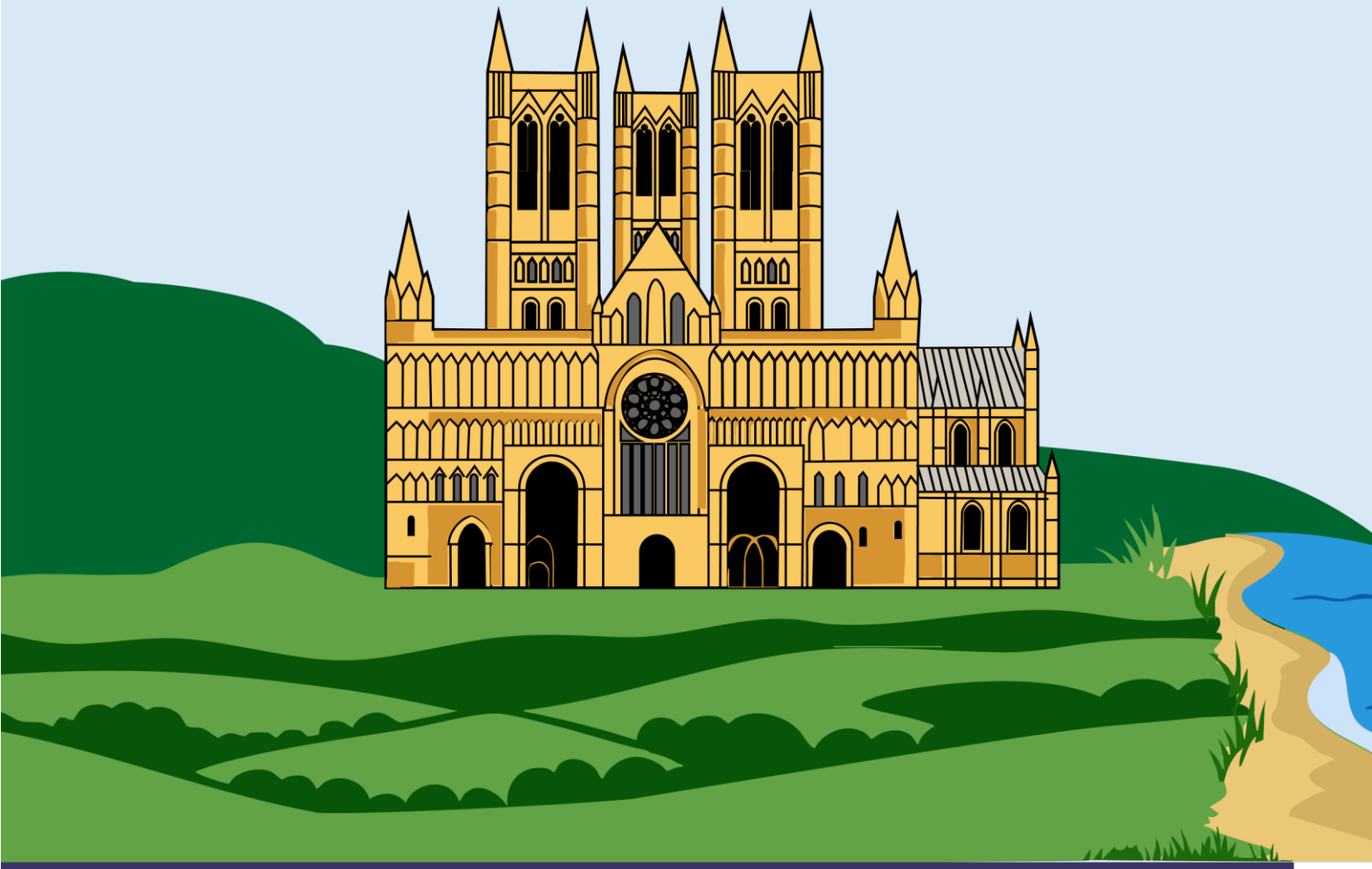
NHS
Lincolnshire
Integrated Care Board



NHS Lincolnshire Integrated Care Board

Annual Report and Accounts

1st April 2025 to March 31st 2026

About this report

This report explains what NHS Lincolnshire 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 Lincolnshire Integrated Care Board (ICB), reflecting another year of progress, partnership and shared purpose across our Integrated Care System (ICS).

The year has been shaped by a challenging and evolving national landscape, with high expectations from Government, NHS England and the public we serve. Despite sustained operational and financial pressures, the system has continued to demonstrate resilience and ambition, while delivering care, transforming services and keeping people and communities at the heart of decision making.

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

This year has also seen significant national reform and organisational change for ICBs, as signalled by the Ten-Year Health Plan for England. The introduction of management cost reduction requirements and the development of a new ICB Operating Model have created a renewed opportunity to work differently. This has seen NHS Lincolnshire ICB establishing formal partnership arrangements with NHS Derby and Derbyshire ICB and NHS Nottingham and Nottinghamshire ICB, operating as an 'ICB Cluster', and since 1 October 2025, I have been jointly appointed as Chair of the three ICBs. This closer joint working brings benefits of shared learning, greater consistency and increased resilience, while ensuring each organisation remains focused on meeting the needs of its own population.

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

The system has continued to show leadership in neighbourhood working, prevention and inclusive service design. I have been encouraged by the commitment across Lincolnshire to tackling health inequalities and supporting people with more complex needs. The Integrated Care Strategy continues to guide our priorities, alongside the new Population Health Strategy and Strategic Commissioning Plan, supported by strong partnership with local authorities, the voluntary sector and regional partners. Since being appointed, I have valued opportunities to hear from colleagues, partners and local services about work taking place across the system. These conversations have reinforced the importance of strong relationships, local insight and the dedication of our workforce and partners.

I would like to thank Board members for their leadership, challenge and support during the year, and acknowledge colleagues who left the Board in year. In particular, I recognise the contribution of Dr Gerry McSorley, who served as Chair of Lincolnshire ICB prior to my appointment. I also thank executive colleagues, partners and staff, whose professionalism and dedication underpin everything we do. Challenges remain, but so do significant opportunities. I look forward to working together, with ambition and purpose, to build a healthier and fairer future for our communities.



Dr Kathy McLean OBE, Chair of NHS Lincolnshire 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 for NHS Lincolnshire Integrated Care Board (ICB) during a period of significant national change for the NHS. I am proud to take on this role at a time when there is a clear opportunity to strengthen how we work across systems, and I have been struck by the commitment, professionalism and collaboration shown by colleagues across Lincolnshire.

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

Quality and safety remain a central focus for the ICB, and we have continued to work closely with providers and partners to ensure robust oversight of services, supporting improvement and maintaining a clear focus on patient experience and outcomes. This has included strengthening system-wide approaches to quality assurance and responding to areas where improvement is required.

Our financial position has required continued focus and strong system leadership. Work has progressed to strengthen financial governance, improve grip and control, and support delivery of statutory responsibilities. This has been underpinned by close collaboration across partners to prioritise resources effectively and ensure the best possible outcomes for our population.

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 Lincolnshire ICB, NHS Derby and Derbyshire 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. I would like to thank our staff for their continued professionalism, resilience and commitment, and I would also like to recognise the contribution of John Turner and Clair Raybould, who served as Chief Executive and Interim Chief Executive of NHS Lincolnshire 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 Lincolnshire ICB, an increasing proportion of our work has been delivered within this broader collaborative context.

Looking ahead, there remains a clear focus on commissioning high-quality, safe and sustainable services for the people of Lincolnshire. While there are challenges ahead, I am confident that through continued partnership working and a focus on improvement, the system will build on its strong foundations and continue to deliver meaningful benefits for local communities.



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

About us

NHS Lincolnshire 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 826,065 people and covers the geographic area of Lincolnshire, including Boston, East Lindsey, Lincoln City, North Kesteven, South Holland, South Kesteven, and West Lindsey.

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 Lincolnshire 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.

The ICB also continues to play an active role within the Lincolnshire Armed Forces Covenant Partnership Board, in line with its commitment to supporting veterans, reservists, service leavers, cadets, cadet adult force volunteers, military spouses and families. During the year, the ICB was proud to receive the Ministry of Defence Employer Recognition Scheme Gold Award, which represents the highest level of recognition for employers who demonstrate outstanding support for the Armed Forces community and upholding the Armed Forces Covenant.

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

The Ten Year Health Plan for England, published on 3 July 2025, signals changes to the role, scale and operating model of ICBs. In line with this, we have established formal partnership arrangements with NHS Derby and Derbyshire ICB and NHS 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, 366 people worked for the ICB (including staff, clinical and professional advisors, and Board members).

Our integrated care system

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

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

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

Our ICS structure includes:

- An Integrated Care Partnership (ICP), which is a statutory committee jointly formed between the ICB and Lincolnshire 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).
- 14 Primary Care Networks (PCNs), which are partnerships between General Practice surgeries who care for neighbourhood populations ranging from approximately 35,000 to 111,000 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 across places, improve quality, efficiency and outcomes, and address unwarranted variation and inequalities in access and experience across providers.

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. 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.

We use the economic levers available to us to develop resilient and inclusive local economies within Lincolnshire through greater local spend, fair employment, and support for a 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 Lincolnshire Health and Wellbeing Board and the ICB, we aim to address socio-economic and environmental determinants of health and support community wealth building across Lincolnshire.

Our strategies and plans

To make the best decisions for our population, we must understand the health and care needs of people living across Lincolnshire. The Joint Strategic Needs Assessment (JSNA) provides the evidence base for this, identifying the health and wellbeing needs of our population, inequalities in outcomes and experience, patterns of demand, and priority areas requiring system-wide action. This information helps to ensure that strategic planning is driven by population need. You can read more about the demographics and health needs of our population at https://lhih.org.uk/jsna/.

The Lincolnshire Integrated Care System uses this information, alongside wider evidence and insight, to inform its strategic priorities through the Joint Health and Wellbeing Strategy and the Integrated Care Strategy. The Joint Health and Wellbeing Strategy sets out the population-level priorities that partners across Lincolnshire will collectively focus on to improve health and reduce inequalities. It is grounded in the JSNA and provides overarching direction for strategic commissioning and partnership working across the system.

Complementing this, the Integrated Care Strategy sets out how partners will work together to deliver these priorities through integration, collaboration, and system-wide action. It reflects a shared ambition for the people of Lincolnshire to have the best possible start in life, and be supported to live, age, and die well. The Integrated Care Strategy identifies four underpinning aims:

- A strong focus on prevention and early intervention.
- Tackling inequalities and ensuring equity of provision.

- Delivering transformational change to improve health and wellbeing.
- Taking collective action across organisations.

As the Joint Health and Wellbeing Strategy and Integrated Care Strategy are closely linked, Lincolnshire has adopted an aligned approach, including a shared introduction, common contextual data drawn from the JSNA, and a shared set of ambitions and aims. The two strategies retain their distinct statutory roles, while helping to avoid duplication or gaps.

The ICB's Joint Forward Plan, developed with our NHS Trust and NHS Foundation Trust partners, sets out the NHS contribution to delivering these strategic priorities over a five-year period. It aligns with the ambitions of the Integrated Care System and the priorities emerging from the Joint Health and Wellbeing Strategy and Integrated Care Strategy. During 2025/26, the ICB contributed to delivery plans supporting the following Joint Health and Wellbeing Strategy priorities:

- Carers – focussing on identifying and supporting unpaid carers to protect their health and wellbeing, improve access to respite and advice services, and help carers continue in employment, education and community life.
- Healthy Weight – aiming to reduce obesity and related health conditions by promoting healthy eating, increasing access to weight management support, and encouraging healthier lifestyles for children, families and adults.
- Homes for Independence – supporting people to live safely and independently through suitable housing, home adaptations, warm homes initiatives, homelessness prevention, and housing support linked to health and care services.
- Mental Health and Dementia – promoting prevention, early intervention and access to support for people experiencing mental ill health or dementia, helping improve quality of life, independence and support for carers.
- Physical Activity – encouraging residents of all ages to be more active through community programmes, active travel, sport and exercise opportunities, improving physical health, mental wellbeing and independence.

The ICB also contributes to wider local strategies through strong partnership working with local government, community organisations and the broader health and care system, primarily through the Lincolnshire Health and Wellbeing Board. As the statutory forum bringing together councillors, NHS commissioners, the Local Authority and wider partners, the Board provides leadership for the JSNA and Joint Health and Wellbeing Strategy, supports alignment across strategic planning and commissioning, and coordinates action to reduce inequalities and improve outcomes. It also oversees delivery of the Joint Health and Wellbeing Strategy priority delivery plans, leads development of the Lincolnshire Neighbourhood Health Plan, and supports joint oversight arrangements between the Local Authority and the ICB to monitor progress and strengthen integrated working.

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://lincolnshire.icb.nhs.uk/about-us/strategies-and-plans/.

Our performance

Service delivery

Whilst we have maintained a strong and consistent focus on performance throughout the year, supported by the oversight and assurance arrangements described elsewhere in this Annual Report, 2025/26 has continued to be a challenging period for service delivery. Our focus has remained on progressing the ambitions set out in our

Integrated Care Strategy and Joint Forward Plan, while responding to significant operational pressures across the system.

Urgent and emergency care services have experienced sustained pressure, driven by high levels of Emergency Department attendances, increased patient acuity and associated bed pressures. These factors contributed to longer waits during the year. Despite this, early improvements were seen through front-door initiatives aimed at avoiding unnecessary admissions, alongside the embedding of a 45-minute ambulance handover model, which began to support improvements in ambulance handover performance.

During the year, progress was made in improving access to primary care, making it easier for people to contact their GP practice and receive timely care based on clinical need. We also continued to focus on tackling elective, diagnostic and cancer backlogs. While significant reductions were achieved in some areas, we were unable to consistently meet planned performance across all national standards, reflecting the scale of demand and capacity challenges facing the system.

We continued to prioritise improving access to mental health services, including for children and young people. Progress was made against access ambitions, alongside exceeding the national target for dementia diagnosis rates. However, while improvements were seen across several mental health pathways, further work remains necessary to address ongoing pressures and variation in performance.

Sustained progress has been made in supporting people with learning disabilities and autistic people to receive care in community settings and in increasing uptake of Learning Disability Annual Health Checks. However, further work is required to reduce the number of adults in inpatient settings. Through the Lincolnshire Local Maternity and Neonatal System, we have continued to maintain oversight and support improvement in maternity and neonatal services, informed by ongoing quality surveillance, engagement with families and national expectations.

We continue to work closely with our health and social care partners to improve performance through the delivery of agreed recovery and improvement plans, recognising that sustained collaboration and system-wide focus are essential to improving outcomes for our population.

Financial performance

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

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 system capacity and flow

pressures across urgent and emergency care, hospital discharge and elective recovery; maintaining the quality and safety of commissioned services, including safeguarding assurance and services subject to enhanced oversight; risks affecting children and young people, vulnerable adults and those requiring timely access to community and specialist services; workforce resilience; financial sustainability; digital and cyber security; and the delivery of organisational change associated with transition to formal ICB clustering arrangements.

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

Performance Analysis

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

How we measure our performance

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

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 Lincolnshire 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

Improving access to Primary Care Services has continued to be a focus for us in 2025/26 as we work on delivering the objectives set out in the Primary Care Access Recovery Plan. During the year, our aim has been on making it easier for people to contact their GP practice, with the aim of ensuring that everyone who needs an appointment gets one within two weeks, and those who contact their practice urgently are assessed the same or next day according to clinical need. The target for appointments offered in two weeks is 85%, and in Lincolnshire during March 2026 we exceeded this standard and achieved 87%. As of March 2026, 60.9% of total appointments were held face to face, 44.9% were same day appointments, and 6% were next day appointments. The total number of GP appointments delivered was above plan in March 2026 with 527,136 appointments delivered against 523,730 plan.

In Lincolnshire, we continue to concentrate on national priority areas such as increasing units of dental activity and as of March 2026, 93% of the contracted units of dental activity were delivered. 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. Lincolnshire dentists have continued to provide additional sessions throughout the year

beyond the national expectation. However, despite this increased provision, utilisation of urgent dental appointments remains below target, and further work is underway to promote services locally and increase uptake.

During 2025/26, community pharmacies in Lincolnshire significantly expanded their role in delivering frontline healthcare, helping to ease pressure on GP services. The Pharmacy First service allows patients with common conditions (such as sore throats, earaches, and urinary tract infections) to receive assessment and treatment directly from pharmacists, including access to some prescription medicines without needing a GP appointment. By March 2026, approximately 98% of pharmacies (113 sites) were offering this service, delivering over 35,500 consultations, most commonly for sore throats (11,583) and urinary tract infections (9,894). Pharmacies in Lincolnshire also carried out over 36,000 blood pressure checks from April 2025 to March 2026. In addition, 97% of community pharmacies in Lincolnshire provide oral contraception services (both initiation and continuation of oral contraception) and have delivered over 15,000 consultations which continues to increase.

