NHS
Derby and Derbyshire
Integrated Care Board

NHS Derby and Derbyshire Integrated Care Board

Annual Report and Accounts

1st April 2025 to March 31st 2026

About this report

This report explains what NHS Derby and Derbyshire 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 Derby and Derbyshire 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 national landscape, with high expectations from Government, NHS England and the public. Despite sustained operational and financial pressures, the system has continued to show resilience and ambition while keeping people and communities at the heart of decision making. Visits to neighbourhood and primary care teams, and to voluntary, community and social enterprise organisations, have reaffirmed the strength of local relationships and the dedication of our workforce and partners.

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.

National reform and organisational change have also shaped the year, including management cost reduction requirements and the development of a new ICB Operating Model. NHS Derby and Derbyshire ICB has established formal partnership arrangements with NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire ICB, operating as an ICB Cluster, and I am now jointly appointed as Chair of the three ICBs. This closer joint working supports shared learning, consistency and resilience while preserving each organisation's focus on its own population. I am grateful for the thoughtful, values-led engagement of Boards, executive teams and partners throughout this period.

Alongside organisational change, we have remained focused on the national ambition to shift care from hospital to community, from analogue to digital, and from treatment to prevention. This has been supported by the development of a new Five-Year Population Health Strategy and Five-Year Strategic Commissioning Plan, which will help us understand population need, target resources more effectively and shape services with partners around prevention, neighbourhood working and improved outcomes.

I am particularly proud of progress in neighbourhood working and inclusive service design, including work to address health inequalities, support people experiencing severe and multiple disadvantage, and develop integrated neighbourhood teams focused on frailty and prevention. These approaches reflect the importance of listening to local people, working with communities and designing services that are better able to respond to the different needs and experiences of our population.

The Integrated Care Strategy continues to guide our shared priorities, complemented by the emerging Population Health Management Strategy and Strategic Commissioning Plan. Together, these provide a clear framework for partnership working with local authorities, the voluntary sector, NHS providers and regional partners.

I would like to thank Board members for their leadership, challenge and support, and acknowledge colleagues who left the Board in year. I also extend sincere thanks to executive colleagues, partners and staff, whose professionalism and dedication underpin everything we do. Challenges remain, but so do significant opportunities, and I look forward to continuing to work together to build a healthier and fairer future for our communities.

Dr Kathy McLean OBE, Chair of NHS Derby and Derbyshire Integrated Care Board

Performance Report

Signed:

Amanda Sullivan
Accountable Officer

16 June 2026

Performance Overview

Statement from our Chief Executive

As I reflect on 2025/26, I do so having taken on the role of Chief Executive of NHS Derby and Derbyshire Integrated Care Board (ICB) during a period of significant national change for the NHS. I have been struck by the professionalism, commitment and collaborative approach shown by colleagues across Derby and Derbyshire, and I am proud to take on this role at a time when there is a clear opportunity to strengthen how we work across the system in the best interests of our population.

During the year, the ICB has continued to deliver against its strategic priorities, with a focus on improving access to services, reducing health inequalities and supporting the sustainability of care. Progress has been made across a range of areas, including the development of primary and community care services and strengthening partnership working across health and care organisations. At the same time, as with systems across the country, sustained pressure on urgent and emergency care, alongside ongoing challenges in patient flow and discharge, has continued to impact performance and operational resilience.

The role of the ICB in providing system leadership and coordination has therefore remained critically important. Throughout the year, the ICB has worked closely with NHS providers, local authorities and other partners to support collective decision-making, manage system pressures and maintain a clear focus on the quality, safety and sustainability of services, while continuing to support longer-term improvement and transformation.

Quality and safety remain central to our approach. The ICB has continued to maintain robust arrangements for oversight of services, working with partners to identify areas of risk or concern, support improvement where required and ensure a consistent focus on patient experience and outcomes. Alongside this, the organisation has maintained a strong focus on its financial responsibilities, strengthening financial governance, improving grip and control, and supporting delivery of its statutory duties within a challenging financial environment.

Nationally, the NHS is undergoing a period of major reform, following the publication of the Government's Ten Year Health Plan for England, which set a clear direction for the future. In response, formal joint working arrangements have been established between NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire 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, and I recognise that this has been a challenging period for many colleagues and would like to thank our staff for their continued professionalism, resilience and commitment. I would also like to recognise the contribution of Dr Chris Clayton, who served as Chief Executive of NHS Derby and Derbyshire ICB prior to my appointment, and whose leadership helped establish strong foundations for integrated working across the system. While this report focuses on the activities and performance of NHS Derby and Derbyshire 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 for the people of Derby and Derbyshire, while playing our part in shaping the future of the NHS, and we remain committed to delivering meaningful and lasting benefits for the people we serve.

Amanda Sullivan, Chief Executive and Accountable Officer of NHS Derby and Derbyshire Integrated Care Board

About us

NHS Derby and Derbyshire 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 serves a population of around 1.4 million people and covers the geographic area of Derby and Derbyshire, including Derby city, Chesterfield, Ilkeston and Long Eaton, Amber Valley, Derbyshire Dales, Bolsover, High Peak and Glossop.

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 Derby and Derbyshire 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 Lincolnshire ICB and NHS Nottingham

and Nottinghamshire 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, 592 people worked for the ICB (including staff, clinical and professional advisors, and Board members). The ICB has also hosted the All Age Continuing Care Team since 1 January 2026, who work on behalf of NHS England and the ICBs across the East Midlands to improve continuing healthcare.

Our integrated care system

The ICB is part of the Derby and Derbyshire 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 Neighbourhood 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 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 Derby City Council and Derbyshire County Council. The ICP brings together a broad alliance of partners concerned with improving the care, health and wellbeing of the population. The ICP 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).
- Eight place-based partnerships which lead the detailed design and delivery of integrated services across their localities and neighbourhoods. These 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.
- Primary Care Networks (PCNs), which are partnerships between General Practice surgeries supporting neighbourhood populations ranging from approximately 70,000 to 275,000 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 providers.

More information about the Derby and Derbyshire ICS can be found on the Joined-up Care Derbyshire website, 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.

We use the economic levers available to us to develop resilient and inclusive local economies within Derby and Derbyshire through greater local spend, fair employment, and support for a larger and more diverse business base, helping to ensure that wealth is retained locally and benefits our communities.

Together, through the collective influence of our partner organisations, including the Derby and Derbyshire Health and Wellbeing Boards and the ICB, we aim to address socio-economic and environmental determinants of health and support community wealth building across Derby and Derbyshire.

The work of the System Anchor Partnership will be incorporated into delivery plans for the Integrated Care Strategy and will consider how best to align this work with key enabling functions and across the Start Well, Stay Well, and Age and Die Well areas of focus.

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.

Our strategies and plans

To make the best decisions for our population, we must understand the health and care needs of people living across Derby and Derbyshire. Joint Strategic Needs Assessments (JSNAs) provide the key evidence base for this, helping us to understand the health and wellbeing needs of our population, inequalities in outcomes and experience, demographic differences across our communities, and priority areas for action. These needs 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://observatory.derbyshire.gov.uk/jsna/ and https://www.derby.gov.uk/health-and-social-care/public-health/jsna/.

The Derby and Derbyshire Integrated Care Partnership (ICP) has used this information, alongside wider evidence and insight, 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:

- Start Well – improving outcomes and reducing inequalities in the health, social, emotional and physical development of children in the early years (0 to 5), including through school readiness.
- Stay Well – improving prevention and early intervention in relation to the three main clinical causes of ill health and early death across Derby and Derbyshire: circulatory disease, respiratory disease and cancer.
- Age and Die Well – enabling older people to live healthy and independent lives in their usual place of residence for as long as possible. Integrated and strength-based services will prioritise health and wellbeing, help people in crisis to remain at home where possible, and maximise a return to independence following periods of escalation.

The Strategy builds on existing system strategies, including the Derbyshire Health and Wellbeing Strategy 2024 to 2027, and sets out shared priorities to improve life expectancy and healthy life expectancy and to reduce health inequalities for the people of Derby and Derbyshire. The Strategy can be found at https://joinedupcarederbyshire.co.uk/about-us/derbyshire-integrated-care-partnership/our-strategy/.

The ICB and its NHS Trust and NHS Foundation Trust partners have developed a Joint Forward Plan which describes how local NHS organisations will implement the NHS Mandate, tackle key issues and contribute to delivery of the Integrated Care Strategy and the Derbyshire Health and Wellbeing Strategy.

The Joint Forward Plan focuses on five key areas:

- Allocating greater resource to activities that prevent, postpone or lessen disease complications, and reduce inequity of provision.
- Giving teams working across Derby and Derbyshire the authority to determine the best ways to deliver improvements in health and care services for local people.
- Giving people more control over their care.
- Identifying and removing activities from the provision of care which consume time and cost but do not materially improve patient outcomes.
- Prioritising improvement of the system's intelligence function and the capacity and capability of its research programme.

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 at https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/our-strategies-and-plan/.

Our performance

Service delivery

While we have maintained a robust and consistent focus on performance throughout the year through the governance and oversight mechanisms described in the Performance Analysis section of this Annual Report, 2025/26 has again been a challenging period in delivering against national and local standards. Our focus has remained on delivering the ambitions set out in the 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, increasing patient acuity and challenges in patient flow and discharge. Performance against the four-hour and 12-hour emergency department standards remained below expectations, with both acute sites experiencing periods of particular strain. However, progress has been made in strengthening

alternatives to hospital admission, including Same Day Emergency Care, Urgent Treatment Centres and community-based urgent responses, alongside continued action to improve ambulance handover processes through system-wide working.

During the year, progress has continued in improving access to primary care, supported by year-on-year improvements in patient experience and sustained delivery of urgent and routine appointments. Expanded use of online consultations and community pharmacy services has helped to relieve pressure on General Practice. The system has also continued to address elective and diagnostic backlogs. While the longest waits have reduced, performance against the 18-week referral to treatment standard and diagnostic waiting time standards remained below plan, reflecting ongoing capacity and workforce challenges. The expansion of Community Diagnostic Centres represents an important step in supporting longer-term recovery.

In cancer services, performance against national waiting time standards remained challenging, including delivery of the Faster Diagnosis Standard and referral-to-treatment targets. Sustained focus has been placed on pathway improvement, diagnostic capacity and best-practice timed pathways, alongside continued progress in screening, targeted case-finding and early diagnosis initiatives. Improving performance against the Faster Diagnosis Standard remains a key priority.

Access to mental health services continued to improve, with progress in expanding access for children and young people, strong performance in talking therapies and delivery of the national target for dementia diagnosis rates. Work has continued to reduce inappropriate adult acute out-of-area placements, supported by expanded local inpatient capacity, although this remains an area requiring further improvement. Mental health services have continued to operate under sustained pressure, necessitating ongoing system oversight.

Progress has continued in supporting people with a learning disability and autistic people to remain in the community, alongside improvements in annual health check delivery and significant strengthening of the LeDeR programme. While targets for children and young people were largely achieved, the number of adults in inpatient settings remained above planned levels at year end and continues to be a focus for improvement.

Through the Local Maternity and Neonatal System, sustained improvement activity has continued to strengthen the quality, safety and equity of maternity and neonatal services, informed by learning from incidents, external reviews and regulatory scrutiny. While progress has been made against national safety programmes, maternity services continued to operate within enhanced oversight arrangements, reflecting the need for sustained system focus.

Across all service areas, we have continued to work closely with NHS providers, local authorities and wider partners to deliver recovery plans and improvement activity. Sustained system-wide collaboration remains essential to improving performance, reducing inequalities and delivering better outcomes for the people of Derby and Derbyshire.

Financial performance

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

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

Going concern

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

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. If services will continue to be provided in the public sector the financial statements should be prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 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 sustained operational pressures across urgent and emergency care, patient flow and discharge, elective recovery, diagnostics, cancer and mental health services; the maintenance of quality and safety within commissioned services, including maternity, mental health, primary care and community provision; ensuring appropriate support and timely pathways for people with learning disabilities and autistic people; workforce resilience and capacity; financial sustainability amid ongoing system pressures; digital capability and cyber security risks; and the delivery of organisational change associated with the 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 'Board papers' section of our website at https://joinedupcarederbyshire.co.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 Derby and Derbyshire system has continued to operate in a highly pressured environment, with sustained demand across all parts of the health and care system. 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. Partnership working has led to positive progress against our ambitions and has improved outcomes for patients in 2025/26.

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

Primary care

A key priority for Derby and Derbyshire during 2025/26 was the implementation of the primary care Access Improvement Plan, developed in response to NHS England's Delivery Plan for Recovering Access to primary care[1]. Through this work, General Practice in Derby and Derbyshire received recognition for enhancing patient satisfaction regarding access to services. The latest GP Patient Survey results show consistent year-on-year improvements in how patients rate their ability to contact their practice, including via telephone, practice websites and the NHS App. People's overall experience has improved, reflecting the impact of continued work across the system to make access better. More patients are finding it easier to use GP practice websites and the NHS App, with fewer reporting difficulties. This reflects strong teamwork across primary care, with GP practices, Primary Care Networks (PCNs), partners and staff working closely over the past two years. Practices have worked with patients to shape access in ways that work better for local communities, and the latest survey results show the positive impact of this shared commitment.

During the year, we have worked to ensure that everyone who needs an appointment gets one within two weeks, and those who contact their practice urgently are assessed the same or next

[1] https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/.

day according to clinical need. The target for routine appointments offered in two weeks is 85%, and in Derby and Derbyshire during March 2026 we achieved 75.4%. Across Derby and Derbyshire, General Practice activity in March 2026 was around 6.7% below plan and 6% down overall for 2025/26; however, delivery was 1.7% higher in March 2026 than in March 2025, with approximately 638,000 appointments being provided. Around 40% of appointments were delivered on the same day, slightly below the national average of 45% for March 2026. Performance for clinically urgent appointments remained strong, with 72% of these appointments taking place on the same day, broadly in line with national levels.

Investment in primary care estates has supported modern ways of working and the delivery of more care in primary and community settings, rather than hospitals. Work with system partners has focused on ensuring facilities are well used, fit for the future, and able to support activity moving closer to people's homes. Practices have been supported to access capital funding to improve their premises, and a more coordinated approach to estates investment has been developed, bringing together different funding streams to support efficiency, sustainability and future service delivery.

Good progress has been made in delivering the modern General Practice agenda and meeting 2025/26 contractual requirements. From 1 October 2025, 100% of Derby and Derbyshire GP practices complied with the requirement to keep online consultation systems open during core hours. The focus is now on improving utilisation, particularly in practices with lower online demand. Lister House Medical Practice in Derby demonstrates effective implementation through a same-day total triage model, reducing queues, managing high demand safely, increasing appropriate pharmacy referrals, and improving both patient experience and staff wellbeing

During 2025/26 the performance standards for adult and children's routine dental appointments has been achieved and as of March 2026 we exceeded contracted units of dental activity. Urgent dental care provision has been expanded in line with the national initiative announced in February 2025, which requires ICBs 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 raise public awareness through campaigns about 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, 194 community pharmacies across Derby and Derbyshire (approximately 97%) were registered to provide the service. 82,424 consultations were delivered between April 2025 and March 2026, enabling residents to access timely treatment without the need for a GP appointment. This activity is estimated to have released more than 13,700 hours of GP and clinical time, improving system capacity and patient experience.

During the year we have continued to deliver our Discharge Medicines Service, which aims at ensuring safe transition of care when patients are discharged from hospitals, and our New Medicines Service, which supports patients with new long-term medication. The Community Pharmacy Independent Prescribing Pathfinder Programme allows trained pharmacists to prescribe NHS medicines directly, improving access to care and reducing pressure on GP services. Delivered at four community pharmacy sites in Derby and Derbyshire and extended to March 2027, the scheme has delivered thousands of consultations that would otherwise have required GP or urgent care appointments.

During the year, we also introduced a new service which enables people to access oral contraception directly from their local pharmacy and this has already saved more than 1,000 hours of GP and healthcare professional time.

