18
Other professional fees	132	295	427	376
Legal fees	657	5	661	448
Education, training and conferences	73	40	113	459
MPET Training Expenditure	-	-	-	-
Funding to group bodies	-	-	-	-
Non cash apprenticeship training grants	-	-	-	-
Total Purchase of goods and services	**2,572**	**3,417,207**	**3,419,778**	**3,245,082**
Depreciation and impairment charges				
Depreciation	291	-	291	241
Total Depreciation and impairment charges	**291**	**-**	**291**	**241**
Provision expense				
Provisions	1,560	1,729	3,289	(612)
Total Provision expense	**1,560**	**1,729**	**3,289**	**(612)**
Other Operating Expenditure				
Chair and Non Executive Members	196	-	196	151
Grants to Other bodies	-	1,148	1,148	-
Research and development (excluding staff costs)	-	264	264	315
Expected credit loss on receivables	-	(31)	(31)	16
Other expenditure	14	6	20	79
Total Other Operating Expenditure	**210**	**1,387**	**1,597**	**561**
Total operating expenditure	**4,633**	**3,420,323**	**3,424,955**	**3,245,272**

6 Payment Compliance Reporting

6.1 Better Payment Practice Code

Measure of compliance	2025-26 Number	2025-26 £'000	2024-25 Number	2024-25 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	53,770	824,874	52,369	811,077
Total Non-NHS Trade Invoices paid within target	52,509	812,286	52,324	808,955
Percentage of Non-NHS Trade invoices paid within target	**97.65%**	**98.47%**	**99.91%**	**99.74%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,554	2,293,657	2,502	2,138,332
Total NHS Trade Invoices Paid within target	2,493	2,286,591	2,493	2,137,878
Percentage of NHS Trade Invoices paid within target	**97.61%**	**99.69%**	**99.64%**	**99.98%**

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

	2025-26 £'000	2024-25 £'000
Amounts included in finance costs from claims made under this legislation	-	1
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	**-**	**1**

7 Income Generation Activities

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

	2025-26			2024-25		
	Income	Full Cost	Surplus/ (deficit)	Income	Full Cost	Surplus/ (deficit)
	£'000	£'000	£'000	£'000	£'000	£'000
Prescription fees and charges	15,492	(259,413)	(243,921)	15,448	(249,362)	(233,914)
Dental fees and charges	20,143	(81,993)	(61,850)	18,416	(76,482)	(58,066)
Total fees and charges	**35,635**	**(341,406)**	**(305,771)**	**33,864**	**(325,844)**	**(291,980)**

8 Other Gains and Losses

There were no other gains and losses during the year

9 Finance Costs

	2025-26 £'000	2024-25 £'000
Interest on lease liabilities	8	**10**
Interest on late payment of commercial debt		**1**
	8	**11**

10 Net gain/(loss) on transfer by absorption

There were no Transfers By Absorption during the year.

11 Property, plant and equipment

2025-26	Information technology £'000	Total £'000
Cost or valuation at 01 April 2025	520	520
Additions purchased	78	78
Cost/Valuation at 31 March 2026	**598**	**598**
Depreciation 01 April 2025	175	175
Charged during the year	76	76
Depreciation at 31 March 2026	**251**	**251**
Net Book Value at 31 March 2026	**347**	**347**
Purchased	347	347
Total at 31 March 2026	**347**	**347**

11.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	0	5 0 **5**

12 Leases

12.1 Right-of-use assets

2025-26	Buildings excluding dwellings £'000	Total £'000	For local accounts use Of which: leased from DHSC group bodies £000
Cost or valuation at 01 April 2025	1,643	1,643	449
Cost/Valuation at 31 March 2026	**1,643**	**1,643**	**449**
Depreciation 01 April 2025	647	647	269
Charged during the year	215	215	89
Depreciation at 31 March 2026	**862**	**862**	**358**
Net Book Value at 31 March 2026	**781**	**781**	**91**

NBV by counterparty	
Leased from DHSC	90
Leased from Non-Departmental Public Bodies	691
Net Book Value at 31 March 2026	**781**