Locally, we have commissioned five community pharmacy independent prescribing pathfinder sites, as part of an NHS England pilot to evaluate the use of independent prescribing in community pharmacy. These sites delivered over 2,700 consultations between April 2025 and March 2026 for a wide range of on the day illnesses and cardiovascular care, including high blood pressure treatment and managing medication shortages by providing alternative treatments. This has ensured continuity of care and reduced burden on General Practitioners. Due to the success of the pilot, the independent prescriber pathfinder program has been extended to improve patient access and further reduce GP workload.

We are committed to ensuring that members of the Armed Forces community have equitable access to health and social care services. In Lincolnshire, this commitment is reflected across primary care, with 81% of GP practices now holding Royal College of General Practitioners Veteran Friendly Practice accreditation. This demonstrates a strong and growing focus on recognising and meeting the needs of those who have served. The ICB also supports a Primary Care Armed Forces Family Staff Network, providing a forum for colleagues with Armed Forces connections to share experiences and help shape system-wide improvements.

Urgent and emergency care

The national four-hour Emergency Department standard requires 95% of patients to be admitted, transferred, or discharged within four hours of arrival. The expectation is to deliver 78% performance, and in March 2026, we exceeded this at 81.3%. While overall demand was below plan for the year, the system continued to experience peaks at certain times of day and days of the week, creating some operational pressures.

During the year, some patients have experienced waits of more than 12 hours in the Emergency Department following a decision to admit; however, recent focused work to improve four-hour performance has had a positive impact on extended waits. At United Lincolnshire Teaching Hospitals (ULTH) during March 2026, the proportion of patients waiting more than 12 hours reduced from approximately 20% earlier in the year, to 11.3%.

During the year, the 45-minute ambulance handover model ‘Release to Respond’ became embedded as a business as usual practice across the system, through joint working between the Emergency Departments and East Midlands Ambulance Services NHS Trust. However, performance against the local ambition that 95% of handovers are completed within this timeframe was not achieved consistently. While there remains variation between hospital sites, in ULTH in March 2026, 86% of ambulances handed over within 45 minutes, and average handover times were approximately 29 minutes.

We have continued to work collaboratively with our partners during the year to improve how patients access services in the Emergency Department. This included changes to pathways and triage in line with the national ‘Model Emergency Department’, expanding the Clinical Decision Unit, direct access pathways to Same Day Emergency Care, increased use of the Medical Emergency Assessment Unit, and improvements in the transfer of patients to wards. These have supported more timely decision-making to focus on

reduced inpatient admissions and decreasing time patients wait in an Emergency Department.

Outside hospital settings, there has been a strong focus on helping people avoid hospital attendance or admission, and to support timely discharge when hospital care is no longer required. Our Community Urgent Response services focused on working in a more joined-up way, ensuring people receive the right care, from the right professional, in the right place, as early as possible. Ongoing work to align community pathways with East Midlands Ambulance Service and NHS 111 has improved access to the Lincolnshire Clinical Assessment Service, enabling more patients to be safely assessed and managed without the need for an attendance at an Emergency Department or Urgent Treatment Centre, or the dispatch of an ambulance.

Over the year, and particularly during the winter period, a range of system-wide actions were implemented to improve urgent and emergency care performance. This included focused work to improve patient flow and ensure ambulance capacity was used as effectively as possible. The Hospital at Home offer was expanded, including access to intravenous therapy, with increased use of virtual wards to support people outside hospital wherever appropriate. Additional patient transport capacity was put in place to support timely discharge, alongside enhanced primary care support for patients with respiratory needs.

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

Diagnostics and elective care

Throughout the year, we have remained focused on reducing elective care waiting times and enhancing diagnostic services. 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 61.2% against a plan of 60%, our focus now will be to sustain this performance into 26/27. As of March 2026, we met the target of reducing the proportion of patients waiting over 52 weeks to below 1% of the total waiting list. However, the complete elimination of 65-week waits was not achieved, as we ended the month with 12 cases, which is a reduction of five compared to the previous month.

Meeting the NHS six-week diagnostic standard remains critical to supporting early treatment, improving outcomes, and reducing patient anxiety. In Lincolnshire, the six-week wait position continues to be significantly underperforming against the plan, with 45% of patients waiting over six weeks against a plan of 5.6%. Across partners, improvement plans with clear recovery targets are in place for selected specialties. Longer-term recovery actions focus on maximising Community Diagnostic Centre capacity and the opening of a new endoscopy unit in Lincoln in the second quarter of 2026/27. Significant progress has already been made, with Community Diagnostic Centres now operating in Grantham, Lincoln and Skegness, and a fourth centre scheduled to open in Boston in 2027.

Community Diagnostic Centres provide patients with faster access to diagnostic tests in more patient-friendly settings, reducing travel time and improving access to care, particularly in areas of higher need and deprivation. During 2025/26, a total of 150,020 tests were delivered through our Community Diagnostic Centres, representing 85% of planned activity and a substantial increase compared with 2024/25, where 78,763 tests were delivered. Alongside the opening of the Boston Community Diagnostic Centre in 2026/27, capacity will be further expanded through the creation of an additional ten clinical rooms at the Lincoln Community Diagnostic Centre and three at the Grantham Community Diagnostic Centre. These developments will enable the expansion of clinical pathways, allowing patients to receive multiple tests and investigations in a single visit, reducing repeat attendances and accelerating diagnosis and treatment. As a result of these improvements, test volumes are forecast to increase to 184,057 in 2026/27.

Cancer care

During 2025/26, we remained focused on cancer prevention, screening and early diagnosis, reflecting their importance in improving outcomes and reducing health inequalities for our population. Performance against the Faster Diagnosis Standard was a key priority throughout the year. The standard requires 75% of patients urgently referred with suspected cancer to receive a diagnosis, or have cancer ruled out, within 28 days. In Lincolnshire, performance remained below the standard during the year, with achievement at 71% in March 2026. Despite this, sustained efforts have been made to improve diagnostic capacity and pathway performance to support progress towards compliance.

The Faster Diagnosis Standard operates alongside the 31-day and 62-day cancer referral-to-treatment standards. Lincolnshire remained off trajectory for both standards in March 2026 and did not achieve planned performance. During the year, a high number of patients waited over 62 days for treatment. While some incremental improvements were achieved across all three standards, overall performance remained below expected levels. The year was marked by significant operational pressures, including large backlogs, rising referral volumes and activity growth exceeding forecasts across most pathways. Targeted improvement plans are in place for priority areas, and cancer performance will remain a key focus in 2026/27.

Progress has also been made in developing the Lung Cancer Screening Programme, a key commitment within our Joint Forward Plan. The programme, scheduled to launch in early 2026, aims to support earlier detection of lung cancer in high-risk populations.

Maternity and neonatal care

During 2025/26, Lincolnshire ICB has continued to focus on the delivery and improvement of maternity and neonatal care, aligned to the NHS Three Year Delivery Plan for maternity and neonatal services. While Lincolnshire maternity services have generally received comparatively stronger regulatory assurance than some other systems, maternity and neonatal care have remained a priority area for system oversight, given national expectations on safety, equity and continuous improvement.

Maternity and neonatal services are coordinated through the Lincolnshire Local Maternity and Neonatal System (LMNS), which brings together providers, commissioners, public health colleagues and service user representatives to oversee quality, safety, performance and improvement activity across the system. These arrangements support collaborative working, consistency of approach and effective system-wide assurance.

During the year, governance and surveillance arrangements continued to mature, supporting routine monitoring of performance, safety and emerging risks. Learning from incidents, reviews and national intelligence has continued to inform system oversight, with risks monitored and managed through established quality governance structures, including escalation through system quality committees where required.

Throughout 2025/26, the LMNS has continued to work collaboratively with providers, women and families, and wider system partners to deliver targeted improvement activity. A sustained focus has remained on maintaining safe services, improving outcomes and experience, and continuing to address inequalities in access and outcomes for maternity and neonatal care.

The voices of women, birthing people and families have continued to inform service design and improvement activity. The Maternity and Neonatal Voices Partnership remains embedded within maternity governance and engagement arrangements in Lincolnshire, supporting co-production, assurance processes and learning across services.

Listening to the voices of families has helped the programme develop a deeper understanding of lived experiences and use these insights to improve maternity outcomes. The team remains committed to working collaboratively with partners across the Lincolnshire maternity and neonatal system, with a strong focus on improving equity for all pregnant women. As part of this work, engagement has been prioritised with families most at risk, including Black and Asian families, military families, Eastern European communities and those living in areas of deprivation.

Key areas of progress during the year include:

- Sustained regulatory assurance for maternity services, with both Lincolnshire maternity units maintaining positive Care Quality Commission

ratings, providing confidence in the overall quality and safety of services delivered.

- Continued delivery of national and system-led maternity improvement programmes, supporting safe, evidence-based maternity and neonatal care and alignment with national maternity policy expectations.
- Ongoing engagement and improvement activity to support personalised care and experience, including attention to communication, continuity and culturally appropriate care.
- Continued development of data, dashboards and performance oversight to support routine monitoring of maternity and neonatal outcomes, safety indicators and inequalities.

Quality and safety remain central to maternity and neonatal oversight within Lincolnshire. During 2025/26, maternity services continued to provide assurance through strong performance against national maternity safety programmes, supported by Local Maternity and Neonatal System governance and routine review through system quality committees.

Quality reports confirm sustained compliance with the Saving Babies' Lives Care Bundle, with both Lincolnshire maternity providers demonstrating high levels of adherence to the Care Bundle elements, supported by routine evidence review and quality assurance processes. This has provided continued assurance that evidence-based approaches to reducing perinatal mortality are embedded in practice.

In parallel, Lincolnshire maternity providers continued to achieve compliance with the safety actions set out in the NHS Resolution Maternity Incentive Scheme, supporting consistent delivery of national maternity safety expectations.

Ongoing quality improvement activity has continued throughout the year, including a focus on maintaining safety standards, responding to learning from incidents and reviews, and ensuring that improvements are sustained alongside day-to-day service delivery pressures.

Recognising that workforce capability and sustainability are essential to the delivery of safe maternity and neonatal services, the Lincolnshire system has continued to prioritise workforce development during 2025/26.

System partners have continued to support education, training and professional development for the maternity and neonatal workforce, aligned with national standards and system priorities. This work sits alongside wider 'One Workforce' activity across Lincolnshire, aimed at supporting recruitment, retention, staff wellbeing and leadership development to underpin safe and sustainable services.

While Lincolnshire maternity services have maintained positive assurance overall, the system recognises the ongoing challenges associated with workforce capacity, increasing demand, and the need to sustain improvement over time. These challenges are consistent with the wider national maternity context and require continued attention to prevent deterioration in quality or experience.

These issues are being addressed through established system oversight arrangements, continued engagement with providers, proactive monitoring of performance and risk, and ongoing engagement with women, families and staff. Improvement activity is underpinned by clear governance structures, continued surveillance of safety indicators, and a commitment to learning and improvement to support the continued delivery of safe, high-quality maternity and neonatal care.

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 as of March 2026 we have achieved the target access rate of 10%.

As of March 2026, 10,675 children and young people were recorded as having at least one contact with mental health services, which is below the plan of 11,829. There has been a 9.9% increase in children and young people mental health access in Lincolnshire. While continuing pressures are impacting on performance, there is a recovery plan in place.

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 48% of schools and 64% of pupils across Lincolnshire, with ambitions to reach 100% by 2028/29.

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 69.7% 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. We remain on track year to date to achieve both the Reliable Recovery and Reliable Improvement Talking Therapies targets. However, we are off track against the complete courses of treatment target and will not meet the end of year standard.

Services for people with a learning disability and/or autism

People with a learning disability often have poorer physical and mental health than other people, and on average, people with a learning disability will die 20 years earlier than the general population. The completion of annual health checks can improve people's health by spotting problems earlier, in turn reducing the health inequalities that this group of people face. By March 2026, 3,745 Learning Disability Annual Health Checks have been completed, which exceeds the planned trajectory of 3,562. Importantly, the majority of checks resulted in a Health Action Plan, demonstrating a clear link between assessment and follow-up care. While quality assurance mechanisms for health checks remain an identified improvement area for 2025/26, uptake and coverage of these did continue to exceed expectations. This provides strong assurance that the system is making progress in reducing health inequalities for people with learning disabilities through proactive and preventative care.

Throughout the year, we remained committed to decreasing the number of people with learning disabilities and/or autism in inpatient facilities, while enhancing community-based services. For 2025/26, we were set targets of no more than 26 adults, and no more than one child or young person (under 18s), being cared for in an inpatient unit by March 2026. As of March 2026, there were two children and young people in inpatients settings and 35 adults. A targeted root cause analysis approach has been undertaken to understand why admissions occur and to identify missed opportunities for prevention, leading to clear actions to strengthen early risk identification, multi-disciplinary oversight and crisis planning. Together, these actions demonstrate an active, learning-focused approach to improving inpatient pathways and flow.

The ICB continues to have a dedicated team that is responsible for coordinating a programme of work to learn from the lives and deaths of people with learning disabilities and autism (the LeDeR programme is a national initiative that aims to improve care for people with learning disabilities and autism). During 2025/26, our LeDeR programme has continued to mature as a core system mechanism for addressing health inequalities. Reviews have been undertaken throughout the year, however ongoing workforce challenges have affected the speed at which reviews can be completed, and as a result, only 29% of reviews were completed within six months. Despite these challenges, learning from LeDeR has continued to be shared and acted upon. Throughout 2025/26, the system delivered a programme of learning events and webinars, focusing on issues identified through local reviews. Work is ongoing to strengthen reviewer recruitment, support and retention, so that reviews can be completed more quickly and learning can have an even greater impact.

Lincolnshire has made steady progress in delivering the Oliver McGowan Mandatory Training across health and care, with a strong focus on Tier 1 learning. With new leadership arrangements in place, the system is now working with neighbouring ICBs to share learning and agree consistent principles for future delivery. A new

proposal from the Lincolnshire Training Hub, due to be considered in 2026, aims to restart and strengthen training provision.

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:

- Weight Management Services – During the year, we engaged with local people to help shape the future of specialist weight management services. Feedback from residents highlighted key priorities, including improving awareness of services, reducing access barriers, and strengthening psychological and clinical support. A patient engagement group was established, enabling people with lived experience to play a direct role in co-designing future provision. This work has laid strong foundations for the development of a more accessible, community-based Weight Management Service in Lincolnshire.
- Tobacco Dependency Services – Over the past year, Tobacco Dependency Services have continued to improve support for people who smoke across hospital, community, mental health and maternity services. A stronger joined-up approach has helped staff identify people who want to quit earlier and offer tailored support that meets individual needs. Services now provide a wider range of evidence-based treatment options, including nicotine replacement therapy, vapes and other stop-smoking medications. Improvements have also been made to support people while they are in hospital and to ensure they can easily access ongoing help once they return to the community. Treating tobacco dependency as a routine part of care is helping more people quit smoking and maintain healthier, smoke-free lives.
- Immunisations – During 2025/26, the immunisation programme team has continued working with providers of vaccination services to better understand and overcome barriers to vaccination. Over the course of the year, we have implemented several projects targeted at improving uptake rates in our most vulnerable patients. This has included using the community vaccination team to run community clinics in low uptake areas for Respiratory Syncytial Virus, Pneumococcal Polysaccharide Vaccine, and COVID-19. As part of our efforts to improve vaccinations in school settings we have attended a number of school events alongside our School Aged Immunisation Service provider.
- Hypertension – Lincolnshire remains a national leader in identifying and managing high blood pressure, with 19% prevalence, the highest of any ICB, reflecting strong detection. Blood pressure control rates continue to exceed national averages, supported by GP practices, community pharmacies, and prevention campaigns.
- Heart Failure – Lincolnshire heart failure services received national recognition during the year for innovative care. A new pilot to treat symptoms like swollen legs and fluid in the lungs allows some patients to receive treatment in their own homes through virtual wards, reducing hospital stays and improving patient experience.
- Respiratory – During the year, two new respiratory services were introduced and delivered within GP practices to support patients closer to home, particularly during the winter months. These focused on early support for people with Chronic Obstructive Pulmonary Disease and rapid, same-day local treatment for respiratory infections, helping reduce the need for hospital care.
- Diabetes – In 2025/26, we continued to improve diabetes prevention and care. Over 640 people were supported through the NHS Diabetes Prevention Programme, while almost 300 people took part in the Type 2 Diabetes Path to Remission Programme to improve blood sugar control and overall health. For

people with Type 1 Diabetes, rollout of Hybrid Closed Loop technology that helps manage blood glucose levels continued in partnership with NHS Trusts, benefiting children, pregnant women and people with complex needs. A new multi-disciplinary team approach has also been piloted to support people with complex diabetes by bringing together GP practices and hospital specialists, with plans to expand this further during 2026/27.