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 Derby and Derbyshire, this target was not consistently met during 2025/26. As of March 2026, 72.1% of patients were seen within four hours (this represents the combined performance of University Hospitals of Derby and Burton NHS Foundation Trust and Chesterfield Royal Hospital 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 7.5% of Emergency Department attendances during the year. Performance has been variable and has generally exceeded this threshold, with the position for March 2026 at 9.7%. Both Trusts have experienced a significant rise due to increased demand and higher patient acuity. During 2026/27 there will continue to be a focus on reducing 12 hour waits and extended lengths of stay.

Ambulance handover performance remains challenging, with continued increases in total handover delays. 45-minute handovers have increased by 27.5% (Chesterfield Royal Hospital) and 0.1% (University Hospitals of Derby and Burton) when compared with 2024/25. Work to reduce ambulance handover delays is ongoing, with 'Release to Respond' implemented at both Trusts, supported by strong multi-agency working, agreed offload plans, and regular review meetings. Joint working continues with East Midlands Ambulance Services NHS Trust to improve handover flow and reduce delays.

During the year, five community urgent treatment centres continued to offer walk-in and NHS 111-booked same-day appointments, delivering activity of 20% above forecast. GP-led urgent treatment centres at University Hospitals of Derby and Burton and Chesterfield Royal Hospital provided point-of-care testing to support front-door streaming and reduce Emergency Department pressure.

We are continuing to see positive patient outcomes from our Central Navigation Hub, which operates as the single point of access for healthcare professionals, improving navigation to appropriate pathways and reducing pressure on urgent care services. In 2025/26 the Hub:

- Redirected around 50 ambulances per day (1,500 patients per month) and over 84% of patients away from Emergency Departments to community services.
- Supported 1,700 patients per month to alternatives to primary care.
- Became the first system in England to incorporate NHS 111 online primary care pathways and support long-lie anticoagulated patients into virtual wards, preventing Emergency Department conveyance for more than 500 patients since July 2025, and reducing the days patients spend on wards to an average of two to three days.

During 2025/26, our Same Day Emergency Care services extended their opening hours and improved referral pathways from ambulance services, General Practice, and the Central Navigation Hub. As a result of service improvements and pilot projects, activity levels rose and helped decrease visits to the Emergency Department.

The System Coordination Centre, throughout 2025/26, has operated daily from 8am to 6pm, providing the Derby and Derbyshire ICB 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. We have prioritised reducing long waits in line with the national ambition to restore the 18-week Referral to Treatment standard. In March 2026 we exceeded the Referral to Treatment standard at 63.9% against a plan of 63.8%, our focus now will be to sustain this performance into 26/27. The number of patients waiting over 52 and 65 weeks has continued to fall and by the end of March 2026,

waits over 65 weeks had reduced to 57 for Derby and Derbyshire patients. While this remains above planned targets, eliminating waits over 65 weeks remains a key priority and a central ambition within our Joint Forward Plan. Throughout the year, partners across Derby and Derbyshire focused on tackling long waits in line with the national ambition to restore the 18-week Referral to Treatment standard. Given the significant backlog at the start of the year, collaboration with NHS providers, the independent sector and clinical teams was strengthened, oversight arrangements enhanced, alternative care models expanded, and theatre and outpatient activity increased. A national validation sprint ensured waiting lists were accurate and clinically up to date. Further action is now underway to address remaining long waits, including increased use of the independent sector and out-of-area NHS providers.

During 2025/26, elective specialty pathways have seen improvements, leading to the following results:

- Ophthalmology – More than 31,800 referrals were managed through the Eyecare eRS system, enabling faster triage and more consistent clinical decision-making. Most patients continue to be treated in community settings, with work underway to introduce a county-wide triage and treatment model.
- Musculoskeletal – A comprehensive review of community musculoskeletal services is helping to standardise pathways and improve equity of access ahead of 2026/27.
- Gynaecology – Improved waiting list management, clearer referral routes and modernised outpatient processes have strengthened the shift toward community based care.
- Dermatology – Rising demand has prompted a service review, with an urgent skin cancer pilot delivering quicker specialist assessment and reducing the need for hospital visits. Work is also progressing to develop a broader community dermatology model.

Meeting the NHS six-week diagnostic standard remains critical to supporting early treatment, improving outcomes and reducing patient anxiety. During 2025/26, diagnostic delays persisted, with 23.6% of patients waiting more than six weeks for a diagnostic test in March 2026, compared to a planned level of 17.3%. While this reflects ongoing system pressures, it has remained a clear focus for improvement throughout the year.

As set out in our Joint Forward Plan, the phased implementation of Community Diagnostic Centres is a key strategic priority to expand diagnostic capacity and improve timeliness. Whitworth Community Diagnostic Centre is fully operational, Walton Community Diagnostic Centre is expanding ahead of its planned 2026 development, and Community Diagnostic Centres at Ilkeston, Florence Nightingale (Derby) and Sir Robert Peel (Tamworth) will continue to increase capacity. Increasingly, Community Diagnostic Centres are acting as the first point of access for many diagnostic pathways, reducing pressure on hospitals and supporting wider elective recovery.

Paediatric audiology remained a particular challenge both locally and nationally, largely due to workforce and estate constraints. In response, coordinated system-wide action is underway to stabilise services and improve timely access for children.

Cancer care

During 2025/26, efforts remained focused on cancer prevention, screening and early diagnosis, recognising their importance in improving outcomes and reducing inequalities. Collaboration with Public Health strengthened targeted outreach in communities with lower screening uptake, reinforced by neighbourhood-based awareness initiatives.

Performance against the Faster Diagnosis Standard remained a central focus throughout the year. The standard aims for 75% of patients urgently referred by their GP with suspected cancer to receive a diagnosis, or have cancer ruled out, within 28 days. In Derby and Derbyshire, performance remained below this ambition at 75.4% in March 2026. However, sustained system focus has been placed on improving diagnostic capacity and pathway transformation to support progress towards the standard.

Working closely with the East Midlands Cancer Alliance, best practice timed pathways were embedded across tumour sites and straight-to-test models were expanded, enabling faster

reassurance for most patients and more rapid progression to treatment where cancer was diagnosed. Additional pathway improvements, including the introduction of direct-access transvaginal ultrasound have further streamlined pathways and reduced unnecessary outpatient demand, which was an ambition in our Joint Forward Plan.

The Faster Diagnosis Standard operates alongside the cancer referral-to-treatment standards (31-day and 62-day), where Derby and Derbyshire remained off trajectory in March 2026 and did not achieve planned performance. Performance against the lower gastrointestinal Faecal Immunochemical Test (FIT) target reached 83.8% in March 2026, which exceeded the planned level. Some tumour sites continue to experience prolonged treatment delays, which will remain a priority area for improvement during 2026/27.

Through the year, work has continued to strengthen faster cancer diagnosis initiatives. Preparations for targeted lung cancer screening progressed significantly, supporting earlier detection in high-risk groups. In addition, partnership working with Heartburn Cancer UK enhanced symptom awareness and encouraged earlier presentation for oesophageal cancer.

Maternity and neonatal care

During 2025/26, the ICB has continued to prioritise the improvement of maternity and neonatal care, as part of its statutory duty to secure continuous improvement in the quality and safety of commissioned services, aligned to the NHS Three Year Delivery Plan for maternity and neonatal services. Maternity services in particular have remained an area of heightened focus, reflecting ongoing regulatory findings and the need for sustained system-level oversight and improvement.

Maternity and neonatal services are coordinated through the Derby and Derbyshire Local Maternity and Neonatal System, working collaboratively with providers, commissioners, public health colleagues and service user representatives to oversee quality, safety, performance and improvement activity across the system. These arrangements support collective decision-making, shared learning and consistent oversight.

Governance and assurance arrangements continued to be strengthened during the year. Perinatal surveillance and oversight structures were reinforced to provide clearer visibility of risks, quality concerns, and improvement actions across providers. Learning from incidents, external reviews and regulatory activity continued to inform system oversight, with risks actively monitored and managed through established quality governance and escalation processes, including the ICB's Quality and Service Improvement Committee.

Throughout 2025/26, the Derby and Derbyshire Local Maternity and Neonatal System continued to work collaboratively with providers, women and families, and wider system partners to deliver targeted improvement activity. A sustained focus remained on strengthening safety, improving clinical outcomes and addressing inequalities in access, experience and outcomes for maternity and neonatal care.

The voices of women, birthing people and families continued to inform improvement activity. An active Maternity and Neonatal Voices Partnership supported improved co-production of services, strengthened governance arrangements for receiving and acting on service-user feedback, and the launch of targeted engagement to hear the voices of communities who are rarely heard, including the development of Maternity and Neonatal Forums shaped by local priorities. Successful '15 Steps' visits were undertaken across maternity and neonatal services, with representation from local communities.

Key areas of progress during the year included:

- Continued delivery of targeted quality improvement activity to support safer maternity care, with a particular focus on stabilising high-risk areas and strengthening perinatal governance and assurance.
- Progress against the NHS Three Year Delivery Plan objectives, including improvements in perinatal outcomes and improvements in the proportion of babies born in the right place.
- Further development of perinatal pelvic health services to support women experiencing birth-related injury, underpinned by revised pathways, dedicated leadership and focused improvement plans.

- Continued work to improve personalised care and cultural safety within maternity services, recognising the importance of experience alongside clinical quality.

Quality and safety remained central to maternity and neonatal oversight in Derby and Derbyshire. During 2025/26, maternity services continued to operate within enhanced regulatory and system oversight arrangements, particularly at University Hospitals of Derby and Burton NHS Foundation Trust, following Care Quality Commission inspection findings, with assurance provided through routine reporting and system quality governance.

Both maternity service providers demonstrated improved performance against national safety programmes. Compliance with Saving Babies' Lives Care Bundle version 3.2 improved at both Chesterfield Royal Hospital NHS Foundation Trust and University Hospitals of Derby and Burton, with most elements achieving full compliance. Perinatal mortality rates were maintained below the national average, and improvements were seen in preterm place of birth. The NHS Maternity Incentive Scheme Year 7 declaration confirmed full compliance at Chesterfield Royal Hospital, with University Hospitals of Derby and Burton meeting nine of the ten safety actions.

In parallel, structured quality improvement work continued to address known safety risks, including postpartum haemorrhage and severe perineal trauma. This was supported through targeted education, enhanced clinical review and strengthened oversight arrangements to promote sustained improvement in safety and outcomes.

Recognising that workforce capability and sustainability are critical to the delivery of safe maternity and neonatal services, workforce development remained a system priority during 2025/26. System partners continued to focus on strengthening education, training and competency-based development for the maternity workforce. This included targeted education to support quality improvement programmes, enhanced clinical leadership within maternity services, and continued work through Derbyshire-wide workforce initiatives to support recruitment, retention and skills development. This activity aligned with the wider One Workforce approach across Derby and Derbyshire, supporting staff wellbeing, leadership development and the creation of sustainable workforce models to underpin safe and effective care.

While progress was made, significant challenges remained within maternity services across Derby and Derbyshire. These included ongoing workforce pressures, the need to sustain momentum and consistency of improvement, and continued regulatory scrutiny, particularly within acute maternity services. These challenges continued to be addressed through strengthened system oversight, enhanced engagement with NHS England, targeted maternity improvement programmes and continued engagement with women, families and staff. Improvement activity was supported through clear governance structures, enhanced perinatal surveillance and a continued commitment to learning from incidents, external 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 for children and young people.

Over the course of 2025/26, we have made progress in improving access to perinatal mental health and have achieved the target access rate of 10%.

As of January 2026, 14,800 children and young people were recorded as having at least one contact with mental health services, exceeding our plan of 14,565. It is a key ambition in our Joint Forward Plan to expand Mental Health Support Teams in schools. The teams play a really 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 63% across Derby and Derbyshire with ambitions to reach 100% by 2030. Children not currently receiving support through this service receive early intervention through the Changing Lives service.

Investment in specialist Child and Adolescent Mental Health Services has increased capacity for routine assessment and care, and early reductions in waiting times are emerging. The young adults service for 18 to 24-year-olds has also expanded,

addressing the previous gap in provision at age 18. This service supports vulnerable young adults who would otherwise not meet thresholds for specialist care and has strengthened integration across mental health pathways.

During 2025/26, work continued with partners across the voluntary sector, education, parent carer forums, health, and social care to develop multi-agency, needs-led pathways for neurodiversity. A pilot in Derby City for children aged 0 to 4 brought together family hubs, health visitors, and speech and language practitioners to provide early support and reduce demand for specialist intervention. Building on this learning, a similar pathway is being developed for children and young people aged 5 to 16, centred around education settings. The ICB also worked with Derby City and Derbyshire County Councils and parent carer forums on the second year of the National Partnership for Inclusion of Neurodiversity in Schools programme. Sixty-five primary schools have participated over two years. While the national evaluation is awaited, local impacts include improved attendance and reductions in exclusions and suspensions.

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, focused action was taken to improve dementia diagnosis rates, and by March 2026 a rate of 69.8% had been achieved, exceeding the national target of 66.7%. This improvement reflects sustained, coordinated efforts across hospital, care home and community settings.

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. Examples of talking therapies include guided self-help, cognitive behavioural therapy and counselling. Following a competitive tender process, a new lead provider for NHS Talking Therapies commenced in July 2025. Despite the scale of service transition, performance remained strong, with reliable improvement rates exceeding the national target and recovery rates close to the national benchmark.

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 26, we had zero patients in out-of-area placements in comparison to three in February 26. The opening of new inpatient accommodation across the county has led to a decrease in inappropriate out-of-area placements over the year. Reducing inappropriate out of area placements will continue to be a primary focus in 2026/27.

Further improvements have been made to the mental health crisis pathway following a system-wide review. Governance arrangements have been strengthened, with progress including the development of a system-wide programme focused on high-impact users, a review of the mental health helpline offer, reductions in out-of-area placements, and improved flow and discharge arrangements. Plans are also underway to establish a Mental Health Assessment Centre in Derby in 2026.

Services for people with a learning disability and/or autism

In 2025/26, Derby and Derbyshire demonstrated strong progress against its learning disability and autism priorities, particularly in governance, learning culture, health checks delivery, and workforce development. By March 2026, 5,364 Learning Disability Annual Health Checks have been completed, which is an increase in comparison to the previous year. Good quality learning disability annual health checks help identify health needs early and make sure reasonable adjustments are acted on, supporting better health outcomes overall.

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/or autism). Improved oversight of the LeDeR programme, alongside increased workforce capacity, has driven a significant improvement in timeliness, with LeDeR reviews being completed within six months of notification, which has risen from 32% in June 2025 to 94% by February 2026. This means learning from reviews is now being picked up and acted on much sooner.

Throughout the year, we remained committed to reducing the number of people with learning disabilities and/or autism cared for in in patient settings, while continuing to strengthen community-based support. For 2025/26, targets were set to have no more than 28 adults and no more than three children and young people (under 18) in inpatient care by March 2026. As of March 26, there were five children and young people in inpatients settings and 37 adults. While this is higher than planned, a remedial action plan is in place, and this will remain a key area of focus during 2026/27. Importantly, all individuals in inpatient care had active, personalised discharge plans supported by clear escalation routes and system-level accountability.

In 2025/26, there was continued system-wide delivery of the Oliver McGowan Mandatory Training, led through a commissioned model with University Hospitals of Derby and Burton NHS Foundation Trust acting as lead provider. During the year, daily tier 1 and weekly tier 2 sessions were held, supported by seven lead trainers and six accredited co-trainers with lived experience. Positive feedback was received, and Derbyshire was recognised for its robust delivery model. Whilst national and workforce pressures continued to affect overall compliance rates, a realistic recovery trajectory was able to be maintained aligned with Code of Practice expectations.