12.2 Lease liabilities

2025-26	2025-26 £'000	2024-25 £'000
Lease liabilities at 01 April 2025	(1,179)	(1,315)
Interest expense relating to lease liabilities	(8)	(10)
Repayment of lease liabilities (including interest)	170	146
Lease liabilities at 31 March 2026	**(1,017)**	**(1,179)**

12.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2025-26 £'000	Of which: leased from DHSC group bodies £000	2024-25 £'000	Of which: leased from DHSC group bodies £000
Within one year	(445)	(301)	(348)	(184)
Between one and five years	(525)	-	(616)	(92)
After five years	(66)	-	(197)	
Balance at 31 March 2026	**(1,036)**	**(301)**	**(1,161)**	**(276)**

Balance by counterparty		
Leased from DHSC	(301)	(276)
Leased from Non-Departmental Public Bodies	(735)	(885)
Balance as at 31 March 2023	**(1,036)**	**(1,161)**

12.4 Amounts recognised in Statement of Comprehensive Net Expenditure

2025-26	2025-26 £'000	2024-25 £'000
Depreciation expense on right-of-use assets	215	215
Interest expense on lease liabilities	8	10

12.5 Amounts recognised in Statement of Cash Flows

	2025-26 £'000	2024-25 £'000
Total cash outflow on leases under IFRS 16	170	146

13.1 Trade and other receivables

	Current 2025-26 £'000	Current 2024-25 £'000
NHS receivables: Revenue		
NHS receivables: Capital	1,160	1,044
NHS prepayments	10	723
NHS accrued income	2,150	1,829
Non-NHS and Other WGA receivables: Revenue	836	1,156
Non-NHS and Other WGA prepayments	2,856	1,826
Non-NHS and Other WGA accrued income	2,074	5,289
invoice	3,068	12,226
Expected credit loss allowance-receivables	(3)	(34)
VAT	804	692
Other receivables and accruals	29	13
Total Trade & other receivables	**12,984**	**24,764**
Total current and non current	**12,984**	**24,764**
Included above:		
Prepaid pensions contributions	-	-

13.2 Receivables past their due date but not impaired

	2025-26 DHSC Group Bodies £'000	2025-26 Non DHSC Group Bodies £'000	2024-25 DHSC Group Bodies £'000	2024-25 Non DHSC Group Bodies £'000
By up to three months	72	12	59	109
By three to six months	-	2	-	42
By more than six months	-	-	3	264
Total	**72**	**14**	**62**	**415**

13.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies	Other financial assets	Total
	£'000	£'000	£'000
Balance at 01 April 2022	**(34)**	**-**	**(34)**
Lifetime expected credit losses on trade and other receivables-Stage 2	**31**	**-**	**31**
Total	**(3)**	**-**	**(3)**

14 Cash and cash equivalents

	2025-26 £'000	2024-25 £'000
Balance at 01 April 2025	9	2
Net change in year	(2)	8
Balance at 31 March 2026	**8**	**10**
Made up of:		
Cash with the Government Banking Service	8	9
Cash and cash equivalents as in statement of financial position	**8**	**9**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2026	**8**	**9**
	-	-

15 Trade and other payables	Current 2025-26	Non-current 2025-26	Current 2024-25	Non-current 2024-25
	£'000	**£'000**	**£'000**	**£'000**
NHS payables: Revenue	2,956	-	1,014	-
NHS accruals	21,505	-	30,985	-
Non-NHS and Other WGA payables: Revenue	19,444	-	24,051	-
Non-NHS and Other WGA accruals	26,607	-	40,377	-
Social security costs	(240)	-	(166)	-
Tax	473	-	441	-
Other payables and accruals	81,578	-	7,662	-
Total Trade & Other Payables	**152,323**	**-**	**104,364**	**-**

16 Provisions

	Current 2025-26 £'000	Non-current 2025-26 £'000	Current 2024-25 £'000	Non-current 2024-25 £'000
Redundancy	2,869	-	-	-
Continuing care	169	-	169	-
Total	**3,038**	**-**	**169**	**-**
Total current and non-current	**3,038**		**169**	