Safeguarding children and young people

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

The ICB is a statutory safeguarding partner within the Lincolnshire Safeguarding Children Partnership (LSCP), alongside Lincolnshire County Council and Lincolnshire Police. The partnership provides the formal safeguarding arrangements through which agencies work together to safeguard and promote the welfare of children, in line with the statutory requirements set out in Working Together to Safeguard Children. The strategic aims of the ICB align with the priorities of the safeguarding partnership. The published safeguarding arrangements and the most recent safeguarding partnership annual report are available on the Lincolnshire County Council LSCP website at https://www.lincolnshirescp.org.uk/.

Safeguarding arrangements in Lincolnshire are supported by established partnership and system safeguarding groups, which strengthen multi-agency working, information sharing, escalation and assurance. This includes joint working across children's and adult safeguarding arrangements, recognising the importance of all-age safeguarding and effective transition between services. The ICB's Safeguarding Team remains actively involved in child safeguarding practice reviews and rapid reviews. Learning from both local and national reviews is routinely considered through safeguarding partnership governance and system quality oversight arrangements.

The Lincolnshire Child Death Overview Panel continues to fulfil its statutory responsibilities, with regular child death review meetings taking place to review the deaths of children normally resident in Lincolnshire. The Panel provides assurance that child deaths are reviewed consistently and that learning and themes are identified and shared with statutory partners to inform service improvement and safeguarding practice across the system.

During 2025/26, the ICB has continued to prioritise safeguarding as part of its commissioning and system leadership role. Safeguarding activity during the year has included learning from national safeguarding reviews, delivery of preventative programmes, and targeted partnership action to support vulnerable children and young people.

The ICB is also responsible for ensuring that safeguarding responsibilities are embedded within the services it commissions. Providers are expected to operate in line with statutory legislation, national guidance and local safeguarding arrangements. The ICB's Safeguarding Policy, published on the ICB's website, sets out how safeguarding 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. Lincolnshire continues to monitor risks associated with workforce capacity and demand pressures, particularly in relation to health assessments for children in care, through routine quality reporting, risk management and partnership escalation routes.

The ICB confirms that it has followed the statutory assurance processes set out in the Safeguarding Accountability and Assurance Framework.

Special Educational Needs and Disabilities (SEND)

The ICB is responsible for arranging health provision and contributing to improved outcomes for children and young people with Special

Educational Needs and Disabilities (SEND), working with partners to ensure access to appropriate health services and effective contributions to Education, Health and Care Plans (EHCPs).

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

The ICB considers SEND to be a critically important area, recognising the role that early support, accessibility and coordinated care play in reducing inequalities and improving life chances for children and young people. A strong focus is therefore placed on early intervention, partnership working and understanding lived experience. The ICB undertakes its SEND responsibilities in line with the 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.

Following the CQC/Ofsted SEND Local Area Partnership Inspection in February 2025[1], SEND has been a clear priority for the Lincolnshire system. The inspection found that arrangements were leading to inconsistent experiences and outcomes for children and young people with SEND, and that the partnership must continue to work jointly to improve them. Improvement activity during 2025/26 focused on EHCP quality, neurodevelopmental pathways, and speech and language therapy, with progress achieved across all three areas. Ongoing oversight continues through six-weekly NHS England and Department for Education meetings. Improvement actions and progress during the year includes:

- EHCP quality has been strengthened through refreshed multi-agency audit arrangements, updated templates, a robust training programme, and clearer guidance for health contributions. The introduction of a cloud-based EHCP system has improved coordination, information sharing and consistency, alongside greater visibility of the child and young person's voice.
- Operational changes have improved access to neurodevelopmental assessment, supported by additional autism assessment capacity. The proportion of referrals converting to assessment appointments improved significantly during the year. Longer term pathway redesign and workforce development remain a focus to sustain progress.
- A new pre-school speech and language therapy model delivered through Family Hubs enabled earlier intervention, including same day advice for families and professionals, contributing to reduced waiting times and improved access. 624 children and young people attended pre-school drop-ins between September and December 2025.
- Feedback from nearly 200 families directly informed improvement actions, helping to address practical barriers such as communication, transport and appointment flexibility, strengthening system responsiveness.
- Where services are closely linked to SEND needs (for example continence services), work progressed to strengthen oversight and consider future service models, supporting greater sustainability and clarity.

The ICB will continue to embed post-inspection improvements, maintain momentum across EHCP quality, neurodevelopmental pathways and therapy services, and focus on workforce sustainability. The ICB will continue to work with local authority partners and providers to maintain appropriate oversight, support ongoing improvement and demonstrate how it is discharging its statutory responsibilities for children and young people with SEND.

[1] CQC/Ofsted report available at https://files.ofsted.gov.uk/v1/file/50276861.

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

The Get Lincolnshire Working Plan[1], led by the Greater Lincolnshire Combined County Authority, aligns with the national Get Britain Working priorities, while reflecting Greater Lincolnshire's distinct rural and coastal context. Informed by local evidence, the plan addresses economic inactivity linked to geographical isolation, higher NEET rates (young people not in education, employment or training) among young people with SEND, seasonal labour volatility, and health-related barriers. The ICB is a core system partner within the plan's delivery arrangements.

The plan is guided by six principles:

- Place-based customisation, targeting areas of highest need across rural, coastal and urban communities.
- Employer-led innovation, working with businesses to address skills gaps in priority sectors.
- Integrated health and employment support, embedding prevention and early intervention.
- Inclusive and equitable access, prioritising disadvantaged groups and customer voice.
- Data-driven decision-making, strengthening intelligence to support workforce planning.
- Sustainability and scalability, testing approaches before wider roll-out.

The ICB recognises that good health and meaningful work are closely linked and that employment is a key wider determinant of health. As a strategic commissioner, the ICB ensures commissioning decisions take account of social and economic factors affecting population health.

The ICB's commissioning approach emphasises prevention, early intervention and neighbourhood-based care, with neighbourhood health services strengthening access to community-based support and wider public-sector services, including employment and voluntary sector organisations.

We contribute to local economic development through stewardship of workforce development across the health and care system.

Commissioning decisions considered through our Joint Commissioning Executive Group arrangements (as described in the Governance Statement of this annual report) have included investment in service capacity and training models to support workforce sustainability, reinforcing the NHS's role as a major local employer and anchor institution.

Partnership working underpins this approach. Through Integrated Care Partnership arrangements, the ICB works with local authorities and partners to align healthcare commissioning with wider place-based strategies. The ICB is represented on Towns Fund Boards across Lincolnshire and has worked with local councils on neighbourhood-focused programmes in Boston, Skegness and Spalding.

In partnership with Lincolnshire Training Hub, the ICB is supporting delivery of a scalable Work, Health and Growth model that seeks to address economic inactivity, health inequalities and workforce shortages. Through the Next Step Lincolnshire Widening Access Demonstrator[2], coordinated place-based delivery is supporting progression into health and care careers aligned to local workforce demand.

The programme provides integrated support across a three-stage pathway: Finding Your Feet, Skills for Employment (including a targeted Skills Bootcamp), and Employment and Progression. A strong community outreach and partnership approach supports engagement through multiple routes, ensuring no wrong door for participants.

Early delivery has engaged approximately 203 individuals, with emerging evidence of progression into positive destinations, including employment within health and care roles. Building on this learning, Lincolnshire has secured continuation into 2026/27 to support further scale and reach.

Learning from this work is informing the ICB's approach to health and work support in 2026/27, aligning with the national WorkWell programme. Subject to funding arrangements, WorkWell is intended to support early intervention for people at risk of leaving work due to ill health and to expand employment advice within neighbourhood health hubs.

[1] Get Lincolnshire Working Plan available at https://greaterlincolnshire-cca.gov.uk/home/get-lincolnshire-working
[2] https://www.lincolnshiretraininghub.nhs.uk/next-steps-lincolnshire/

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 / 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 £3.7 million against a planned target of £3.7 million. 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 pressures during the financial year, mainly due to higher than planned acute provider activity, prescribing, and mental health out of area placements. These pressures were mitigated through robust financial management, including maximising delivery of efficiency and financial recovery 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 its wider NHS system partners financial performance for the reporting period, including an analysis of the ICB's total expenditure

Duty	Target (£m)	Actual (£m)
Income and expenditure (ICB): Expenditure not to exceed income	2,300.9	2,297.2
Income and expenditure (NHS system): Expenditure not to exceed income	2,300.9	2,292.7
Running costs (ICB): Remain within running cost allowance	26.0	17.1

Category of expenditure	Total 2025/26 spend (£m)	Total 2024/25 spend (£m)
Acute (hospital) care	1,087.8	1,022.7
Specialised acute (hospital) care	162.7	148.6
Community care	201.6	201.5
Mental health care	273.1	232.4
Primary care	291.6	274.8
Prescribing	169.1	169.7
Continuing care	75.3	74.4
Other non-healthcare	18.8	12.9
Corporate running costs	17.1	14.4
Total	**2,297.2**	**2,151.5**

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	2,300.9	2,142.0	1,797.9	1,229.7
Gross Operating Costs	2,297.2	2,151.5	1,829.6	1,241.2

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

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

outturn expenditure on mental health services, increased by the programme allocation growth percentage.

Total mental health expenditure for 2025/26 equates to £211.7 million. This includes an increase in recurrent expenditure of 26.1% 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 0.64%.
- 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 1.0%.

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 9.2% (2024/25: 7.9%), which is demonstrated in the table below:

Mental health expenditure	2025/26	2024/25
Mental health spend (£m)	211.7	167.9
ICB Programme Allocation (£m)	2,275.0	2,127.5
Mental health spend as a proportion of ICB Programme Allocation (%)	9.3%	7.9%

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 joint plan is intended to provide transparency for local residents, patients, NHS staff and other stakeholders on how capital funding is prioritised and used to support the delivery of strategic aims.

During 2025/26, capital resources across Lincolnshire were managed collaboratively with partner organisations, with planning and oversight aligned to national guidance and the agreed system capital envelope.

Capital expenditure during 2025/26 was as follows:

Capital expenditure	Plan (£000)	Actual (£000)	Variance (£000)
Capital allocation (Trusts)	133,058	141,279	8,221
Capital allocation (ICB)	2,989	2,846	-143
Total capital spend	**136,047**	**144,125**	**8,078**

In year, capital expenditure focused on core operational and infrastructure priorities, including backlog maintenance to maintain safe and compliant estates, replacement of critical medical equipment, digital and technology investment (notably the electronic patient record programme), and energy efficiency improvements aligned to NHS Green principles. Investment also supported service capacity and quality improvements, particularly where existing estate constraints and ageing infrastructure posed risks to operational delivery.

Where applicable, the system also benefited from national capital funding streams supporting major programmes and priority schemes, including Community Diagnostic Centres, the Lincoln Endoscopy expansion, eradication of mental health dormitory accommodation, and nationally supported digital transformation initiatives. These investments contributed to increased diagnostic and treatment capacity, improved patient safety, privacy and experience, strengthened infection prevention and control, enhanced digital maturity across the system, workforce recruitment and retention, and progress towards longer-term service transformation and sustainability. 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 Lincolnshire, the most significant quality concerns during the year have particularly related to United Lincolnshire Teaching Hospitals NHS Trust and Lincolnshire Partnership NHS Foundation Trust, alongside system-wide pressures affecting urgent and emergency care and infection prevention and control.

United Lincolnshire Teaching Hospitals has remained subject to enhanced oversight during 2025/26, particularly in relation to infection prevention and control, urgent and emergency care performance, ophthalmology capacity, and the management of mixed-sex accommodation breaches. The Trust continues to be monitored through established oversight arrangements, with focused improvement activity in place and ongoing engagement between the Trust, the ICB and NHS England.

Lincolnshire Partnership NHS Foundation Trust has operated within the NHS Oversight Framework at an enhanced level during the year, following regulatory concerns arising from unannounced Care Quality Commission inspections. Key areas of focus have included rapid tranquilisation, restraint practices, care planning, and risk assessment. Improvement actions have been implemented and assurance has continued to be provided through ICB-led quality review meetings, with national partners engaged as appropriate.

In addition to provider-specific concerns, Lincolnshire has continued to experience system-wide pressures in relation to urgent and emergency care, ambulance handover delays, and

the delivery of timely care pathways for adults, children and young people. Following the CQC/ Ofsted Special Educational Needs and Disabilities (SEND) Local Area Partnership Inspection in February 2025, Lincolnshire has delivered a substantial programme of improvements to strengthen outcomes for children and young people with SEND.

These challenges continue to require coordinated action across health and local authority partners, supported by strengthened oversight and risk management arrangements. 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 Lincolnshire's population.

This work is underpinned by the ten principles set out in the ICB's People and Communities Strategy. These principles guide how the ICB listens, builds relationships, and works alongside patients, carers, partners, voluntary and community organisations, and local communities. The ICB also works as part of the wider Lincolnshire Integrated Care Partnership, recognising the importance of partnership working across health and care, local government, and the voluntary, community and social enterprise sector in improving health and wellbeing across the county.

During 2025/26, this approach was reflected in work to:

- Co-produce the Lincolnshire 'age well' campaign through a frailty co-production group, helping to shape campaign materials including videos, social media content, leaflets and a signposting booklet.

- Engage local people on proposals to relocate echocardiology services in Lincolnshire, ensuring that service change planning was informed by the views and experiences of those affected.
- Hear directly from local people to help shape the future Tier 3 Specialist Weight Management Service, through a county-wide survey, community outreach, social media activity and an invited patient group to support ongoing co-design.
- Undertake a public consultation on proposed changes to the prescribing of gluten-free bread and flour, specifically seeking views from people affected by coeliac disease or dermatitis herpetiformis.
- Work with system partners and support groups to carry out a county-wide survey on the experiences of people living with Functional Neurological Disorder, helping to inform development of a new county strategy and identify priorities for improvement.
- Hear from people affected by prostate cancer to better understand what mattered most to them, including where support, information and follow-up care could be strengthened.

These activities helped strengthen the ICB's understanding of local needs and experiences and informed the ongoing development of services in line with the priorities of Lincolnshire communities.

Further detail on activity undertaken during the year, including examples of how the ICB has worked with people and communities, is set out in the published Annual Working with People and Communities Annual Report, which is available on the ICB's website at https://lincolnshire.icb.nhs.uk/lets-talk-health-and-wellbeing-lincolnshire/.

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. Lincolnshire's strategic framework also places tackling inequalities and ensuring equity of provision at its core.

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

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

Health inequalities are closely linked to differences in life expectancy and rates of avoidable mortality. 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 underpinned by system intelligence and population health management analysis provided by the ICB's Strategic Analytics and Intelligence Unit (SAIU), which operates across the Integrated Care System. The SAIU supports a shared understanding of population need and patterns of inequality, including variation in access and outcomes, enabling evidence-based planning and effective oversight of progress in reducing health inequalities.

During 2025/26, this has been reflected in targeted work across a number of programmes and population groups. This has included:

- Taking a health inequalities approach to musculoskeletal and pain pathways, including self-referral routes to improve access for people who may struggle to access primary care.
- Improving communication and inclusion through co-produced health literacy and language training, delivered with the Personalisation Programme and people with lived experience.
- Using grant funding to support voluntary and community sector organisations and cancer projects focused on improving access and experience for deprived communities and Core20PLUS5 groups.
- Treating digital inclusion as a core component of the inequalities agenda, supported by the Lincolnshire Digital Inclusion Strategy.
- Developing an Inclusion Health Strategic Plan through a multi-agency oversight group, informed by public engagement on the barriers faced by inclusion health groups, including difficulties accessing mental health support, long waits, transport problems, digital exclusion and fragmented care.

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

Equality, diversity and inclusion

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

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

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

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

The ICB recognises that inequality can affect people differently depending on their circumstances and protected characteristics, including age, disability, sex, race, pregnancy and maternity, religion or belief, sexual orientation, gender reassignment, and marriage and civil partnership. While not all activity is specific to individual characteristics, due regard is

demonstrated through inclusive commissioning, equality impact assessments, accessible communication, workforce equality standards, and targeted action where inequalities are identified.

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

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

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

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

Oversight of equality, diversity and inclusion is embedded within the ICB's governance framework through executive leadership responsibility, routine reporting, statutory workforce equality standards and the Equality Delivery System. During 2025/26, the Board received an Annual Equality Assurance Report, which provided assurance on how the ICB, working with NHS Derby and Derbyshire ICB and NHS 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 the ICB to have regard to joint health and wellbeing strategies when exercising its functions.

