Cambridgeshire & Peterborough Integrated Care System

NHS Cambridgeshire & Peterborough

# Annual Report & Accounts
# 1 April 2024 – 31 March 2025

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# Performance Report

## Performance Overview

This section provides an outline of the performance of NHS Cambridgeshire & Peterborough Integrated Care Board (ICB) from 1 April 2024 to 31 March 2025. It gives an overview of how we have commissioned services and discharged our statutory functions on behalf of the population we serve.

## Statement from Jan Thomas, Chief Executive Officer

Hello and welcome to our 2024/25 Annual Report. Thank you for taking the time to find out more about the work that we have led over the last year.

The last year has seen the local NHS make significant progress with our financial position and with productivity, underpinned by a focus on the positive impact this will have on the local people we care for.

I want to start with a focus on our finances. Last year I concluded my statement with a reflection that managing our finances would continue to be a challenge. This has been true over the last year with rising inflation, Industrial Action and prescribing pressures to manage. But I am pleased to report that the ICB, and the wider Integrated Care System (ICS), have delivered a break-even financial position.

This achievement means that not only will the ICS be awarded an additional capital and revenue funding for next year, our historic debt of £132.6m has now officially been written off by NHS England. This is a significant milestone and one that reflects sustained effort, careful management, and system working over the last three years. This outcome means we are now able to move forward with a clean slate and renewed focus on the future.

Of course, whilst working within our budget is important, the healthcare services that local people can access, and their experiences of those services are what matters most. Over the last year we have:

- **Increased productivity** with an 8% increase in elective activity, 15% higher cancer activity, and 27% more diagnostics compared to 23/24. This has improved our cancer performance and allowed us to reduce the number of patients waiting over 52 weeks for elective treatment by 40% and increased the proportion of patients who receive diagnostic tests they need within six weeks by 15%.
- **Used data to drive prevention work** through Your Healthier Future – a population health approach to identify and support people who are at higher risk of cardiovascular disease.
- **Boosted vaccination uptake** with our Access & Inequalities Vaccine Project, to improve uptake of childhood and respiratory immunisations in the area. Working with GP practices who have particularly low uptake rates, we ran a series of targeted pop-up community clinics, delivering over 4,000 additional vaccinations.

- **Supported people who frequently visit A&E** via our High Impact User team, run in collaboration with Cambridgeshire County Council, by putting in place over 6,000 personalised care plans for people identified as high users of A&E, or at risk of becoming so. This is already reducing trips to A&E at the same time as better supporting this group of local people.

We have also invested in research; played a pivotal role in developing a brand-new Level 3 Safeguarding Support Officer Apprenticeship scheme; welcomed around 2,500 children and young people to our second Careers Expo; provided grant funding to Voluntary Sector organisations to tackle health and wellbeing issues within local communities; launched the WorkWell programme with local partners to help people who may be struggling to find or keep a job due to a health problem; and, helped hundreds of people quit smoking via the NHS Treating Tobacco Dependency programme.

Underpinning all of this work is our Strategic Commissioning Plan, which sets out our approach and vision for healthcare services for around a million people in Cambridgeshire, Peterborough and Royston. The Plan sets out how we will approach the delivery of better care and better outcomes for local people over the next three years and will be used to inform decisions about how we use our funding and other resources to deliver sustainable, effective NHS services locally.

Looking to the year ahead, we have some challenging choices to make to ensure that we can operate within our new, reduced, budgets, but also many opportunities to work in new ways and in greater partnership than ever before, putting patients at the heart of everything we do.

**Jan Thomas,**
Chief Executive

June 2025

## Purpose and Activities of the Organisation

NHS Cambridgeshire & Peterborough, is a statutory NHS organisation that is responsible for planning and delivering local health and care services. It came into being on 1 July 2022. Working collaboratively with partner organisations, including the Voluntary, Community and Social Enterprise(VCSE) sector, the ICB oversees the commissioning, performance, financial management and transformation of the local NHS, as part of the Cambridgeshire & Peterborough Integrated Care System (ICS).

The ICB covers Cambridgeshire, Peterborough, and Royston. Within this area, there are five NHS Trusts, 87 GP practices, and 143 pharmacies. The population of around one million people is ethnically, culturally and economically diverse.

We see significant inequalities within our aging population. For example, men living in the poorest areas of Peterborough have a life-expectancy ten years shorter than those living in the most affluent areas of Cambridge.

The NHS Cambridgeshire & Peterborough (ICB) Board works together to consider and make decisions on recommendations from each of our work programmes, whilst also monitoring progress and holding providers to account for delivery.

Our Board is accountable to NHS England (NHSE) for the successful development and implementation of the health and care transformation agenda. Current members of the Board can be found on our website.

## Performance Summary and Analysis

Set out in the tables below are the Key Performance Indicators (KPIs) that all ICBs were required to meet during 2024/25, these indicators form part of the NHS System Oversight Framework and contribute to our oversight rating. It is recognised that, as well as our successes, there are some ongoing challenges that we continue to seek improvement against. Performance is being monitored against these indicators through Quality, Performance and Finance ICB committee and through the Integrated Care Board.

Delivery in 2024/25 has remained challenging as we continue to work through recovery and mitigate risks including industrial action and general practice collective action, higher than usual demand profiles and during winter, a quad-demic of infectious illness, with flu levels and norovirus at levels not seen since before the COVID pandemic.

Demand in 2024/25 has been considerable, with increases in the number of patients presenting to all healthcare settings. Compared to the previous year, General Practice are seeing 4.1% more patients, 10% more patients are accessing our emergency departments and specialty referrals for elective care have increased by 7%.

We have mitigated this through delivering more activity that ever before, with elective activity 8% higher than the previous year, cancer activity 15% higher and diagnostics 27% higher. This has contributed to an improvement in our cancer performance with delivery of the 28-day Faster Diagnosis Standard (FDS) for seven consecutive months. It has supported a 40%

reduction in the number of patients waiting over 52 weeks for elective treatment and an 18% improvement in patients receiving diagnostics within 6 weeks from 65% (April 2024) to 83% (March 2025).

The ICS is on track to deliver its plan for 26 of the 34 national indicators at 2024/25-year end, though indicator data for full year remains unvalidated or unavailable at the time of report publication. The eight areas of non-delivery against plan are shown in the table below and a full breakdown of performance in 2024/25 is included in Table 2.

Table 1 - Operational plan indicators areas of non-delivery

| Key performance indicators | 23/24 | 24/25 Plan | 24/25 Actual |
|---|---|---|---|
| Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025 | 59.5% (full year) | 78% | 69.1% |
| Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25 | 33 min | 30 mins | 40.7 mins |
| Improve community services waiting times, with a focus on reducing long waits (>52 weeks) * | 448 | 333 | 1,018 |
| Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025 | 71.7% | 75.0% | 70.7% (Q4 2024/25) |
| Eliminate waits of over 65 weeks for elective care as soon as possible (except where patients choose to wait longer or in specific specialties) | 1,841 | 0 | 54 |
| Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement and 48% reliable recovery | N/A | Access 67% Recovery 48% | Access 64% Recovery 46% |
| Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate | 58.7% | 63.4% | 60.6% |
| Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels | 67.8% | 69% | 80% |

**Community waiting list data is subject to ongoing data quality and validation checks.*

*Table 2 - full breakdown of performance in 2024/25*
*Data shown is for March 2025 unless indicated*

| Area | Objective | 23/24 | 24/25 Actual | 24/25 Plan | Performance vs. 24/25 submitted plan |
|---|---|---|---|---|---|
| Quality and patient safety | Implement the Patient Safety Incident Response Framework (PSIRF) | N/A | Implemented | N/A | ✓ Met |
| Urgent and emergency care | Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025 | 59.5% | 69.1% (YTD) | 78% | X Did not meet |
| | Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25 | 33 min | 40.7 mins (YTD) | 30 min | X Did not meet |
| Primary and community services | Improve community services waiting times, with a focus on reducing long waits (>52 weeks) | 448 | 1,016 | 333 | X Did not meet |
| | Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need | 81.6% | 81.6% | 81.6% | ✓ Met |
| | Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels | 67.8% | 69% | 80% | X Did not meet |
| Diagnostics | Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% | 62% | 85.3% | 82% | ✓ Met |

| | | | | | |
|---|---|---|---|---|---|
| Elective | Eliminate waits of over 65 weeks for elective care as soon as possible (except where patients choose to wait longer or in specific specialties) | 2,057 | 54 | 0 | X Did not meet |
| | Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107% | 120% | 128% | >107% | ✓ Met |
| | Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25 | N/A | 46% | 46% | ✓ Met |
| | Improve patients' experience of choice at point of referral – implement Patient Initiated Requests to Move Provider(PIDMAS) | N/A | Implemented | N/A | ✓ Met |
| Cancer | Improve performance against the headline 62-day standard to 70% by March 2025 | 59.4% | 71.9% | 70% | ✓ Met |
| | Improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026 | 70.3% | 81.5% | 77% | ✓ Met |
| | Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028 | 40.3% | 67% (excluding unknown diagnoses) | N/A | ✓ Expected to meet |
| Mental health | Improve patient flow and work towards eliminating inappropriate out of placements | 30 | 6 | 10 | ✓ Met |
| | Increase the number of people accessing transformed models of adult community mental health (to 400,000), perinatal mental health (to 66,000) and children and young people services | Adult: New metric Perinatal: 790 CYP: 16,085 | Adult: 5,900 Perinatal: 900 CYP: 10,130 | Adult: 5,900 Perinatal:790 CYP: 13,546 | ✓ Expected to meet |

| | | | | | |
|---|---|---|---|---|---|
| | (345,000 (CYP) additional CYP aged 0–25 compared to 2019) | | | | |
| | Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement and 48% reliable recovery | New | Access: 64% Recovery: 46% | Access: 67% Recovery: 48% | X Did not meet |
| | Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025 | 60.2% | 69.8%) | 75% | ✓ Expected to meet |
| | Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate | 58.7% | 60.6% | 63.4% | X Did not meet |
| Learning disabilities and autism | Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025 | 71.7% | 72.5% | 75% | X Not expected to meet |
| | Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12–15 under 18s for every 1 million population. | 19 | 10 | 19 | ✓ Met |
| Maternity, neonatal and women's health | Continue to implement the three-year delivery plan for maternity and neonatal services, including making progress towards the national safety ambition and increasing fill rates against funded establishment | N/A | Implemented | N/A | ✓ Met |
| | Establish and develop at least one women's health hub in every ICB by December 2024, | N/A | Implemented | N/A | ✓ Met |

| | | | | | |
|---|---|---|---|---|---|
| | working in partnership with local authorities | | | | |
| Workforce | Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of the People Promise retention interventions | N/A<br>N/A | Implementation underway | N/A | ✓ Met |
| | Improve the working lives of doctors in training by increasing choice and flexibility in rotas, and reducing duplicative inductions and payroll errors | | Implementation underway | N/A | ✓ Met |
| | Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan | N/A | Implementation underway | N/A | ✓ Met |
| Resource | Deliver a balanced net system financial position for 2024/25 | N/A | On track | Breake ven | ✓ Met |
| | Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25 | 2.7% | 1.5% | 2.2% | ✓ Met |
| Health inequalities | Increase the % of patients with hypertension treated according to NICE guidance | 64.3% | 66.8% (December) | N/A | ✓ Expected to meet |
| | Increase the percentage of patients aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025 | 58.6% | 61.5% (September) | 65% | ✓ Expected to meet |
| | Increase vaccination uptake for children and young people year on year towards World Health Organization (WHO) recommended levels | New | Implementation underway | N/A | ✓ Met |
| | Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people | N/A | Implementation underway | N/A | ✓ Met |

## Operational Performance Overview

Throughout the 2024/25 period, the ICB has diligently addressed several significant challenges within the healthcare system. These include protracted waiting lists for patients requiring treatment, substantial pressures on urgent and emergency care services, and the persistent impact of industrial action, which has disrupted both planned and unplanned care provision for our population.

The ICB remains steadfast in its commitment to implementing strategic initiatives to address these challenges, ensuring the delivery of high-quality, timely healthcare services that meet the needs of our community. To navigate the evolving demands during this period, ICB teams and healthcare providers have demonstrated exceptional adaptability. This has included, at times, prioritising resources and services for urgent and emergency care to maintain critical support for patients. Our dedicated colleagues have worked tirelessly to enhance service provision and improve access, driven by a shared commitment to achieving the best possible outcomes and experiences for our population.