	Redundancy £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2025	**-**	**169**	**-**	**169**
				-
Arising during the year	2,869	-	643	**3,512**
Utilised during the year	-	-	(420)	**(420)**
Reversed unused	-	-	(223)	**(223)**
Balance at 31 March 2026	**2,869**	**169**	**-**	**3,037**
Expected timing of cash flows:				
Within one year	2,869	169	0	**3,037**
Balance at 31 March 2026	**2,869**	**169**	**0**	**3,037**

17 Contingencies

	2025-26 £'000	2024-25 £'000
Contingent liabilities		
Redundancy	752	-

18 Commitments

18.1 Capital commitments

The ICB has no Capital Commitments at the year end.

18.2 Other financial commitments

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

	2025-26 £'000	2024-25 £'000
In not more than one year	94,242	102,736
In more than one year but not more than five years	-	3,698
In more than five years	-	-
Total	**94,242**	**106,434**

19 Financial instruments

19.1 Financial risk management

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

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

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

19.1.1 Currency risk

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

19.1.2 Interest rate risk

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

19.1.3 Credit risk

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

19.1.4 Liquidity risk

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

19.1.5 Financial Instruments

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

19 Financial instruments cont'd

19.2 Financial assets

	Financial Assets measured at amortised cost 2025-26 £'000	Total 2025-26 £'000
Trade and other receivables with NHSE bodies	2,792	2,792
Trade and other receivables with other DHSC group bodies	518	518
Trade and other receivables with external bodies	6,007	6,007
Cash and cash equivalents	8	8
Total at 31 March 2026	**9,324**	**9,324**

19.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2025-26 £'000	Total 2025-26 £'000
Trade and other payables with NHSE bodies	507	**507**
Trade and other payables with other DHSC group bodies	23,954	**23,954**
Trade and other payables with external bodies	127,628	**127,628**
Private Finance Initiative and finance lease obligations	1,017	**1,017**
Total at 31 March 2026	**153,106**	**153,106**

20 Operating segments

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

21 Pooled budgets

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

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

The table below shows the full year detail of the pooled budget.

	2025-26 £'000	2024-25 £'000
Balance at 31 March		
Income		**1,639**
Nottinghamshire County Council ASCH&PP		1,393
Nottinghamshire County Council CFCS		641
Nottinghamshire City Council ASCH & CYP		888
NHS Nottingham & Nottinghamshire ICB		8,596
Other income		111
TOTAL INCOME	**0**	**13,268**
Expenditure		
Partnership Management & Administration costs		1,369
Contract delivery and collection costs		1,423
ICES Equipment		8,815
Minor Adaptations		297
Direct Payments		0
TOTAL EXPENDITURE	**0**	**11,904**
Balance at 31 March	**0**	**1,364**
Carry Forward by Partner		
Nottinghamshire City Council ASCH		89
Notts County Council - ASCH		813
Notts County Council - CYPS		135
Notts County Council - PDSS/EY		75
ICELS Staffing reserves		12
NHS Nottingham & Nottinghamshire ICB		240
Balance at 31 March	**0**	**1,364**

The second pooled budget is 'The Better Care Fund (BCF)' and is hosted by Nottingham City Council, and jointly commissions services to achieve national and local objectives to integrate health and social care services in Nottingham City.

It is between NHS Nottingham and Nottinghamshire ICB Nottingham City Council, and its aims are to improve the quality & efficiency of services.

The table below shows the full year detail of the pooled budget.

Memorandum Account for Nottingham City Better Care Fund

	2025-26 £'000	2024-25 £'000
Funding		
NHS Nottingham & Nottinghamshire ICB	34,973	34,319
Nottingham City Council (Capital)	3,435	3,020
Nottingham City Council (Discharge Funding)	0	3,879
Nottingham City Council (Improved Better Care Fund)	20,483	16,603
Total Funding	**58,891**	**57,821**
Expenditure		
Access & Navigation	0	1,610
Assistive Technology	294	352
Carers	694	714
Co-ordinated Care	0	16,603
Proactive Care	26,093	0
Capital Grants	3,435	3,020
Reablement / Discharge	0	7,462
Programme Costs	0	0
Integrated Care	0	21,767
Redcucing the need for long term residential care	14,559	0
Primary Care	3,711	3,173
Preventing Unnecessary Hospital Admissions	2,323	0
Timely Discharge from Hospital	7,743	3,043
Housing Related Schemes	39	77
Total Expenditure	**58,891**	**57,821**
Balance Carried forward for all partners	**0**	**0**