Preventative care and management of long-term conditions

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

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

- Long Covid Service Review – A structured assessment of outcomes, patient experience, and pathway performance informed a redesigned model that is sustainable, evidence-based, and responsive to local need.
- Obesity Digital Weight Management – The team strengthened alignment with local authority services and launched a targeted communications campaign in February 2026 to increase referrals from patients and General Practice.
- Tobacco Dependency Treatment Services – Smoking cessation support continued for inpatients, with a specific focus on mental health and maternity services. Around 5,300 inpatients were referred, 64% of which were seen at bedside; 1,750 patients opted into the service, with an 18% quit rate, consistent with national averages; and 885 maternity patients were referred, 35% engaged in support, which resulted in 87 quits to date.
- Virtual Wards – The service expanded its reach, with more than 4,500 patients supported this year, a 38% increase from 2024/25. Most patients received care at home, avoiding unnecessary hospital admission. Average length of stay remained within the national 14-day target, and bed utilisation and occupancy rates improved steadily, reflecting growing confidence in the model.
- Stroke Rehabilitation – A comprehensive review and improvement programme was delivered for community stroke rehabilitation. Enhancements include a new early supported discharge team in the High Peak, expanded stroke-specific psychology capacity, and a new Stroke Association service model offering additional peer support and education. These changes will reduce waiting times and strengthen outcomes.

- Primary/Secondary Care Interface – A System-wide working group oversaw implementation of a Single Point of Contact for General Practice to liaise directly with acute and community providers. This reduced administrative burden and improved resolution of issues related to waiting times, results, and appointments. Ongoing work continues to address interface challenges and refine pathways.
- Work, Health and Skills – The team supported development of the Get East Midlands Working Plan by mapping over 80 services, producing population insights, and identifying gaps. The team contributed to mobilisation of the 'Work with You' pilot in Chesterfield which supports people with health needs from deprived communities to remain in work or access employment opportunities. This also strengthened links with primary care through training needs assessments, pathway design, and workforce training.

Safeguarding children and young people

The ICB is committed to safeguarding and promoting the welfare of children and young people who access services across Derby and Derbyshire. While the ICB has specific statutory responsibilities in relation to safeguarding, effective safeguarding relies on strong multi-agency partnership working across health, local authority, police and commissioned provider organisations. The ICB therefore works closely with partners and providers to strengthen systems, improve safeguarding practice and maintain effective oversight and assurance.

The ICB is a statutory safeguarding partner within the Derby and Derbyshire Safeguarding Children Partnership, alongside Derby City Council, Derbyshire County Council and Derbyshire Constabulary. The partnership provides 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 with the safeguarding priorities of the partnership. The published safeguarding arrangements and the most recent safeguarding partnership annual report are available on the Partnership's website at www.ddscp.org.uk.

Safeguarding partnership arrangements are supported by established system safeguarding groups, which strengthen multi-agency working, information-sharing, oversight and assurance. The ICB's Safeguarding Team actively participates in safeguarding children practice reviews and rapid reviews and learning from local and national reviews and independent inquiries is routinely considered through partnership governance and system quality forums. This ensures that learning is translated into service improvement and safeguarding practice across commissioned services.

The Derby and Derbyshire Child Death Overview Panel continues to fulfil its statutory role, with regular meetings to review child deaths across the system. The Panel provides assurance that child deaths are reviewed consistently and that learning, themes and recommendations are identified and shared with statutory partners to inform system-wide improvement. Statutory partners receive recurring update reports through established governance routes. The Child Death Overview Panel's annual report is available at www.ddscp.org.uk.

During 2025/26, the ICB has continued to prioritise safeguarding within its roles as commissioner and system leader. Quality assurance reporting has confirmed that statutory safeguarding duties for children and young people are being fulfilled, with assurance frameworks in place and active engagement in safeguarding boards, reviews and partnership activity.

Areas of focus during the year have included maintaining oversight of safeguarding arrangements within commissioned services, supporting partnership working for children in care, and ensuring that safeguarding learning informs commissioning, quality improvement and risk management. Safeguarding intelligence and risks are considered through routine reporting to quality committees and through the ICB's wider quality and performance oversight arrangements.

The ICB is responsible for ensuring that safeguarding responsibilities are embedded within the services it commissions. Providers are required to operate in line with statutory legislation, national guidance and local safeguarding

arrangements. The ICB's Safeguarding Children Policy, published on the ICB's website, sets out how these responsibilities are discharged.

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 NHS England's Safeguarding Children, Young People and Adults at Risk – Safeguarding Accountability and Assurance Framework. These assurance processes are supported by the ICB's Safeguarding Team, which provides expert advice and challenge, and by routine reporting and escalation through established quality governance structures.

The ICB follows the statutory safeguarding 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 quality reports and routine consideration through system quality and risk governance.

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 views SEND as a key priority, recognising that effective early support and well-coordinated services can make a significant difference to children's development, educational engagement and longer-term health outcomes. The ICB is committed to working with partners across health, education and social care to support children and young people with SEND and their families.

The ICB undertakes its SEND responsibilities in line with 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 specialist assessments has continued to increase across the Derby and Derbyshire partnership, particularly in relation to EHCP needs assessments, neurodevelopmental assessment and mental health pathways. Despite this growth in demand the majority of NHS providers continue to deliver health advice as part of EHCP processes within set timescales, and quality of advice remained consistently high during the year.

Pressure remains most evident within neurodevelopmental and mental health services, where waiting times and access continue to be a focus for system partner transformation.

SEND quality and performance are overseen through children and young people governance arrangements, with assurance and scrutiny provided through the ICB's Quality and Service Improvement Committee, and System Quality Group. This ensures SEND priorities remain integrated with wider children and young people commissioning and quality improvement activity.

Improvement actions and progress during the year include:

- Annual SEND quality assurance meetings, completed with the majority of NHS providers, are strengthening assurance alongside existing oversight of EHCP health advice quality via two-yearly audit reports, and SEND self-assessment and action plans as documented in each Trust's Annual SEND Report.
- EHCP quality has been strengthened by rollout of multi-agency quality assurance of EHCPs and level three training for NHS services.
- ICB and NHS provider services have continued to work jointly with local authorities to support delivery of SEND improvement priorities following inspection in the County and inspection readiness in Derby City. This included supporting the refresh of local SEND strategies and self-evaluation frameworks and joint commissioning arrangements, strengthening partnership governance and improving the use of data and intelligence. Improvement activity across neurodevelopmental and mental health pathways has focused on access, waiting times

and support for children and families while waiting for assessment or treatment.

- A neurodiversity early-years model for children aged 0 to 4, delivered through Family Hubs, improved access to early support. Learning from this work alongside the Partnerships for Inclusion of Neurodiversity in Schools Project within both Derby and Derbyshire, informed pathway development for children and young people aged 5 to 16, centred around education settings.
- In parallel, the new Community Nursing in Education Settings service continued its phased roll-out, supporting clearer and more consistent understanding of the role of education and health partners in the delivery of health interventions within education environments.

The ICB will continue to work with local authority partners and NHS providers to maintain appropriate oversight, support ongoing improvements post-inspections and demonstrate how it is discharging its statutory responsibilities for children and young people with SEND, including its role in supporting the implementation of both local areas SEND Reform plans following the publication of the government's 'Every Child Achieving and Thriving' White Paper (2026).

The ICB will also continue to work in partnership with both local authorities and NHS providers to sustain high-quality EHCP health advice, embedding strengthened assurance, and improving access and early intervention across neurodevelopmental and related pathways.

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 wider social and economic factors influencing population health.

The Get East Midlands Working plan aligns with the national Get Britain Working priorities, adapting them to the East Midlands economic context. This ambitious initiative, developed by the East Midlands Combined County Authority (EMCCA) in partnership with the Department for Work and Pensions (DWP) and the two local ICBs, sets out a bold vision to help more people across Derby, Derbyshire, Nottingham and Nottinghamshire access good jobs, improve their health, and enjoy a better quality of life.

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

During the year, the ICB was a key system partner in the Chesterfield Connect to Work pilot with Chesterfield Borough Council. This pilot highlighted the important role of social prescribers as trusted referral partners, while also demonstrating the need for wider primary care engagement to ensure support reaches patients who may benefit most. Targeting deprived communities was critical in addressing health-related worklessness, and engagement with VCSE organisations supported trust-building within local communities.

Learning from the pilot is informing 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 holistic, early-intervention work, health and skills service, providing personalised assessment and coordinated support for people at risk of leaving work due to ill health, those recently out of work with low-level needs, and those struggling to remain in work because of health conditions.

The ICB's commissioning approach places strong emphasis on prevention, early intervention and

neighbourhood-based care. Neighbourhood health services are designed to promote independence, reduce avoidable deterioration and strengthen links with community assets and wider public-sector partners, including employment and voluntary sector organisations.

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

Through Integrated Care Partnership arrangements, the ICB works with local authorities and partners to align healthcare commissioning with broader strategies addressing social, environmental and economic conditions. While the ICB does not directly deliver employment programmes, it plays an enabling role through commissioning and by embedding health considerations into place-based decision-making.

The ICB also participated in the development of the EMCCA Inclusive Growth Plan and will continue engagement during 2026/27 to explore how the NHS can contribute as a local anchor institution, including supporting wider social and economic objectives.

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. The ICB delivered a surplus of £0.1 million against a planned target of breakeven (2024/25: £1.4 million surplus). The ICB and its wider NHS system partners have worked as a collective throughout the financial year to identify efficiencies and deliver their financial positions.

The ICB faced significant financial pressures during 2025/26. These included continued demand-led growth across independent sector acute services and neurodivergent assessments, and additional cost pressures associated with changes in commissioning responsibilities and organisational restructuring, including redundancy and joint working costs. These pressures were mitigated through coordinated system-wide financial management, including delivery of efficiency and productivity programmes, strengthened in-year expenditure controls, careful prioritisation and phasing of investment, and the use of NHS England's in-year financial risk share arrangements for agreed areas of exceptional expenditure. Together, these actions enabled the ICB to maintain delivery against its statutory financial duties and to achieve its planned year-end position.

The ICB is statutorily required to deliver key financial targets, including an income and expenditure target. 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 (£000)	Actual (£000)
Income and expenditure (ICB): Expenditure not to exceed income	3,149.83	3,149.76
Income and expenditure (NHS system): Expenditure not to exceed income	3,149.83	3,190.31
Running costs (ICB): Remain within running cost allowance	27.49	22.24

Category of expenditure	Total 2025/26 spend (£m's)	Total 2024/25 spend (£m's)
Acute (hospital) care	1,479.69	1,393.25
Specialised acute (hospital) care	253.05	202.46
Community care	196.41	188.49
Mental health care	363.02	331.59
Primary care	444.37	405.15
Prescribing	202.24	203.09
Continuing care	141.82	135.49
Other non-healthcare	84.46	73.33

Category of expenditure	Total 2025/26 spend (£m's)	Total 2024/25 spend (£m's)
Corporate running costs	23.74	19.48
Total	**3,188.80**	**2,952.33**

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. 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	(3,188.9)	(2,953.7)	(2,512.4)	(1,706.8)
Gross Operating Costs	3,188.8	2,952.3	2,511.4	1,721.6

Mental Health Investment Standard

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

Total mental health expenditure for 2025/26 equates to £287 million. This includes an increase in recurrent expenditure of 26.0% when compared with 2024/25.

There have been two changes in mental health reporting since 2024/25:

- Service Development Funding: The MHIS target scope has been amended by NHS England to include Service Development Funding expenditure that has now become baseline funding, increasing the proportion of mental health spend by 0.58%.
- 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 included within the MHIS target, increasing the reported proportion of mental health spend by 0.96%.

For the purposes of MHIS, mental health spend excludes learning disability, autism and dementia, and spend relating to Mental Health Service Development Funds. The proportion of mental health spend by the ICB of the overall programme allocation was 9.19% (2024/25: 7.86%), which is demonstrated in the table below:

Mental health expenditure	2025/26	2024/25
Mental Health Spend (£m)	287.0	227.7
ICB Programme Allocation (£)	3,122.6	2,897.0
Mental health spend as a proportion of ICB Programme Allocation (%)	9.19	7.86

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 purpose 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 system priorities.

During 2025/26, capital resources across Derby and Derbyshire were managed in collaboration with partner organisations within the Joined-up Care Derbyshire system. Capital planning and investment decisions were taken in line with national guidance and within the available system capital envelope.

Capital expenditure during 2025/26 was as follows:

Capital expenditure	Plan (£000)	Actual (£000)	Variance (£000)
Capital allocation (Trusts)	95,128	94,841	(287)

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

Capital expenditure	Plan (£000)	Actual (£000)	Variance (£000)
Capital allocation (ICB)	2,567	2,080	(487)
Total capital spend	**97,695**	**96,921**	**(774)**

In-year capital expenditure was directed towards operational and infrastructure priorities, including new builds to ensure the estate was fit for purpose for future health care delivery, addressing backlog maintenance requirements on existing sites, replacement of service critical equipment and investment in IT infrastructure. As host commissioner for Derbyshire the capital envelope also included funding for East Midlands Ambulance Service NHS Trust, therefore expenditure also included the purchase of fleet and emergency response vehicles.

Where applicable, the system also benefited from national capital funding streams supporting major programmes and priority schemes. These investments contributed to the mental health dormitory eradication programme, digital transformation initiatives, the Acute Front Door and Outwoods schemes at Royal Derby Hospital, and funding for schemes that support net zero initiatives.

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 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, 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.

As in previous years, quality improvement activity during 2025/26 has been shaped by ongoing quality and safety challenges within a small number of providers and services, requiring enhanced oversight, regulatory engagement and sustained improvement support.

Within Derby and Derbyshire, the most significant quality concerns during the year have primarily related to Derbyshire Healthcare NHS Foundation Trust and University Hospitals of Derby and Burton NHS Foundation Trust, both of which have required focused quality oversight through established system and national arrangements.

Derbyshire Healthcare NHS Foundation Trust has been subject to continued scrutiny during 2025/26, particularly in relation to mental health urgent care pathways, crisis line performance, inpatient flow and the use of out-of-area placements. The Trust has operated within the NHS Oversight Framework at an enhanced level, with improvement activity overseen through clinical quality review processes and supported by the ICB and national partners. While progress has been made in some areas, the pace and sustainability of improvement remain a focus of ongoing assurance.

University Hospitals of Derby and Burton NHS Foundation Trust has remained within the NHS Oversight Framework Segment Three during the year. While the Trust continues to demonstrate generally stable quality performance and has received positive feedback from recent regulatory activity, it remains subject to routine enhanced oversight in line with national expectations. The ICB has continued quality insight visits and contract and performance review mechanisms to ensure early identification and management of quality risks.

In addition to provider-specific concerns, there have been ongoing challenges across Derby and Derbyshire in relation to children and young people, including those with Special Educational Needs and Disabilities, and the delivery of timely and effective mental health and neurodevelopmental pathways. These issues continue to require multi-agency collaboration and strengthened oversight across health and local authority partners.

These quality issues and associated risks are kept under regular review through established governance structures and are reflected within the ICB's risk management and assurance processes.

The 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 Special Educational Needs and Disabilities 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, 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, supporting the development of patient safety capability across the system. Patient Safety Partners are 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 support NHS partners to strengthen

learning, improvement and system-wide sharing of patient safety insight, with ongoing monitoring of maturity and impact through established reporting routes.

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 the population.

During the year, the ICB continued to prioritise a relationship based approach to working with people and communities. This approach focuses on trust, transparency and shared ownership, and values lived experience alongside professional expertise. It supports stronger relationships with communities and helps ensure that insight from local people informs priorities, service improvement and wider system development across Derby and Derbyshire.

During 2025/26, examples of this approach included:

- The Community Health Alliance, established to build trust with Black African and Caribbean communities.
- Partnership working in Barrow Hill to support residents to influence the development of the Memorial Hall Health Hub.
- The use of storytelling to inform the development of Local Navigation Hubs, supporting learning and action across teams and partners.
- The Community Partnership addressing maternity and neonatal health inequalities.
- Work to empower women to influence system change in relation to women's health services, particularly within General Practice.

These activities supported communities to influence service development and helped ensure that local insight informed commissioning and improvement activity.

Further detail on activity undertaken during the year, including examples of how the ICB has worked with people and communities, is provided in the published Annual Working with People and Communities Annual Report which is available at https://joinedupcarederbyshire.co.uk/involving-people-communities/.

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 Joint Strategic Needs Assessments, population health management and wider 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.

- Following a clear 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 routine Board reporting, committee assurance and wider governance processes.