Throughout this period, the ICS saw activity in line with or below our operational plans. For several of the ICB's KPIs, performance was below national or locally expected targets in 2024/25. There have been some improvements compared to the previous year (2023/24), in particular, our long wait position for elective, diagnostics and cancer care.

## Urgent and Emergency Care

Urgent and emergency care across Cambridgeshire and Peterborough remained challenged throughout the year achieving 69.1% in March 2025 and therefore below the 78% expectation. However, overall full-year performance improved from 59% in 2023/24 to 68.3% in 2024/25. Category 2 ambulance response times have been below the targeted 30min average across 2024/25 at 40.7mins. This is adverse to the previous year's average response time of 39.1 minutes.

To support and improve the challenged urgent and emergency care (UEC) position, the ICB has led Tiering meetings with colleagues from the Acute Trusts to monitor and review improvement plans, performance, risks and escalations. Several initiatives were implemented to support the position at both trusts. For Cambridge University Hospitals NHS Foundation Trust, (CUH) this included a review of infection prevention and control (IPC) procedures to optimise plans for the turnover and reopening of beds, review of discharge processes particularly looking at weekends, and additional streaming support in the Emergency Department. For North West Anglia NHS Foundation Trust (NWAFT), resources were reviewed to amend shift patterns in response to capacity and demand modelling, early discharge processes were improved and increased operational and medical support was put in place to assist with the overall flow and discharge.

Due to the ongoing challenges, both Trusts received support from the National Rapid Improvement Offer (RIO) team, who supported for a short period on key areas of improvement agreed by the system. CUH focused on same-day emergency care (SDEC), patient streaming, Flow (including length of stay and frailty), and Internal Professional Standards (IPS).

Peterborough City Hospital (NWAFT) focused on board and ward round processes, length of stay and IPS. Several ongoing programmes and recommendations are underway following the RIO team input.

As part of the 2024/25 UEC Improvement plan, several winter schemes were agreed to support the increased winter demand. The agreed schemes which were subsequently implemented are:

- UEC Hub and hub additional capacity
- Acute frailty support (including targeted care home intervention)
- Additional Pathway 1 capacity

NWAFT is implementing a series of measures to enhance ambulance handover performance, with the overarching objective of improving community response times. The Trust has relaunched its handover process to achieve measurable improvements in handover efficiency across both of its sites.

To support this initiative, NWAFT is prioritising an enhanced senior clinical presence within its two Accident and Emergency departments, working in tandem with the reintroduction of the Trust's Internal Professional Standards (IPS). Specialty clinicians will assume clear responsibilities and ownership of patients in the Emergency Department, thereby reducing patient dwell time and facilitating earlier ambulance offloading.

Additionally, nursing rotas are under review to ensure alignment with demand patterns, minimising delays in critical diagnostics such as blood tests, electrocardiograms (ECGs), and other associated procedures. Looking ahead, the Trust plans to establish a fully operational 24/7 Surgical Same Day Emergency Care (SDEC) service. This development is expected to further improve four-hour performance metrics and reduce 12-hour patient journey times in the ED, thereby increasing capacity for ambulance offloads.

This work is part of the Trust's 'Back on Track' improvement programme which also includes work on improving patient flow through several initiatives including reducing length of stay (LoS), improving discharging processes and frailty pathways. These schemes also contribute to the overall plan to enhance ambulance handover performance, community response times and A&E performance.

Collaboration with system partners remains a key focus. Initiatives include optimising the utilisation of available HUC capacity and working constructively with EEAST to adopt the Handover45 framework, ensuring patient safety is consistently prioritised.

## UEC Hub

The UEC Hub aligns to the national directive around the development of Unscheduled Care Coordination Hubs to act as the single point of access for community and alternative to emergency department (ED) pathways. The ICS has developed a hub with two main functions: advice and guidance for healthcare professionals to receive senior clinical support around conveyance to ED, and our Trusted Assessors who receive and triage referrals for community admission avoidance and signpost to the most appropriate service based on capacity and criteria. One of the main referral sources to the Hub is the East of England Ambulance service (EEAST) Ambulance Stack, whereby Category 3-5 999 calls deemed appropriate for community

response are pulled from the stack into the Hub to avoid ambulance dispatch and subsequent conveyance.

Since the Hub launched in December 2025, we have received 11,290 referrals (to March), of which 61% (6,887) were managed via our Urgent Community Response (UCR) Teams or via the Hub Clinicians with home care advice. 687 jobs were triaged, accepted and completed from the stack, therefore avoiding an unnecessary ambulance dispatch/potential conveyance. Prior to the Hub going live, our UCR teams were receiving referrals directly and during the period April 2024 – November 2024, the teams received 12,093 referrals. This demonstrates an increase in the number of patients being managed in the community, from a monthly average of 2,015 before the Hub and 2,822 since its establishment, which is resulting in management of ambulance demand, lower attendances at A&E and fewer patients being unnecessarily admitted to hospital. Throughout 24/25 our two-hour response has consistently been delivered with 92% of patients referred receiving their first contact within two hours.

## UEC Hub additional capacity

In February 2025, we launched our additional capacity appointments which offers Primary Care level interventions to patients who have been streamed/redirected from the Emergency Departments at both Addenbrookes Hospital and Peterborough City Hospital. The service is still in development but offers both GP and Health Care Assistant appointments from 8am – 8pm, seven days per week in Peterborough and Cambridge.

Since going live, the Peterborough site has supported 837 referrals from Peterborough City Hospital. Outcomes have included assessment, issuing prescriptions, advice and guidance, or wound support. The Sawston service started in March and has therefore seen lower numbers to date, however 60 patients were supported in the first three weeks of operation.

An evaluation is being completed at the end of Quarter 1 25/26 to review the capacity, demand and effectiveness of the service to inform future delivery.

## Acute Frailty support

The ICB commissioned bespoke North and South Frailty projects, with an aim of providing advanced care and support to frail older people across acute and community pathways. The aims of the offer were to provide rapid access frailty clinics offering a multi-disciplinary team (MDT) Comprehensive Geriatric Assessment, alongside 'in reach' care home work to support both nursing and residential care homes to avoid unnecessary attendance at ED. Due to struggles with recruitment, the schemes were not able to be fully implemented until March 2025. Therefore, it has been agreed for the projects to rollover into Q1 of 2025/26 and an evaluation completed to review the impact.

Up to March 2025, the North Scheme has been offering 15 Frailty Virtual Ward beds, with 176 patients being onboarded from the community to this service, via Call before Convey; of these 32 patients were onboarded from Care Homes. 11 patients have also been booked into community frailty "hot clinics".

The South scheme has focused on enhancing the existing frailty offer/pathways with additional community clinics being put in place which went live in March 2025. There is also targeted in-reach to identified Care Homes which is due to start imminently.

## Cancer Care

The 62-day cancer referral-to-treatment performance has demonstrated sustained improvement since April 2024, rising from 51% to 71.9% in March 2025. This figure is slightly below the 70% target set for March 2025. The 62-day backlog has decreased from 531 in April 2024 to 350 in February 2025. Performance against the 28-day FDS remains a notable strength, achieving 81.5% in March 2025, with 11 consecutive months of performance above the 77% target expectation.

NWAFT was moved out of tiering for cancer performance in October 2024 after demonstrating a continued improvement to its performance metrics throughout the year. The team has introduced a new governance structure that has facilitated greater focus on key actions delivering sustainable improvement. CUH has continued with previous high levels of performance – particularly the 28-day FDS standard. Additional tracking support and waiting list have supported. Due to low numbers of treatments and being solely a tertiary provider, Royal Papworth Hospital NHS Foundation Trust's (RPHFT) performance has varied greatly throughout the year. Work is planned during 2025/26 to identify what further support can be provided to ensure improvements and greater consistency.

In February 2025, the ICS was the fourth highest performing ICS in the country for the FDS, recognising the hard work of all.  There continues to be focused work across the ICS on improving cancer care, treatment and earlier diagnosis.

## Lung Cancer Screening Programme

The Lung Cancer Screening Programme (previously known as the Targeted Lung Health Checks) has been progressed throughout 2024/25 with all providers and went live in February 2025 with the aim to diagnose lung cancers at an earlier stage. This programme will continue to be developed with a phased rollout throughout 2025/26.

## Cervical Screening

Additional funding was targeted in 2024/25 to particularly focus on improving the uptake in cervical screening targeting both 25–49-year-olds and 50–65-year-olds. This has delivered the following:

- A partnership cervical screening webinar held in November 2024
- Outreach clinics in the community – including the Health Outreach Bus
- A suite of cervical screening videos have been launched
- Education and information sessions delivered by local GPs and nurses
- Cervical screening awareness slots on local radio stations

## Cambridge Cancer Research Hospital

The Secretary of State for Health and Social Care confirmed on 20 January 2025 that the Cambridge Cancer Research Hospital is one of the 'Wave 1' schemes of the New Hospitals Programmes. The Full Business Case is now being developed to be submitted to regulators by July 2025. The ICB continues to work with CUH and wider stakeholders as this case develops.

## Elective Care

Our system elective recovery and improvement plans continue to be over seen through our ICS Planned Care Board.

We have significantly reduced our number of patients waiting the longest, by the end of March 2025 we had 60 patients waiting over 65-weeks compared to 1,841 in April 2024. The overall referral to treatment (RTT) waiting list was 149,539 in February 2025, a reduction from 152,711 in April 2024.

During 2024/25, we treated all patients who had been waiting over 78 weeks, reducing the number to zero and overall elective activity was 106% of our 24/25 plan. By the end of January 2025, the system was 32% ahead of its 24/25 plan to reduce the number of patients waiting longer than 52 weeks.

NWAFT was removed from national tiering for sustaining improvements across elective long waits in October 2024.

## Elective Hubs

The Elective Hub in Cambridge widened its case mix from the original business case to incorporate three full day lists per week for neuro spines. The Hub is forecast to have completed 2,407 operations during 2024/25 against a plan of 2,736. This was adverse due to unplanned industrial action, high cancellation rates over January and February due to seasonal illnesses and manpower pressures that are resolved from March 2025.

The Elective Hub in Huntingdon is still working on its accreditation due to issues with ventilation in the new theatre building. Activity is continuing with any shortfall being made up through the treatment centre and main theatres whilst this issue is being resolved.

The Enhanced Recovery Unit (ERU) at RPHFT opened to five beds in May 2024 increasing to 10 in September 2024. These ringfenced beds for elective activity has ensured an improvement in its RTT performance and reduction in their overall waiting list.

## Best Practice

There has been focused work throughout 2024/25 across the system on delivering elective recovery with the implementation of best practice, reviews against the Getting it Right First Time (GIRFT) Further Faster programmes and a focus on maximising capacity through productivity. An example of success is the Patient Initiated Follow Up (PIFU) performance which as a system is 4.6%, which is significantly above the national median of 3.4% with an ambition

to increase this to 6.8% by the end of 2025/26. There was a system wide high volume low complexity (HVLC) GIRFT review lead by Professor Tim Briggs in April 2025 for which there was positive feedback on several areas. Further work was recommended on greater utilisation of the elective hubs and reviewing job plans to increase the numbers of appointments in clinics which the system will continue to focus on in 2025/26.

## Dermatology Pathway Review

During 2024/25 the ICS agreed to an end-to-end pathway review of dermatology services to support wider improvements across primary, community and secondary care provision; maximising opportunities to reduce the reliance on secondary care provision; improving access and information to the local population, supporting self-care and embracing technology, digital solutions and national and international best practice. This programme was launched in quarter 4 of 2024/25 and will be completed in 2025/26.

## Diagnostics

The proportion of patients waiting over six weeks for diagnostic procedures significantly improved, decreasing from 37.5% in April 2024 to 16.7% in March 2025. This equates to c8,000 more patients seen monthly within the 6-week period than at the start of the year. However, the overall waiting list increased from 24,425 to 27,811 during this period. This rise was driven by an increase in waiting list procedures performed, which grew from 21,737 in April 2024 to 22,349 in February 2025, alongside an increase in planned procedures, which rose from 4,690 to 5,244 over the same timeframe. Monitoring of system wide performance and key deliverables has been through the System Diagnostic Board.