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

	2025-26 £'000	2024-25 £'000
Income		12,255
Expenditure		-12,255
TOTAL	**0**	**0**

22 Related party transactions

Details of related party transactions with individuals are as follows:

2025-26	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Derby Health United Health Care CIC	5,309	0	970	0
NHS Confederation	35	0	0	0
Portland College	49	0	2	0
Specsavers Opticians	3,544	0	0	0
Nottingham Trent University	6	0	16	0
HFMA	7	0	0	0
Nottingham City Transport	1	0	0	0
Primary Integrated Community Services	1,417	-158	20	0
Nottingham University Hospitals NHS Trust	1,116,503	158	11,271	158
Nottinghamshire Healthcare NHS Foundation Trust	372,885	0	254	1
Sherwood Forest Hospitals NHS Foundation Trust	448,486	75	9,013	115
Nottingham City Council	55,514	1,096	795	0
Nottinghamshire County Council	98,294	972	733	720
NHS Trusts	100,665	104	2,173	91
NHS Foundation Trusts	188,332	142	1,243	161
NHS England Group	2,115	1,282	506	2,792
Other Group Bodies	14,916	0	1,391	0
Department of Health	0	27	0	0
Special Health Authorities	10	0	2	0

2024-25				
Derby Health United Health Care CIC	10,641	0	0	0
NHS Confederation	55	0	0	0
NHS Professionals	0	3	0	0
Portland College	152	0	17	0
Specsavers Opticians	6,744	0	0	0
Florence Nightingale Foundation	1	0	0	0
Nottingham Trent University	84	0	0	0
Nottingham University Hospitals NHS Trust	1,081,424	83	10,581	5
Nottinghamshire Healthcare NHS Foundation Trust	348,030	568	12,347	487
Sherwood Forest Hospitals NHS Foundation Trust	446,934	289	7,507	257
Department of Health	0	25	0	0
NHS England	2,305	1,518	980	2,086
NHS Trusts	91,871	74	91	161
Foundation Trusts	167,535	18	493	599
Special Health Authorities	4	0	16	0
Other Group Bodies	13,706	0	1,862	0
Nottingham City Council	53,763	88	4,643	417
Nottinghamshire County Council	97,195	1,066	2,494	2,720

23 Events after the end of the reporting period

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

24 Financial performance targets

NHS Integrated Care Board have a number of financial duties under the NHS Act 2006 (as amended).

NHS Integrated Care Board performance against those duties was as follows:

	Achievement Y/N	2025-26 Target	2025-26 Performance	2024-25 Target	2024-25 Performance
Expenditure not to exceed income	N	3,474,174	3,480,388	3,285,318	3,285,305
Capital resource use does not exceed the amount specified in Directions	Y	78	78	248	248
Revenue resource use does not exceed the amount specified in Directions	N	3,434,237	3,440,451	3,246,451	3,246,438
Revenue administration resource use does not exceed the amount specified in Directions	Y	32,189	29,009	22,487	20,980

25 Losses and special payments

Losses

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

	Total Number of Cases 2025-26 Number	Total Value of Cases 2025-26 £'000	Total Number of Cases 2024-25 Number	Total Value of Cases 2024-25 £'000
Administrative write-offs	-	-	4	24
Total	**-**	**-**	**4**	**24**

Special payments

	Total Number of Cases 2025-26 Number	Total Value of Cases 2025-26 £'000	Total Number of Cases 2024-25 Number	Total Value of Cases 2024-25 £'000
Compensation payments	1	13	-	-
Total	**1**	**13**	**-**	**-**

26 Mental Health expenditure

	2025-26 £'000	2024-25 £'000
Minimum expenditure in mental health services to meet the Mental Health Investment Standard as notified by NHS England	302,973	223,290
Eligible mental health expenditure	303,403	223,495
Mental health expenditure above/(below) minimum investment required	430	205
Mental health expenditure as a percentage of total expenditure	8.82%	6.88%

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 year ended 31 March 2026 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 financial position of the ICB as at 31 March 2026 and of its income and expenditure for the year 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 23 April 2025 as being relevant to ICBs in England and included in the Department of Health and Social Care Group Accounting Manual 2025/26; 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.