Health inequalities are closely linked to differences in life expectancy and rates of avoidable mortality. 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 through routine Board and committee oversight, alongside wider population health reporting and intelligence, helping to inform strategic priorities and longer-term system planning.

This work is also underpinned by system intelligence and population health management analysis, including support from the Strategic Analytics and Intelligence Unit (SAIU), which helps build a shared understanding of population need and patterns of inequality, including variation in access and outcomes. This supports evidence-based planning and strengthens oversight of progress in reducing health inequalities.

During 2025/26, this has also been reflected in targeted work to improve access and outcomes for specific communities and population groups. This has included:

- Continuing to align delivery to the Core20PLUS5 approach, helping to focus improvement activity on groups and communities who experience the poorest outcomes and the greatest barriers to access, and ensuring that health inequalities are considered through both planning and performance oversight arrangements.
- Developing plans to expand access to NHS Talking Therapies delivered in British Sign Language, recognising the barriers that Deaf people can face in accessing timely and appropriate mental health support and the importance of providing services in a way that better meets communication needs.
- Supporting the development of women's health champions to strengthen awareness, advocacy and improvement in women's health, helping to ensure that women's needs are better recognised and reflected within service development and delivery.
- Working with communities to co-produce improvements to sickle cell services through a community health alliance, alongside supporting the establishment of a new Sickle Cell patient group, helping to strengthen service design through lived experience and improve support for a group whose needs have often been underserved.
- Delivering collaborative work with communities to improve hypertension outcomes, which received national recognition through an NHS Communicate Award, reflecting the value of partnership-based approaches in addressing inequalities in prevention, early intervention and long-term health outcomes.

As part of annual reporting requirements, the ICB also publishes a separate statement demonstrating how it is meeting its legal duties to reduce health inequalities. Our statement for 2025/26 reflects both our progress and challenges and informs our ongoing efforts to target resources where need is greatest and ensure equitable care for all communities. The statement is published alongside this Annual Report on our website.

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 Lincolnshire ICB and NHS Nottingham and Nottinghamshire 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

Derby City and Derbyshire 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 Derby City and Derbyshire 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 the City and County Councils, the Boards' memberships include a range of local partners, including Derbyshire Police, Derbyshire Fire and Rescue Service, Healthwatch Derby and Derbyshire, NHS England, local NHS Trusts and representatives from the voluntary sector.

We are active members of the Derby City and Derbyshire 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 Derby City and Derbyshire County Joint Local Health and Wellbeing Strategies and the Derby and Derbyshire Integrated Care Strategy, produced by our Integrated Care Partnership.

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

Environmental matters

Sustainable development is recognised as an integral part of delivering healthcare. Climate change is not only a major threat to our planet, but to our health as well. NHS England aims to be the world's first net zero national health service, which requires us all to act on our NHS Carbon Footprint and our NHS Carbon Footprint Plus. As an ICB, we have a key leadership role in supporting this ambition and we actively support collaborative action across health and care partners to meet these duties.

Our sustainability strategy is set out in the refreshed ICS Green Plan 2025-28, approved by the ICB's Board in September 2025. Developed with system partners, the plan defines actions across eight priority areas aligned with national requirements. Oversight is provided through the ICS Greener Delivery Group, chaired by the ICB.

Throughout 2025/26, progress continued across key areas, including:

- Development of a system-wide training offer to support sustainability in everyday practice.
- Securing over £1 million in national funding for estate decarbonisation.
- Capping all nitrous oxide pipework to reduce environmental impact.
- Continued increases in the prescribing of greener inhalers.

Environmental considerations are also embedded within wider ICB processes. This has included:

- Embedding a sustainability impact assessment within commissioning processes to ensure environmental considerations are included in service change decisions.
- Applying a minimum 10% weighting for Net Zero and Social Value in ICB procurements.
- Requiring suppliers to have a Carbon Reduction Plan in place.

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, 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 the 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 Derby and Derbyshire, 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 eight 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 personalised care have been reflected in our wider commissioning, engagement and service development arrangements. This has included:

- A dedicated Joined-up Care Derbyshire webpage setting out opportunities for patient and public involvement.
- Co-produced guidance for patient and public partner recruitment, developed through the Peer Support Network.
- The Joined-up Care Derbyshire online engagement platform, supporting interactive dialogue between citizens and health and care partners.
- A Readers' Panel of volunteers who review patient-facing information for clarity and accessibility.
- A Patient Participation Group Network representing General Practice populations across Derby and Derbyshire.
- Derbyshire Dialogue, a programme of interactive sessions between residents and senior clinicians or officers to support transparency, learning and two-way communication.

During the year, lived experience has continued to inform service development and improvement. This has included the contribution of volunteer Experts by Experience to the Mental Health Together programme, helping shape work such as the regional NHS 111 press 2 initiative. The ICB has also 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.

Ensuring patient choice

Patients have a legal right of choice and ICBs are required to act with a view to enabling patient choices with respect to aspects of health services provided to them. This duty is implicit within our established arrangements. We commission healthcare services, in line with our commissioning responsibilities, from a range of NHS and independent sector providers, ensuring that these are made known to patients at the point of referral via the contracts we hold with our primary care providers.

In practice, this means that patients requiring elective care can consider factors such as where waiting times are the shortest, including outside our area where possible, or a personal preference when considering their treatment. To support this, we have:

- Established a list of self-referral services on our website so that patients can contact certain healthcare services directly without first needing to see a GP or consultant.
- Operated a Patient Initiated Digital Mutual Aid System, enabling us to proactively offer patients the ability to opt in to move provider when they have been waiting over 40 weeks for care.

Patients can also make a choice of mental health provider and team for a consultant-led assessment and subsequent treatment, where this is clinically appropriate and care can continue to be delivered in an integrated way. Some exclusions to patient choice apply, including urgent, emergency or crisis services, where people are in a hospital setting 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 and to change GP if they are not satisfied with the care provided. We also ensure that appropriate choices are offered in end-of-life care, to help ensure people experience end of life according to their personal and individual wishes.

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

During the year, we have also had a focus on digital solutions to improve choice, including increasing use of digital correspondence, improving patient access to services through digital and NHS App engagement, and providing accessible information digitally.

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 established a Clinical and Professional Leadership Group, comprised of senior clinical and care giving leaders from across all system partners. This group is responsible for:

- Providing advice and assurance on the development and review of clinical pathways and policy.
- Ensuring that clinical transformation plans lead to desired outcomes.
- Facilitating, strengthening and building clinical professional leadership within the ICS so that the best outcomes for the population are achieved collectively.

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 their functions. In Derby and Derbyshire, this is supported through our wider strategic, commissioning and transformation arrangements, including our focus on data, analytics and intelligence, digital and GP IT, service configuration, care pathway optimisation, research, evaluation and innovation.

Our organisational arrangements support innovation through:

- Use of data, analytics and intelligence, including population health segmentation,

forecasting and modelling, to inform commissioning and service improvement.

- Digital transformation and digital infrastructure to support more effective and accessible service delivery.
- Service configuration and care pathway optimisation to enable new ways of delivering care.
- Partnership working across the system, including with wider stakeholders and academic partners where relevant.

During the year, innovation has continued to be supported through commissioning, service development and transformation activity across Derby and Derbyshire, including work to strengthen neighbourhood health, improve digital capability, and develop more proactive and responsive models of care. This has been underpinned by the ICB's wider role in strategic planning, market development, population health management and system partnership working

Promoting research

ICBs have a statutory duty to facilitate or otherwise promote research on matters relevant to the health service, and to promote the use in the health service of evidence obtained from research. We recognise that research supports improvements in clinical and care practice, contributes to a healthier population, supports a skilled and engaged workforce, and helps improve outcomes and reduce inequalities.

During 2025/26, research activity across Derby and Derbyshire has included:

- Continued collaboration with the NIHR Applied Research Collaboration East Midlands, supporting its successful application for the next five-year funding period from April 2026.
- A new collaborative partnership with the University of Derby, bringing together a broad range of health and care partners.
- A system sandpit event enabling diverse stakeholders, including people with lived experience, to identify shared research priorities aligned to the system priority of reducing harm related to drugs and alcohol.
- Continued work through the Inter-Disciplinary Partnership on Health Inequalities and Race to support knowledge exchange and the development of interdisciplinary research agendas.
- Continued delivery of the REBALANCE Research Engagement Network to improve inclusion and diversity in research participation and reduce barriers for underserved groups.

Participation in research has also remained strong during the year. During 2025/26:

- 8,923 individuals from Derby and Derbyshire participated in National Institute for Health and Care Research studies.
- The four local NHS trusts collectively offered 185 different studies, enrolling 7,595 participants.
- General Practices enabled an additional 1,328 individuals to participate in ten different primary care research studies.
- 13,598 people in Derby and Derbyshire had registered with Be Part of Research since July 2022, including 2,149 new registrants in 2025/26.
- 88% of respondents to the Research Experience Survey agreed or strongly agreed that they would consider participating in research again.

Through these arrangements, the ICB has continued to facilitate research activity at scale, strengthen workforce and system capability, and support the 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.

Our education and training agenda across Derby and Derbyshire during 2025/26 has included:

- Oliver McGowan tier one, part two training, to help ensure the health and social care workforce has the right skills and knowledge to

provide safe, compassionate and informed care to autistic people and people with a learning disability.

- Cultural competency training, focused on developing cultural awareness, understanding unconscious bias, promoting inclusivity and supporting practical action planning.
- Community pharmacy services training, coproduced alongside three Primary Care Networks in Derbyshire and delivered across the system, covering referral processes for Pharmacy First, oral contraception and blood pressure checks.
- The Derbyshire Leader Network, providing core leadership development opportunities for aspiring and existing leaders across health, social care and the voluntary sector.
- The Microsoft 365 Digital Champions Programme, supporting staff who are passionate about digital tools to build confidence, enhance skills, increase productivity and expand networks.

Together, these activities support safe, inclusive and effective care while strengthening workforce capability, leadership development and service transformation across Derby and Derbyshire.

Promoting integration

We have a duty to ensure that health, social care and health-related services are provided in an integrated way to prioritise prevention and early intervention to avoid ill-health and improve outcomes; reduce inequalities in outcomes, experience and access; develop care that is strengths based and personalised; improve connectivity and alignment across Derby and Derbyshire; ensure people experience joined-up care; and create a sustainable health and care system.

Achieving this integration depends on a culture of collaboration, bringing together:

- Our communities, who 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 involved in health and care, as well as supporting broader determinants of health.
- Other public services such as schools, police, fire and job centres.

We have satisfied this duty through a range of workstreams during the year, including:

- Work with Derby City and Derbyshire County Councils to develop a Derbyshire Carers Strategy, co-produced with carers, health and care providers and voluntary, community, faith and social enterprise organisations to strengthen early intervention and integrated support.
- Development and agreement of a Neighbourhood Model for Derby and Derbyshire through extensive engagement, including workshops and a Neighbourhood Summit.
- Continued development of integrated approaches across neighbourhood, place and system level to support more coordinated, person-centred care.

The Neighbourhood Model sets out an integrated approach to health and care operating across three levels of scale:

- Integrated Neighbourhood Teams, responsible for delivering coordinated care to local communities.
- Neighbourhood Health Alliances, responsible for organising and aligning resources to meet population needs.
- Place partnerships, responsible for enabling strategic integration and wider system alignment.

Through these partnerships and delivery approaches, the ICB has 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 Derby and Derbyshire.

Having regard to the wider effects of decisions

The Health and Care Act 2022 introduced a 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 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 delivery of the Integrated Care Strategy. This joint approach to planning helps ensure 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, ensuring that the Triple Aim is embedded in decision-making and evaluation processes. Our 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://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/icb-leadership-team/.

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.

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 Derby and Derbyshire ICB's Board was revised during the year in line with the establishment of formal partnership arrangements with NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire 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
Michelle Arrowsmith	Chief Strategy and Delivery Officer (to 10 October 2025)
Dr Dave Briggs	Executive Director of Outcomes (from 1 November 2025)
Chris Clayton	Chief Executive (to 30 September 2025)
Jill Dentith	Non-Executive Member (to 31 October 2025)
John Dunstan	Non-Executive Director (from 1 November 2025)
Margaret Gildea	Non-Executive Director
Ellie Houlston	Local Authority Partner Member (to 31 October 2025)
Professor Dean Howells	Chief Nurse Officer (to 31 October 2025)
Stephen Jackson	Non-Executive Director (from 1 November 2025)
Mehrunnisa Lalani	Non-Executive Director (from 1 November 2025)
Dr Kathy McLean	Chair
Dr Andrew Mott	Primary Medical Services Partner Member
Dr Adedeji Okubadejo	Clinical Lead Member (to 31 October 2025)
Stephen Posey	Chief Executive NHS Foundation Trust Partner Member
Mark Powell	NHS Foundation Trust Partner Member (to 31 October 2025) and Ordinary Member for Mental Health (from 1 November 2025)
Maria Principe	Executive Director of Commissioning (from 1 November 2025)
Lee Radford	Chief People Officer (to 31 October 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
Paul Simpson	Local Authority Partner Member
Nigel Smith	Non-Executive Member (to 31 October 2025)
Amanda Sullivan	Chief Executive (from 1 October 2025)
Sue Sunderland	Non-Executive Member (to 31 October 2025)
Jon Towler	Non-Executive Director (from 1 November 2025)
Rosa Waddingham	Executive Director of Quality (from 1 November 2025)
Dr Chris Weiner	Chief Medical Officer (to 31 October 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://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/icb-leadership-team/.

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 Governance Committee and Audit Committee

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

- Sue Sunderland (Chair)
- Jill Dentith
- Dr Adedeji Okubadejo
- Nigel Smith

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 Committee (or equivalent) 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 https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/conflicts-of-interest/.

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, 43 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.

Two data protection breaches have required reporting to the Information Commissioner's Office (ICO) during 2025/26. Appropriate action was taken by the ICB in response, and the ICO has since closed both cases following review.

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 our website at https://joinedupcarederbyshire.co.uk/download/modern-slavery-statement/.

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 Derby and Derbyshire 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.

During the year, there was a change in the appointment of the Accountable Officer for NHS Derby and Derbyshire ICB. Chris Clayton served as Accountable Officer until 30 September 2025, and Amanda Sullivan was appointed by NHS England as Accountable Officer with effect from 1 October 2025.

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 Derby and Derbyshire 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 Derby and Derbyshire 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 Derby and Derbyshire. 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 Derby and Derbyshire ICB has established formal partnership arrangements with NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire 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 Derby and Derbyshire 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.

I am also appointed as the Accountable Officer for NHS Nottingham and Nottinghamshire ICB (since 1 July 2022) and NHS Lincolnshire ICB (since 1 October 2025). The following sections describe how NHS Derby and Derbyshire 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 on our website at: https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/.

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 Derby and Derbyshire ICB, NHS Lincolnshire ICB, and Nottingham and Nottinghamshire 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 Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire 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 85%.

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 Lincolnshire ICB and NHS Nottingham and Nottinghamshire 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: cyber security; the Board Assurance Framework; 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.

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 Lincolnshire ICB and NHS Nottingham and Nottinghamshire 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 Governance Committee (1 April to 19 November 2025) and Audit Committee (20 November 2025 to 31 March 2026)

Until 19 November 2025, the Audit and Governance 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

Lincolnshire ICB and NHS Nottingham and Nottinghamshire 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 Governance Committee met five times and the Audit Committee met twice, with 100% attendance. 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, digital, health and safety, emergency preparedness, resilience and response, standards of business conduct, and environmental sustainability.

Remuneration 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 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 Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire 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 five times with an average attendance of 68%, 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 seven times with an average attendance of 86%, 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 strategic estates plans. The Committees also maintained oversight of actions to mitigate the key operational risks relevant to their remits.

Quality, Safety and Improvement Committee and People and Culture 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, Safety and Improvement Committee provided assurance to the Board on quality improvement, clinical effectiveness, medicines optimisation, patient experience, and safeguarding, while the People and Culture Committee provided assurance relating to 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 the three Committees comprised Non-Executive Directors and the relevant Executive Directors and Senior Leaders responsible for quality, medical leadership, delivery and operations, finance, strategy, and workforce transformation, in line with the applicable terms of reference. The Committees were also routinely supported by relevant subject matter experts and governance leads.