## Diagnostic Review

In 2023/24, a system wide external deep dive into diagnostic capacity and demand was undertaken. This identified a range of opportunities across diagnostic modalities for the system to take forward to improve access, productivity and overall performance. Through the system diagnostic board, with providers and the ICB, this work was developed into a programme of key deliverables that have been implemented during 2024/25.

In the second half of 2024/25, the System Diagnostic Board completed a full review of progress and system wide priority areas. Three system wide priorities were identified with each provider taking a lead: audiology, echo workforce and cardiac CT capacity. Task and finish groups commenced for these in quarter 4 and will continue to progress actions and deliverables in 2025/26.

## Community Diagnostic Centres

Work has been ongoing in 2024/25 to increase activity and pathways through Ely and Wisbech Community Diagnostic Centres (CDC) working across system boarders to ensure that services meet the needs of the local communities.  Further work on increasing pathways is ongoing.

During 2024/25, the Peterborough CDC future development was shaped and approved with a future location and build at Wellington Street, Peterborough. This will offer Dexa, X-ray, Ultrasound, MRI and CT capacity with a new build expected to be open in late 2025.

## Pathology Services

Work has been ongoing across pathology services across the system with Pathology turnaround times improving in year though they remain a concern. The ICS is fully engaged and involved in the Pathology Network to continue to develop sustainable long term pathology services.

## Mental Health

In March 2025, the diagnosis rate for expected dementia cases reached 60.6%, and while falling short of the national ambition of 66.7% the diagnosis rate has continued to increase throughout the year. The proportion of patients with severe mental illness (SMI) receiving a physical health check in Q3 2024/25 exceeded the 60% target, achieving 65.3%. Similarly, the number of adults with SMI receiving two or more contacts from NHS community mental health services was significantly above the planned figure, with 10,010 individuals recorded against a target of 5,900 for January 2025.

Performance in talking therapies showed variation throughout the year. By the end of March 2025, the year-to-date position demonstrated that 46% of patients receiving talking therapies achieved reliable recovery, delivering against the national expectation. Additionally, 64% of patients demonstrated reliable improvement, which is marginally below the national ambition.

## Dementia Diagnosis

While further research is necessary to achieve the national dementia diagnosis ambition, progress has been made to gradually enhance the diagnosis rate throughout the year. There is a clear recognition that improving access to timely diagnosis will enable individuals living with dementia, their caregivers, and families to access appropriate treatment, care, and support. Additionally, it will facilitate the planning of an informed, shared decision-making approach to manage the impact of the disease. The ICB has collaborated with system partners, such as the Memory Assessment Service and the Alzheimer's Society, as well as patients and carers, to develop co-produced plans that not only aim to improve diagnosis rates but also provide pre- and post-assessment support.

## Talking therapies

Throughout the year, there has been a concerted effort to achieve reliable improvement and reliable recovery rates, as well as enhancements to access waiting times and in-treatment waiting times. This has been achieved through collaborative service improvement initiatives undertaken with the ICB's four talking therapies providers. Additionally, there has been a focus on improving access and support for segments of the population that utilise talking therapies to a lesser extent, such as older adults. Consequently, a comprehensive programme of work has been implemented to enhance awareness of talking therapies among older adults, to identify and address access barriers, including perceived stigma, and to mitigate against potential attrition rates, although rates tend to be lower among this group.

## Crisis Pathway / Right Care, Right Person

Significantly reducing inappropriate out-of-area placements through revised care delivery models has led to monthly placements decreasing from 30 in 2023/24 to 6 in January 2025. This service improvement has been accompanied by wider ICB-led work to enhance the mental health crisis response. The focus has been on addressing a pathway deemed excessively complex and challenging for patients and carers to navigate, particularly during a mental health crisis. Among the anticipated outcomes from this ongoing work will be improved patient flow through mental health crisis and acute pathways, resulting in a reduction in the average length of stay in adult acute beds.

Integrated into our system's approach to enhancing mental health crisis management has been the successful implementation of the national Right Care, Right Person (RCRP) during 2024/25. Cambridgeshire has been designated as an evaluation site for the implementation of the national RCRP agreement, which establishes a collective commitment from the Home Office, Department of Health and Social Care, the National Police Chiefs' Council, Association of Police and Crime Commissioners, and NHS England to collaborate in ending the inappropriate and avoidable involvement of police in responding to incidents involving individuals with mental health needs. The ICB has collaborated with the Police, East of England Ambulance Service (EEAST), acute hospitals, mental health and social services to implement RCRP through three distinct managed stages. Our collaborative work is ongoing, with shared system handover escalation policies being refined, sustainable training embedded, and ongoing data mapping and learning sets being implemented.

## Primary Care

On 1 April 2023, the ICB took on further delegated responsibilities for community pharmacy, optometry and dental services (POD), these are in addition to general medical services delegated in 2017.

The ICB is one of the six ICBs in the East region that form part of a Memorandum of Understanding (MoU) that is in place with Hertfordshire and West Essex ICB (HWE) to host the delegated functions for community pharmacy and optometry services. This sees a small number of staff assigned from the previous NHS England regional primary care team, deployed to support the delivery of delegated functions through an at scale delivery model with input and oversight from each ICB.

## Primary Care Delegation – Pharmacy, Ophthalmic and Dentistry Services Internal Audit Outcome 2024/25

During March 2025, RSM Risk Assurance Services LLP undertook a review of the processes and management of the ICB's Primary Care Services, in line with the approved Internal Audit Plan for 2024/25. The objective of the review was to evaluate the effectiveness of the arrangements the ICB has put in place to exercise the primary medical care commissioning functions of NHS England as set out in the Delegation Agreement.

## Scope of the review

The following areas were considered as part of the review:

- Commissioning and procurement of primary medical services across the system.
- Planning the provision of primary medical care services across the system, including carrying out needs assessments and consulting with other relevant agencies, as necessary. This included how the quality of services are assessed as part of the assessment process of potential providers.
- The processes adopted in the procurement of primary medical care services, including decisions to extend existing contracts.
- The process for managing and documenting identified or potential conflicts of interest in line with policy.
- The involvement of patients / public in those commissioning and procurement decisions.
- The effective commissioning of Directed Enhanced Services and any Local Incentive Schemes (including the design of such schemes); Arrangements for undertaking quality and equality impact assessments.
- Review the extent of the engagement with key stakeholders including patient, public and GP engagement, including how issues are escalated from stakeholders to NHS England.
- The monitoring and management of primary care budgets and the process in place should an increase in fees be identified.
- The billing process and how only actual activity is being billed and paid for.
- The reporting and monitoring arrangements to/by the various forums including the ICB Board.

RSM Risk Assurance Services LLP has now concluded the audit and issued a final report on the outcome of the internal audit assignment for 2024/25.

## Conclusion

Overall, RSM found that the ICB's control framework for managing and commissioning primary medical care was well-designed and operating effectively.

Audit testing confirmed that oversight of general and primary medical care agreements was consistently maintained through practice visits and performance monitoring via the GP Dashboard. Additionally, since April 2024, all primary care service procurements have included patient representation in decision-making. Key processes were in place to evaluate options, mitigate conflicts of interest and ensure effective moderation.

The recently updated impact assessment templates comprehensively address key areas, and RSM verified that baseline payments to the sampled GPs were accurate and aligned with the agreed payment schedule.

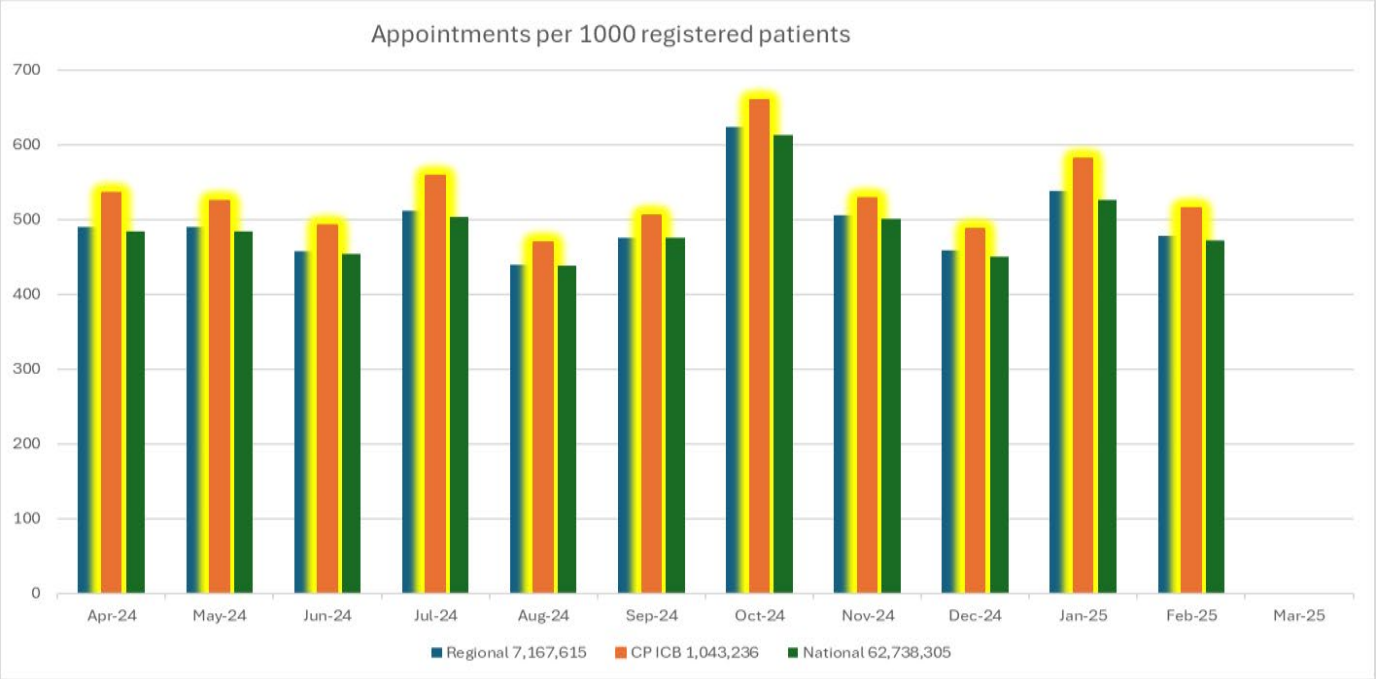
The outcome report from the 2024/25 internal audit confirmed Substantial Assurance was achieved.