In Lincolnshire, the Health and Wellbeing Board is the statutory partnership established to provide strategic leadership for improving the health and wellbeing of the population and reducing health inequalities. The Board brings together elected members of the County Council, NHS commissioners, the Local Authority and a wide range of system partners to provide a shared forum for setting priorities and overseeing delivery.

The Lincolnshire health and care system operates within a coherent strategic framework comprising the Joint Strategic Needs Assessment, the Joint Health and Wellbeing Strategy, and the Integrated Care Strategy. The Joint Strategic Needs Assessment provides the evidence base identifying population need, inequalities and patterns of demand, and directly informs both the Joint Health and Wellbeing Strategy and the Integrated Care Strategy, ensuring that system planning is driven by population need.

The Joint Health and Wellbeing Strategy sets out the population-level priorities which system partners will collectively focus on to improve health outcomes and reduce inequalities. The Integrated Care Strategy complements this by setting out the strategic enablers, integration approaches and system-wide actions required to deliver those priorities. The ICB's approach to planning and commissioning aligns with this framework.

The ICB is an active member of the Lincolnshire Health and Wellbeing Board and contributes to the delivery of the Joint Health and Wellbeing Strategy through partnership working across the system. During the year, the Health and Wellbeing Board has been engaged in the development and

oversight of system plans, including consideration of the NHS Joint Forward Plan and updates on delivery against Joint Health and Wellbeing Strategy priorities. Through this role, the Board provides strategic oversight, supports alignment across organisations, and monitors progress in addressing health inequalities and improving outcomes for local people.

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.

Taskforce on Climate-related Financial Disclosures (TCFD)

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

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

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

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

Governance

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

Management responsibility for assessing and managing climate-related matters sits within established executive and operational arrangements. This supports delivery of the ICB's Green Plan, estates and infrastructure planning, commissioning, procurement 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

The ICB uses nationally consistent information, alongside local sustainability metrics, to monitor system-wide progress and inform assurance reporting to the Board and relevant committees. 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.

Performance against environmental sustainability objectives is monitored through a combination of national reporting mechanisms, including the NHS Greener NHS Dashboard, and local oversight of delivery against the priorities set out in the ICB's Green Plan. The Green Plan identifies actions across a number of nationally defined focus areas, covering decarbonisation of the NHS estate, clinical and operational activity, medicines and prescribing, travel and transport, procurement and supply chains, and adaptation to the impacts of climate change. Progress against these priorities is tracked through a supporting Green Action Plan and monitored against agreed delivery milestones and system-level metrics, providing assurance on progress towards national NHS net zero targets 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.

Patients are at the heart of everything we do, and we actively encourage people living in Lincolnshire to help shape our plans and the work we do to transform services. The ICB supports patient and public involvement through a range of approaches designed to ensure that people and communities can influence planning, service development and improvement activity.

Our Involvement Team advocates for the use of social media as a positive platform to share events and engagement opportunities, while also recognising that not everyone will want or be able to engage digitally. We therefore also offer other routes, including direct engagement through local communities and support groups.

During 2025/26, this has included:

- Continuing to use Facebook and Nextdoor to promote engagement activities and campaigns and reach local people and communities.
- Ensuring that engagement opportunities remained available through non-digital routes, including visits to local communities and support groups.
- Developing the Digital Inclusion Strategy with system-wide organisations and people with lived experience through our Involvement Team.
- Working with local people to help shape future services, including engagement on Functional Neurological Disorder, the Tier 3 Specialist Weight Management Service, and prostate cancer experience.
- Using surveys, outreach, newsletters, engagement bulletins and direct contact with support groups to hear directly from people affected by services and use this learning to inform future improvements.

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

Ensuring patient choice

Patients have a legal right of choice and ICBs are required to act with a view to enabling patient choices with respect to aspects of health services provided to them. This duty remains implicit within the ICB's established commissioning and contracting arrangements. The ICB commissions healthcare services (in line with its commissioning responsibilities, as described in the About us section of this Annual Report) from a range of NHS and independent sector providers, ensuring that these are made known to patients at the point of referral via the contracts held with primary care providers.

In practice, this means that patients requiring elective care can consider factors such as where waiting times are the shortest (including those outside of our area where possible) or a personal preference when considering their treatment.

A key mechanism for supporting this is the ICB's Single Point of Access, 'the Elective Activity Coordination Hub', which assists patients in exercising choice when referred for NHS treatment to community services and hospital providers, including independent sector providers. The Hub supports patients to consider available options and waiting times, enabling informed decisions where choice applies.

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

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

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

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 place great importance on clinical and care professional leadership and engagement.

In Lincolnshire, this is supported through dedicated clinical leadership arrangements that provide expert advice to inform decision-making. The ICB employs a range of healthcare professionals who, as part of their roles, provide specialist clinical and professional input, including executive medical and nurse leadership, supported by senior clinical leaders and professional advisers. Together, these roles bring expertise across primary care, community and proactive 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, helping to ensure that decisions are informed by evidence, population health insight and clinical experience.

The ICB has also established collaborative clinical and care leadership arrangements across the Lincolnshire system, bringing together senior clinical and care leaders from partner organisations to support the development of clinical policy and inform transformation activity. This work is supported by wider engagement with clinical and care professionals across the system

and informs the ICB's formal decision-making processes.

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 membership of its key decision-making and assurance committees includes 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 Lincolnshire, innovation is supported through the ICB's wider strategic and operational arrangements, including digital transformation, pathway redesign, quality improvement, research and partnership working with education, community and system partners.

During 2025/26, this has included:

- Improving continuing healthcare pathways through a major joint project between the ICS Personalisation Team and Lincolnshire Continuing Healthcare, using Quality Improvement methodology to analyse inefficiencies and redesign the pathway to support a more streamlined and person-centred process.
- Continuing to attract early-stage innovators seeking to use the ICS as a testbed environment to generate evidence and support national scaling.
- Launching CONNECTPlus, a women's health app for Lincolnshire providing advice and guidance on a wide range of female wellbeing topics.
- Taking forward digital innovation through the Lincolnshire Care Record, supporting access to selected patient information across multiple organisations and systems.
- Supporting a wider culture of innovation through local improvement activity, design work with education partners and innovation-focused system events.

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

Promoting research

ICBs have a statutory duty under the Health and Care Act 2022 to facilitate or otherwise promote research on matters relevant to the health service, and to promote the use in the health service of evidence obtained from research. We recognise that research and the application of evidence are fundamental to improving population health outcomes, addressing inequalities, and ensuring that commissioning decisions are effective, proportionate and sustainable. The ICB discharges this duty by embedding research, evaluation and evidence use across its system leadership, commissioning and transformation arrangements, ensuring that research activity is aligned with system priorities and integrated with population health management, prevention and service improvement.

The Lincolnshire Research and Innovation Hub provides a focal point for system collaboration, bringing together NHS providers, academic partners, local authorities and other stakeholders to support research development and participation. Activity during the year included:

- Delivery of the first Lincolnshire Research and Innovation Conference in May 2025, bringing together system partners to showcase research activity, promote collaboration and support research capability within a predominantly rural and coastal health system.
- Facilitation of partnerships with academic institutions and system partners to support research, evaluation and innovation aligned to local population need.

Alongside facilitating research activity, the ICB has promoted the use of evidence derived from research to inform commissioning and service redesign. Evaluation, population health analysis, and lived experience insight are embedded within major commissioning and transformation programmes, including:

- Prevention and population health management.
- Frailty and ageing-well programmes.
- Digital inclusion and access.
- Neurodiversity pathways.
- Weight management and long-term condition services.

Through these arrangements, we have ensured that service design, prioritisation and resource allocation are informed by robust evidence and best practice.

Promoting education and training

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

We satisfy this duty through our system leadership role in developing and delivering our People and Workforce Plan. This sets out a system-wide approach to recruiting, retaining and developing staff, aligned with national priorities to support a sustainable, digitally enabled workforce and improve patient care.

By prioritising education and training, our workforce is equipped with the necessary knowledge and skills to ensure our population continues to receive high-quality healthcare services.

During 2025/26, this has included:

- Coordinated attraction and recruitment activity through the Be Lincolnshire campaign, supporting both domestic and international recruitment, particularly in rural and coastal areas.
- Work through the People Promise to strengthen retention and culture, with a focus on flexible working, staff wellbeing and reducing violence against staff.
- Close working with education partners, including the University of Lincoln and its Medical School, to grow our own workforce and support long-term sustainability.
- Continuing delivery of the Primary Care People Plan to address workforce pressures in general practice, including improving access and staff morale.

Promoting integration

We have a duty to ensure that health, social care and health-related services are provided in an integrated way where this would improve the quality of the services, reduce inequalities of access or reduce inequalities in outcomes. This is reflected in Lincolnshire's wider strategic framework and partnership arrangements. The Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and Integrated Care Strategy are closely linked, with the latter setting out the strategic enablers, integration approaches and system-wide actions required to deliver shared priorities.

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

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

This approach is supported through:

- The Integrated Care Partnership, as the guiding mind of the local health and care system.
- 14 Primary Care Networks providing services designed around the specific needs of local communities.
- A provider collaborative at scale to improve quality, efficiency and outcomes and address unwarranted variation and inequalities.
- The development of a Lincolnshire Neighbourhood Health Plan to support the hospital-to-community shift.

During the year, this integrated approach has also been reflected in work on older people's strategy delivery, neighbourhood-based care, digital inclusion, the Lincolnshire Care Record, and joint

oversight arrangements between the Local Authority and the ICB.

Having regard to the wider effects of decisions

The Health and Care Act 2022 introduced a new duty for ICBs, along with other NHS organisations, to have regard to the effects of their decisions on the Triple Aim of: the health and wellbeing of the people of England, including inequalities in that health and wellbeing; the quality of services provided or arranged by NHS organisations, including inequalities in the 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 shared strategic framework through the Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and Integrated Care Strategy. The Joint Forward Plan sets out the NHS response to these strategic priorities over a five-year period, aligned with wider system ambitions and priorities.

This joint approach to planning helps ensure that we consider the wider effects of our decisions by default. It also supports joint oversight arrangements between the Local Authority and the ICB to monitor progress and strengthen integrated working.

Together, these arrangements help ensure that decisions are taken with regard to health outcomes, inequalities, quality, value for money and the wider social and economic development of Lincolnshire.

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

Skills, knowledge and experience of members

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

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

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

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

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

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

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

The Board has also secured regular attendance at its meetings by senior colleagues with subject matter expertise in public health and governance, to advise Board Members when discharging their responsibilities. The Managing Director of Lincolnshire Voluntary Engagement Team also attends meetings; to bring the perspective of the voluntary, community, faith-based and social enterprise sector, and the people and communities it supports, to the work of the Board.

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

Accountability Report

Signed:

Amanda Sullivan
Accountable Officer

16 June 2026

Corporate Governance Report

Members Report

Composition of the Board

The composition of NHS Lincolnshire ICB's Board was revised during the year in line with the establishment of formal partnership arrangements with NHS Derby and Derbyshire ICB and NHS 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
Wendy Bowkett	Local Authority Partner Member (to 2 May 2025)
Dr Dave Briggs	Executive Director of Outcomes (from 1 November 2025)
Sarah Connery	Ordinary Member for Mental Health (to 31 October 2025)
Anita Day	Non-Executive Director (to 31 October 2025)
Karen Dunderdale	NHS Trust/Foundation Trust Partner Member
John Dunstan	Non-Executive Director
Phillip Earnshaw	Non-Executive Director (to 31 October 2025)
Martin Fahy	Chief Nurse (to 31 October 2025)
Matt Gaunt	Director of Finance (to 30 September 2025)
Sunil Hindocha	Medical Director (to 31 October 2025)
Margaret Gildea	Non-Executive Director (from 1 November 2025)
Stephen Jackson	Non-Executive Director (from 1 November 2025)
Dawn Kenson	Non-Executive Director (to 31 October 2025)
Mehrunnisa Lalani	Non-Executive Director (from 1 November 2025)
Dr Kathy McLean	Chair (from 1 October 2025)
Dr Gerry McSorley	Chair (to 30 September 2025)
Julie Pomeroy	Non-Executive Director (to 31 October 2025)
Mark Powell	Ordinary Member for Mental Health (from 1 November 2025)
Maria Principe	Executive Director of Commissioning (from 1 November 2025)
Clair Raybould	Director for System Delivery (from 1 April to 17 June and from 1 to 31 October 2025), Interim Chief Executive (from 18 June to 30 September 2025) and Executive Director of Strategy and Citizen Experience (from 1 November 2025)
Sharon Robson	Non-Executive Director
Bill Shields	Interim Director of Finance (from 1 to 31 October 2025) and Executive Director of Finance (from 1 November 2025)
Martin Samuels	Local Authority Partner Member (from 6 June 2025)
Amanda Sullivan	Chief Executive (from 1 October 2025)
Kevin Thomas	Primary Care Partner Member
John Turner	Chief Executive (to 17 June 2025)
Jon Towler	Non-Executive Director (from 1 November 2025)
Rosa Waddingham	Executive Director of Quality (from 1 November 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://lincolnshire.icb.nhs.uk/about-us/our-board-and-committees/meet-the-board/.

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

Audit Committee

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

- John Dunstan (Chair)
- Dawn Kenson
- Julie Pomeroy

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://lincolnshire.icb.nhs.uk/about-us/our-board-and-committees/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, eight personal data related incidents and four 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://lincolnshire.icb.nhs.uk/about-us/safeguarding/modern-day-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 Lincolnshire 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 Lincolnshire ICB. John Turner served as Accountable Officer until 17 June 2025. Clair Raybould was then appointed by NHS England as Interim Accountable Officer from 18 June to 30 September 2025, with Amanda Sullivan appointed as Accountable Officer of the ICB 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 Lincolnshire 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 Lincolnshire 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 Lincolnshire. 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 Lincolnshire ICB has established formal partnership arrangements with NHS Derby and Derbyshire 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 Lincolnshire 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 Derby and Derbyshire ICB (since 1 October 2025). The following sections describe how NHS Lincolnshire 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://lincolnshire.icb.nhs.uk/governance/.

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 Lincolnshire ICB, NHS Derby and Derbyshire ICB, and NHS 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 Lincolnshire ICB, NHS Derby and Derbyshire ICB, and NHS Nottingham and Nottingham 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 86%.

During 2025/26, the Board maintained strong oversight of the ICB's statutory responsibilities during a period of significant change, financial constraint and sustained service pressures. A central and recurring focus was the transition to formal ICB clustering arrangements with NHS Derby and Derbyshire ICB and NHS 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 four development sessions during the year to support continuous improvement in Board effectiveness and collective leadership. These sessions focused on: 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 Derby and Derbyshire 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, with the exception of one meeting of the former Finance and Resource Committee, two meetings of the former Quality and Patient Experience Committee, and one meeting of the former Primary Care Commissioning Committee.

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

Until 19 November 2025, the Audit and Risk Committee provided assurance to the Board on

the effectiveness of the ICB's systems of governance, risk management and internal control. From 20 November 2025, these responsibilities were assumed by the Audit Committee, which met in common with the Audit Committees of NHS Derby and Derbyshire ICB and NHS Nottingham and Nottinghamshire ICB as part of the revised cluster governance arrangements. A formal handover report supported the transition to the new committee arrangements, ensuring continuity of oversight and clear ownership of ongoing priorities, including internal audit actions and risk management arrangements.

Memberships of both Committees were comprised solely of Non-Executive Directors, with the Committees' Chairs having recent and relevant financial experience. Meetings were routinely attended by the Executive Director of Finance, governance leads, internal and external audit representatives, and the Local Counter Fraud Specialist as required.

The former Audit and Risk Committee met five times and the Audit Committee met twice, with attendance at 100%. 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, emergency preparedness, resilience and response, and standards of business conduct.

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. From 20 November 2025, these responsibilities were carried forward by the Joint Remuneration and Human Resource Committee, established jointly by NHS Lincolnshire ICB, NHS Derby and Derbyshire ICB and NHS Nottingham and Nottinghamshire ICB as part of ICB clustering arrangements. The Joint Committee also took on responsibility for ICB human resource management and organisational development. 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 three times with an average attendance of 83%, 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 Resource Committee and Service Delivery 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 Resource Committee provided assurance to the Board regarding financial planning and on the effective discharge of the ICB's statutory financial duties, while the Service Delivery and Performance Committee provided assurance relating to operational 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 the three 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. Memberships of the two former Committees also included Non-Executive Directors from NHS provider organisations across Lincolnshire.

The Finance and Resource Committee met seven times with an average attendance of 67%, the Service Delivery and Performance Committee met six times with average attendance of 67%, 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) and annual budgets; monitoring delivery of the ICB's statutory financial duties, in-year financial performance of the ICB and wider NHS system, and associated 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, learning disability and autism services, community services and primary care access); and oversight of the delivery of estates, digital and environmental sustainability priorities. The Committees also maintained oversight of actions to mitigate the key operational risks relevant to their remits.