The Quality, Safety and Improvement Committee met five times with average attendance of 92%, the People and Culture Committee met three times with average attendance of 80%, and the Joint Committee met three times with an average attendance rate of 89%. 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; monitoring of safeguarding, infection prevention and control, medicines optimisation, immunisation and vaccination arrangements, and system workforce plans. The Committees also maintained oversight of actions to mitigate the key operational risks relevant to their remits.

Strategic Commissioning 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 Commissioning 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.

The Committees' memberships 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 five times and the Joint Committee met three times, with attendance rates of 90% 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; monitoring of the contract management framework; development of clinical policies; and oversight of the better care fund, women's health, winter planning arrangements, and the public involvement in prioritisation framework, including engagement with ethnic minority communities. 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 Derby and Derbyshire, an ICP has been established as a joint committee of Derby City Council, Derbyshire County Council and NHS Derby and Derbyshire ICB. The primary role of the ICP is to lead on creating an Integrated Care Strategy to reduce health inequalities and improve health and care outcomes and experiences for the Derby and Derbyshire population.

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

The ICP met five times 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 Derby and Derbyshire ICB has established a formal Joint Working Agreement with NHS Leicester, Leicestershire and Rutland ICB, NHS Lincolnshire ICB, NHS Northamptonshire ICB, and NHS Nottingham and Nottinghamshire 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 Lincolnshire ICB and NHS Nottingham and Nottinghamshire 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 the delivery of its statutory functions, service performance, quality of care and financial sustainability. The ICB's risk profile reflected sustained operational pressures across health and care services, alongside risks associated with financial recovery, workforce resilience, digital capability and the transition to aligned ICB cluster arrangements.

The most significant operational risks during the year related to system capacity and patient flow, particularly within urgent and emergency care, hospital discharge and elective recovery.

Continued pressures across ambulance handovers, acute capacity and community services created risks to patient experience, safety and system performance. These risks were subject to ongoing system oversight, with actions monitored through established governance arrangements.

Mental health services remained a key area of risk, reflecting pressures on inpatient bed availability and community placement options. These pressures had the potential to impact timeliness of care, continuity of treatment and system affordability, and were kept under close review through quality, performance and risk reporting mechanisms.

Quality-related risks continued to be monitored, including the need to sustain improvements within commissioned services and to maintain public confidence in areas such as maternity services, mental health, primary care and community provision. Risks affecting people with learning disabilities and autistic people were also monitored, particularly where delays in access to appropriate community-based support could result in extended inpatient stays.

Workforce risks were a continued focus, recognising the potential impact of high workloads, vacancies and organisational change on staff wellbeing, sickness absence, retention and productivity. The requirement to reduce running costs and implement workforce change arrangements during the year increased the importance of maintaining organisational resilience and capacity to deliver core statutory functions.

Financial risks remained significant throughout the reporting period, reflecting ongoing cost pressures, delivery of efficiency requirements and the challenge of maintaining financial sustainability while progressing transformation programmes and system priorities. These risks were reviewed through the Board and its committees as part of routine financial and performance oversight.

Digital and cyber risks were also assessed during the year, including risks associated with digital transformation capacity, interoperability, implementation of new systems and resilience to cyber threats, recognising the potential impact on service continuity, data quality and information security.

As part of the formal partnership arrangements established with NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire ICB, the ICB shared a number of key risks across the cluster. These included risks associated with the future of commissioning support services, delivery of ICB priorities during organisational transition, workforce change affordability and the effectiveness of communication and engagement during change. These shared risks were subject to joint oversight and assurance arrangements, while maintaining accountability for local statutory duties and 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.

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:

- 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 limited weaknesses in access controls and transactional approvals within finance systems. 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.
- 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 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	High risk/high confidence *(Opinion in line with the DSPT Independent Assessment Framework)*
Provider Selection Regime	Significant
Business Continuity	Significant
Board Assurance Framework	Significant
Cost Improvement Plan Governance	Significant
Public Involvement	Moderate
S117 Contract Governance	Limited
Cyber Resilience and Governance	Moderate

Three further advisory reports have been issued. Two were undertaken with NHS system partners: MSK service provision; and elective recovery fund. The third related to a follow-up of actions agreed as part of the 2024/25 Data Quality and Performance Management Framework review. No opinions were provided for these reports; however, areas of learning were highlighted, and actions were suggested to enhance existing arrangements.

An internal audit review of Section 117 contract governance concluded a limited assurance opinion. This reflected areas where control arrangements required strengthening to ensure consistent application and oversight.

In response, management has developed and is implementing an action plan to address the findings, with progress monitored through established governance arrangements, including reporting to the Audit Committee.

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 31 October 2025, the Remuneration Committee operated as a committee of NHS Derby and Derbyshire 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 1 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 Committee during the period 1 April to 19 November 2025:

- Margaret Gildea (Chair)
- Dr Kathy McLean
- Dr Adedeji Okubadejo
- Nigel Smith
- Sue Sunderland

The following Non-Executive Directors were members of the Joint Remuneration and Human Resources 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 Resources 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%	–
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	1%	–

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%	–
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	1%	–

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%.

Due to the national restructuring of ICBs, there has been a high level of staffing changes at the ICB during the year. As a result, the employee percentage change is lower than the 3.6% uplift awarded. As part of this restructuring, the ICB has partnered with NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire 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 £272,500 (2024/25: £217,500). 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 at 31 March 2026 and 31 March 2025.

2025/26	25th percentile	Median pay ratio	75th percentile
Total remuneration (£)	32,968	50,273	62,682
Salary component of total remuneration (£)	31,049	49,874	62,682
Pay ratio information	8:1	5:1	4:1

2024/25	25th percentile	Median pay ratio	75th percentile
Total remuneration (£)	29,970	48,526	63,702
Salary component of total remuneration (£)	29,970	48,526	60,504
Pay ratio information	7:1	4:1	3:1

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

Remuneration ranged from £22,500 to £272,500 (2024/25: £22,500 to £217,500). 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 Resources 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 Members and the Local Authority Partner Members are unremunerated appointments. The Primary Care Partner Member will be required to commit time to the ICB in relation to their appointment for which they will not be remunerated by their practice. As such, this role is remunerated at a standard sessional rate, calculated based on backfill costs.

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

Standard contracts have been established for all senior manager posts, which differ depending on whether the post is appointed for a term of office (as is the case for some Board roles, such as our Non-Executive Directors and Partner Members) or is an employed position (as is the case for our Executive Directors). 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:					
Name and title	**(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[3])*	**(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)*
Tracy Allen, Participant Member to the Board, Derbyshire Community Health Services NHS Foundation Trust	–	–	–	–	–	–	0-5	0	0	0	0	0-5
Michelle Arrowsmith, Chief Strategy and Delivery Officer	85-90	0	0-5	0	0	85-90	155-160	0	0-5	0	37.5-40	200-205
James Austin, Chief Digital Information Officer	–	–	–	–	–	–	25-30	700	0	0	25-27.5	50-55
Dr Avi Bhatia, Clinical and Professional Leadership Group Participant Member of the Board	–	–	–	–	–	–	70-75	0	0	0	0	70-75
Dr Dave Briggs, Executive Director of Outcomes (Medical)	20-25	0	0	0	2.5-5	25-30	–	–	–	–	–	–
Dr Chris Clayton, Chief Executive	110-115	100	0	0	35-37.5	145-150	215-220	1,200	0	0	42.5-45	260-265
Jill Dentith, Non-Executive Member	5-10	100	0	0	0	5-10	10-15	300	0	0	0	10-15
Helen Dillistone, Executive Director of Transition	110-115	100	0	0	50-52.5	160-165	145-150	300	0	0	32.5-35	180-185
John Dunstan, Non-Executive Director	0-5	0	0	0	0	0-5	–	–	–	–	–	–
Claire Finn, Interim Chief Finance Officer	–	–	–	–	–	–	40-45	0	0	0	0	40-45
Linda Garnett, Interim Chief People Officer	–	–	–	–	–	–	85-90	0	0	0	0	85-90
Maragaret Gildea, Non-Executive Director	10-15	0	0	0	0	10-15	15-20	0	0	0	0	15-20
Keith Griffiths, Chief Finance Officer	–	–	–	–	–	–	120-125	600	0	0	0-2.5	25-30
Ellie Houlston, Local Authority Partner Member	0	0	0	0	0	0-5	0-5	0	0	0	0	0-5
Prof Dean Howells, Chief Nurse Officer	95-100	6,500	0	0	0	100-105	160-165	5,800	0	0	70-72.5	240-245
Stephen Jackson, Non-Executive Director	0-5	0	0	0	0	0-5	–	–	–	–	–	–
Mehrunnisa Lalani, Non-Executive Director	0-5	0	0	0	0	0-5	–	–	–	–	–	–
Dr Kathy McLean, ICB Chair	45-50	100	0	0	0	45-50	50-55	200	0	0	0	55-60
Dr Andrew Mott, Primary Care Partner Member	0-5	0	0	0	0	0-5	5-10	0	0	0	0	5-10
Dr Adedeji Okubadejo, Clinical Lead Member	25-30	0	0	0	0	25-30	40-45	0	0	0	0	40-45
Stephen Posey, NHS Trust/Foundation Trust Partner Member	0	0	0	0	0	0-5	0-5	0	0	0	0	0-5
Mark Powell, Ordinary Member for Mental Health	0	0	0	0	0	0-5	0-5	0	0	0	0	0-5
Maria Principe, Executive Director of Commissioning	20-25	0	0	0	15-17.5	35-40	–	–	–	–	–	–
Lee Radford, Chief People Officer	80-85	0	0	0	22.5-25	105-110	100-105	100	0	0	77.5-80	180-185
Clair Raybould, Executive Director of Strategy and Experience	20-25	0	0	0	22.5-25	45-50	–	–	–	–	–	–
Sharon Robson, Non-Executive Director	0-5	0	0	0	0	0-5	–	–	–	–	–	–
Peerveez Sadiq, Local Authority Partner Member	–	–	–	–	–	–	0-5	0	0	0	0	0-5

[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:					
Name and title	**(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[3])*	**(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)*
Bill Shields, Executive Director of Finance	95-100	0	0	0	532.5-535	630-635	–	–	–	–	–	–
Paul Simpson, Local Authority Partner Member	0	0	0	0	0	0-5	0-5	0	0	0	0	0-5
Nigel Smith, Non-Executive Member	5-10	0	0	0	0	5-10	0-5	0	0	0	0	0-5
Amanda Sullivan, Chief Executive	45-50	0	0	0	0	45-50						
Sue Sunderland, Non-Executive Member	5-10	0	0	0	0	5-10	10-15	100	0	0	0	10-15
Jon Towler, Non-Executive Director	0-5	0	0	0	0	0-5	–	–	–	–	–	–
Rosa Waddingham, Executive Director of Quality (Nursing)	20-25	0	0	0	12.5-15	35-40	–	–	–	–	–	–
Dr Chris Weiner, Chief Medical Officer	90-95	1,800	0	0	22.5-25	115-120	150-155	1,200	0	0	12.5-15	165-170
Richard Wright, Non-Executive Member	–	–	–	–	–	–	10-15	0	0	0	0	10-15

Notes

1. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.
2. No payments were made to partner members from Local Authorities or NHS bodies, nor were recharges made by their employers.
3. Where a salary amount sits exactly on a pay boundary then the salary is reported at the lower band. For example, if an employee had a salary of £50,000, they would be shown in the salary band (£'000) 45-50.
4. Due to the national restructuring of the NHS, there have been a large number of changes to the members of the Board, due to the ICB entering into a formal partnership arrangement with NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire ICB.
   - Chris Clayton ceased his role as Chief Executive on 30 September 2025. Payments for employment continued after this date as part of a secondment arrangement, which are excluded from the above table.
   - Michelle Arrowsmith ceased her role on 10 October 2025, and Prof. Dean Howells, Lee Radford and Dr Chris Weiner ceased their Executive Director roles on 31 October 2025. Payments for employment continued after these dates due to a range of exit arrangements including (i) Directors who worked their contractual notice period at the ICB; (ii) Directors who, whilst awaiting national approval to progress redundancies, remained employed but moved into alternative roles within the NHS; and (iii) Directors who moved into other roles and subsequently left without redundancy. Such payments for continuous employment are excluded from the above table. Exit packages have been agreed in year for Prof. Dean Howells, Lee Radford and Dr Chris Weiner, which are disclosed in the 'Compensation on early retirement or for loss of office' and ' Exit packages' disclosure of the Annual Report.
   - Helen Dillistone held the role of Chief of Staff until 31 October 2025 and then commenced the role of Executive Director of Transition from 1 November 2025.
   - Jill Dentith, Nigel Smith and Sue Sunderland ceased their roles as Non-Executive Members on 31 October 2025. Dr Adedeji Okubadejo also ceased being a Board member on 31 October 2025 and his Clinical Lead Member role ceased on 30 November 2025.
   - The number of Partner Members on the Board reduced from five to three. As a result, Ellie Houlston ceased her role on 31 October 2025. Dr Andrew Mott, Stephen Posey and Paul Simpson maintained their Board membership throughout the year. Mark Powell maintained Board membership throughout the year; however, his role changed from NHS Trust/Foundation Trust Partner Member to Ordinary Member for Mental Health from 1 November 2025.
5. The following became members of the Board for NHS Derby and Derbyshire ICB, and are jointly appointed as Board members of NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire ICB:
   - Amanda Sullivan commenced as Chief Executive from 1 October 2025.
   - Dr. Dave Briggs, Rosa Waddingham, Maria Principe, and Clair Raybould commenced Executive Director roles from 1 November 2025.
   - Jon Towler, Stephen Jackson, Mehrunnisa Lalani, Sharon Robson, and John Dunstan commenced Non-Executive Director roles from 1 November 2025.

   The table above includes the share of their remuneration for NHS Derby and Derbyshire ICB only based on population size.
6. Margaret Gildea maintained her Board membership throughout the year and Helen Dillistone served as an Executive Director throughout the year. Their salary and expense values from 1 April to 31 October 2025 are wholly reported within NHS Derby and Derbyshire ICB values above. From 1 November 2025 both were jointly appointed with NHS Lincolnshire and NHS Nottingham and Nottinghamshire ICB. As such, 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.
7. Bill Shields maintained Board membership throughout the year. His salary and expense values from 1 April to 31 October 2025 are shared with NHS Nottingham and Nottinghamshire ICB. 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.
8. The 'Performance pay and bonuses' value for Michelle Arrowsmith was due to a non-consolidated payment for recruitment and retention.
9. The total remuneration disclosed in the table above for Dr Andrew Mott and Dr Adedeji Okubadejo includes clinical advisory services provided to the ICB unrelated to their roles as senior managers. Dr Adedeji Okubadejo's remuneration also includes a clinical excellence award.
10. James Austin is employed by Derbyshire Community Healthcare Services NHS Foundation Trust. The ICB was charged for 50% of his time as a Director and time proportioned to 1 August 2024 when his position ceased with the ICB. The new Chief Digital Officer is not considered a senior manager and hence the remuneration of this post is no longer disclosed.
11. Linda Garnett's contract as Interim Chief People Officer was terminated in July 2024. Termination benefits of £47k are included within the salary figure, and form part of the 'Exit Packages' disclosure within the Annual Report. Lee Radford commenced as Chief People Officer in July 2024.
12. Keith Griffiths retired in November 2024 as Chief Finance Officer, and Claire Finn carried out this role between December 2024 and March 2025.
13. Richard Wright ceased his role as Chair in April 2024 and resumed his Non-Executive Member role until November 2024. Dr Kathy McLean commenced as Chair in May 2024, and Nigel Smith commenced as Non-Executive Member in January 2025.

14. Perveez Sadiq ceased his role as Local Authority Partner Member in October 2024; Paul Simpson commenced in this role from November 2024.
15. 'Expense payments (taxable)' disclosed in the above table include business miles and salary sacrifice lease cars.
16. 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 £14,314.89.
17. Tracy Allen ceased her role as a participant member for Place in September 2024.
18. 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.