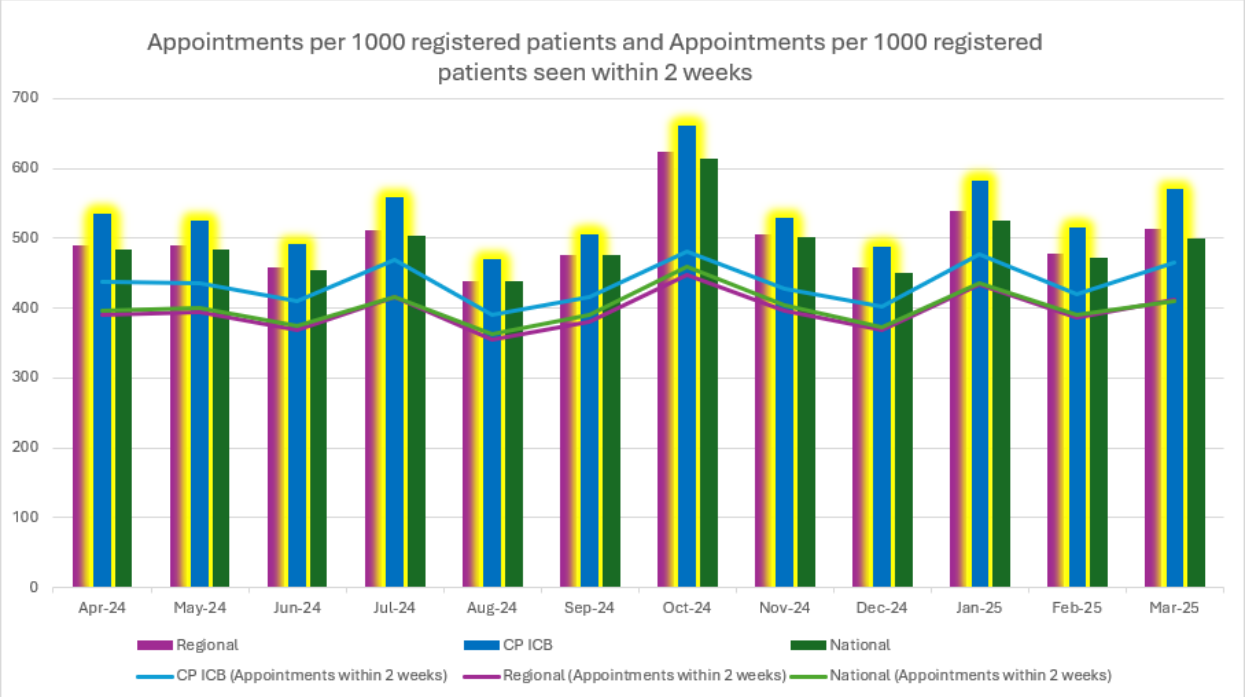
## Primary Care Access Recovery Plan

The 2024/25 Primary Care Access Recovery Plan (PCARP) draws on the work outlined in the ICB's Forward View and Working Together documents which also support the primary and secondary care interface programme being led by the Medical Directorate. The Plan was used as an enabling tool to bring together system partners in delivery of primary care services. The Plan set out our local approach to support Primary Care, and reaffirmed the ICB's commitment to embed the Fuller Stocktake vision for integrated primary care by supporting practices to move to a modern general practice access model. This programme was also intrinsically linked to the ICB's GP Sustainability Programme.

Successful implementation of the ICB's PCARP during 2024/25 helped to reduce the waiting times for accessing GP appointments, including same day access for those that need it, and aligned to a number of key metrics that were established nationally as part of monitoring PCARP and the ICB's operating framework.

As demonstrated in the charts below, the number of appointments per 1000 registered patients and the number of appointments delivered in two weeks per 1000 registered patients is higher in the ICS than both regionally and nationally.




## PCARP deliverables

- Increase the use of NHS App and other digital channels to enable more patients to access their prospective medical records (including test results) and manage their repeat prescriptions
- Continue to expand self-referrals to appropriate services
- Extend uptake of pharmacy first services
- Complete implementation of better digital telephony
- Complete implementation of highly usable and accessible online journeys for patients
- Complete implementation of faster care navigation, assessment and response
- Provision of universal and targeted transformation / improvement national support offer

- Link to long term workforce plan
- Make further progress on the four Primary Care Secondary Care Interface (AoRMC) recommendations
- Make online registration available in all practices by October 2024

## Patient experience – Friends and family test

The GP friends and family test (FFT) dataset includes responses for the latest month from GP practices (January 2025). Data is submitted directly to NHS Digital's Calculating Quality Reporting System (CQRS) each month.

- The data shows that the percentage of positive responses received in January 2025 are higher than regionally and nationally
- GP practices are actively being reminded at the practice visits to record and upload their FFT data.
- The total number of responses in January 2025 is 28% higher than November 2024 (9,152 responses) indicating increased engagement.

| | Practice List Size | Total Responses | Responses Positive | Responses Negative |
|---|---|---|---|---|
| National | 63,702,696 | 1,060,595 | 92% | 4% |
| Regional | 7,335,627 | 97,177 | 91% | 4% |
| C & P ICB | 1,055,911 | 11,733 | 93% | 4% |

*General Practice Local Commissioning and Investment Plan 2024/25*

It was important that our ICB's commissioning and investment priorities aligned to national's ambition to improve patient access and experience, implement Modern General Practice and achieve resilience and sustainability across our primary care providers, through a more integrated way of working and population health needs-based model of investment

In 2024/25 the ICB committed investment of £11,736,707.00 to support delivery of the 2024/25 General Practice Local Commissioning Agreement and introduced new investment streams to support cardiovascular disease (CVD) and delivery of the COVID-19 medicines programme.

A key purpose of the ICS is to reduce health inequity. This requires the ICB to ensure there is better alignment of the funding of services to support population health needs

As part of the Primary Care Roadmap, which was introduced in November 2022, the ICB made a commitment to help address the inequality that the current Carr-Hill formula creates through the design and implementation of a population health needs-based model of investment that

aligns to the funding model originally introduced by NHS Leicester, Leicestershire and Rutland (LLR) Clinical Commissioning Group.

In 2024/25, the ICB implemented a levelling up of core general medicinal services (GMS) Practice funding by re-investing underspend from the 2024/25 Local Commissioning and Investment budget topped up with £1.2m of additional monies from the system development funding allocation to help address the variation in core funding and inequality that the national Carr-Hill formula creates.

Phase one of levelling up supported 40 GMS funded GP practices in areas of high deprivation where patient needs are greater and whose Carr-Hill formula weighting is less than one, therefore resulting in a negative impact on the core funding that the practice receives.

By re-distributing existing funding and by investing additional monies, the ICB's intention is to support these GMS Practices to remain sustainable and be better resourced to help address the health inequalities that the national funding model creates.

### *Protected learning time*

The ICB continued to invest in protected learning time for practices and encouraged Primary Care Network representative attendance at a series of Primary Care Integration and Engagement events to encourage more collaborative discussions with wider primary care teams (Dental, Community Pharmacy & Optometry) at integrated neighbourhood and place level.

### *Community Pharmacy – Pharmacy First*

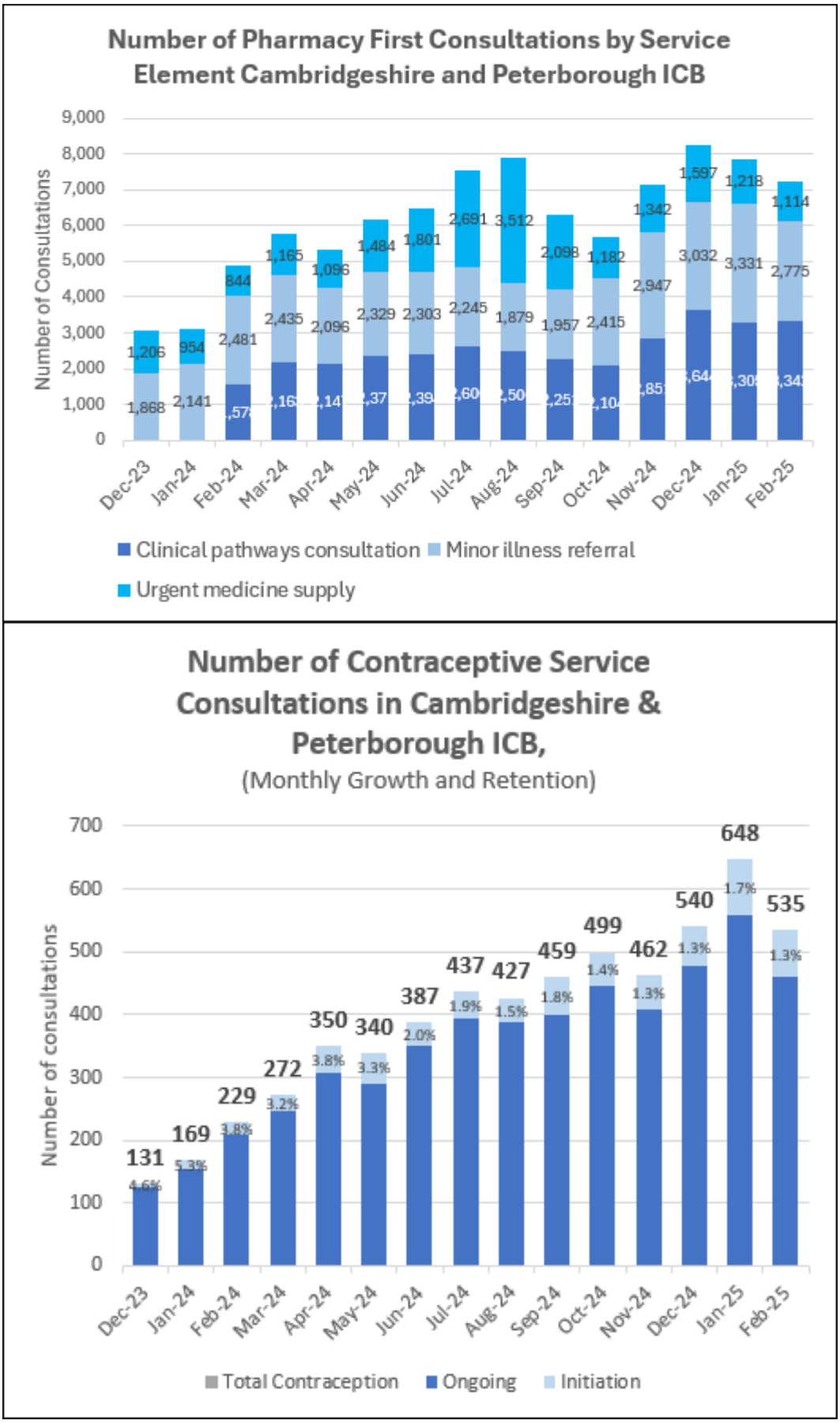
The Primary Care Access Recovery Plan for Community pharmacy contained two key components

- Expanding community pharmacy services by commissioning a Pharmacy First service which enables supply of NHS medicines for seven common health conditions
- Increasing provision of the community pharmacy Oral Contraceptive Service and the Hypertension Case Finding Service

Through effective implementation of the PCARP, during 2024/25 143,632 consultations have been conducted since the Pharmacy First launch (December 2023 to February 2025).

The Pharmacy First Service (PFS) consists of three elements:

1. Clinical Pathways: Pharmacists can manage seven common infections, providing advice and supplying over the counter or prescription-only medicines as appropriate.
2. NHS Referrals for Minor Illness: GPs and 111 can refer patients with minor illnesses to pharmacies for consultation and treatment.
3. Urgent Repeat Medicine Supply: Patients can obtain repeat prescriptions from pharmacies in urgent situations.


Number of Pharmacy First Consultations by Service Element Cambridgeshire and Peterborough ICB
Number of Consultations
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
1,206
954
844
1,165
1,096
1,484
1,801
2,691
3,512
2,098
1,182
1,342
1,597
1,218
1,114
1,868
2,141
2,481
2,435
2,096
2,329
2,303
2,245
1,879
1,957
2,415
2,947
3,032
3,331
2,775
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Clinical pathways consultation
Minor illness referral
Urgent medicine supply


Number of Contraceptive Service Consultations in Cambridgeshire & Peterborough ICB,
(Monthly Growth and Retention)
Number of consultations
700
600
500
400
300
200
100
0
131
4.6%
169
5.3%
229
3.8%
272
3.2%
350
3.8%
340
3.3%
387
2.0%
437
1.9%
427
1.5%
459
1.8%
499
1.4%
462
1.3%
540
1.3%
648
1.7%
535
1.3%
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Total Contraception
Ongoing
Initiation

## Community Optometrists

In September 2023, NHSE issued a revised national model General Ophthalmic Services contract and model contract variation for both mandatory and additional services. An overview of the number of contractors for mandatory and additional services in the ICB is set out below.

| Mandatory | Additional |
|---|---|
| 75 | 16 |

During 2023/24, the ICB re-negotiated the community ophthalmic minor eye conditions (MEC) service with local providers to ensure it remained fit for purpose and sustainable in supporting the system to manage minor eye conditions in a community setting.

Work has continued with the community MEC service in 2024/25 through the planned care Eye Care Group; identifying further opportunities for increasing community services and improving pathways into secondary care services for patients that require it.

## NHS Dental Services

The National NHS dental recovery plan was published in February 2024, to help address the National shortfall in provision of NHS Dental services.

As part of the ICB's local dental recovery plan to improve access and support the sustainability of NHS Dental services in our system, we implemented several local initiatives to run alongside any national initiatives to help address the inequalities that exist. The following projects formed part of our local Dental improving access and sustainability programme.