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

Until 19 November 2025, the Quality and Patient Experience Committee provided assurance to the Board on quality improvement, clinical effectiveness, and patient experience. From 20 November 2025, these responsibilities were carried forward by the Joint Quality and Service Improvement Committee under the revised governance arrangements. The Joint Committee also took on responsibility for medicines optimisation, safeguarding, and strategic workforce matters. A formal handover report ensured continuity of oversight and transfer of key priorities into the successor committee.

Membership of both Committees comprised Non-Executive Directors and the relevant Executive Directors and Senior Leaders responsible for quality, medical leadership, delivery and operations, finance, and strategy, in line with the applicable terms of reference. The Committees were also routinely supported by relevant subject matter experts and governance leads. Membership of the former Committee also included Non-Executive Directors from NHS provider organisations across Lincolnshire and Local Authority representation.

The former Committee met four times with average attendance of 61%, and the Joint Committee met three times with average attendance 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, and patient experience; and monitoring of safeguarding, infection prevention and control, medicines optimisation, and immunisation and vaccination arrangements. The Committees also maintained oversight of actions to mitigate the key operational risks relevant to their remits.

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

Until November 2025, the Primary Care Commissioning Committee oversaw the review, planning, commissioning and procurement of primary care services. From 20 November 2025, these responsibilities were carried forward by the Joint Strategic Commissioning Committee under the revised governance arrangements. The Joint Committee also took on responsibility for oversight of the ICB's wider strategic commissioning functions and service transformation priorities. 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' membership included Non-Executive Directors together with the Chief Executive and the relevant Executive Directors and Senior Leaders responsible for strategy and citizen engagement, commissioning, outcomes, finance, and quality. The Committees were also routinely supported by relevant programme, governance and subject matter leads.

The former Committee met four times and the Joint Committee met three times, with attendance rates of 86% and 92% respectively. The Committees' key areas of focus during the year included: development of the Five-Year Population Health Strategy and Five-Year Strategic Commissioning Plan; scrutiny of progress against major transformation and service redesign priorities, including the delivery and development of primary care services and neighbourhood health; and overseeing arrangements for public and patient involvement. 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's 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 the appointment of the ICB's external auditor.

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 Lincolnshire, an ICP has been established as a joint committee of Lincolnshire County Council and NHS Lincolnshire ICB. The primary role of the ICP is to lead on creating an Integrated Care Strategy and Outcomes Framework to reduce health inequalities and improve health and care outcomes and experiences for the Lincolnshire population.

More information about the ICP's terms of reference and membership is available here: https://lincolnshire.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=1686.

The ICP has met once during 2025, confirming its governance arrangements through the appointment of its Chair and Vice-Chair, and reaffirming its terms of reference. The ICP also considered its forward plan in support of the wider 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 Lincolnshire ICB has established a formal Joint Working Agreement with NHS Derby and Derbyshire ICB, 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 Derby and Derbyshire 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 delivery of its statutory functions, service performance, quality of care and financial sustainability. The ICB's risk profile reflected significant operational pressures across health and care services, alongside risks associated with financial recovery, workforce resilience, digital resilience and the transition to aligned ICB cluster arrangements. Risks were reviewed through established governance and reporting arrangements, with mitigating actions in place and escalation where required.

The most significant operational risks during the year related to system capacity and flow, particularly in relation to urgent and emergency care, hospital discharge and elective recovery. These pressures had potential implications for patient experience, outcomes, and system efficiency, particularly during periods of sustained demand.

Quality-related risks remained a key focus, including safeguarding assurance, maintenance of quality standards within commissioned services, and sustaining improvement within provider organisations subject to enhanced oversight. Specific attention was given to risks affecting children and young people, vulnerable adults, and patients reliant on timely access to community and specialist services.

Workforce-related risks were monitored throughout the year, recognising the potential impact of organisational change, cost reduction requirements and service pressures on staff wellbeing, retention and organisational capacity. These risks were particularly relevant during the delivery of management of change processes and transition to cluster working.

Financial risks remained significant, reflecting rising costs, delivery of efficiency requirements, reliance on transformation programmes and the need to maintain financial sustainability while meeting statutory duties. Mitigations included strengthened financial grip and control, executive-led recovery planning, enhanced reporting and system-wide productivity and efficiency oversight.

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

In addition, the ICB shared a number of risks with NHS Derby and Derbyshire ICB and NHS Nottingham and Nottinghamshire ICB. These included risks associated with the future of commissioning support services, delivery of ICB priorities during organisational change, workforce change affordability, and the effectiveness of communication during transition arrangements. These shared risks were subject to joint oversight and assurance arrangements through the Board Assurance Framework and aligned committee structures.

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 the Board-approved 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:

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

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

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

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

Control Issues

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

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

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

- Clear Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions have been set out to ensure proper stewardship of public money and assets. The ICB also has clear policies in relation to the required standards of business conduct.
- A Procurement and Provider Selection Policy is in place, which reflects the requirements of the NHS Provider Selection Regime. The Policy sets out the organisation's approach for establishing contracts that provide value for money, in line with the principles of good procurement practice, and clearly requires the ICB to ensure the delivery of improved efficiency and effectiveness in the provision of healthcare and non-healthcare services. The Audit Committee (or equivalent) oversees compliance with the requirements of the NHS Provider Selection Regime relating to annual

reporting, monitoring and publication arrangements, including review of all provider representations received in relation to procurement and contract award decisions for healthcare services. The Committee also scrutinises all instances where requirements for formal competitive tendering have been waived in relation to non-healthcare services.

- The ICB has a strategic decision-making framework and service review process, which ensure the robust evaluation of business case proposals for new investments, recurrent funding allocations and decommissioning and disinvestment of services in several areas, including clinical and cost effectiveness, productivity and value for money, affordability, anticipated health benefits (improved health outcomes and reduced health inequalities).
- Robust financial procedures and controls and effective financial management and financial planning arrangements have also been established, which are set out within the organisation's Standing Financial Instructions. These cover the management of resource allocations for healthcare services and running cost allowances to cover the ICB's management costs and costs of commissioning support. The Executive Director of Finance provides reports to every meeting of the Board and the Joint Finance and Performance Committee (or equivalent) on financial performance, including performance against the organisation's statutory financial duties and the delivery of required efficiencies.
- 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:

"My overall opinion is that Reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk"

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

Audit	Level of assurance
Board Assurance Framework and Risk Management	Reasonable
Key Financial Controls	Reasonable
Cost Improvement Plan	Reasonable
Continuing Healthcare	Reasonable
Patient Safety – Management of Serious Incidents	Reasonable
Patient Engagement	Reasonable
Management of IT Assets	Reasonable
Weighted Value Framework	Reasonable
Medicines Optimisation – Delivery of Cost Savings	Reasonable

Two further advisory reports have been issued:

- Partnership Working - Social Finance
- Cyber Security

No opinions were provided for these reports; however, areas of learning were highlighted, and actions were suggested to enhance existing arrangements.

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

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive directors and senior managers within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me, 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 Resources Committee

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

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

- Julie Pomeroy (Chair)
- Dr Philip Earnshaw
- Dawn Kenson
- Sharon Robson
- Gerry McSorley (up to 30 September 2025)

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	40.4%	0
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	4.4%	0

2024/25	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	18.7%	0
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	8.3%	0

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%. The 40.4% rise in the remuneration of the highest paid director is a result of NHS restructuring during 2025/26. Directors are now responsible for healthcare across the three counties of Derbyshire, Lincolnshire and Nottinghamshire, rather than just one county.

Pay ratio information (subject to audit)

Reporting bodies are required to disclose 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 ICB's workforce. Total remuneration of the employee at the 25th

percentile, median, and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director in the ICB during 2025/26 was £312,500 (2024/25: £222,500). The relationship to the remuneration of the ICB's workforce is disclosed in the tables below.

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.

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	31,049	46,580	62,599
Salary component of total remuneration	31,049	46,580	62,599
Pay ratio information	10.06	6.71	4.99

2024/25	25th percentile	Median pay ratio	75th percentile
Total remuneration	29,114	44,962	56,454
Salary component of total remuneration	29,114	44,962	56,454
Pay ratio information	7.64	4.95	3.52

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

As at 31 March 2026, remuneration ranged from £7,500 to £312,500 (March 2025: £2,500 to £222,500) using midpoints of the bands based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff).

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)

Name and title	1 April 2025 to 31 March 2026: (a) Salary (bands of £5,000)	(b) Expense payments (taxable)[5] (to nearest £100[6])	(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)	1 April 2024 to 31 March 2025: (a) Salary (bands of £5,000)	(b) Expense payments (taxable) (to nearest £100[1])	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
Wendy Bowkett, Local Authority Partner Member	0	0	0	0	0	0	0	0	0	0	0	0
Dr Dave Briggs, Executive Director of Outcomes (Medical)[7]	15-20	0	0	0	2.5.5	20-25						
Pete Burnett, Director of Strategic Planning, Integration and Partnerships[8]	20-25	0	0	0	0	20-25	130-135	0	0	0	20-22.5	150-155
Sarah Connery, Ordinary Member for Mental Health	0	0	0	0	0	0	0	0	0	0	0	0
Anita Day, Non-Executive Director[9]	5-10	100	0	0	0	5-10	10-15	0	0	0	0	10-15
Helen Dillistone, Executive Director of Transition[7]	15-20	0	0	0	7.5-10	20-25	–	–	–	–	–	–
John Dunstan, Non-Executive Director[10]	10-15	0	0	0	0	10-15	–	–	–	–	–	–
Karen Dunderdale, NHS Trust/Foundation Trust Partner Member	0	0	0	0	0	0	–	–	–	–	–	–
Dr Phillip Earnshaw, Non-Executive Director[11]	5-10	0	0	0	0	5-10	0-5	0	0	0	0	0-5
Martin Fahy, Director of Nursing[9]	85-90	100	0	0	37.5-40	125-130	145-150	0	0	0	12.5-15	160-165
Matt Gaunt, Director of Finance[12]	90-95	0	0	0	30-32.5	120-125	180-185	0	0	0	0	180-185
Margaret Gildea, Non-Executive Director[7]	0-5	0	0	0	0	0-5	–	–	–	–	–	–
Dr Sunil Hindocha, Medical Director[9]	100-105	0	0	0	25-27.5	125-130	165-170	0	0	0	40-42.5	210-215
Stephen Jackson, Non-Executive Director[7]	0-5	0	0	0	0	0-5	–	–	–	–	–	–
Dawn Kenson, Non-Executive Director[9]	10-15	200	0	0	0	10-15	20-25	400	0	0	0	20-25
Mehrunnisa Lalani, Non-Executive Director[7]	0-5	0	0	0	0	0-5	–	–	–	–	–	–

[5] The expenses shown relate to travel costs which were outside the normal limits for non-taxable refund.
[6] Taxable expenses and benefits in kind are expressed to the nearest £100.
[7] Commenced in role on 1 November 2025, as part of formal partnership arrangements established between NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB. The table above includes the share of remuneration for NHS Lincolnshire ICB only based on population size. Full year equivalent remuneration is as follows:
- Dr Dave Briggs: £170,000 to £175,000.
- Helen Dillistone: £150,000 to £155,000.
- Maragaret Gildea: £15,000 to £20,000.
- Stephen Jackson: £15,000 to £20,000.
- Merunnisa Lalani: £20,000 to £25,000.
- Maria Principe: £150,000 to £155,000.
- Jon Towler: £15,000 to £20,000.
- Rosa Waddingham: £165,000 to £170,000.

[8] Ceased in role on 1 June 2025.
[9] Ceased in role on 31 October 2025.
[10] Remuneration and expenses payments (where relevant) wholly reported for the period 1 April to 31 October 2025, with remuneration for the period 1 November 2025 to 31 March 2026 shared across NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB based on population size, as part of formal partnership arrangements.
[11] Commenced in role on 1 March 2025 and ceased in role on 31 October 2025.
[12] Left on secondment on 1 October 2025, Board membership ceased on 31 October 2025 and subsequently left the organisation on 1 March 2026.

Name and title	1 April 2025 to 31 March 2026: (a) Salary (bands of £5,000)	(b) Expense payments (taxable)[5] (to nearest £100[6])	(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)	1 April 2024 to 31 March 2025: (a) Salary (bands of £5,000)	(b) Expense payments (taxable) (to nearest £100[1])	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
Anne Lloyd, Director of Workforce Transformation[13]	80-85	0	0	0	30-32.5	110-115	30-35	0	0	0	115-117.5	145-150
Dr Kathy McLean, Chair[14]	10-15	100	0	0	0	10-15	–	–	–	–	–	–
Dr Gerry McSorley, Chair[15]	30-35	0	0	0	0	30-35	65-70	0	0	0	0	65-70
Sarah Jane Mills, Director for Primary Care and Community and Social Value[9]	75-80	0	0	0	30-32.5	110-115	130-135	0	0	0	10-12.5	140-145
Andrew Morgan, NHS Trust/Foundation Trust Partner Member	0	0	0	0	0	0	0	0	0	0	0	0
Julie Pomeroy, Non-Executive Director[9]	5-10	0	0	0	0	5-10	10-15	0	0	0	0	10-15
Margaret Pratt, Non-Executive Director	–	–	–	–	–	–	10-15	0	0	0	0	10-15
Maria Principe, Executive Director of Commissioning[7]	15-20	0	0	0	12.5-15	25-30	–	–	–	–	–	–
Sharon Robson, Non-Executive Director[10]	10-15[16]	0	0	0	0	10-15	15-20[17]	0	0	0	0	15-20
Clair Raybould, Executive Director of Strategy and Citizen Experience[10]	115-120	1,400	0	0	115-117.5	240-245	140-145	1,000	0	0	0	140-145
Martin Samuels, Local Authority Partner Member	0	0	0	0	0	0	0	0	0	0	0	0
Bill Shields, Executive Director of Finance[18]	25-30	0	0	0	157.5-160	185-190	–	–	–	–	–	–
Amanda Sullivan, Chief Executive[19]	30-35	0	0	0	0	30-35	–	–	–	–	–	–
Kevin Thomas, Primary Care Partner Member	0	0	0	0	0	0	0	0	0	0	0	0
Jon Towler, Non-Executive Director[7]	0-5	0	0	0	0	0-5	–	–	–	–	–	–
John Turner, Chief Executive[20]	50-55	0	0	0	0	50-55	260-265	0	0	0	0	260-265
Rosa Waddingham, Executive Director of Quality[7]	15-20	0	0	0	7.5-10	25-30	–	–	–	–	–	–
Sandra Williamson, Director for Health Inequalities and Regional Collaboration[9]	75-80	0	0	0	27.5-30	105-110	130-135	0	0	0	15-17.5	145-150

[13] Commenced in role on 1 January 2025 and ceased in role on 31 October 2025.
[14] Commenced in role on 1 October 2025, as part of formal partnership arrangements established between NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB. Full year equivalent remuneration is £110,000 to £115,000
[15] Ceased in role on 30 September 2025.
[16] Note that £1,094 relates to short-term additional responsibilities undertaken as part of Non-Executive Director role.
[17] Note that £1,875 relates to short-term additional responsibilities undertaken as part of Non-Executive Director role.
[18] Commenced in role as Interim Executive Director of Finance on 1 October 2025, becoming permanent with effect from 1 November 2025, as part of formal partnership arrangements established between NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB. Full year equivalent remuneration is £225,000 to £230,000
[19] Commenced in role on 1 October 2025, as part of formal partnership arrangements established between NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB. Full year equivalent remuneration is £240,000 to £245,000.
[20] Ceased in role on 17 June 2025.
[21] 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 £3,455.50.
[22] 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)*				
Dr Dave Briggs, Executive Director of Outcomes	2.5-5	0-2.5	35-40	80-85	751	34	820	0
Pete Burnett, Director of Strategic Planning, Integration and Partnerships	0-2.5	0	45-50	0	707	0	735	0
Helen Dillistone, Executive Director of Transition	2.5-5	2.5-5	50-55	120-125	1,000	69	1,106	0
Martin Fahy, Director of Nursing	0-2.5	0-2.5	80-85	220-225	1,870	51	2,006	0
Matt Gaunt, Director of Finance	0-2.5	0	50-55	0	834	32	935	0
Dr Sunil Hindocha, Medical Director	0-2.5	0	5-10	0	53	21	111	0
Anne Lloyd, Director of Workforce Transformation	0-2.5	0	5-10	0	84	20	138	0
Sarah Jane Mills, Director for Primary Care and Community and Social Value	0-2.5	0-2.5	65-70	170-175	1,583	0	167	0
Maria Principe, Executive Director of Commissioning	5-7.5	7.5-10	45-50	105-110	873	110	1,017	0
Clair Raybould, Executive Director of Strategy and Citizen Experience	5-7.5	10-12.5	45-50	110-115	850	112	1,047	0
Bill Shields, Executive Director of Finance	55-57.5	177.5-180	55-60	175-180	0	1	29	0
Rosa Waddingham, Executive Director of Quality	2.5-5	0	60-65	0	864	63	962	0
Sandra Williamson, Director for Health Inequalities and Regional Collaboration	0-2.5	0-2.5	55-60	135-140	1,141	34	1,235	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
Pete Burnett, Director of Strategic Planning, Integration and Partnerships	0-2.5	0	45-40	0	633	17	707	0
Martin Fahy, Director of Nursing	0-2.5	0	75-80	210-215	1,708	31	1,870	0
Matt Gaunt, Director of Finance	0	0	45-50	0	792	0	834	0
Dr Sunil Hindocha, Medical Director	2.5-5	0	0-5	0	0	32	53	0
Anne Lloyd, Director of Workforce Transformation	0-2.5	0	5-10	0	0	20	84	0
Sarah Jane Mills, Director for Primary Care and Community and Social Value	0-2.5	0	60-65	165-170	1,446	25	1,583	0
Clair Raybould, Executive Director of Strategy and Citizen Experience	0-2.5	0	35-40	90-95	805	0	850	0
Sandra Williamson, Director for Health Inequalities and Regional Collaboration	0-2.5	0	50-55	130-135	1,036	20	1,141	0