Emphasis of matter – going concern

We draw attention to the disclosure made in note 1.1 to the financial statements which explains that on 1 April 2027 NHS Nottingham and Nottinghamshire ICB is expected to be dissolved and its services transferred to a new body. Under the continuation of service principle the financial statements of NHS Nottingham and Nottinghamshire ICB have been prepared on a going concern basis because its services will continue to be provided by the successor public sector entity. Our opinion is not modified in this respect.

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 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 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/other reasons specific to this audit, 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.

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 therefore assessed that there was limited opportunity for the ICB to manipulate the income that was reported.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on high risk criteria and comparing the identified entries to supporting documentation. These included unusual entries to cash, unusual entries to expenditure, and entries created and posted by certain users.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Inspecting transactions in the period after 31 March 2026 to verify expenditure had been recognised in the correct accounting period.
- Assessing a sample of accruals and verifying they had been accurately recorded within the financial statements.

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 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.

As described in the section of this report dealing with other legal and regulatory matters, we made a referral under Section 30(1)(b) of the Local Audit and Accountability Act 2014 to the Secretary of State on 18 June 2026 on the basis that the ICB had failed to meet two of its statutory financial duties for the year ended 31 March 2026. We have also qualified our regularity opinion in respect of this matter.

The ICB is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws, anti-bribery, employment law, recognising the nature of the ICB's activities and its legal form. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the directors and other management and inspection of regulatory and legal correspondence, if any. Therefore if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

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 fraud 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 year is consistent with the financial statements.

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 2025/26.

Accountable Officer's and Audit and Risk Committee responsibilities

As explained more fully in the statement set out on page 41, 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.

The Audit and Risk Committee is responsible for overseeing the ICB's financial reporting process.

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

Qualified Opinion on regularity

The Accountable Officer is responsible for ensuring the regularity of expenditure and income.

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

Except for the effects of the matter described in the basis for qualified opinion on regularity section of our report set out below, 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.

Basis for qualified opinion on regularity

On 18 June 2026 we made a referral to the Secretary of State under Section 30 (1)(b) of the Local Audit and Accountability Act 2014, and notified NHS England of the matter, on the basis that the ICB's draft financial statements for the year ended 31 March 2026 disclosed that it had failed to meet two of its statutory financial duties. Expenditure incurred by the ICB in the year ended 31 March 2026 exceeded its Revenue Resource Limit by £6.214 million and total expenditure exceeded its income by £6.214million.

We conducted our work on regularity in accordance with Statement of Recommended Practice - Practice Note 10: *Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024)* issued by the FRC. We planned and performed procedures to obtain sufficient appropriate evidence to give an opinion over whether 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. The procedures selected depend on our judgement, including the assessment of the risks of material irregular transactions. We are required to obtain sufficient appropriate evidence on which to base our opinion.

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 41, 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 are also not required to satisfy ourselves that the ICB has achieved value for money during the year.

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 issue a report in the public interest under section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we make written recommendations to the ICB under Section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or

We have nothing to report in these respects.

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 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.

On 18 June 2026 we made a referral under Section 30(1)(b) to the Secretary of State, and notified NHS England of the matter, on the basis that expenditure incurred by the ICB and recorded in its draft financial statements for the year ended 31 March 2026 exceeded its Revenue Resource Limit by £6.214 million and that total expenditure exceeded its income by £6.214 million.

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.

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the ICB's accounts consolidation template for the year ended 31 March 2026 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of NHS Nottingham and Nottinghamshire Integrated Care Board for the year ended 31 March 2026 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the NAO Code of Audit Practice.

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

18 June 2026