2025/26	**(a) Real increase in pension at pension age**	**(b) Real increase in pension lump sum at pension age**	**(c) Total accrued pension at pension age at 31 March 2026**	**(d) Lump sum at pension age related to accrued pension at 31 March 2026**	**(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	*(bands of £2,500)*	*(bands of £2,500)*	*(bands of £5,000)*	*(bands of £5,000)*				
Michelle Arrowsmith, Chief Strategy and Delivery Officer	0-2.5	0-2.5	50-55	130-135	1,241	0	1,123	0
Dr Dave Briggs, Executive Director of Outcomes (Medical)	0-2.5	0-2.5	35-40	80-85	751	5	820	0
Dr Chris Clayton, Chief Executive	0-2.5	0-2.5	50-55	100-105	911	31	1,016	0
Helen Dillistone, Executive Director of Transition	2.5-5	2.5-5	50-55	120-125	1,000	51	1,106	0
Prof Dean Howells, Chief Nurse Officer	0-2.5	0	55-60	125-130	1,241	70	1,400	0
Maria Principe, Executive Director of Commissioning	0-2.5	0-2.5	45-50	105-110	873	16	1,017	0
Lee Radford, Chief People Officer	0-2.5	0-2.5	95-100	0-5	1,626	32	1,727	0
Clair Raybould, Executive Director of Strategy and Experience	0-2.5	0-2.5	45-50	110-115	850	24	1,047	0
Bill Shields, Executive Director of Finance	22.5-25	77.5-80	55-60	175-180	0	0	29	0
Rosa Waddingham, Executive Director of Quality (Nursing	0-2.5	0	60-65	0	864	9	962	0
Dr Chris Weiner, Chief Medical Officer	0-2.5	0-2.5	40-45	100-105	897	25	990	0

2024/25 Name and title	(a) Real increase in pension at pension age *(bands of £2,500)*	(b) Real increase in pension lump sum at pension age *(bands of £2,500)*	(c) Total accrued pension at pension age at 31 March 2025 *(bands of £5,000)*	(d) Lump sum at pension age related to accrued pension at 31 March 2025 *(bands of £5,000)*	(e) Cash Equivalent Transfer Value 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
Michelle Arrowsmith, Chief Strategy and Delivery Officer	2.5-5	0-2.5	55-60	150-155	1,104	43	1,241	0
James Austin, Chief Digital Information Officer	0-2.5	0-2.5	25-30	0-5	395	23	472	19
Dr Chris Clayton, Chief Executive	2.5-5	0-2.5	45-50	100-105	799	32	911	0
Helen Dillistone, Chief of Staff	2.5-5	0-2.5	45-50	110-115	889	33	1,000	0
Prof Dean Howels, Chief Nurse Officer	2.5-5	2.5-5	55-60	140-145	1,075	75	1,241	0
Lee Radford, Chief People Officer	2.5-5	0-2.5	90-95	0-5	1,405	82	1,626	0
Dr Chris Weiner, Chief Medical Officer	0-2.5	0-2.5	40-45	95-100	805	13	897	0

Notes

For 2025/26:

1. Pensions figures included in the above table are for senior managers that have pensions paid directly by the ICB and include all of their NHS Service not just pension payments that relate to the period to 31 March 2026.
2. The CETVs shown in the table above, and prior year comparator values have been provided by the NHS Business Services Authority (BSA) and have been used to calculate the real movement in CETV value.
3. The McCloud public sector pensions remedy affects members who were in the NHS 1995 and 2005 (old schemes) pension scheme between 1 April 2018 and 31 March 2022. Members in the old schemes can decide before retirement whether the pension contributions for the period April 2018 to March 2022 go into the old pension schemes or the new 2015 scheme. For the purposes of the pension calculations these contributions have been included in the old pension scheme. This applies to: Michelle Arrowsmith, Dr Chris Clayton, Helen Dillistone, Prof Dean Howells, Lee Radford and Dr Chris Weiner.
4. The part year effect of the real increase values has been shown for Michelle Arrowsmith (to 10 October 2025), Dr Chris Clayton (to 30 September 2025), Prof Dean Howells, Lee Radford and Dr Chris Weiner (all to 31 October 2025). This reflects the end of their roles as Senior Managers.
5. Helen Dillistone's real increase values from 1 April to 31 October 2025 are wholly reported within Derby and Derbyshire ICB values above. The real increase 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.
6. Dr. Dave Briggs, Rosa Waddingham, Maria Principe, and Clair Raybould became members of the Board for NHS Derby and Derbyshire ICB from 1 November 2025 and are jointly appointed as Board members of NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire ICB. Their real increase values reflect a part year effect and NHS Derby and Derbyshire ICB's share based on population size.
7. Amanda Sullivan opted out of the pension arrangements during the reporting period.
8. Michelle Arrowsmith's pension benefit is based on the data provided by the NHS Pensions Agency. The data does not appear to be wholly accurate and has been queried with the Agency, however no update was provided to the ICB at the time of finalising this report.

For 2024/25:

9. Pensions figures included in the above table are for senior managers that have pensions paid directly by the ICB and include all of their NHS Service not just pension payments that relate to the period to 31 March 2025.
10. The CETVs shown in the table above, and prior year comparator values have been provided by the NHS Business Services Authority (BSA) and have been used to calculate the real movement in CETV value.
11. The Interim Chief Finance Officer, Claire Finn, and Interim Chief People Officer, Linda Garnett, chose not to be covered by the pension arrangements during the reporting period.
12. The Chief Information Officer, James Austin's pension balances have been disclosed in full in this report but have been time proportioned to 1 August 2024. Their role was shared with Derbyshire Community Healthcare Services NHS Foundation Trust who will also disclose pension balances.
13. Keith Griffiths was Chief Finance Officer until 30 November 2024 and took retirement on this date.
14. The McCloud public sector pensions remedy affects members who were in the NHS 1995 and 2005 pension scheme (old schemes) between 1 April 2018 and 31 March 2022. Members in the old schemes can decide before retirement whether the pension contributions for the period April 2018 to March 2022 go into the old pension schemes or the new 2015 scheme. For the purposes of the pension calculations these contributions have been included in the old pension scheme. This applies to: Michelle Arrowsmith, Dr Chris Clayton, Helen Dillistone, Keith Griffiths, Prof Dean Howells, Lee Radford and Dr Chris Weiner.

Cash Equivalent Transfer Value

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

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

Through the national restructuring of the NHS across ICBs, NHS England, and Commissioning Support Units, a number of Directors' contracts have been terminated during the financial year. Compensation for loss of office packages totalling £150k was paid to three Directors of the ICB following redundancy. The compensation comprised contractual redundancy payments, payments in lieu of notice, and payments in lieu of untaken annual leave (as applicable) arising from the early termination of employment.

The payments were approved in accordance with the ICB and HM Treasury remuneration policies and are included within the exit packages disclosed in the Staff report.

Payments to past directors

During the year, compensation for loss of office of £150k was paid to a number of former Directors of the ICB as outlined in the 'Compensation on early retirement or for loss of office' disclosure above.

Continued employment remunerations were also paid to a number of former Directors of the ICB across a range of exit arrangements including: (i) Directors who worked their contractual notice period at the ICB; (ii) Directors who, whilst awaiting national approval to progress redundancies, remained employed but moved into alternative roles within the NHS; and (iii) Directors who moved into other roles and subsequently left without redundancy. Continued employment remunerations are included within the 'Staff numbers and costs' disclosure of the Staff report.

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	88	4	92
Band 4	61	4	65
Band 5	60	10	70
Band 6	68	12	80
Band 7	95	17	112
Band 8a	54	19	73
Band 8b	34	10	44
Band 8c	19	6	25
Band 8d	6	6	12
Band 9	0	1	1
Very senior managers (non-Board members)	8	10	18
Any other spot salary (non-Board members)	0	0	0
Board members	1	0	0
Totals	**494**	**99**	**592**

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 8.9 days in 2025.

Total days lost (whole-time equivalent)	3,371
Total days available (whole-time equivalent)	165,980
Average working days lost due to sickness absence (per whole-time equivalent)	**8.9**

Staff turnover percentages

The ICB's staff turnover rate (staff leaving the organisation) during the reporting period was 6.5% (on a whole-time equivalent basis).

Staff engagement percentages

The ICB participated in the 2025 NHS Staff Survey, published in March 2026, which provides a comprehensive view of staff experience, engagement and wellbeing and is reported against the NHS People Promise framework. The ICB achieved a response rate of 74%, placing it in the upper range of response rates across participating ICBs.

Survey results demonstrated positive performance in a number of areas, including compassionate and supportive line management, positive team culture and inclusive behaviours. These findings suggest that staff experience at team level remains a relative strength for the organisation, despite wider system pressures.

As with the wider NHS, the results also highlighted areas requiring continued attention, including staff wellbeing, workload pressures and engagement. These challenges align with national NHS Staff Survey trends and reflect the context of ongoing organisational change 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.

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 £nil (2024/25: £nil). 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	0	0
Of which, the number that have existed:		
For less than one year at the time of reporting	0	0
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 off-payroll engagements between 1 April 2025 and 31 March 2026, for more than £245[4] per day:

	Number 2025/26	Number 2024/25
No. of temporary off-payroll workers engaged between 1 April 2025 to 31 March 2026	0	2
Of which:		
Number not subject to off-payroll legislation[2]	0	2
Number subject to off-payroll legislation and determined as in-scope of IR35[5]	0	0
Number subject to off-payroll legislation and determined as out of scope of IR35[5]	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	0	0

[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.

	2025/26	2024/25
significant financial responsibility, during reporting period[1]		
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]	25	19

[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 £12,793k, 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	25,213	380	25,593	Salaries and wages	23,155	672	23,827
Social Security Costs	3,389	4	3,393	Social Security Costs	2,551	-	2,551
Employer NHS Pension Contributions	5,457	4	5,461	Employer NHS Pension Contributions	5,244	-	5,244
Other Pension Costs	3	-	3	Other Pension Costs	2	-	2
Apprenticeship Levy	110	-	110	Apprenticeship Levy	100	-	100
Termination Benefits	12,793	-	12,793	Termination Benefits	-	-	-
Gross Employee Benefits	**46,965**	**388**	**47,353**	**Gross Employee Benefits**	**31,052**	**672**	**31,724**
Less recoveries in respect of employee benefits	(421)	(37)	(458)	Less recoveries in respect of employee benefits	(240)	–	(240)
Total Net Employee Benefit Costs	**46,544**	**351**	**46,895**	**Total Net Employee Benefit Costs**	**30,812**	**672**	**31,484**

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 £9,953k (2024/25: £174k) were agreed for 144 members of staff during the year (204/25: 4). During the year to 31 March 2026, the ICB along with ICB partnering organisations NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire 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	3	23,086	3	23,086	0	0
£10,000 to £25,000	0	0	18	288,224	18	288,224	0	0
£25,001 to £50,000	1	26,667	36	1,455,548	37	1,482,215	0	0
£50,001 to £100,000	2	93,333	49	3,553,587	51	3,646,920	0	0
£100,001 to £150,000	0	0	27	3,248,463	27	3,248,463	0	0
£150,001 to £200,000	0	0	8	1,264,205	8	1,264,205	0	0
Greater than £200,000	0	0	0	0	0	0	0	0
Totals	**3**	**120,000**	**141**	**9,833,114**	**144**	**9,953,114**	**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	3	123,012	0	0	3	123,012	0	0
£50,001 to £100,000	1	51,429	0	0	1	51,429	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	**4**	**174,441**	**0**	**0**	**4**	**174,441**	**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	141	9,803
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice[1]	2	30
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
Total	**143**	**9,833**

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 Derby and Derbyshire ICB is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report from page 69. An audit certificate and report is also included in this Annual Report at page 102.

Annual Accounts

Signed:

Amanda Sullivan
Accountable Officer

16 June 2026

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The Primary Statements:

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	(38,888)	(36,065)
Other operating income	2	(151)	(29)
Total operating income		**(39,039)**	**(36,094)**
Staff costs	4	47,353	31,724
Purchase of goods and services	5	3,140,133	2,919,697
Depreciation and impairment charges	5	248	483
Provision expense	5	900	(75)
Other operating expenditure	5	163	494
Total operating expenditure		**3,188,797**	**2,952,323**
Net Operating Expenditure		**3,149,758**	**2,916,229**
Finance expense	9	6	20
Net expenditure for the Year		**3,149,764**	**2,916,249**
Comprehensive Expenditure for the year		**3,149,764**	**2,916,249**

Statement of Financial Position as at 31 March 2026

	Note	2025-26 £'000	2024-25 £'000
Non-current assets:			
Property, plant and equipment	8	461	347
Right-of-use assets	9	88	175
Total non-current assets		**549**	522
Current assets:			
Trade and other receivables	10	12,576	18,248
Cash and cash equivalents	11	244	214
Total current assets		**12,820**	**18,462**
Total assets		**13,369**	**18,984**
Current liabilities			
Trade and other payables	12	(147,622)	(137,803)
Lease liabilities	9.2	(91)	(87)
Provisions	13	(3,579)	(514)
Total current liabilities		**(151,292)**	(138,404)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(137,923)**	(119,420)
Non-current liabilities			
Lease liabilities	9.2	-	(91)
Provisions	13	-	(286)
Total non-current liabilities		**-**	**(377)**
Assets less Liabilities		**(137,923)**	(119,797)
Financed by Taxpayers' Equity			
General fund		(137,923)	(119,797)
Total taxpayers' equity:		**(137,923)**	(119,797)

The notes on pages 75 to 101 form part of this statement

The financial statements on pages 71 to 74 have been 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
Changes in taxpayers' equity for 2025-26	
Balance at 01 April 2025	(119,797)
Adjusted NHS Integrated Care Board balance at 31 March 2025	**(119,797)**
Changes in NHS Integrated Care Board taxpayers' equity for 2025-26	
Net operating expenditure for the financial year	(3,149,764)
Net Recognised NHS Integrated Care Board Expenditure for the Financial year	**(3,149,764)**
Net funding	3,131,638
Balance at 31 March 2026	**(137,923)**

	General fund £'000
Changes in taxpayers' equity for 2024-25	
Balance at 01 April 2024	(102,438)
Adjusted NHS Integrated Care Board balance at 31 March 2025	**(102,438)**
Changes in NHS Integrated Care Board taxpayers' equity for 2024-25	
Net operating costs for the financial year	(2,916,249)
Net Recognised NHS Integrated Care Board Expenditure for the Financial Year	**(2,916,249)**
Net funding	2,898,890
Balance at 31 March 2025	**(119,797)**

The notes on pages 75 to 101 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		(3,149,764)	(2,916,249)
Depreciation and amortisation	5	248	483
Interest paid / received	9	6	12
Finance Costs	5	-	(7)
Unwinding of Discounts	7	-	8
(Increase)/decrease in trade & other receivables	10	5,671	223
Increase/(decrease) in trade & other payables	12	9,719	18,025
Provisions utilised	13	(173)	(856)
Increase/(decrease) in provisions	13	2,952	(68)
Net Cash Inflow (Outflow) from Operating Activities		**(3,131,341)**	(2,898,429)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		(174)	(160)
Net Cash Inflow (Outflow) from Investing Activities		**(174)**	(160)
Net Cash Inflow (Outflow) before Financing		**(3,131,515)**	(2,898,589)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		3,131,638	2,898,890
Repayment of lease liabilities	9	(93)	(366)
Net Cash Inflow (Outflow) from Financing Activities		**3,131,545**	2,898,525
Net Increase (Decrease) in Cash & Cash Equivalents	11	**30**	(65)
Cash & Cash Equivalents at the Beginning of the Financial Year		**214**	279
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**244**	214

The notes on pages 75 to 101 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 basis 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 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 Derby and Derbyshire 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 Joint arrangements

Joint operations are arrangements in which the Integrated Care Board has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Integrated Care Board includes within its financial statements its share of the assets, liabilities, income and expenses.

The Integrated Care Board's participation in Section 75 agreements (see note 1.5) are joint arrangements.