Notes

1. The above information is based on data provided by the NHS Pensions Agency.
2. The employer's contribution rate to pension benefits was 20.68% of pensionable pay from April 2024 to March 2025, and in the financial year from April 2025 to March 2026.
3. Pension figures included in the table above are for senior managers that have pensions paid directly by the ICB and include all of their NHS service, not just pension payments that related to the year in question.
4. Where an employee has been in post for part of the year their pension amount is time apportioned to reflect their time in post.
5. Where an employee is shared across organisations, their pension amount is further apportioned across the organisations pro rata to the county population figures.
6. Negative values are not disclosed in this table but are substituted with a zero. This applies to Sarah-Jane Mills in 2025/26 and to Martin Fahy, Matt Gaunt, Sarah-Jane Mills, Clair Raybould and Sandra Williamson in 2024/25.
7. Staff can make additional voluntary contributions alongside their regular contributions.
8. The Department of Health and Social Care Group Accounting Manual confirms that where a senior manager has opted out of the pension arrangements for the whole of the year, no pension figures should be reported and this guidance has been applied. John Turner and Amanda Sullivan opted out of the pension arrangements during the reporting period.
9. The calculation of the real increase in Cash Equivalent Transfer Value includes allowance for employee contributions. It should be noted that on some occasions a small proportion of the employee contributions relates to a previous financial period.
10. The benefits and corresponding Cash Equivalent Transfer Value disclosed in tables above does not allow for any potential adjustment in relation to the McCloud judgement.

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 (subject to audit)

Through the national restructuring of the NHS across ICBs, NHS England, and Commissioning Support Units, a number of Executives' contracts have been terminated during the financial year. Compensation for loss of office packages totalling £478,107 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 payment was approved in accordance with the ICB and HM Treasury remuneration policies and is included within the exit packages disclosed in the Staff report.

Payments to past directors (subject to audit)

During the year, compensation for loss of office of £478,107 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, whilst awaiting national approval to progress redundancies, remained employed but moved into alternative roles within the NHS; and (ii) 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.

There were no payments to past directors made in 2024/25.

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	3	1	4
Band 3	29	8	37
Band 4	30	4	34
Band 5	30	6	36
Band 6	44	13	57
Band 7	50	9	59
Band 8a	41	12	53
Band 8b	16	11	27
Band 8c	15	6	21
Band 8d	4	5	9
Band 9	3	2	4
Very senior managers (non-Board members)	4	4	6
Any other spot salary (non-Board members)	11	4	13
Board members	1	0	1
Totals	**281**	**85**	**366**

Sickness absence data

Sickness absence data for the ICB for the period January to December 2025 has been provided by NHS England using Electronic Staff Record (ESR) data. The key measure is the average working days lost per employee, which was 7.5 days during the period.

Total days lost (whole-time equivalent)	2,728
Total days available (whole-time equivalent)	133,368
Average working days lost due to sickness absence (per whole-time equivalent)	**7.5**

Staff turnover percentages

The ICB's staff turnover rate (staff leaving the organisation) during the reporting period was 11.78% (on a whole-time equivalent basis).

Staff engagement percentages

The ICB took part in the 2025 NHS Staff Survey, published in March 2026. The survey captures staff views on engagement, wellbeing and experience, using the NHS People Promise framework. The ICB achieved a response rate of 71%, broadly consistent with response rates across participating ICBs.

The results identified strengths in team level working (including respectful behaviour), supportive colleagues, and positive relationships with line managers. These findings suggest that staff experience at team level remains a relative strength for the organisation, despite wider system pressures.

The survey also highlighted challenges that are seen across the NHS nationally, including pressures on staff wellbeing, workload and engagement. These themes continue to inform organisational focus on staff support, wellbeing and inclusion, particularly in the context of ongoing organisational change.

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 Lincolnshire. 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 £57k (2024/25: £208k).

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

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 2025	0	2
Of which, the number that have existed:		
For less than one year at the time of reporting	0	1
For between one and two years at the time of reporting	0	1
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[21] per day:

	Number 2025/26	Number 2024/25
No. of temporary off-payroll workers engaged between 1 April 2025 to 31 March 2025	0	2
Of which:		
Number not subject to off-payroll legislation[2]	0	0
Number subject to off-payroll legislation and determined as in-scope of IR35[22]	0	0
Number subject to off-payroll legislation and determined as out of scope of IR35[22]	0	2
Number of engagements reassessed for compliance or assurance purposes during the year	0	2
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]	32	16

[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)

The staff costs for 2025/26 and 2024/25 are shown in table below. There has been an increase of £9.7 million since 2024/25:

- £8.4 million comes from termination benefits during the year.
- £0.4 million comes from increased salary costs due to the national pay award of 3.6%, reduced slightly from a drop in average staff pay.
- £0.6 million comes from the pay award combined with national increases to employer national insurance costs.
- £0.3 million comes from the pay award combined with an increase of employer pension contributions from 20.6% to 23.7%.

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

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	19,133	208	19,341	Salaries and wages	18,375	593	18,968
Social Security Costs	2,633	35	2,668	Social Security Costs	2,043	–	2,043
Employer NHS Pension Contributions	4,123	–	4,123	Employer NHS Pension Contributions	3,803	–	3,803
Other Pension Costs	–	–	–	Other Pension Costs	–	–	–
Apprenticeship Levy	81	–	81	Apprenticeship Levy	75	–	75
Termination Benefits	8,474	–	8,474	Termination Benefits	8	–	8
Gross Employee Benefits	**34,444**	**242**	**34,686**	**Gross Employee Benefits**	24,304	593	**24,897**
Less recoveries in respect of employee benefits	–	–	–	Less recoveries in respect of employee benefits	(45)	–	(45)
Total Net Employee Benefit Costs	**34,444**	**242**	**34,686**	**Total Net Employee Benefit Costs**	**24,259**	**593**	**24,853**

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 £6,504,725 (2024/25: £6,700) were agreed for 95 members of staff during the year (2024/25: 1).

During the year to 31 March 2026, the ICB along with ICB partnering organisations NHS Derby and Derbyshire 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 for these provisions and hence they are not included within this disclosure.

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	7	58,875	7	58,875	0	0
£10,000 to £25,000	0	0	12	213,552	12	213,552	0	0
£25,001 to £50,000	0	0	17	601,705	17	601,705	0	0
£50,001 to £100,000	1	72,518	36	2,649,197	37	2,721,715	0	0
£100,001 to £150,000	0	0	17	2,028,553	17	2,028,553	0	0
£150,001 to £200,000	1	199,363	3	474,735	4	674,098	0	0
Greater than £200,000	1	206,226	0	0	1	206,226	0	0
Totals	**3**	**478,108**	**92**	**6,026,617**	**95**	**6,504,725**	**0**	**0**

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	1	6,700	0	0	0	0
£10,000 to £25,000	0	0	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0	0	0
Greater than £200,000	0	0	0	0	0	0	0	0
Totals	**0**	**0**	**1**	**6,700**	**0**	**0**	**0**	**0**

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

Analysis of other departures

	Agreements Number	Total value of agreements £000s
Voluntary redundancies including early retirement contractual costs	92	6,026,617
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs		
Contractual payments in lieu of notice[1]	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
Total	**92**	**6,026,617**

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.

No non-contractual payments 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 Lincolnshire 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 66. An audit certificate and report is also included in this Annual Report at page 65.

Annual Accounts

Signed:

Amanda Sullivan
Accountable Officer

16 June 2026

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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	(25,527)	(24,187)
Other operating income	2	-	(0)
Total operating income		**(25,527)**	**(24,187)**
Staff costs	4	34,686	24,897
Purchase of goods and services	5	2,287,822	2,150,344
Depreciation and impairment charges	5	78	67
Provision expense	5	(27)	217
Other operating expenditure	5	127	197
Total operating expenditure		**2,322,686**	**2,175,722**
Net Operating Expenditure		**2,297,159**	**2,151,535**
Finance expense	10	7	10
Other Gains & Losses	9	-	-
Net expenditure for the Year		**2,297,166**	**2,151,545**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**2,297,166**	**2,151,545**
Total other comprehensive net expenditure		**-**	**-**
Comprehensive Expenditure for the year		**2,297,166**	**2,151,545**

Statement of Financial Position as at 31 March 2026

	Note	2025-26 £'000	2024-25 £'000
Non-current assets:			
Property, plant and equipment	12	484	58
Right-of-use assets	13	150	217
Total non-current assets		**634**	275
Current assets:			
Trade and other receivables	17	15,174	13,224
Cash and cash equivalents	20	1,973	7
Total current assets		**17,147**	**13,231**
Non-current assets held for sale	21	-	-
Total current assets		**17,147**	13,231
Total assets		**17,781**	13,506
Current liabilities			
Trade and other payables	23	(91,014)	(82,184)
Lease liabilities	13	(70)	(68)
Provisions	30	(1,664)	(361)
Total current liabilities		**(92,748)**	(82,613)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(74,967)**	(69,107)
Non-current liabilities			
Lease liabilities	13	(92)	(162)
Provisions	30	(14)	(21)
Total non-current liabilities		**(106)**	**(183)**
Assets less Liabilities		**(75,073)**	(69,290)
Financed by Taxpayers' Equity			
General fund		(75,073)	(69,290)
Total taxpayers' equity:		**(75,073)**	(69,290)

The notes on pages 68 to 100 form part of these financial statements.

The financial statements on pages 68 to 100 were approved by the Audit Committee on 16 June 2026 and signed on its behalf by:

Chief Accountable Officer
Amanda Sullivan

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

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2025-26		
Balance at 01 April 2025	(69,290)	(69,290)
Transfer between reserves in respect of assets transferred from closed NHS bodies	-	-
Adjusted NHS Integrated Care Board balance at 31 March 2025	**(69,290)**	**(69,290)**
Changes in NHS Integrated Care Board taxpayers' equity for 2025-26		
Total transition adjustment for initial application of IFRS 16	-	-
Net operating expenditure for the financial year	(2,297,166)	**(2,297,166)**
Total revaluations against revaluation reserve		-
Net Recognised NHS Integrated Care Board Expenditure for the Financial year	**(2,297,166)**	**(2,297,166)**
Net funding	2,291,383	**2,291,383**
Balance at 31 March 2026	**(75,073)**	**(75,073)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2024-25		
Balance at 01 April 2024	(56,665)	**(56,665)**
Transfer of assets and liabilities from closed NHS bodies	-	-
Adjusted NHS Integrated Care Board balance at 31 March 2025	**(56,665)**	**(56,665)**
Changes in NHS Integrated Care Board taxpayers' equity for 2024-25		
Total transition adjustment for initial application of IFRS 16	-	-
Net operating costs for the financial year	(2,151,545)	(2,151,545)
Total revaluations against revaluation reserve		-
Net Recognised NHS Integrated Care Board Expenditure for the Financial Year	**(2,151,545)**	**(2,151,545)**
Net funding	2,138,920	2,138,920
Balance at 31 March 2025	**(69,290)**	**(69,290)**

The notes on pages 68 to 100 form part of these financial statements.

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		(2,297,166)	(2,151,545)
Depreciation and amortisation	5	77	67
Interest paid / received		7	10
(Increase)/decrease in trade & other receivables	17	(1,950)	11,028
(Increase)/decrease in other current assets		-	-
Increase/(decrease) in trade & other payables	23	8,451	1,348
Increase/(decrease) in other current liabilities		-	-
Provisions utilised	30	(70)	-
Increase/(decrease) in provisions	30	1,366	217
Net Cash Inflow (Outflow) from Operating Activities		**(2,289,285)**	(2,138,875)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		(58)	-
Net Cash Inflow (Outflow) from Investing Activities		**(58)**	-
Net Cash Inflow (Outflow) before Financing		**(2,289,343)**	(2,138,875)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		2,291,383	2,138,920
Repayment of lease liabilities		(75)	(75)
Net Cash Inflow (Outflow) from Financing Activities		**2,291,308**	2,138,845
Net Increase (Decrease) in Cash & Cash Equivalents	20	**1,966**	(30)
Cash & Cash Equivalents at the Beginning of the Financial Year		**7**	-
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		-	37
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**1,973**	7

The notes on pages 68 to 100 form part of these financial statements.

Notes to the financial statements

1 Accounting Policies

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

1.1 Going Concern

These accounts have been prepared on a going concern where the continued provision of services is expected, as evidenced by the inclusion of funding for those services in published plans.
In March 2025, the Government announced significant changes affecting the Department of Health and Social Care, NHS England and a number of other NHS organisations. In response, NHS England and ministers formally approved, in July 2025, the grouping of NHS Derby and Derbyshire Integrated Care Board, NHS Lincolnshire Integrated Care Board, and NHS Nottingham and Nottinghamshire Integrated Care Board into a new cluster. These ICBs will continue to operate while progressing towards a single merged organisation over the next 12 months, with the a merger date expected to be confirmed during 2026/27. Although the ICB will cease to exist at that point, its functions will continue to be delivered by the successor organisation.

In accordance with the Department of Health and Social Care Group Accounting Manual, the ongoing provision of healthcare services within the public sector supports the preparation of the accounts of NHS Lincolnshire 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

Arrangements over which the Integrated Care Board has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the Integrated Care Board is a joint operator, it recognises its share of, assets, liabilities, income and expenses in its own accounts.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

1.5 Pooled Budgets

The Integrated Care Board has entered into a pooled budget arrangement with Lincolnshire County Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for Learning Disabilities, Child and Adolescent Mental Health, Community Equipment and Proactive Care in the Community. Note 35 to the financial statements provides details of the income and expenditure.

The pool is hosted by Lincolnshire County Council. The Integrated Care Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

The Integrated Care Board reviews the Section 75 agreements to determine which party has control over the services being delivered, in accordance with IFRS 11 and the accounting policy at 1.4 for joint arrangements.

The Integrated Care Board has considered the NHS lead commissioning arrangement under IFRS 15 Revenue from Contracts with Customers for all elements contained within the individual section 75's and has concluded that the Integrated Care Board is acting as both the 'principal' and the 'agent' for different parts of the arrangement and should therefore account for gross expenditure and income arising from the arrangement within the financial statements and the net expenditure and income arising from the agreement respectively.

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.

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 taken.

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

1.8.2 **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.

1.12 **Intangible Assets**

1.12.1 **Recognition**

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

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

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

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

1.12.2 **Measurement**

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

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

1.12.3 **Depreciation, Amortisation & Impairments**

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

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

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

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

1.13 **Leases**

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

1.13.1 **The ICB as Lessee**

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

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

The 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.

1.13.2 **The ICB as Lessor**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases
When the group is an intermediate lessor, it accounts for the head lease and the sub-lease as two separate contracts. The sub-lease classification is assessed with reference to the right-of-use asset arising from the head lease.

Amounts due from lessees under finance leases are recognised as receivables at the amount of the ICB's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the net investment in the lease.

Rental income from operating leases is recognised on a straight-line basis over the term of the relevant lease.

1.14 **Cash & Cash Equivalents**

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

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

1.15 **Provisions**

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

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

• A nominal short-term rate of 3.64% (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.

1.16 **Clinical Negligence Costs**

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

1.17 **Non-clinical Risk Pooling**

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

1.18 **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.

1.19 **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.

1.19.1 **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.

1.19.2 **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.