In 2024/25, non-recurrent funding of £6.1m was approved by the ICB Board, to produce a local Dental Improvement Plan which was underpinned by the development of local dental initiatives which included:

- Additional access sessions (created dental access for approximately 23,000 patients).
- Support with the NHS Orthodontic waiting list (aid access for 260 additional patients).
- Additional funding to create resources within the Special Care Dental Service to continue to support 500 plus legacy patients.
- A review of the paediatric dental pathway to produce a more robust, sustainable pathway to aid timely access at an appropriate point of prevention and treatment.

Alongside this, the ICB began working with IQVIA Connected Intelligence, to determine the mechanisms that need to be put in place to enable NHS dental services to be more sustainable in the future across the system, phase 1 and 2 have been completed which has helped develop the test phase which will commence on 1 April 2025.

As part of the Dental Investment Plan, during 2024/25 we commissioned additional sessions from Dental Providers that hold an NHS contract in Cambridgeshire and Peterborough.

In total five providers with 10 contracts delivered an additional 104 sessions per week, with 14,584 additional patients seen. These additional sessions ran until 31 March 2025.

| 1 March 2024- 31 March 2025 | Total Appointment Booked | Total 'Did Not Attends' | Total Patients seen | Total 'New' patients | Total patients under 16 | Total patients 16-40 | Total patients 40- 60 | Total patient over 60 |
|---|---|---|---|---|---|---|---|---|
| | 15714 | 1130 | 14584 | 5296 | 6380 | 3414 | 2430 | 2360 |
| | | 7.19% | 92.81% | 36.31% | 43.75% | 23.41% | 16.66% | 16.18% |

## Key Operational Risks

Our key operational risks in 2024/25 are reflective of the risks identified in 2023/24

## GP Collective Action

Some GPs may stop or reduce certain work as part of collective action, which could potentially put patients at risk, even if GPs are fulfilling their contracts. For example, capping appointments or stopping voluntary services that fill commissioning gaps could negatively impact patients.

## Our workforce

The wellbeing and work satisfaction of our employees is key to delivering the high quality and compassionate care we expect for patients. We know our workforce is feeling the pressure of ongoing industrial action and the legacy of the pandemic, which is having a negative impact on our staff's job satisfaction and feeling valued in the work they do. The system has several plans to address staff retention and wellbeing.

## Mental health

The ICB has maintained its efforts to fulfil the long-term plan commitments of the NHS while simultaneously prioritising local needs to improve access to high-quality mental health services and provide effective support. This focus includes:

- Enhancing the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies, ensuring reliable improvement and recovery while reducing waiting times to access support.
- Reducing waiting times for assessment and treatment for adults, children and young people.
- A system-wide approach to mental health crisis pathways to improve patient access, experience and support.
- Significantly reducing inappropriate out-of-area placements through revised care delivery models. Monthly placements have decreased from 27 in April 2024 to 10 in January 2025 (the most recent data available).

| Financial Years | 2023/24 | 2024/25 |
|---|---|---|
| Mental Health Spend | 183,288 | 196,742 |
| ICB Programme Allocation | 1,981,078 | 2,397,114 |
| Mental Health Spend as a proportion of ICB Programme Allocation | 9.25% | 8.21% |

## Children and Young People (CYP) and Adults safeguarding

The safeguarding of children, young people and adults at risk remains a core priority for the ICB alongside our statutory partners Cambridgeshire Constabulary, Cambridge County Council and Peterborough City Council. The ICS continues to evolve and adapt safeguarding practices to meet the needs of the local population to protect those accessing our services from abuse and harm. It requires effective joint working with partner agencies, professionals and voluntary groups so that vulnerable individuals and groups in the community are protected from harm.

There have been several changes and restructures within some of our key statutory partner agencies including separation by the local authorities of some of their shared services. Resulting in the changes at the local safeguarding partnership boards.

The ICB has an executive group overseeing the Cambridgeshire Adults and Children's Partnership Board and the Peterborough Adults and Children Partnership Board, with representation from the ICB Chief Executive Officer and Chief Nursing Officer. Board meetings for Cambridgeshire and Peterborough are held separately with shared sub-groups focusing on the strategic priorities of the boards.

The multiagency safeguarding arrangements have been agreed and can be found at Safeguarding Arrangements Document (updated 2024) | Cambridgeshire and Peterborough Safeguarding Partnership Board . The Safeguarding Partnership Board's annual reports can be accessed at Annual Reports | Cambridgeshire and Peterborough Safeguarding Partnership Board , and these outline the achievements made over the previous reporting year. An independent chair and independent scrutineer have been appointed for the boards to provide effective support and challenge with the aim of driving continuous improvement in partnership practice and implementation of the multi-agency safeguarding arrangements.

Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence Partnership (DASV) is in the process of restructuring and alignment to local authorities' boundaries. The strategic priorities and annual reports can be accessed at Cambridgeshire County Council DASV Partnership - Strategic Documents The ICB is also a key member of the County Wide High Harms Board, which coordinates and delivers statutory duties and agreed specific priority issues such as drugs, serious violence, violence against women and girls, and serious and organised crime. Its annual report can be found on its Annual Reports webpage.

The ICB is represented at all levels of the partnership boards. It is a testimony to the high regard that agencies have for safeguarding that they have continued to prioritise the protection of children, young people and adults in our area, in the midst of these changes.

Our safeguarding work is guided by a robust governance framework with safeguarding activity reported via the ICB Quality, Performance and Finance Committee and is underpinned by statutory legislation and guidance: Children Act 2004, Children and Social Work Act 2017, Working Together to Safeguard Children (2023), Mental Capacity Act 2005, Care Act 2014, Domestic Abuse Act 2021, Serious Violence Duty 2021 and the Prevent Duty 2023.

The Safeguarding Accountability and Assurance Framework (SAAF) 2024 identifies core duties for individuals working in providers of NHS-funded care settings and NHS commissioning organisations which the ICB is compliant with. The ICB has contractual arrangements via schedule 32 of the NHS Standard Contract and assurance processes for safeguarding with all its providers, and the executive board ensure the discharge and compliance of statutory functions. In 2024/25, the use of NHS England Safeguarding Integrated Data Dashboard (SIDD), Safeguarding Case Review Tracker (SCRT) and Safeguarding Clinical Assurance Tool (S-CAT) have been embedded. The ICB safeguarding team have attended regional and national NHS England meetings and forums, disseminated learning and considered the implications of findings for the ICS.

Ensuring that staff members are equipped with the necessary skills and knowledge to identify and respond to safeguarding concerns is critical. Over the past year, the safeguarding team has updated the Prevent, MCA and domestic abuse policies and supported the development of the ICB sexual misconduct policy in line with NHS Sexual Safety Charter. We have delivered safeguarding training programmes ranging from basic awareness, for example Serious Violence, to advanced multi-agency training including hosting a child death conference supported by external guest speakers, and commissioning safeguarding supervision training for Named Nurses/ Professionals across the Integrated Care System. ICB Board safeguarding training has also been achieved. Additionally, we have supported primary care training and development via safeguarding webinars and Safeguarding Matters events covering topics including domestic abuse, bruising in babies, and serious violence, and via a quarterly newsletter. A review of the ICB safeguarding training strategy has commenced in preparation for next year.

The Safeguarding Supervision for Continuing Health Care (CHC) Team is integral and has strengthened awareness of potential organisational safeguarding in care providers. Alongside this, supervision is offered to all Named Nurses and necessary staff, with a quarterly health safeguarding group in place to provide the opportunity to share experiences and learning

The Mental Capacity Act health leads group and the Prevent health leads steering group were established in 2024 and continue to meet quarterly. Both groups receive direction from local and regional meetings and feed into Safeguarding Partnership Boards to ensure legislation, guidance and best practice remains current and that training needs can be reviewed and delivered.

Our Safeguarding People Team has continued to take part in various reviews and panels for various age groups, such as Child Safeguarding Practice Reviews, Safeguarding Adult reviews, Child Death Overview Panel, Learning from lives and deaths - people with a learning disability and autistic people (LeDeR) functions and domestic abuse related death reviews. They have also supported on the devolved NHS England role for reviewing domestic abuse related deaths for Home Office quality assurance panels.

These reviews help us to understand the circumstances of safeguarding concerns, areas for development and to ensure that lessons are learned across the system. This has included a review of the processes for conducting reviews by the Safeguarding Partnership Boards, implementation of a neglect strategy and development of a Lived Experience of the Child Guidance. The Designated Doctor for Safeguarding Children leads on the Child Sexual Abuse sub-group of the safeguarding partnership board and is assessing the impact of the sexual abuse strategy and ensuring this is aligned to learning from the National Safeguarding Practice Review Report on sexual abuse within the family environment.

A review of the ICS' multi-agency safeguarding hubs (MASH) health function and child protection medical service has been completed and service specifications reviewed in line with national guidance to ensure that commissioning arrangements meet the needs of children who are at risk of child abuse.

The Designated Doctor for Safeguarding Children and Child Deaths, alongside the Child Death Overview Panel (CDOP) manager have ensured the ICB meets its statutory responsibility to review all deaths of a child under 18 years. An increase in child deaths has been identified again this year in comparison to the previous year, with 60 deaths from April 2024 – March 2025, and 57 deaths from April 2023 – March 2024. In response to this, the frequency of child death overview panels has increased, and there is no evidence of a theme resulting in the increase in deaths being reported.

All CDOP processes have been reviewed this year to align Working Together 2023 and National Child Mortality Database (NCMD) guidance. The ICB CDOP team has completed 21 child death review meetings for all extreme premature babies who do not meet the criteria for a perinatal mortality review. It also supported child death review meetings where children had died in a hospice or community setting and this will be reviewed next year to align these with providers.

The Designated Doctor for Child Death was a key member of the Child Deaths Due to Asthma or Anaphylaxis report, produced by the National Child Mortality Database.

The Designated Nurse and Designated Doctor for Children in Care and Care Leavers provide a strategic overview of all health-related issues for this group of children and young people. During 2024, a review of service specifications has been conducted to support service delivery models and performance. The Health of Children in Care Partnership meeting is a professional group with representatives from health and care services, and the local authority, and was formed to support the health of children in care and care leavers. It is chaired by the Designated Nurse for Children in Care, meets bi-monthly and enables collaboration of pathways and valuable pieces of work including co-produced guidance to improve the timeliness of notifications to health when a child becomes looked after.

Looking ahead, the safeguarding team will be supporting the implementation of the Child Protection Information System (CPIS) in line with the national roll out of phase 2 and working alongside our statutory partners to implement the Families First Partnership Programme and Victim and Prisoners Act 2024.

## Research

The ICB hosted Research Office provides specialist research and development (R&D) support for the National Institute for Health and Care Research (NIHR) (including commercial) in primary care and wider community settings. It also hosts a portfolio of NIHR studies relevant to primary, community and social care and population health, promoting high-quality research and the use of research evidence in support of local system needs, including increased research access and inclusion for underserved groups. This is in line with the ICS Research and Innovation Strategy aims.

In 2024-25, we deployed over £460,000 in Research Capability Funding (RCF) to build strategic research capacity and capability in out-of-hospital settings. For the first time, this included awards to local researchers to scope and co-develop novel research applications aligned to system priorities, such as addressing specific health inequalities; improving end-of-life care; and supporting workforce resilience. Oversight of funding decisions has been strengthened by creation of a new Research Panel with membership from multiple ICB directorates, including Medical, Nursing, Finance and the Strategic Commissioning Unit.

New opportunities for effective knowledge mobilisation and shorter pathways from research to system impact are in development through partnering with the Anglia Ruskin University's Health & Care Research Centre and new Primary Care Research Centre, alongside our long-standing relationship with the University of Cambridge Department of Public Health and Primary Care.

We secured £85,000 from the Department for Health and Social Care (DHSC) and NHS England Research Engagement Network (REN) programme to support work with Voluntary Community and Social Enterprise (VCSE) and wider system partners to provide:

- Ongoing support for the Peterborough Community Research Champions
- Research engagement at regular Healthwatch Cambridgeshire and Peterborough cross-region Health and Care Forum public meetings
- East of England Research Inclusion Summit
- System-level Research Inclusion Group to co-ordinate outreach opportunities and share resources and expertise
- Suite of new guidance for Research Ethics Committees on working productively with inclusion health groups

As the NIHR Research Delivery Network (RDN) transformation process proceeds, Research Office staff continue to play a significant role in informing and influencing developments, especially for research taking place closer to where our populations live and work. The Associate Director for Research and Impact is now a trustee of the national R&D Forum and co-chair of their ICB working group. Staff have also participated in an NHS England working group developing new guidance on ICB research metrics and reporting, as well as a DHSC roundtable and consultations on primary care research.