Joint ventures are arrangements in which the Integrated Care Board has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

1.5 Pooled Budgets

The Integrated Care Board has entered into a pooled budget arrangement for better care with Derbyshire County Council; and separately with Derby City Council (both arrangements are in accordance with section 75 of the NHS Act 2006). Under the arrangements, the two funds are separately pooled for the Derbyshire County "Better Care Fund", and Derby City "Better Care Fund", respectively. The Better Care funds aim to improve the provision of health and social care, with the overarching objective to support the integration of health and social care and align commissioning, as agreed between the partners.

Additionally, the Integrated Care Board is a partner of the "Children and Young People with Complex Needs" pooled budget with Derbyshire County Council. Under the arrangement, funds are pooled for children with a range of health and special educational needs that cannot collectively be addressed by local or ordinary services.

The Integrated Care Board is also in a pooled arrangement with Derby City Council for the "Integrated Disabled Children's Centre and Services in Derby". This arrangement provides funds for the purchase and supply of equipment and technological aids for disabled children in Derby.The Derbyshire County "Better Care Fund" and "Children and Young People with Complex Needs" pools are both hosted by Derbyshire County Council.

The Derby City "Better Care Fund" and "Integrated Disabled Children's Centre and Services in Derby" pools are both hosted by Derby City Council.The Integrated Care Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budgets, identified in accordance with the pooled budget agreements.

1.6 Operating Segments

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

1.7 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. There are no significant terms.

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.

1.8 Employee Benefits

1.8.1 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

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.

1.8.2 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.

1.9 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.

1.10 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.

1.11 Property, Plant & Equipment

1.11.1 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.

1.11.2 Measurement

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

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

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

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

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

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

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

1.11.3 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.

1.11.4 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.

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.

1.2 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 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).

1.22 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.

1.22.1 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.

• The Integrated Care Board has assessed the pooled element of the Better Care Fund as being a lead commissioning arrangement under IFRS 11: Joint Arrangements. The Integrated Care Board will report balances with the lead commissioner (local authority) only and not the providers with which the local authority contracts.

1.22.2 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) The restructure of the Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire ICBs partnering arrangement has resulted in redundancy accruals being recognised. These accruals are based on the agreed and expected voluntary redundancy packages. It has also resulted in the estimation of redundancy provisions for expected further reductions in staff numbers as the ICBs move towards implementing their new staffing structure. Voluntary redundancies are due to commence in early 2026/27. Further reductions to staffing levels are expected during 2026/27 following conclusion of the wave 3 consultation and move to the new structure.

1.32 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.

1.33 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.

2 Other Operating Revenue

	2025-26 Total	2024-25 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	**4,595**	3,393
Prescription fees and charges	**13,127**	13,147
Dental fees and charges	**18,902**	17,558
Other Contract income	**1,806**	1,727
Recoveries in respect of employee benefits	**458**	240
Total Income from sale of goods and services	**38,888**	**36,065**
Other operating income		
Non cash apprenticeship training grants revenue	**57**	29
Other non contract revenue	**94**	-
Total Other operating income	**151**	**29**
Total Operating Income	**39,039**	**36,094**

Revenue does not include allocation or cash received from NHS England. This is drawn down directly into the bank account of the Integrated Care Board and credited to the General Fund.

NHS Derby & Derbyshire ICB certifies that it has complied with the HM Treasury guidance on cost allocation and the setting of charges. The following table provides details of income generation activities whose full cost exceeded £1million or was otherwise material (responsibility for the commissioning of Pharmaceutical and Dental services was delegated to the Integrated Care Board from NHSE on the 1st April 2023.

Activity	**2025-26 Income**	**2025-26 Full Cost**	**2025-26 Surplus / (Deficit)**	2024-25 Income	2024-25 Full Cost	2024-25 Surplus / (Deficit)
	£'000	**£'000**	**£'000**	£'000	£'000	£'000
Dental fees and charges	18,901	71,030	(52,129)	17,558	70,759	(53,201)
Prescription fees and charges	13,126	234,018	(220,892)	13,147	229,602	(216,455)
Total Fees and Charges	**32,027**	**305,048**	**(273,021)**	**30,705**	**300,361**	**(269,656)**

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

The financial objective is to collect charges from those patients that do not meet the eligibility criteria for free prescriptions and dental treatments.
Prescription charges are a contribution to the cost of pharmaceutical services including the supply of drugs. In 2025-26, the NHS prescription charge for each medicine or appliance dispensed was £9.90. However, the majority of prescription items are dispensed free each year where patients are exempt from charges. In addition, patients who were eligible to pay charges could purchase pre-payment certificates at £32.05 for 3 months or £114.50 for a year.

NHS dental charges fall into 3 bands dependent on the level and complexity of care provided. Those who meet the eligibility criteria for exemption are not required to pay such charges. In 2025-26, the charge for Band 1 treatments was £27.40, for Band 2 was £75.30 and for Band 3 was £326.70.

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	Other Contract income	Recoveries in respect of employee benefits	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Source of Revenue						
NHS	542	-	-	-	-	542
Non NHS	4,053	13,126	18,901	1,806	458	38,344
Total	**4,595**	**13,126**	**18,901**	**1,806**	**458**	**38,886**

	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income	Recoveries in respect of employee benefits	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Timing of Revenue						
Point in time	-	-	-	-	-	-
Over time	4,595	13,126	18,901	1,806	458	38,886
Total	**4,595**	**13,126**	**18,901**	**1,806**	**458**	**38,886**

3.2 Transaction price to remaining contract performance obligations

NHS Derby and Derbyshire Integrated Care Board had no contract revenue expected to be recognised in a future period, relating to contract performance obligations not yet completed at the reporting date (2024/25 £nil).

4. Employee benefits and staff numbers

4.1.1 Employee benefits 2025-26

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	25,213	380	**25,593**
Social security costs	3,389	4	**3,393**
Employer Contributions to NHS Pension scheme	5,457	4	**5,461**
Other pension costs	3	-	**3**
Apprenticeship Levy	110	-	**110**
Termination benefits	12,793	-	**12,793**
Gross employee benefits expenditure	**46,965**	**388**	**47,353**
Less recoveries in respect of employee benefits (note 4.1.2)	(458)	-	**(458)**
Net employee benefits excluding capitalised costs	**46,507**	**388**	**46,895**

4.1.1 Employee benefits 2024-25

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	23,155	673	**23,827**
Social security costs	2,551	-	**2,551**
Employer Contributions to NHS Pension scheme	5,244	-	**5,244**
Other pension costs	2	-	**2**
Apprenticeship Levy	100	-	**100**
Gross employee benefits expenditure	31,052	673	**31,724**
Less recoveries in respect of employee benefits (note 4.1.2)	(240)	-	**(240)**
Net employee benefits excluding capitalised costs	**30,812**	**673**	**31,484**

4.1.2 Recoveries in respect of employee benefits

	2025-26			2024-25
	Permanent Employees £'000	Other £'000	Total £'000	Total £'000
Employee Benefits - Revenue				
Salaries and wages	(357)	-	(357)	(191)
Social security costs	(51)	-	(51)	(22)
Employer contributions to the NHS Pension Scheme	(50)	-	(50)	(27)
Total recoveries in respect of employee benefits	**(458)**	**-**	**(458)**	**(240)**

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	**480**	**3**	**483**	**457**	**8**	**465**

Nil staff were engaged on capital projects (2024-25 nil staff).

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	-	-	3	23,086	3	23,086
£10,001 to £25,000	-	-	18	288,224	18	288,224
£25,001 to £50,000	2	66,667	36	1,455,548	38	1,522,215
£50,001 to £100,000	1	53,333	49	3,553,587	50	3,606,920
£100,001 to £150,000	-	-	27	3,248,463	27	3,248,463
£150,001 to £200,000	-	-	8	1,264,205	8	1,264,205
Over £200,001	-	-	-	-	-	-
Total	**3**	**120,000**	**141**	**9,833,113**	**144**	**9,953,113**

	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	3	123,012	-	-	3	123,012
£50,001 to £100,000	1	51,429	-	-	1	51,429
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**4**	**174,441**	**-**	**-**	**4**	**174,441**

Analysis of Other Agreed Departures

	2025-26 Other agreed departures		2024-25 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	141	9,803,223	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	2	29,890	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**143**	**9,833,113**	**-**	**-**

* As a single exit package can be made up of several components each of which will be counted separately in this table, the total number will not necessarily match the total number in the table above, which will be the number of individuals.
These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the Agenda for Change rules.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Where entities has 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.

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

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

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.

4.5.3 Defined contribution workplace pension scheme

As an alternative to the NHS Pension Scheme the Integrated Care Board offers employees the option of the National Employment Savings Scheme (NEST).

7 employees were in the NEST scheme during 2025-26 with employer costs totalling £3k (5 employees with employer costs totalling £2k in 2024-25).

5. Operating expenses

	2025-26 Total £'000	2024-25 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	9,762	10,218
Services from foundation trusts	1,855,765	1,727,336
Services from other NHS trusts	230,727	205,139
Services from Other WGA bodies	1	1
Purchase of healthcare from non-NHS bodies	388,407	345,809
Purchase of social care	67,634	64,073
General Dental services and personal dental services	71,030	70,759
Prescribing costs	189,214	191,267
Pharmaceutical services	44,805	38,336
General Ophthalmic services	12,855	11,551
GPMS/APMS and PCTMS	254,379	236,467
Supplies and services – clinical	1,109	44
Supplies and services – general	3,330	8,512
Consultancy services	0	-
Establishment	4,561	4,323
Transport	11	14
Premises	4,351	4,168
Audit fees	246	180
Other non statutory audit expenditure		
· Other services	53	18
Other professional fees	1,113	1,001
Legal fees	376	283
Education, training and conferences	347	169
Non cash apprenticeship training grants	57	29
Total Purchase of goods and services	**3,140,133**	**2,919,697**
Depreciation and impairment charges		
Depreciation	248	483
Total Depreciation and impairment charges	**248**	**483**
Provision expense		
Change in discount rate	-	(7)
Provisions	900	(68)
Total Provision expense	**900**	**(75)**
Other Operating Expenditure		
Chair and Non Executive Members	110	128
Expected credit loss on receivables	53	(13)
Other expenditure	-	379
Total Other Operating Expenditure	**163**	**494**
Total operating expenditure	**3,141,444**	**2,920,599**

Internal Audit services are provided by 360 Assurance (hosted by University Hospitals of Derby and Burton NHS Foundation Trust) and the associated expenditure is included within "Other Professional Fees".

The audit fees relating to the statutory external audit were £205k excluding VAT for 2025-26. The final statutory fees for 2024-25 were £170,000 excluding VAT.

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	57,081	336,762	59,478	429,266
Total Non-NHS Trade Invoices paid within target	56,989	335,435	57,699	420,168
Percentage of Non-NHS Trade invoices paid within target	**99.84%**	**99.61%**	**97.01%**	**97.88%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	4,087	2,106,543	4,082	1,948,884
Total NHS Trade Invoices Paid within target	4,078	2,106,429	4,070	1,948,477
Percentage of NHS Trade Invoices paid within target	**99.78%**	**99.99%**	**99.71%**	**99.98%**

The Better Payment Practice Code requires the Integrated Care Board to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The target is 95% across all indicators, which has been achieved.

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

The Integrated Care Board incurred £nil charges relating to claims made under this legislation (2024-25 £nil).

7 Finance costs

	2025-26 £'000	2024-25 £'000
Interest		
Interest on lease liabilities	6	12
Total interest	**6**	**12**
Provisions: unwinding of discount	-	8
Total finance costs	**6**	**20**

8 Property, plant and equipment

2025-26	Information technology £'000
Cost or valuation at 01 April 2025	1,087
Additions purchased	275
Disposals other than by sale	(442)
Cost/Valuation at 31 March 2026	**920**
Depreciation 01 April 2025	740
Disposals other than by sale	(442)
Charged during the year	161
Depreciation at 31 March 2026	**459**
Net Book Value at 31 March 2026	**461**
Purchased	461
Total at 31 March 2026	**461**

The information technology equipment, comprising of laptops and associated equipment, is depreciated on a straight line basis over a useful economic life of 3 years.

Disposals other than by sale relates to fully depreciated assets at the end of its useful economic life that has been removed from the cost and brought forward depreciation figures.

9 Leases

9.1 Right-of-use assets

2025-26	Buildings excluding dwellings £'000	For local accounts use Of which: leased from DHSC group bodies £'000
Cost or valuation at 01 April 2025	651	391
Cost/Valuation at 31 March 2026	**651**	**391**
Depreciation 01 April 2025	476	391
Charged during the year	87	
Depreciation at 31 March 2026	**563**	**391**
Net Book Value at 31 March 2026	**88**	**-**

Office space is leased from NHS Property Services Ltd at Scarsdale, Chesterfield. No formal lease contract is in place. The Integrated Care Board continue to use the Scarsdale building into 2026-27 but without a lease arrangement and have not recognised an ongoing lease or liability for this site in the 2025-26 accounts.

The Integrated Care Board leases part of the Council Building from Derby City Council. This is the only lease included in the table above as at 31 March 2026.

9.2 Lease liabilities

2025-26	2025-26 £'000	2024-25 £'000
Lease liabilities at 01 April 2025	(179)	(270)
Addition of Assets	-	(262)
Interest expense relating to lease liabilities	(6)	(12)
Repayment of lease liabilities (including interest)	94	365
Lease liabilities at 31 March 2026	**(91)**	**(179)**

9.3 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	(91)	-	(93)	-
Between one and five years	-	-	(93)	-
Balance at 31 March 2026	**(91)**	**-**	**(186)**	**-**
Balance by counterparty				
Leased from other bodies	(91)		(186)	
Balance as at 31 March 2026	**(91)**		**(186)**	

9.4 Amounts recognised in Statement of Comprehensive Net Expenditure

2025-26	2025-26 £'000	2024-25 £'000
Depreciation expense on right-of-use assets	87	349
Interest expense on lease liabilities	6	12

9.5 Amounts recognised in Statement of Cash Flows

	2025-26 £'000	2024-25 £'000
Total cash outflow on leases under IFRS 16	94	366

10.1 Trade and other receivables

	Current 2025-26 £'000	Current 2024-25 £'000
NHS receivables: Revenue	2,739	2,377
NHS prepayments	69	53
NHS accrued income	680	5,206
NHS Contract Receivable not yet invoiced/non-invoice	624	-
Non-NHS and Other WGA receivables: Revenue	2,060	4,795
Non-NHS and Other WGA prepayments	2,180	1,743
Non-NHS and Other WGA accrued income	166	515
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	3,166	3,087
Expected credit loss allowance-receivables	(56)	(3)
VAT	947	469
Other receivables and accruals	1	6
Total Trade & other receivables	**12,576**	**18,248**
Total current and non current	**12,576**	**18,248**

There are no prepaid pension contributions included in note 10.1 (31 March 2025, £nil).

10.2 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	1,150	389	26	541
By three to six months	-	-	17	422
By more than six months	-	384	20	596
Total	**1,150**	**773**	**63**	**1,559**

10.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000
Balance at 01 April 2025	**(3)**
Lifetime expected credit losses on trade and other receivables-Stage 2	**(53)**
Total	**(56)**

(A stage 2 adjustment is for the provision of a credit loss where the debt has the potential to become a bad debt).

11 Cash and cash equivalents

	2025-26	2024-25
	£'000	£'000
Balance at 01 April 2025	214	279
Net change in year	30	(65)
Balance at 31 March 2026	**244**	**214**
Made up of:		
Cash with the Government Banking Service	244	214
Cash and cash equivalents as in statement of financial position at 31 March 2026	**244**	**214**

The Integrated Care Board does not hold patients monies.

12 Trade and other payables	**Current 2025-26**	Current 2024-25
	£'000	£'000
NHS payables: Revenue	479	571
NHS payables: Capital	-	-
NHS accruals	32,712	32,194
Non-NHS and Other WGA payables: Revenue	10,146	9,111
Non-NHS and Other WGA payables: Capital	-	-
Non-NHS and Other WGA accruals	79,613	77,469
Social security costs	415	318
Tax	372	326
Other payables and accruals	23,885	17,814
Total Trade & Other Payables	**147,622**	**137,803**
Total current and non-current	**147,622**	**137,803**

The Integrated Care Board does not have any liabilities included above for arrangements to buy out the liability for early retirement (31st March 2025 £nil).