1.19.3 **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.

1.19.4 **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.

1.20 **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.

1.20.1 **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.

1.20.2 **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.

1.21 **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.

1.22 **Foreign Currencies**

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

1.23 **Losses & Special Payments**

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

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

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

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

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

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

The Integrated Care Board has assessed the pooled element of the Better Care Fund as being a lead commissioner 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. Note 35 Joint arrangements - interests in joint operations provides further detail.

1.24.2 **Sources of estimation uncertainty**

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

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

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

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

(d) The restructure of the Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire ICBs cluster 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.

1.25 **Gifts**

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

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

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

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

The application of IFRS 18 and IFRS 19 would not have a material impact on the accounts for 2025-26, were they applied in the year.

2 Other Operating Revenue

	2025-26 Total	2024-25 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Education, training and research	-	-
Non-patient care services to other bodies	174	23
Patient transport services	-	-
Prescription fees and charges	12,278	12,262
Dental fees and charges	11,671	10,914
Income generation	-	-
Other Contract income	1,177	943
Recoveries in respect of employee benefits	227	45
Total Income from sale of goods and services	25,527	24,187
Total Other operating income	-	0
Total Operating Income	25,527	24,187

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 Lincolnshire 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 £1 million or was otherwise material:

	2025-26			2024-25		
	Income	Full Cost	Surplus / (Deficit)	Income	Full Cost	Surplus / (Deficit)
	£'000	£'000	£'000	£'000	£'000	£'000
Prescription fees and charges	12,278	(210,043)	(197,765)	12,262	(204,095)	(191,833)
Dental fees and charges	11,671	(36,075)	(24,404)	10,914	(38,778)	(27,864)
Total fees and charges	23,949	(246,118)	(222,169)	23,176	(242,873)	(219,697)

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. A number of other charges were payable for wigs and fabric supports.

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 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	-	-	-	69	227	296
Non NHS	174	12,278	11,671	1,108	-	25,231
Total	**174**	**12,278**	**11,671**	**1,177**	**227**	**25,527**

	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	-	12,278	11,671	-	-	23,949
Over time	174	-	-	1,177	227	1,578
Total	**174**	**12,278**	**11,671**	**1,177**	**227**	**25,527**

Integrated Care Board revenue is entirely from the supply of services. NHS Lincolnshire Integrated Care Board receives no revenue from the sale of goods.

The contract income that has been recognised was not included within the opening balances of contract liabilities.

There is no contract revenue expected to be recognised in the future periods related to contract performance obligations not yet completed at the reporting date.

4. Employee benefits and staff numbers

4.1.1 Employee benefits	Total 2025-26		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
Employee Benefits			
Salaries and wages	19,133	207	**19,340**
Social security costs	2,633	35	**2,668**
Employer Contributions to NHS Pension scheme	4,123	-	**4,123**
Apprenticeship Levy	81	-	**81**
Termination benefits	8,474	-	**8,474**
Gross employee benefits expenditure	**34,444**	**242**	**34,686**
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	**-**
Total - Net admin employee benefits including capitalised costs	**34,444**	**242**	**34,686**
Less: Employee costs capitalised	-	-	**-**
Net employee benefits excluding capitalised costs	**34,444**	**242**	**34,686**

4.1.1 Employee benefits	Total 2024-25		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
Employee Benefits			
Salaries and wages	18,375	594	**18,969**
Social security costs	2,043	-	**2,043**
Employer Contributions to NHS Pension scheme	3,803	-	**3,803**
Apprenticeship Levy	75	-	**75**
Termination benefits	8	-	**8**
Gross employee benefits expenditure	24,304	594	**24,898**
Less recoveries in respect of employee benefits (note 4.1.2)	(45)	-	**(45)**
Total - Net admin employee benefits including capitalised costs	24,259	594	**24,853**
Less: Employee costs capitalised	-	-	**-**
Net employee benefits excluding capitalised costs	**24,259**	**594**	**24,853**

4.1.2 Recoveries in respect of employee benefits	2025-26			2024-25
	Permanent Employees	Other	Total	Total
	£'000	£'000	£'000	£'000
Employee Benefits - Revenue				
Salaries and wages	-	-	-	(37)
Social security costs	-	-	-	(4)
Employer contributions to the NHS Pension Scheme	-	-	-	(4)
Total recoveries in respect of employee benefits	**-**	**-**	**-**	**(45)**

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	**363.44**	**3.12**	**366.56**	**333.00**	**32.55**	**365.55**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.4 Exit packages agreed in the financial year

	2025-26 Compulsory redundancies		2025-26 Other agreed departures		2025-26 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	7	58,875	7	58,875
£10,001 to £25,000	-	-	12	213,552	12	213,552
£25,001 to £50,000	-	-	17	601,705	17	601,705
£50,001 to £100,000	1	72,518	36	2,649,197	37	2,721,715
£100,001 to £150,000	-	-	17	2,028,553	17	2,028,553
£150,001 to £200,000	1	199,363	3	474,735	4	674,098
Over £200,001	1	206,226	-	-	1	206,226
Total	**3**	**478,107**	**92**	**6,026,617**	**95**	**6,504,724**

	2024-25 Compulsory redundancies		2024-25 Other agreed departures		2024-25 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	1	6,700	1	6,700
Total	**-**	**-**	**1**	**6,700**	**1**	**6,700**

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

Analysis of Other Agreed Departures

	2025-26 Other agreed departures		2024-25 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs *	92	6,026,617	-	-
Contractual payments in lieu of notice	-	-	1	6,700
Total	**92**	**6,026,617**	**1**	**6,700**

* 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.

Note that compulsory redundancy payments are made up of £340,000 redundancy payments and £138,107 contractual payments in lieu of notice.

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 terms and conditions of the NHS contract.

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.

There were no non-contractual payments made to individuals where the payment value was more than 12 months' of their annual salary, and none in 2024-25.
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.

National Employment Savings Trust (NEST)

The National Employment Savings Trust (NEST) Corporation is the Trustee of the NEST occupational pension scheme. The scheme, which is run on a not-for-profit basis, ensures that all employers have access to suitable, low-charge pension provision. The Integrated Care Board is required to comply with workplace pension legislation and to auto enrol employees into a pension scheme. Where employees are ineligible to join the NHS Pension Scheme the Trust enrols the employee into NEST. NEST is a defined contribution scheme.

As at 31 March 2026 there were 378 employees employed by the Integrated Care Board (31 March 2025:416), of these 329 are members of the NHS Pension Scheme (31 March 2025: 353), 12 are enrolled within NEST (31 March 2025: 13) and 37 are not currently contributing through a workplace pension scheme (31 March 2025: 50).

5. Operating expenses

	2025-26 Total £'000	2024-25 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	4,457	4,216
Services from foundation trusts	427,989	386,909
Services from other NHS trusts	1,089,679	1,015,858
Services from Other WGA bodies	23	30
Purchase of healthcare from non-NHS bodies	295,524	291,810
Purchase of social care	-	-
General Dental services and personal dental services	36,075	38,778
Prescribing costs	173,807	174,114
Pharmaceutical services	36,236	31,127
General Ophthalmic services	8,372	7,937
GPMS/APMS and PCTMS	205,112	187,661
Supplies and services – clinical	802	50
Supplies and services – general	2,197	2,148
Consultancy services	57	209
Establishment	2,945	3,624
Transport	44	56
Premises	3,074	3,618
Audit fees	231	265
Other non statutory audit expenditure		
· Internal audit services	87	89
· Other services	(33)	63
Other professional fees	872	1,414
Legal fees	265	344
Education, training and conferences	7	24
Total Purchase of goods and services	**2,287,822**	**2,150,344**
Depreciation and impairment charges		
Depreciation	77	67
Total Depreciation and impairment charges	**77**	**67**
Provision expense		
Provisions	(27)	217
Total Provision expense	**(27)**	**217**
Other Operating Expenditure		
Chair and Non Executive Members	118	161
Clinical negligence	8	6
Expected credit loss on receivables	-	28
Other expenditure	2	2
Total Other Operating Expenditure	**128**	**197**
Total operating expenditure	**2,288,000**	**2,150,825**

Statutory Audit is provided by KPMG LLP. The fees, inclusive of non-recoverable VAT, for the period reported was £228,000.

Internal audit services are provided by TIAA Limited, fees for the reported financial year were £81,620 exclusive of reclaimable 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	54,287	654,541	59,961	573,066
Total Non-NHS Trade Invoices paid within target	53,645	649,081	59,099	569,915
Percentage of Non-NHS Trade invoices paid within target	**98.82%**	**99.17%**	**98.56%**	**99.45%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,973	1,781,014	1,861	1,486,323
Total NHS Trade Invoices Paid within target	1,956	1,780,633	1,859	1,486,322
Percentage of NHS Trade Invoices paid within target	**99.14%**	**99.98%**	**99.89%**	**100.00%**

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

The Integrated Care Board did not incur any interest charges from the late payment of commercial debts during 2025-26 (2024-25, nil).

7 Income Generation Activities

The Integrated Care Board did not undertake any income generation activities where full cost exceeds £1 million or was otherwise material for the financial year ended 31 March 2026 (2024-25, nil).

8. Investment revenue

The Integrated Care Board received no investment revenue for the financial year ended 31 March 2026 (2024-25, nil).

9. Other gains and losses

Other gains and losses are largely associated with the disposal of fixed assets, and changes in the value of financial assets and liabilities. The Integrated Care Board had no such gains or losses for the financial year ended 31 March 2026 (2024-25, nil).

10. Finance costs

Finance costs are principally associated with interest charges on loans, PFI contracts and LIFT contracts. The Integrated Care Board doesn't have any of these arrangements. The Integrated Care Board has finance costs relating to interest expenses on lease liabilities associated with the rental of corporate premises for financial year ended 31 March 2026.

10.1 Finance costs

	2025-26	2024-25
	£'000	£'000
Interest		
Interest on lease liabilities	7	10
Total interest	**7**	10
Total finance costs	**7**	10

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

Absorption accounting is explained in paragraph 1.3.of Note 1 (Accounting Policies). NHS Lincolnshire Integrated Care Board had no gains or losses on transfer by absorption during 2025-26 (2024-25; nil).

12 Property, plant and equipment

2025-26	Information technology £'000	Total £'000
Cost or valuation at 01 April 2025	58	58
Addition of assets under construction and payments on account	-	-
Additions purchased	436	436
Cost/Valuation at 31 March 2026	**494**	**494**
Depreciation 01 April 2025	-	-
Charged during the year	11	11
Depreciation at 31 March 2026	**11**	**11**
Net Book Value at 31 March 2026	**483**	**483**
Purchased	483	483
Total at 31 March 2026	**483**	**483**
Asset financing:		
Owned	483	483
Total at 31 March 2026	**483**	**483**

The Integrated Care Board has no property or plant. The figures above relate to IT equipment.

There were no additons to assets under construction, no donated asset, no Government granted assets s and no revaluations during the year (2024-25, nil).

12.1 Temporary idle assets

There were no temporary idle assets during the year (2024-25, nil).

12.9 Economic lives

The economic life of equipment is as shown below.

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

13 Leases

13.1 Right-of-use assets

2025-26	Buildings excluding dwellings £'000	Total £'000
Cost or valuation at 01 April 2025	418	418
Cost/Valuation at 31 March 2026	**418**	**418**
Depreciation 01 April 2025	201	201
Charged during the year	67	67
Depreciation at 31 March 2026	**268**	**268**
Net Book Value at 31 March 2026	**150**	**150**

The right-of-use asset reported above relates to one building that is leased from from NHS Property Services Ltd within the NHS England Group.

13.2 Lease liabilities

2025-26	2025-26 £'000	2024-25 £'000
Lease liabilities at 01 April 2025	(230)	(295)
Interest expense relating to lease liabilities	(7)	(10)
Repayment of lease liabilities (including interest)	75	75
Lease liabilities at 31 March 2026	**(162)**	**(230)**

13 Leases cont'd

13.3 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	(75)	(75)	(75)	(75)
Between one and five years	(75)	(94)	(169)	(169)
After five years	(94)	-	-	-
Balance at 31 March 2026	**(244)**	**(169)**	**(244)**	**(244)**

The right-of-use asset reported above relates to one building that is leased from from NHS Property Services Ltd within the NHS England Group.

13.4 Amounts recognised in Statement of Comprehensive Net Expenditure

2025-26	**2025-26 £'000**	2024-25 £'000
Depreciation expense on right-of-use assets	67	67
Interest expense on lease liabilities	7	10

13.5 Amounts recognised in Statement of Cash Flows

	2025-26 £'000	2024-25 £'000
Total cash outflow on leases under IFRS 16	75	75

There are no restrictions or covenants imposed by the lease agreement and there are no sale and leaseback

14 Intangible non-current assets

The Integrated Care Board did not hold any intangible non-current assets for the financial year ended 31 March 2026 (2024-25, nil).

15 Investment property

The Integrated Care Board did not hold any investment property for the financial year ended 31 March 2026 (2024-25, nil).

16 Inventories

The Integrated Care Board had no inventories for the financial year ended 31 March 2026 (2024-25, nil).

17.1 Trade and other receivables

	Current 2025-26 £'000	Non-current 2025-26 £'000	Current 2024-25 £'000	Non-current 2024-25 £'000
NHS receivables: Revenue	606	-	1,939	-
NHS prepayments	46	-	-	-
NHS accrued income	1,207	-	1,243	-
Non-NHS and Other WGA receivables: Revenue	633	-	511	-
Non-NHS and Other WGA prepayments	1,925	-	2,325	-
Non-NHS and Other WGA accrued income	6,799	-	2,581	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	3,733	-	4,213	-
Expected credit loss allowance-receivables	(37)	-	(34)	-
VAT	114	-	235	-
Other receivables and accruals	148	-	211	-
Total Trade & other receivables	**15,174**	**-**	**13,224**	**-**
Total current and non current	**15,174**		**13,224**	
Included above:				
Prepaid pensions contributions	-		-	

17.2 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	4	133	200	8
By three to six months	-	-	-	58
By more than six months	134	69	-	17
Total	**138**	**202**	**200**	**83**

17.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000	Other financial assets £'000	Total £'000
Balance at 01 April 2025	**(37)**	**-**	**(37)**
Total	**(37)**	**-**	**(37)**

18 Other financial assets

The Integrated Care Board had no other financial assets for the financial year ended 31 March 2026

19 Other current assets

The Integrated Care Board had no other current assets for the financial year ended 31 March 2026

20 Cash and cash equivalents

	2025-26	2024-25
	£'000	£'000
Balance at 01 April 2025	7	37
Net change in year	1,966	(30)
Balance at 31 March 2026	**1,973**	**7**
Made up of:		
Cash with the Government Banking Service	1,973	7
Cash with Commercial banks	-	-
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in statement of	**1,973**	**7**
Total bank overdrafts	**-**	**-**
Balance at 31 March 2026	**1,973**	**7**
Patients' money held by the integrated care board, not included above	-	-

21 Non-current assets held for sale

The Integrated Care Board has no non-current assets held for sale to disclose for the financial year ended 31 March 2026.

22 Analysis of impairments and reversals

The Integrated Care Board had no property, plant or equipment, intangible assets, inventories or financial assets during 2024-25. There were no impairments or reversals for the financial year ended 31 March 2026 (2024-25, nil).

23 Trade and other payables .	**Current 2025-26 £'000**	**Non-current 2025-26 £'000**	Current 2024-25 £'000	Non-current 2024-25 £'000
NHS payables: Revenue	6,063	-	4,908	-
NHS payables: Capital	224	-	58	-
NHS accruals	17,591	-	7,098	-
NHS deferred income	2	-	-	-
Non-NHS and Other WGA payables: Revenue	11,981	-	12,188	-
Non-NHS and Other WGA payables: Capital	212	-	-	-
Non-NHS and Other WGA accruals	33,084	-	36,214	-
Social security costs	274	-	239	-
Tax	272	-	267	-
Other payables and accruals	21,311	-	21,213	-
Total Trade & Other Payables	**91,014**	**-**	**82,185**	**-**
Total current and non-current	**91,014**		**82,185**	

There are no liabilities included above for people due in future years under arrangements to buy out the liability for early retirement over 5 years.

Other payables include £1,213,982.62 outstanding pension contributions at 31 March 2026 (£1,099,758 at 31 March 2025). This includes amounts related to GP pensions (£882,459.98) and outstanding contributions to the NHS Pension Scheme (£329,968.01) and NEST scheme contributions (£1,554.63).

24 Other financial liabilities

The Integrated Care Board had no other financial liabilities for the financial year ended 31 March 2025 (2024-25, nil).

25 Other liabilities

The Integrated Care Board had no other liabilities for the financial year ended 31 March 2026 (2024-25, nil).