## Environmental matters

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

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

TCFD recommended disclosures, as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025-26 financial year.

For 2024/25, the phased approach incorporates the disclosure requirements of the following 'pillars': governance, risk management, and metrics and targets. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in this report and in other external publications.

## Governance

A Programme Board was set up to oversee delivery and meets quarterly, focusing on measuring implementation, identifying blockers to progress and opportunities to drive forward delivery A specialist transport sub-group was established, alongside existing groups (estates and pharmacy) to take on the responsibility of delivery against our targets. The ICS Green Plan is currently being refreshed as it has come to the end of its cycle. Progress this year includes:

- Board and Executive training: Net Zero Leadership training was held in May with a follow up session in the New Year.
- Combined Impact Assessment: the new system launched in October and now incorporates Environmental Impact Assessment with guidance and advice.
- Work to include a 'Green thread' in all strategies and policies continues and is evident in our Outcomes Framework and the system Joint Strategic Needs Assessment (JSNA) compiled by the local authority. We are now working to deliver the JSNA climate change recommendations.
- We contributed to a series of local authority led workshops to look locally determined contributions to net zero emissions.
- We compiled evidence to support the Well Led element of potential Care Quality Commission's (CQC) inspection
- Next year, we plan to incorporate discussions on achievement against Green Plan targets in quarterly Trust contract meetings in line with s18 requirements and as part of our Contract Meetings and System Assurance Framework (SAF) Oversight Process
- We are also working to fully integrate sustainable healthcare into our health utilisation approach supported by bids for a Sustainability Clinical Fellow and a two-year research bid in partnership with Anglia Ruskin University in addition.

## Risk management

- Adaptation to Climate Change is included in Directorate and Corporate risk registers
- Work is ongoing to get this risk included in the Board Assurance Framework
- We continue to work on adaptation to climate change and held a system workshop in October in partnership with the East of England Ambulance Service NHS Trust (EEAST) and

the NHS England Regional Office, engaging a range of front-line delivery and planning staff. Trusts are working on their individual plans.

## Metrics and targets

- Progress across the ICS is outlined below, broken down by work area.

## Workforce and leadership

- ICB Board and Executive Staff received sustainability training this year. All new staff are also provided sustainability training on induction, and management training also now includes a sustainability module.
- Training has also been offered across the ICB and Trusts throughout the year for staff at all levels. Most of the trusts now operate Champions or similar support networks that volunteer to engage with staff. Some Trusts run reward schemes and competitive programmes.
- A national programme of bespoke General Practice training was offered across the system and four practices have engaged.
- Work continues to weave climate change and sustainability considerations into all our processes and strategies. The New Model of Care will provide a significant opportunity to change the way we deliver services in a more sustainable and resilient way, while delivering better health outcomes.
- At the second two-day Health and Care Careers Expo in Peterborough, we talked to students about sustainable health and care and discussed insights and ideas on the next Green Plan.

## Travel and transport

- Many Trusts have already embarked on developing their Sustainable Travel Strategy and there are a range of growing initiatives to encourage behaviour change, moving both patient and workforce to more active travel choices and use of public transport. Success varies depending on Trust, given different geographies and opportunities. A staff survey was carried out to learn more about staff's travel, which will feed into the ICB's Sustainable Travel strategy
- Work has started on community transport to health and care settings and looking at gaps in provision.
- ICS partnership work (working across Trusts and local authority and transport provider bodies) is ongoing to tackle the challenges of introducing charging infrastructure for electric vehicles (EVs).

## Estates

- Most of our Trusts have been successful with bids for national finance schemes, with over

£80,0000 awarded to support actions with reducing energy usage and moving to renewable sources of energy.

- As an ICS, we continue to explore how we can look to benefit from local heat networks, heat network zoning and equipping our estate to maximise potential for production of our own renewable energy through tech such as solar. This has been supported by the East of England Renewable Energy Study.
- We are also focused on looking at the potential for improved performance and reduced energy usage and reliance on fossil fuels, through the New Hospital Programme and a range of building improvements and energy saving measures, from the primary care estate to hospital sites.

## Research and Innovation

- We continue to support our local research bodies and have supported several research funding bids, including bids by Cambridge University and Anglia Ruskin University.
- As an ICB, we have started supporting the Research Panel in considering application for research and assist in providing guidance to all applicants on links to climate change/net zero and health outcomes and promoting applications in this space.
- We continue to support Cranfield University student research theses, on topics suggested by us as an ICB.

## Procurement

- We are looking at the implementation of the NHS Supplier Roadmap and the new social value requirements in all NHS tenders and the monitoring of contracts thereafter. The quality of responses by suppliers to the mandatory climate change question in tenders is improving, as is our ability to shape better and more focused questions.

## Waste

- The focus this year has been a campaign to reduce the use of single use gloves to only where clinically necessary and appropriate. This has meant pulling back from practices developed during Covid and reverting to more robust methods around good hand hygiene. At regional level we have engaged, and the ICS has taken a lead, while working with our Infection Prevention and Control Team. Progress and initiatives are growing across Trusts, care homes and primary care. As a result, we are reducing waste, saving costs, improving techniques such as better hand hygiene (washing hands), while improving patient care and staff's hand health.
- Many of the Trusts have made the switch away for some other single use items and continue to explore more sustainable solution for consumables.
- We held a system workshop on waste in March attended by all our Trusts and which covered various topics including waste reduction and disposal, contracts management. Information sharing, expertise, latest advice and tools techniques and innovation.

## Sustainable care pathways and digital

- With the appointment of a second Sustainability Clinical Fellow, we have continued to build

on the start already made on sustainable surgery with several projects at trust level ongoing.
- Our Clinical Fellow is also working on the redesign of the dermatology pathway, looking at opportunities to embed sustainability into the new process.

## Medicines

- With use of Desflurane, an anaesthetic gas cut to almost zero in the system, and it only being used in very rare clinically critical occasions, we are now focussing on reducing waste of Nitrous Oxide.
- We embarked upon a programme supporting targeted GP practices, those that were known to face a particular challenge, to review asthma patients, improve technique  such as showing patients and staff how best to use inhalers, and where appropriate move to greener inhalers.
- We are developing a project with Primary Care and Medicines Optimisation teams looking to reduce medicines wastage based on the very successful model rolled out in Dorset.

## Improve quality

A key requirement of the ICB's role in quality assurance and oversight is to ensure that fundamental standards of safe care are consistently delivered, and that services are continually improved. Throughout the year, there has been increased collaboration across the ICS. A focal point this year, and into the upcoming year, is the further development of the system-wide Improving Quality Strategy. This strategy is aligned with the National Quality Board's Shared Commitment and Position Statement for ICSs.

During 2024/25, we refreshed and expanded the membership of the System Quality Group to better reflect the diverse stakeholders and expertise needed to drive quality improvements across the system. The group met on a regular basis and as part of the assurance meeting, the system agrees a grading for individual providers based on their assessment of risk. This grading enables the ICB to prioritise provider support.

While this strategy provides a coordinated approach, it does not replace the need for individual organisations within the ICS to have their own strategies, monitoring, and benchmarking processes. Instead, it emphasises the importance of quality within our wider system working and aims to maximize opportunities for collaborative improvement efforts.

A notable achievement has been the application of the Quality Assurance Framework for General Practice, in collaboration with the Primary Care Directorate. The General Practice dashboard was updated to incorporate a wider range of quality metrics and clinical outcomes, which has helped identify vulnerable practices and directed assurance visits. The team has also supported extensive training and shadowing opportunities, enabling effective oversight and the identification of themes for quality improvement.

The ICB's quality team has broadened its portfolio to include independent sector providers. In addition to previous performance metrics, all providers are now required to meet local quality standards, thus enhancing the ICB's awareness of service quality and patient experiences across the sector. The ICB continued to oversee quality assurance by reviewing all the quality evidence. The quality evidence from provider reports received was reviewed, and areas of clarification or concern were raised with the individual providers whilst ensuring that the ICB team offered and gave support as needed.

All this intelligence feeds into the Internal ICB Quality Assurance Group. This group has representatives from all ICB directorates, which enabled the sharing of quality issues being discussed across all areas of the ICB. attend monthly quality and patient safety meetings with the main large providers. This enables providers to highlight positive initiatives and outcomes as well as identifying areas of concern and focus. We offered support to all providers as needed specifically by them, with the outcomes at these meetings informing the discussions held at the provider assurance meetings.

We continue to collaborate with providers through quality visits, either ICB-led or provider-led, to gain assurance regarding the quality of services and patient experiences.

Implementation of the national Patient Safety Strategy continued during 2024/25. Following the transition of larger acute and community providers to the Patient Safety Incident Response Framework (PSIRF) in January 2024, the ICB quality team has collaboratively monitored providers' PSIRF plans and quality improvement programmes. Throughout the year, we have supported smaller independent providers with the development of their PSIRF policies and plans, with some successfully implementing and transitioning to PSIRF.

We facilitate a successful ICS-wide community of practice, bringing together larger providers to share their experiences with incidents under the new framework and to discuss how they are using these processes to improve patient safety.

National training for Levels 3 and 4 was funded by NHS England and delivered by Loughborough University. Two members of the ICB staff completed the training and graduated alongside colleagues from all the main trusts. Information is awaited from NHS England regarding whether a second course will be funded and delivered in 2025/26. Several smaller providers within Cambridgeshire and Peterborough have registered their interest should the course become available once again

We have continued to promote and recruit Patient Safety Partners (PSPs), with four in post as of March 2025. All main Trusts have recruited PSPs and are now focused on developing and embedding these roles. During 2025/26, we will continue our recruitment efforts to support smaller independent providers.

In 2024/25, a system-wide Community of Practice was established, bringing together representatives from across the system. The agenda is shaped by PSPs' requests to support their development and learning, and this approach will continue in 2025/26. Additionally, PSPs across the system have participated in regional workshops.

A key development for 2024/25 is ensuring the ICB Quality Impact Assessment (QIA) becomes embedded and integral to the contracting and performance systems and processes. Aligned with the National Quality Board's shared view of quality, this tool has been incorporated into procurements and mobilisations, providing essential scrutiny and assurance that newly commissioned services are of the highest quality. This ensures that the patient remains at the centre of all improvement initiatives.

Maternity has continued to have a high level of focus. During 2024, NHS North West Anglia Foundation Trust's (NWAFT) Maternity Improvement Board was finalised and stepped down due to the successful completion of their action plan.

NHS Cambridge University Hospitals NHS Foundation Trust's (CUH) Maternity Improvement Board continues and we, along with regional colleagues, were members of the Board, continuing to have a significant role in the oversight and assurance of the improvements being introduced.

Both Trusts completed the 10 Steps to Safety self-declaration form and action plan as required, which were signed off by the ICB's Accountable Officer in March 2025. Both Trusts have declared compliance with all 10 safety actions, and action plans are in place to address further required improvements, which are currently being implemented.

Cambridgeshire & Peterborough Local Maternity and Neonatal System (LMNS) continued to collaboratively work together in line with the three-year strategy approved in 2024. Both Trusts have developed their own strategies that align with the LMNS strategy and have been signed off by each of their Boards.

## System leadership and CQC readiness

As a key partner, the ICB has driven a system-wide culture of continuous improvement and inspection preparedness. This year's achievements include:

## Strategic quality leadership

- Chairing our High-Impact System CQC Steering Group (meeting monthly with high attendance from provider partners) to coordinate compliance strategies and share intelligence.
- Playing an integral role in Cambridgeshire's and Peterborough's local authorities' CQC inspections, providing expert health perspective.
- Representing the system at East of England Regional CQC forums to align priorities and escalate cross-sector challenges.