Other payables include £2.54m outstanding pension contributions at 31 March 2026 (at 31 March 2025, £2.29m).

13 Provisions

	Current 2025-26 £'000	Non-current 2025-26 £'000	Current 2024-25 £'000	Non-current 2024-25 £'000
Redundancy	2,052	-	-	-
Continuing care	239	-	395	-
Other	1,288	-	119	286
Total	**3,579**	**-**	**514**	**286**
Total current and non-current	**3,579**		**800**	

	Redundancy £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2025	**-**	**395**	**405**	**800**
Arising during the year	2,052	-	1,215	**3,267**
Utilised during the year	-	(156)	(17)	**(173)**
Reversed unused	-	-	(315)	**(315)**
Balance at 31 March 2026	**2,052**	**239**	**1,288**	**3,579**
Expected timing of cash flows:				
Within one year	2,052	239	1,288	**3,579**
Balance at 31 March 2026	**2,052**	**239**	**1,288**	**3,579**

As at 31 March 2026 the Integrated Care Board recognised a provision of £2,052k relating to organisational restructure and £1,215k for IT domain contract migration.
The continuing healthcare retrospective claims were partially utilised during the year with £157k being used leaving a balance of £239k.

The Other provisions opening balance included a property dilapidations provision of £375k. £16k has been utilised in year and the updated calculation resulted in £271k being released in year leaving a closing balance of £88k.

14 Contingencies

The Integrated Care Board recognised contingent liabilities of £1,835k as 31 March 2026. This relates to organisational restructure/redundancy costs of £1,773k (nil 2024-25) and £62k for employment tribunal (£47k 2024-25).

15 Commitments

15.1 Capital commitments

The Integrated Care Board does not have any capital commitments as at 31 March 2026 (nil at 31 March 2025).

16 Financial instruments

16.1 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 Derby and Derbyshire 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 Derby and Derbyshire 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 Derby and Derbyshire Integrated Care Board in undertaking its activities.

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

16.1.1 Currency risk

The NHS Derby and Derbyshire 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 Derby and Derbyshire Integrated Care Board has no overseas operations and therefore has low exposure to currency rate fluctuations.

16.1.2 Interest rate risk

The NHS Derby and Derbyshire 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 Derby and Derbyshire Integrated Care Board therefore has low exposure to interest rate fluctuations.

16.1.3 Credit risk

Because the majority of the NHS Derby and Derbyshire 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.

16.1.4 Liquidity risk

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

16.1.5 Financial Instruments

As the cash requirements of NHS Derby and Derbyshire 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 Derby and Derbyshire Integrated Care Board expected purchase and usage requirements and NHS Derby and Derbyshire Integrated Care Board is therefore exposed to little credit, liquidity or market risk.

16 Financial instruments cont'd

16.2 Financial assets

	Financial Assets measured at amortised cost 2025-26 £'000	Financial Assets measured at amortised cost 2024-25 £'000
Trade and other receivables with NHSE bodies	1,395	2,433
Trade and other receivables with other DHSC group bodies	2,647	5,149
Trade and other receivables with external bodies	5,393	8,403
Cash and cash equivalents	244	214
Total at 31 March 2026	**9,679**	**16,199**

16.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2025-26 £'000	Financial Liabilities measured at amortised cost 2024-25 £'000
Trade and other payables with NHSE bodies	557	553
Trade and other payables with other DHSC group bodies	32,634	32,245
Trade and other payables with external bodies	113,643	104,360
Private Finance Initiative and finance lease obligations	91	179
Total at 31 March 2026	**146,925**	**137,337**

17 Operating segments

The Integrated Care Board has one operating segment, the commissioning of healthcare services.

18 Joint arrangements - interests in joint operations

The "Better Care Funds", "Children and Young People with Complex Needs" and "Integrated Disabled Children's Centre and Services in Derby", are pooled individually under the Section 75 arrangements of the NHS Act 2006. The total of the Integrated Care Board's share of all pooled budgets are as follows:

	2025-26	2024-25
	£'000	£'000
Income	(118,572)	(111,564)
Expenditure	118,561	111,250
	(11)	(314)

Better Care Fund (BCF)

The Integrated Care Board has two BCFs: The Derbyshire County BCF; and the Derby City BCF, which both became operational in 2015.

NHS Derby and Derbyshire Integrated Care Board is a partner to the Derbyshire County BCF, along with Derbyshire County Council. NHS Tameside and Glossop Clinical Commissioning Group were part of this arrangement until 30 June 2022 when the Glossop healthcare responsibilities were transferred to NHS Derby and Derbyshire Integrated Care Board. NHS Derby and Derbyshire Integrated Care Board is also a partner to the Derby City BCF, along with Derby City Council. The operation of the pools is ultimately managed by the Derbyshire Health and Wellbeing Board represented by members from each of the partners. The Funds operate as Section 75 pooled budgets.

Total annual agreed contributions to the Derbyshire County BCF Pool are £141,294k including iBCF funding (£108,255k excluding iBCF). Total annual agreed contributions to the Derby City BCF Pool are £44,162k, including iBCF funding (£33,300k excluding iBCF).

The BCF aims to improve the provision of health and social care. All partners contribute to a pooled fund and the overarching objective of the fund is to support the integration of health and social care and align commissioning as agreed between the partners.

In April 2017 the Improved Better Care Fund (iBCF) commenced. This is a direct grant to local government, with a condition that it is pooled into the local BCF plan. In the 2025-26 Derbyshire County Council received an additional £7,306k; and Derby City Council an additional £2,814k, of discharge funding direct from the Government with the aim of:

- Meeting adult social care needs
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
- Ensuring that the local social care provider market is supported

Under the agreements, the two BCF pools are each split into 2 areas:
- Contributions to a pooled fund by all partners and commissioned by the local authority who are host and lead
- Commissioning of existing funded schemes directly by each partner

18 Joint arrangements - interests in joint operations, continued

The memorandum account for the "Derbyshire County Better Care Fund" pooled budget is:

	2025-26 £'000	2025-26 Pool Share %	2024-25 £'000	2024-25 Pool Share %
Income				
NHS Derby & Derbyshire ICB	(86,801)	61.43	(81,362)	60.04
Derbyshire County Council	(54,493)	38.57	(54,160)	39.96
Total Income	**(141,294)**	**100.00**	(135,522)	100.00
Expenditure				
ICB schemes aimed at reducing non elective activity	35,547		31,226	
ICB schemes - wheelchairs	1,273		1,265	
Derbyshire County Council schemes	9,800		8,615	
ICES (Integrated Community Equipment Service)	6,974		6,973	
Reablement	21,498		20,685	
Administration, Performance and Information Sharing	665		640	
Care Bill	2,825		2,718	
Delayed Transfer of Care	9,199		9,671	
Carers	2,706		2,604	
Integrated Care	3,617		3,487	
Workforce Development	500		488	
Dementia Support	508		489	
Autism and Mental Health	2,100		2,020	
iBCF	33,039		31,995	
Winter Pressures Grant	3,737		3,737	
Discharge Fund	7,306		8,349	
Total Expenditure	**141,294**		134,962	
Net position for Pool	**(0)**		(560)	
Balance Brought Forward as at 1 April 2025	(373)			
Balance carried Forward at the end of period	**(373)**			
NHS Derby and Derbyshire ICB share of surplus as at end of period	**(229)**			

The Derby County BCF pooled budget reported a breakeven position for the period, with a total accumulated underspend of £373k at 31 March 2026. NHS Derby and Derbyshire Integrated Care Board's share of the overspend was £229k. This amount has been carried forward in the pool.

The memorandum account for the "Derby City Better Care Fund" pooled budget is:

	2025-26 £'000	2025-26 Pool Share %	2024-25 £'000	2024-25 Pool Share %
Income				
NHS Derby & Derbyshire ICB	(26,250)	59.44	(25,142)	58.87
Derby City Council	(17,912)	40.56	(17,563)	41.13
Total Income	**(44,162)**	**100.00**	(42,705)	100.00
Expenditure				
ICB schemes aimed at reducing non elective activity	4,826		4,645	
Derby City Council schemes	2,883		2,534	
Community Health Services	9,864		9,318	
Social Care	10,868		10,487	
Mental Health	650		650	
Accident & Emergency	212		212	
iBCF	10,862		10,862	
Winter Pressures Grant	1,183		1,183	
Discharge Fund	2,814		2,814	
Total Expenditure	**44,162**		42,705	
Net position for Pool	**-**		(0)	
Balance Brought Forward as at 1 April 2025	(109)			
Balance Carried forward	**(109)**			
NHS Derby and Derbyshire ICB share of surplus as at end of period	**(65)**			

The Derby City BCF pooled budget reported a breakeven position for the period, with a total accumulated surplus of £109k at 31 March 2026. NHS Derby and Derbyshire Integrated Care Board's share of the underspend was £65k. This amount has been carried forward in the pool.

18 Joint arrangements - interests in joint operations, continued

NHS Derby and Derbyshire Integrated Care Board is also a partner of the "Children and Young People with Complex Needs" pooled budget along with Derbyshire County Council. This pool is hosted by Derbyshire County Council.

The memorandum account for the "Children and Young People with Complex Needs" pooled budget is:

	2025-26 £'000	**2025-26 Pool Share %**	2024-25 £'000	2024-25 Pool Share %
Income				
NHS Derby and Derbyshire ICB	(4,444)	28.49	(3,995)	33.00
Derbyshire County Council	(11,157)	71.51	(8,111)	67.00
Total Income	**(15,601)**	**100.00**	(12,106)	100.00
Expenditure				
Purchase of equipment and healthcare services	15,601		12,106	
Total Expenditure	**15,601**		12,106	
Net position for Pool	**-**		-	

NHS Derby and Derbyshire Integrated Care Board is also a partner of the "Integrated Disabled Children's Centre and Services in Derby" pooled budget, along with Derby City Council. This pool is hosted by Derby City Council.

The memorandum account for the "Integrated Disabled Children's Centre an Services in Derby" pooled budget is:

	2025-26 £'000	**2025-26 Pool Share %**	2024-25 £'000	2024-25 Pool Share %
Income				
NHS Derby and Derbyshire ICB	(1,077)	45.91	(1,065)	46.53
Derby City Council	(1,269)	54.09	(1,224)	53.47
Total Income	**(2,346)**	**100.00**	(2,289)	100.00
Expenditure				
Residential Services	1,361		1,348	
Community Service Team (Outreach Service)	-		48	
Disability and Fieldwork Social Work Services	-		-	
Management and Administration	962		929	
Total Expenditure	**2,323**		2,325	
Net position for Pool	**(23)**		36	
Balance Brought forward at 1st April 2025	(145)			
Balance carried forward as at end of period	**(168)**			
NHS Derby and Derbyshire ICB share of surplus as at end of	**(77)**			

The Integrated Disabled Children's Centre and Services in Derby pooled budget reported an underspend of £23k for the period, with a total accumulated underspend of £168k at 31 March 2026.

NHS Derby and Derbyshire Integrated Care Board's share of the accumulated underspend was £77k. This amount has been carried forward in the pool.

19 Related party transactions

During the year none of the Board Members or parties related to them have undertaken any material transactions with NHS Derby and Derbyshire Integrated Care Board, other than those set out below (transactions identified were not with the members but between the Integrated Care Board and the related party):

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Amber Valley Health Ltd	1,000	-	-	-
Black Country Healthcare NHS Foundation Trust	86	-	-	-
College Street Medical Practice	902	-	-	-
Derby And Derbyshire GP Provider Board	860	-	-	-
Derby City Council	20,248	434	1,595	136
Derbyshire Community Health Services NHS Foundation Trust	190,936	1,702	564	1,291
Derbyshire County Council	96,047	4,052	1,947	1,696
Derbyshire Health United CIC	28,711	-	160	-
Derbyshire Healthcare NHS Foundation Trust	202,675	-	-	501
Devon ICB	182	-	-	-
Erewash Health Partnership	1,529	-	-	-
First Steps	260	-	-	-
HFMA	30	-	-	-
High Peak & Buxton PCN	3,151	-	-	-
IBC	2,713	-	51	-
Jessop Medical Practice	2,908	-	93	-
Moir Medical Centre	2,274	-	71	-
NHS England	19	2,747	-	1,783
Nottingham and Nottinghshire ICB	213	267	-	-
Nottinghamshire County Council	1,275	-	-	-
Nottingham University Hospitals NHS Trust	109,184	-	456	-
Accurx Ltd	568	-	-	-
NHS Confederation	45	-	-	-

All transactions have been at arm's length as part of NHS Derby and Derbyshire Integrated Care Board's healthcare commissioning.

2024-25 details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Accurx Ltd	473	-	-	-
Amber Valley CVS	117	-	-	-
Amber Valley Health Ltd	1,094	-	-	-
Cera Care Ltd	3	-	-	-
College Street Medical Practice	880	-	29	-
Derby And Derbyshire GP Provider Board	779	-	-	-
Derby City Council	25,736	409	288	273
Derbyshire Community Health Services NHS Foundation Trust	182,966	312	507	146
Derbyshire County Council	94,138	6,268	1	4,045
Derbyshire Healthcare NHS Foundation Trust	190,330	82	448	-
Erewash Health Partnership	1,555	-	-	-
First Steps	195	-	-	-
High Peak & Buxton PCN	2,748	-	-	-
Jessop Medical Practice	2,896	-	17	-
Moir Medical Centre	2,051	-	10	-
NHS Confederation	110	-	-	-
NHS England	9	60	6	1,802
Nottingham University Hospitals NHS Trust	102,500	5	2,193	37
Nottinghamshire Healthcare NHS Foundation Trust	5,736	4	768	-
University Hospitals of Derby & Burton NHS Foundation Trust	784,243	-	17,739	-
Police & Crime Commissioner For Derbyshire	27	39	-	7

20 Events after the end of the reporting period

After 31 March 2026, the Integrated Care Boards for Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire continued work to formalise joint governance and partnering arrangements, following agreement in principle prior to year end. Each Integrated Care Board remains a separate statutory body, with no transfer of assets, liabilities, or commissioning responsibilities as at the reporting date. Accordingly, these arrangements have no impact on the financial position at 31 March 2026. Further developments will be progressed during 2026/27.

21 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:

	2025-26 Target	**2025-26 Performance**	**Duty Achieved? Yes/No**	2024-25 Target	2024-25 Performance
	£'000	**£'000**		£'000	£'000
Expenditure not to exceed income	3,189,144	3,189,079	Yes	2,954,165	2,952,765
Capital resource use does not exceed the amount specified in Directions	276	275	Yes	422	422
Revenue resource use does not exceed the amount specified in Directions	3,149,829	3,149,764	Yes	2,917,649	2,916,249
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-		-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-		-	-
Revenue administration resource use does not exceed the amount specified in Directions	27,217	22,261	Yes	20,402	18,699

22 Losses and special payments

Losses

There were no losses recognised during 2025-26 (1 case with a value of £4k in 2024-25)
The total number of NHS integrated care board losses and special payments cases, and their total value, was as follows:

Special payments

There were no special payments during 2025-26 (nil in 2024-25)

23 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	286,733	227,140
Eligible mental health expenditure	287,060	227,701
Mental health expenditure above/(below) minimum investment required	327	561
Mental health expenditure as a proportion of total expenditure	9.19%	7.86%

The 2025-26 value includes Specialised Commissioning Mental Health which was delegated to the ICB in 2025-26

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS DERBY AND DERBYSHIRE INTEGRATED CARE BOARD

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Derby and Derbyshire 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 Derby and Derbyshire 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 Derby and Derbyshire 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.

Firstly, 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.

Secondly, 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 responsibilities

As explained more fully in the statement set out on page 40, 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

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.

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 opinion on regularity

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

We have nothing to report in these respects.

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 Derby and Derbyshire 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 Derby and Derbyshire 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
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EastWest
Tollhouse Hill
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NG1 5FS

18 June 2026