26 Borrowings

The Integrated Care Board had no borrowings for the financial year ended 31 March 2026 (2024-25, nil).

27 Private finance initiative, LIFT and other service concession arrangements

The Integrated Care Board had no private finance initiative, LIFT and other service concession arrangements for the financial year ended 31 March 2026 (2024-25, nil).

28. Finance lease obligations

The Integrated Care Board had no finance lease obligations for the financial year ended 31 March 2026 (2024-25, nil).

29. Finance lease receivables

The Integrated Care Board had no finance lease receivables for the financial year ended 31 March 2026 (2024-25, nil).

30 Provisions

	Current 2025-26 £'000	Non-current 2025-26 £'000	Current 2024-25 £'000	Non-current 2024-25 £'000
Redundancy	1,394	-	-	-
Continuing care	25	8	46	15
Other	245	6	315	6
Total	**1,664**	**14**	**361**	**21**
Total current and non-current	**1,678**		**382**	

	Redundancy £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2025	**-**	**61**	**321**	**382**
Arising during the year	1,394	33	27	**1,454**
Utilised during the year	-	-	(70)	**(70)**
Reversed unused	-	(61)	(27)	**(88)**
Unwinding of discount	-	-	-	**-**
Change in discount rate	-	-	-	**-**
Transfer (to) from other public sector body	-	-	-	**-**
Transfer (to) from other public sector body under absorption	-	-	-	**-**
Balance at 31 March 2026	**1,394**	**33**	**251**	**1,678**
Expected timing of cash flows:				
Within one year	1,394	25	245	**1,664**
Between one and five years	-	8	6	**14**
After five years	-	-	-	**-**
Balance at 31 March 2026	**1,394**	**33**	**251**	**1,678**

Continuing Care

The Integrated Care Board is responsible for liabilities, legal and financial elements relating to NHS Continuing Healthcare claims connecting to periods of care since the establishment of the former Lincolnshire Clinical Commissioning Groups (1 April 2013). The total value of NHS Continuing Healthcare provision at 31 March 2026 is based on live claim cases, including appeals, and has been evaluated based on historical experience of claim success rates and average rates within the Integrated Care Board and legacy Clinical Commissioning Groups and is £33,841.58.

Under the accounts direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before the establishment of the former Clinical Commissioning Groups. The Integrated Care Board is responsible for liabilities, legal and financial, relating to NHS Continuing Healthcare claims relating to periods of care since the establishment of the former Lincolnshire Clinical Commissioning Groups.

Redundancy

Redundancy provisions have been made as part of partnering arrangements with Nottingham and Nottinghamshire ICB and Derby and Derbyshire ICB.

Other

The Integrated Care Board included other provisions for the following:
- Remedial building works at primary care premises.
- Mental Health Investment Standard audit fees for the 2025/26 financial year where the timing of committed expenditure was unknown.
- Stranded costs resulting from a termination of a contract
- Employees excess travel costs following the closure of the Cross O'Cliff premises
- Legal fees and clinical negligence costs.

31 Contingencies

	2025-26 £'000	2024-25 £'000
Contingent liabilities		
Redundancy	303	-
Continuing Healthcare	299	478
Amounts recoverable against contingent liabilities	-	-
Net value of contingent liabilities	**602**	**478**

Continuing Healthcare
The Integrated Care Board is responsible for liabilities, legal and financial, relating to NHS Continuing Healthcare (CHC) claims for periods of care since the establishment of the Integrated Care Board and former Clinical Commissioning Groups. The Integrated Care Board has provided for the anticipated costs of continuing care claims (see Note 30 Provisions) where it is probable that it will incur costs. Note 31 Contingencies discloses the difference

Redundancy
Redundancy contingent liabilities have been made as part of partnering arrangements with Nottingham and Nottinghamshire ICB and Derby and Derbyshire ICB.

Contingent assets
The Integrated Care Board had no contingent assets as at 31 March 2026
(2024-25, nil).

32 Commitments
The Integrated Care Board had no capital or other financial commitments for the financial year ended 31 March 2026 (2024-25, nil).

33 Financial instruments

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

Because NHS Lincolnshire 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 Lincolnshire 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 Lincolnshire Integrated Care Board in undertaking its activities.

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

33.1.1 Currency risk
The NHS Lincolnshire 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 Lincolnshire Integrated Care Board has no overseas operations and therefore has low exposure to currency rate fluctuations.

33.1.2 Interest rate risk
The NHS Lincolnshire 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 Lincolnshire Integrated Care Board therefore has low exposure to interest rate fluctuations.

33.1.3 Credit risk
Because the majority of the NHS Lincolnshire Integrated Care Board revenue comes parliamentary funding, NHS Lincolnshire 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.

33 Financial instruments cont'd

33.1.4 Liquidity risk

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

33.1.5 Financial Instruments

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

33.2 Financial assets

	Financial Assets measured at amortised cost 2025-26 £'000	Total 2025-26 £'000	2024-25 £'000
Trade and other receivables with NHSE bodies	1,806	1,806	2,878
Trade and other receivables with other DHSC group bodies	8	8	423
Trade and other receivables with external bodies	11,313	11,313	7,397
Other financial assets	-	-	-
Cash and cash equivalents	1,973	1,973	7
Total at 31 March 2026	**15,100**	**15,100**	**10,706**

33.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2025-26 £'000	Total 2025-26 £'000	2024-25 £'000
Loans with external bodies	(6,848)	**(6,848)**	-
Trade and other payables with NHSE bodies	50	**50**	179
Trade and other payables with other DHSC group bodies	23,828	**23,828**	11,866
Trade and other payables with external bodies	66,588	**66,588**	69,614
Other financial liabilities	-	-	-
Private Finance Initiative and finance lease obligations	162	**162**	230
Total at 31 March 2026	**83,780**	**83,780**	**81,909**

34 Operating segments

NHS Lincolnshire Integrated Care Board considers it has only one operating segment: commissioning of

35 Joint arrangements - interests in joint operations

ICBs should disclose information in relation to joint arangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

The 2025-26 pooled budgets are for Learning Disabilities, Child and Adolescent Mental Health Services (CaMHS), Proactive Care and Integrated Community Equipment Services (ICES). These budgets are predominantly hosted and managed on a day to day basis by Lincolnshire County Council, in instances where this is not the case the Integrated Care Board jointly host and manage. As a commissioner of healthcare services, the Integrated Care Board makes a contribution to the pool which is then used to purchase healthcare services. The Integrated Care Board accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreement in line with the 2025-26 Group Accounting Manual and as defined in IFRS 11.

The pooled budget represents contributions to the areas of identified spend; it is quite likely that the respective organisations have spend relating to the schemes over and above these contributions.

All cash is transacted by all parties in the month concerned. There are no outstanding cash balances or liabilities at each period end for all organisations concerned.

Lincolnshire County Council is responsible for the production of memorandum accounts for the pooled budget. These will not be produced until after the publication of the Integrated Care Board's accounts.

The Integrated Care Board's share of the assets, liabilities, income and expenditure as handled by the pooled budgets for the financial year ended 31 March 2026 were:

35.1 Interests in joint operations

			Amounts recognised in 2025-26		Amounts recognised in Entities 2024-25	
Name of arrangement	**Parties to the arrangement**	**Description of principal activities**	**Income**	**Expenditure**	**Income**	**Expenditure**
			£'000	**£'000**	**£'000**	**£'000**
Better Care Fund - Proactive Care S75	Lincolnshire County Council	Lead commissioning to ensure delivery of improved Health and Wellbeing for the population of Lincolnshire - HOST	(14,218)	87,976	(14,218)	53,591
	NHS Lincolnshire ICB	Lead commissioning to ensure delivery of improved Health and Wellbeing for the population of Lincolnshire - Non-host	0	28,258	0	27,807
Better Care Fund - Learning Disabilities s75	Lincolnshire County Council	Joint Commissioning to commission the provision of LD services in Lincolnshire - HOST	(39,505)	66,427	(35,504)	68,102
	NHS Lincolnshire ICB	Joint Commissioning to commission the provision of LD services in Lincolnshire - Non-Host	0	39,505	0	35,504
Better Care Fund - Child and Adolescent Mental Health Services s75	Lincolnshire County Council	Lead to commission the provision of CaHMS services in Lincolnshire - HOST	(21,763)	725	(18,827)	1,785
	NHS Lincolnshire ICB	Lead Commissioning to commission the provision of CaHMS services in Lincolnshire - Non-Host	0	21,763	0	18,827
Better Care Fund - Integrated Community Equipment Stores s75	Lincolnshire County Council	Joint Commissioning to commission the provision of Community Equipment in Lincolnshire - HOST	(4,819)	2,837	(4,611)	4,738
	NHS Lincolnshire ICB	Joint Commissioning to commission the provision of Community Equipment in Lincolnshire - Non-Host	0	4,819	0	4,611
Better Care Fund - Wheelchair Service	Lincolnshire County Council	Joint Commissioning to commission the provision of Community Equipment in Lincolnshire - HOST	(2,199)	0	(2,525)	0
	NHS Lincolnshire ICB	Joint Commissioning to commission the provision of Community Equipment in Lincolnshire - Non-Host	0	2,199	0	2,525
Better Care Fund - Partnership Agreement	Lincolnshire County Council	Joint Commissioning to commission the provision of Community Equipment in Lincolnshire - HOST	(56)	56	(103)	102
	NHS Lincolnshire ICB	Joint Commissioning to commission the provision of Community Equipment in Lincolnshire - Non-Host	0	56	0	103

36 NHS Lift investments

The Integrated Care Board had no Lift investments for the financial year ended 31 March 2026 (2024-25, nil).

37 Related party transactions

Details of related party transactions with individuals are as follows:

During the reported period none of the Governing Body Members or parties related to them have undertaken any material transactions with NHS Lincolnshire Integrated Care Board, other than those set out below (transactions identified were not with the member but between the Integrated Care Board and the related party).
All transactions have been at arm's length as part of NHS Lincolnshire Integrated Care Board's healthcare commissioning.

Details of related party transactions with individuals for the financial year ended 31 March 2026 are as follows:

Board Member	Related Party Name	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
		2025-26 £'000	2025-26 £'000	2025-26 £'000	2025-26 £'000
Kathy McLean	NHS Confederation	23	-	-	-
Bill Shields	Healthcare Financial Management	60	-	-	-
Rosa Waddingham	Nottingham Trent University	29	-	-	-
Rosa Waddingham	Specsavers	8,324	-	-	-
Martin Samuels	Lincolnshire County Council	82,793	174	2,085	-
Anita Day	East & North Hertfordshire NHS Trust	108	-	-	-
Dr Sunil Hindocha	Heart Of Lincoln Medical Group	4,775	-	-	-
Dr Sunil Hindocha	Lincoln City Football Club Company Limited	0	-	-	-
Julie Pomeroy	Nottingham City Care Partnership CIC	25	-	-	-
Karen Dunderdale	Lincolnshire Community Health Services NHS Trust	132,787	54	5,811	8
Karen Dunderdale	United Lincolnshire Teaching Hospitals NHS Trust	790,902	5	10,726	46
Kevin Thomas	East Lindsey PCN	2,774	-	-	-
Kevin Thomas	Lincolnshire Training Hub Ltd	1,634	-	-	-
Kevin Thomas	Market Rasen Surgery	3,629	-	-	-
Mark Powell	Derbyshire Healthcare NHS Foundation Trust	776	-	-	-
Phillip Earnshaw	Humber Teaching NHS Foundation Trust	108	-	-	-
Stephen Jackson	Birmingham Women's & Children's NHS Foundation Trust	406	-	-	-
Stephen Jackson	DHU Health Care CIC	6,136	-	-	-
Total at 31 March 2026		1,035,289	233	18,622	54

Details of related party transactions with individuals for the financial year ending 31 March 2025 are as follows:

Board Member	Related Party Name	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
		2024-25 £'000	2024-25 £'000	2024-25 £'000	2024-25 £'000
Dr Sunil Hindocha	Heart of Lincoln Medical Group	3,692	-	-	-
Dr Sunil Hindocha	Lincoln City Foundation	10	-	-	-
Ms Dawn Kenson	Turning Point	-	37	-	-
Ms Julie Pomeroy	Nottingham City Care Partnership	25	-	2	-
Total at 31 March 2025		3,727	37	2	-

The Department of Health & Social Care is regarded as a related party. During the reported period the Integrated Care Board had a significant number of material transactions

- NHS England
- NHS Foundation Trusts
- NHS Trusts
- NHS Arden and Greater East Midlands Commissioning Support Unit

Details of such organisations with whom the Integrated Care Board had contracts with for the financial year ended 31 March 2026 are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	2025-26 £'000	2025-26 £'000	2025-26 £'000	2025-26 £'000
Cambridge University Hospitals NHS Foundation Trust	16,005	-	-	650
Cambridgeshire & Peterborough NHS Foundation Trust	1,335	-	32	-
Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust	2,111	-	-	113
East Midlands Ambulance Service NHS Trust	56,046	-	134	-
Hull University Teaching Hospitals NHS Trust	10,153	-	21	-
Lincolnshire Community Health Services NHS Trust	132,787	54	5,811	8
Lincolnshire Partnership NHS Foundation Trust	139,592	4	1,549	-
NHS ARDEN & GREATER EAST MIDLANDS CSU	4,501	-	-	-
Norfolk & Norwich University Hospitals NHS Foundation Trust	1,690	-	-	24
North West Anglia NHS Foundation Trust	114,302	-	4,121	-
Northern Lincolnshire & Goole NHS Foundation Trust	72,262	-	-	324
Nottingham University Hospitals NHS Trust	64,282	-	1,148	-
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	16,473	-	13	-
Royal Papworth Hospital NHS Foundation Trust	8,146	-	254	-
Sheffield Children's NHS Foundation Trust	4,958	-	-	2
Sheffield Teaching Hospitals NHS Foundation Trust	6,022	-	-	241
Sherwood Forest Hospitals NHS Foundation Trust	5,973	-	-	452
United Lincolnshire Teaching Hospitals NHS Trust	790,902	5	10,726	46
University College London Hospitals NHS Foundation Trust	1,600	-	-	52
University Hospitals Of Derby & Burton NHS Foundation Trust	3,410	-	-	76
University Hospitals Of Leicester NHS Trust	34,263	-	450	-
York & Scarborough Teaching Hospitals NHS Foundation Trust	203	-	7	-
Total at 31 March 2026	**1,487,016**	**63**	**24,266**	**1,988**

In addition, the Integrated Care Board has had a number of material transactions with other government departments and other central and local government bodies, namely Lincolnshire County Council.

NHS Lincolnshire Integrated Care Board also has material transactions with all the GP Practices within its locality and membership.
The Integrated Care Board has not made any provision for doubtful debts for any of the above related parties.
All transactions have been at arm's length as part of NHS Lincolnshire Integrated Care Board's healthcare commissioning.

38 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.

39. Losses and special payments

39.1 Losses

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

	Total Number of Cases 2025-26 Number	**Total Value of Cases 2025-26 £'000**	Total Number of Cases 2024-25 Number	Total Value of Cases 2024-25 £'000
Administrative write-offs	-	-	2	0
Fruitless payments	3	1	-	-
Total	**3**	**1**	**2**	**0**

During the financial year 2025/26 NHS Lincolnshire Integrated Care Board had 3 fruitless payments totalling £644.00.

39.2 Special payments

	Total Number of Cases 2025-26 Number	**Total Value of Cases 2025-26 £'000**	Total Number of Cases 0 Number	Total Value of Cases 0 £'000
Compensation payments	-	-	1	3
Extra Contractual Payments	-	-	1	0
Ex Gratia Payments	1	1	-	-
Total	**1**	**1**	**2**	**3**

In 2025/26 the Integrated Care Board made 1 special payment of £1,000.00.

40 Third party assets

The Integrated Care Board did not have any third party assets for the financial year ended 31 March 2026 (2024-25, nil).

41 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**	2024-25 Target	2024-25 Performance
Expenditure not to exceed income	2,326,413	2,322,693	2,166,217	2,175,732
Capital resource use does not exceed the amount specified in Directions	437	436	60	58
Revenue resource use does not exceed the amount specified in Directions	2,300,886	2,297,166	2,142,030	2,151,545
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	26,882	17,098	14,504	14,438

42 Analysis of charitable reserves

The Integrated Care Board did not hold any charitable funds during the financial year ended 31 March 2026 (2024-25, nil).

43 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	211,601	167,860
Eligible mental health expenditure	211,664	167,928
Mental health expenditure above/(below) minimum investment required	63	67
Mental health expenditure as a proprortion of total expenditure	0	0

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Lincolnshire 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 Lincolnshire 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 Lincolnshire 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 38, 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 38, 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 Lincolnshire 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 Lincolnshire 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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NG1 5FS

18 June 2026