## Operational support framework

- Co-designed and deployed our 'Inspection Ready' toolkit, adopted by all acute and mental health providers, featuring:
    - Dynamic self-assessment templates
    - Mock inspection scenarios
    - Education and training tools

- A mapping tool that links the quality statements with the regulations that underpin the evidence required

## Partnership Model

Delivered joint CQC preparation workshops with system partners, focusing on:

- Education and training
- Capturing the evidence
- Self-assessment and quality improvement
- System support and continuous learning
- Maintained monthly quality briefings with CQC regional teams to anticipate regulatory changes

Our proactive approach has strengthened system-wide governance, with 100% of provider partners reporting improved readiness in this year's maturity assessment. The ICB remains committed to sustaining this collaborative model as we enter the 2025/26 inspection cycle.

## Infection protection and control

The ICB's Infection Prevention and Control Team continues to work collaboratively with providers across the system to promote high standards of infection prevention and control (IPC). All provider organisations have participated in the quarterly healthcare associated infection assurance meetings which align with the PSIRF model, giving an overview of cases, actions and prevention strategies for healthcare associated infections (HCAI). Hand hygiene, IPC audit results and environmental cleanliness are included in monthly reports and at quarterly infection prevention and control committee meetings, along with review of the Board Assurance Framework and annual work plans.

The Infection Prevention and Control Board meets quarterly and receives reports and escalations from the IPC System-wide collaborative Group. The Infection Prevention and Control Board membership includes System Directors from NHS health and local authority social care sectors and is chaired by the Chief Nurse of the ICB.

The system-wide collaborative is a subgroup of the Board and is chaired by the ICB Deputy Director of Infection Prevention and Control with membership from the system infection prevention and control leads including team members and the ICB lead antimicrobial stewardship pharmacist. The group provides system awareness of new and emerging threats, provides a networking and discussion forum, offers peer review and supports a level of standardising practice across sites.

Task and finish groups have been convened as appropriate throughout 2024/25 to work on specific projects including the Clostridioides difficile *(*C.diff) collaborative and quality improvement initiative. A second C.diff awareness week was organised and coordinated across the system and included all providers who offer a variety of opportunities for staff engagement. Following a national incident declaration for C.diff, a quality improvement initiative was undertaken, leading to the development of a C.diff tool kit where providers contributed useful tools for the management of this infection. The tool was shared with all organisations, who signed a commitment to support the initiative, and this has been implemented in January 2025.

Feedback from all providers on actions and outcomes will be reported quarterly throughout 2025-26.

Following the successful development of the It All Counts hydration campaign, materials and resources continue to be used across the system. A small number of care homes have received education and training from the ICB and local authority IPC nurses, to support the continued development of the campaign in 2024/25. Plans include rolling the campaign out to more care homes and sessions on the initiative included in the new care home link worker program.

The ICB and ICS continue to work collaboratively with the NHSE infection IPC regional lead. Monthly meetings are held between all ICBs in the region, chaired by NHSE, to provider updates on HCAI and other relevant IPC issues such as outbreaks and incidents. This meeting provides an opportunity for escalation, peer support and networking. In addition, regional study days have been attended to address specific actions such as rising healthcare associated infections, c. diff and antimicrobial stewardship.

Antimicrobial stewardship remains an important part of the ICB IPC work program, and the IPC Team works collaboratively with the Antimicrobial Lead to support the system.

Collaborative working with the local authorities of Peterborough City Council and Cambridgeshire County Council continues and the ICB hosts the local authority IPC nurse. Clinical supervision and support is provided by the IPC team as required. The local authority post includes building relationships with providers of residential care, mental health and learning disability services/supported living, day centers and domiciliary care and IPC visits to providers and providing specialist advice.
While the IPC electronic audit system previously funded by the ICB ended in March 2024, several practices have continued to self-fund and use the system and the ICB IPC team remain as a contact and support for those using the system.

Environmental and general premises issues are supported through working directly with the Primary Care and Estates Teams to ensure buildings are fit for purpose and refurbishments/new buildings meet the current national standards.

Two training study days for Practice Nurses were carried out in January and March 2025. They were very well attended and provided positive feedback. Awareness around the importance of mask fit testing and a number of other subjects were discussed.

Over the winter season, there has been an increase in outbreaks leading to bed closures which have impacted patient flow. Mitigating actions by IPC teams has expedited reopening as quickly as possible but a lack of side room capacity in some provider organisations has meant this was challenging.

## Engaging People and Communities

Our area is home to a vibrant and diverse population of over one million people. At the heart of everything we do is a simple but powerful belief: when we listen to our local people and communities, we make better decisions - decisions that improve lives and help create healthier futures for everyone.

Over the past year, we've deepened our commitment to meaningful engagement with local people and communities, ensuring their voices directly inform the way healthcare services are shaped and delivered. From exploring how digital technology could improve access to care, to understanding people's experiences of local GP services, our approach has been rooted in openness, curiosity, and collaboration.

We've also equipped local people with the information and support they need to make positive changes for their health and wellbeing via targeted communications and marketing campaigns, from helping people get the right support for their needs during another very busy winter season to encouraging individuals at higher risk of cardiovascular disease to take part in the innovative Your Healthier Future programme.

Our Let's Talk engagement campaign continued this year, with a focus on digital technology in healthcare. The ICB want to better support local people by giving them greater digital or online access to healthcare information, options and services (where they wish to use it).
To do this, we asked local people to help us understand what works well for them and what would improve their experience. We heard from over 1,300 people via our survey, held ten focus groups from July to October 2024 to dig further into the feedback we had heard, and ran focused stakeholder engagement sessions to hear from NHS staff and partners.

The feedback we received told us that people want the ability to book appointment, order medication and see results online, all in one place. They don't want to log into a number of different systems to access information about their healthcare, they want systems to be integrated, secure and easy to use. For younger people in particular, they also want access to healthcare at a time that suits them.

This better understanding of the needs of our local people, and our stakeholders, will help to shape how we improve digital access to healthcare in future.

On a more local basis, we have undertaken focused engagement work with communities about the General Practice services they receive in their local area. In Sutton, we worked with Priors Field PPG to secure a long-term provider of GP services for their local community in a building that is now owned by the NHS; at Maple Surgery in Bar Hill we spoke to over 100 people about their experiences of healthcare services and their concerns about access to services with a large community being built close by; and in East Barnwell we engaged local people in the procurement of provider of General Practice services at their local surgery. We have also worked with wheelchair service users to hear their views of the current service.

Local Integrated Neighbourhood Teams have also continued to develop their relationships with their communities, gathering insights, sharing information and running targeted events and clinics to meet specific local needs. This has included localised cervical screening campaigns to increase uptake, and 'Stronger for Longer' events to help people at risk of frailty, working with local PCNs. These relationships are of increasing importance in moving care closer to people's homes and to support vital prevention work.

Of course, local healthcare sits in the context of national guidance, which is why we were keen to support the national NHS Change engagement campaign, designed to gather feedback and shape the new NHS ten-year plan. Alongside promotion of the online platform to encourage local input and leading the recruitment of local NHS workers to a staff deliberative event held

in Peterborough, we wanted to ensure that we heard from a range of voices in our community. We asked Healthwatch Cambridgeshire and Peterborough to run two workshops for us – one with the South Asian Community and another with young people, as well as running our own staff workshop and one for communications professionals across our area. We shared the insights with the national team, and added the feedback to our new Insights Bank to ensure all system partners can access this important information.

Beyond our focused engagement campaigns, our Health Alliance has evolved and developed into the Voluntary Sector Network, with a clear structure and strategic steering board, to support further amplification of community voices within the ICS. A three-year action plan to continue delivering the ICS VCSE Strategy was approved in January 2025 and aligns closely with the ambitions of the People and Communities Engagement Strategy. As part of this work, we have established voluntary and community sector representation across ICB Board, subcommittees, Place and Accountable Business Units, supporting further amplification of community voices in decision-making.

Our Careers Expo has continued to grow. Now in its second year, around 2,500 students attended the event over the course of two days to learn more about the wide range of careers available in the health and care sector. Opening up important conversations with our future workforce.

Underpinning all of this we have continued to grow our system-wide Participation and Involvement Group, which brings together 130 cross-sector involvement specialists to address shared challenges. We have worked in partnership with ICBs across the East of England to develop a Reward, Recognition and Support Framework to ensure greater consistency in supporting people with sharing their lived experience, which included The Patients Association sharing over 600 responses from a survey into people's experiences of involvement activities and how they would like to be supported in future to inform development of the framework. Looking ahead to the future, we have commissioned Healthwatch to establish an engagement forum to amplify local people's voices in ICB decision making. The forum will be flexible in nature to ensure relevant and diverse lived experiences are heard relating to the agenda. We will continue to have meaning conversations with local people and partners via Let's Talk to better understand their experiences, needs and challenges, keeping the voice of our communities at the heart of what we do.

The Cambridgeshire and Peterborough Joint Health and Wellbeing Integrated Care Strategy was launched in December 2022. As a joint strategy the Health and Wellbeing Board were coproducers of this strategy where four clear strategic objectives were set out. The monitoring of this strategy takes place at our Joint Health and Wellbeing and ICP Board. In support of this strategy the first Cambridgeshire and Peterborough Joint Forward Plan (JFP) led by the ICB was published on 20th June 2023, first refreshed in March 2024 and then reviewed in early 2025. We have worked with partners and determined that a light touch approach to refreshing the JFP was most appropriate, recognising the national backdrop to strategic and operational planning, including the anticipated publication of the 10-year Health Plan in 2025.

Given the current strategic and planning context for the ICB, there were therefore no material changes to the Joint Forward Plan for 2025-30, and no new priorities. Minor changes have been made to the document to acknowledge the current policy context, edit any out-of-date references and include some recent achievements via updated case studies and examples of

delivery. There were also no changes to our Health and Wellbeing Integrated Care Strategy 2022-2030 as the objectives are long term the Joint Cambridgeshire & Peterborough HWB ICP board received an update on progress for 2024-25 on the four priority areas at the June 2025 meeting.

Delivery, however, has continued during 2024/25, including the ICB Board approved the Strategic Commissioning Plan 2025-2028, which sets out priority programmes for delivery, informed by analysis of activity and demand. Work is ongoing with our partners to listen to feedback, learn from effective approaches and collaboratively develop our plans.
Taking a deeper dive into our system wide strategic objectives, we have seen great progress on the following:

- Priority 1 Innovative approaches to improving immunisations uptake in children has had a positive result.
- Priority 1 A focus on improving educational attendance which has included the establishment of a cross-system taskforce on Emotion-Based School Avoidance (EBSA)
- Priority 3a The Healthy Places JSNA was completed with recommendations around housing and work in Cambridgeshire on “Stay Well this Winter” aimed to minimise the risks associated with living in cold homes for our vulnerable groups.
- Priority 3b WorkWell programme launched to help people overcome health barriers to work, which hit 75% of its target in the first year and continues to grow.
- Priority 3b System-wide, multi-agency oversight group formed and working together to progress health and employment priority.
- Priority 2 Significant progress has been made in the identification and management of obesity and associated health conditions, including the launch of Your Healthier Future launched and implemented, which targets key clinical and behavioural risk factors for cardiovascular disease, which has delivered an increase in identified patients and treatments commenced. Workplace NHS Health Checks national pilot area resulted in over 14,000 self-service health kiosk checks in our area, which identified 67% of participants were overweight or obese.
- Priority 2 Over the last year we achieved the highest number of NHS Health Checks ever for our area.
- Priority 2 Behavioural Insight work surveyed over 1,000 residents in Cambridgeshire on their diet and physical activity behaviours. Full report and recommendations June2025
- Priority 2 Adult Behaviour Change Services recommissioned which includes weight management services and the introduction of “obesity drugs” in line with national guidance.
- Priority 2 Cambridgeshire County Council and Peterborough City Council introduced local policies to reduce obesity related advertising.
- Priority 2 School based innovation fund set up 84 separate physical activity and healthy eating initiatives including healthy eating workshops, active play, staff training, oral health, cooking classes and grow your own.
- Priority 4 Continuation of the “Keep your Head” website providing local information on accessing mental health services was refreshed and promoted alongside promotion of the “how you are” resources on community mental health support.

## Reducing health inequalities

Health inequalities are systematic, avoidable and unfair differences in health outcomes that exist between different groups or populations. These inequalities arise from the unequal distribution of social, environmental, and economic conditions within societies (poverty, education, housing, employment, and access to green spaces, clean air and transport). They can significantly impact an individual's overall health and wellbeing and disproportionately impact people from a range of demographic groups.

Healthcare inequalities relate to inequalities in the access people have to health services, in their experiences of using such services, and the outcomes they receive. Inequalities in health reflect the inequalities in society at large, with many of those most in need often facing the biggest barriers to accessing the necessary support.

We recognise that healthcare inequalities exist across the country, and within Cambridgeshire and Peterborough is no exception. The ICB is committed to reducing healthcare inequalities, paying particular attention to groups or sections of society where improvements in health and wellbeing are not keeping pace with the rest of the population.

Despite it seemingly being a healthy place to live, we know significant healthcare inequalities exist across Cambridgeshire and Peterborough. Life expectancy in Cambridgeshire is higher than in Peterborough for both males and females, although there is considerable variation across Cambridgeshire's districts, with life expectancy in Fenland very similar to that of Peterborough. Average healthy life expectancy rates at birth are higher in Cambridgeshire than the England average, but lower in Peterborough. However, these rates have declined in recent years, with declines being more pronounced in Peterborough for both males and females. Healthy life expectancy data at district-level is not available, but we would expect to see considerable variations within Cambridgeshire in the same way that is observed for standard life expectancy.

These trends follow the broader conclusions that both life expectancy and healthy life expectancy at birth are lowest for those people living in more deprived areas. Which means those living in the more deprived areas not only tend to die earlier but also spend a greater proportion of their lives in poor health. The difference is 7.5 years for men and 6.7 years for women. This means that although a large proportion of our population benefit from living healthy lives and experience better health outcomes when compared to the rest of the country, some of our residents are dying at an earlier age; the main causes being circulatory conditions, cancer, and respiratory disease.

There is also a life expectancy gap between individuals born in the most deprived communities compared to those born in the least deprived.

To help measure the whole system's success in keeping the population well and reducing illness, the ICS' Outcomes Framework has been developed. The framework has been developed based on the overarching aims of the Health & Wellbeing Integrated Care Strategy, supports the evolution and delivery of the ICB's Joint Forward Plan, and helps guide the development of place-based partnership delivery plans. One of the ambitions of the Outcomes Framework is to monitor several healthcare inequality metrics. These metrics will evolve to help identify disparities in health outcomes through the lenses of deprivation, ethnicity and other protected

characteristics. Alongside the Outcomes Framework, the ICB has also produced an health inequalities information statement data pack in response to NHS England's Information Statement (NHS England's statement on information on health inequalities). The health inequalities information statement data pack is also available on the ICB's website. **Health Inequalities Information Statement 24-24 CP**

## Health Inequality Focus

Our overarching ambition is to increase the number of years people live in good health and reduce premature mortality. To achieve this, there is a renewed focus on primary and secondary prevention, partnership working to address the root causes of health inequalities and promoting population health management approaches. Our objectives to tackle health inequalities, outlined in our Joint Forward Plan (Our Joint Forward Plan | CPICS Website), are to:

- Ensure reducing health inequalities is a priority for everyone and embedding a Core20PLUS approach. Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The Core20 element identifies the most deprived 20% of the population, plus additional groups experiencing poorer health outcomes, such as the Gypsy, Roma and Travellers (GRT), homeless and migrant populations.
- Be informed by our data and wider insights and be evidence-led in our approaches.
- Promote healthy lifestyles and behaviours and increase access to early intervention services.
- Improve access to healthcare services for vulnerable and marginalised populations.
- Improve the quality of care and patient experience across the ICS.
- Ensure resources are allocated based on need.
- Work closely with research and innovation functions to adopt and implement both clinical and non-clinical best practice to better support our underserved communities.
- Work with local people and communities to better understand the challenges they experience and co-produce solutions that best meet their needs.

To deliver these objectives, the ICB refreshed its governance through the establishment of a new Population Health Improvement (PHI) Board, which brings together the ICB's prevention, population health management and health inequalities programmes. To ensure the ICB discharges its duty to have regard to the need to reducing inequalities and to ensure effective co-ordination of the health inequalities agenda, a system-wide Health Inequalities Strategic Oversight Group (HISOG) was also established. The group, managed by a central team within the ICB's Strategic Commissioning Unit and co-chaired by both ICB and Public Health representatives, is responsible for co-ordinating and driving action across NHS providers on NHS England's strategic priorities for tackling health inequalities and embedding the Core20PLUS5 approaches.

In 2024, the PHI Board approved the recommendation from HISOG to align the Cambridgeshire and Peterborough healthcare inequalities programme to NHS England's strategic priorities and embed a Core20PLUS5 approach.

To deliver against these ambitions and to strengthen the governance of the healthcare inequalities programme, the ICB established an NHS Provider Health Inequalities sub-group and a Primary Care Network (PCN) Health Inequalities Leads network. These serve as collaborative forums; help identify opportunities for partnership working; and encourage the sharing of best practice across the ICS.

## Impact assessment process

In its NHSE-commissioned report on Reducing Health Inequalities through New Models of Care, the Institute of Health Equity recommended that Health Inequalities Impact Assessments (HIIAs) are undertaken as an integral part of policy development and decision making to reduce health inequalities.

In September 2024, the ICB introduced a new, consolidated two-stage impact assessment process, overseen by its Strategic Commissioning Unit. The updated process ensures compliance with the ICB's statutory duty under both the Health Care Act 2012 and the Public Sector Equality Duty to evaluate the impacts of its decisions, while embedding the need to assess the impact in relation to equality and health inequalities and those population groups most at risk of experiencing health inequalities.

Embedding a robust health inequality impact assessment process ensures all proposals that seeks ICB funding, decommissioning or transformation of services, are accompanied by a robust impact assessment. The process has been designed after months of collaboration with internal and external stakeholders to assure the safety, quality and fairness of the services the ICB commissions.

## Prevention

As outlined previously, CVD is one of the major contributors to the life expectancy difference between the most and least deprived areas within Cambridgeshire, contributing to almost 25 per cent of the gap in women (Office for Health Improvement and Disparities: Segment Tool).

The Your Healthier Future (YHF) programme, launched by the ICB in conjunction with Cambridgeshire and Peterborough public health teams, is a two-year programme which targets key clinical and behavioural risks associated with CVD. The programme risk stratifies people with a high or increasing risk of a major adverse cardiovascular event and enables GP practices to better support patients and reduce premature mortality.
The programme has a number of elements. Those which launched in 2024/25 are:

- Lipid detection and optimisation: to identify and treat at-risk patient groups with high cholesterol
- Hypertension detection and optimisation: to identify and optimise patients with known high blood pressure.

Early indications are that the YHF programme is having a positive impact upon Core20PLUS groups. For example, in terms of deprivation, once contact is made with an individual, those from the most deprived two deciles (Core20) are more likely to take up a lipid lowering therapy than those from other deciles. In terms of ethnic minority patient groups, mental health and learning disability groups, early results show the YHF programme is achieving proportionately

higher uptake rates for lipid lowering therapies, directly contributing to delivering better outcomes for Core20PLUS populations through preventative measures.

Across Cambridgeshire and Peterborough, the NHS Treating Tobacco Dependency programme, a cross-cutting priority of the Core20PLUS5 approach, has resulted in new smoke-free pathways being established in all acute and mental health inpatient hospitals and maternity units. Since commencement of the pathways in 2023, provider data up to the end of 2024/25 reported a total of 3,972 smokers having been identified and referred to in-house specialist stop smoking services; 1,901 people having initially set a quit date as a result of that referral; and 581 (45 per cent) having quit smoking as measured by the standard 28-day quit target.

In July 2024, additional funding was allocated to expand the treating tobacco dependency programme given the overwhelming evidence which demonstrates the positive impact it has on tackling health inequalities, preventing ill health, and the wider socio-economic benefits. The additional funding will support further development of the existing pathways whilst also helping to explore new opportunities to develop smoking cessation pathways in outpatient and emergency departments and strengthening the discharge pathways into community stop smoking services.

Additionally, the Access & Inequalities Vaccine Project seeks to improve uptake of childhood and respiratory immunisations in Cambridgeshire and Peterborough. Focusing specifically on Core20PLUS population groups, which have particularly low vaccine uptake, the project provides additional opportunities for these population groups to take up the offer of a vaccination. This includes supporting GP practices with low uptake rates and organising pop-up community clinics to target specific populations. The project commenced in July 2024 and a total of 4,099 additional vaccinations have been given in the last 37 weeks, across various sites and events. Sites have included GP practices situated in deprived areas, all three asylum seeker hotels within the ICS footprint, within the Gypsy, Roma and Traveller community, and across our university campuses. Originally funded for 12-months, the project will now continue until June 2026 because of the positive impact that the project is having on local people.

The High Intensity Use (HIU) programme has been designed to effectively identify and manage those who utilise or are at rising risk of utilising healthcare services more frequently to reduce demand and help increase capacity across the system.
High intensity use of services is linked to health inequalities, with those attending most frequently generally low in numbers, but their impact on the wider health system is significant. In Cambridgeshire and Peterborough approximately 110 individuals (0.01 per cent of the total population) attended Accident and Emergency (A&E) departments in the system 20 or more times in a 12-month period between March 2023 and February 2024. This resulted in 2,004 A&E attendances (1.3 per cent of the overall total).

Over the same period, patients attending A&E five or more times represented less than 0.5 per cent of the registered population in the area but accounted for more than 1 in 10 (11.8 per cent) of A&E attendances, with a total of 17,652 attendances.

Previous work carried out by the British Red Cross to explore high intensity use has generally shown those who attend A&E most frequently are people living in the most deprived communities; are more likely to be admitted to hospital than people who attend less frequently; have poorer physical and mental health; and experience poorer than average

health outcomes despite the high use of services. To help better meet the needs of such individuals, the ICB has established a two-tiered HIU programme as follows:

- Tier 1: A specialist service focusing on people who are already high users of urgent and emergency NHS services, particularly focusing on those who have attended A&E 10 or more times in the previous 12-months; and
- Tier 2: A targeted service focusing on those people identified by general practice and Integrated Neighbourhood Teams who are at increasing risk of utilising A&E services, and/or being admitted to a hospital bed in the future.

Both approaches centre on a model that offers a more proactive and personalised approach to addressing high or increasing use of services, working with partners to understand the gaps in service use, current gaps in care and support, and explore opportunities for care and support to be better coordinated through pathway transformation and personalised care approaches. The model acknowledges that no single organisation or system partner can do this alone.

The Tier 1 Service, which is being delivered in partnership with Cambridgeshire County Council, commenced in October 2024. The team is hosted within the Council's Communities Service Directorate and works across the ICS footprint with a lead aligned to both North and South Place. The service has been initially funded for 18-months with the specific aim of reducing A&E attendances, non-elective hospital admissions, 999 and 111 calls, and ambulance conveyances within the selected cohort.

Despite only recently launching, the service is already having a profound impact on the lives of those who are being supported by the approach with key trends emerging:

- A&E attendances are reducing – individuals' reliance on emergency services as they build trust and resilience and are connected to community-based support.
- Mental health is a core issue – many referrals to the HIU service involve long-term mental health challenges compounded by addiction, social isolation, or trauma.
- Relational support is key – tailored, non-judgemental support helps individuals navigate complex systems without feeling stigmatised.
- Collaborative working – the HIU link workers break down silos between health, social care and community services
- Boundaries build trust – clear, consistent boundaries allow the team to deliver high levels of support while promoting independence.

The Tier 2 HIU service, which has been operational since November 2023, has resulted in the development of approximately 6,000 personalised care plans for those individuals identified as requiring proactive support to manage conditions and to reduce the reliance on urgent and emergency care. An analysis of the impacts the Tier 2 service is currently underway with the final report due to be available in September 2025.

## Inclusion health

Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple interacting risk factors for poor health, such as stigma, discrimination, poverty, violence, and complex trauma. People in inclusion health groups tend to have poor experiences of healthcare services because of barriers created by service design.

These negative experiences can lead to people in inclusion health groups avoiding future contact with NHS services and being least likely to receive healthcare despite have high needs. This can result in significantly poorer health outcomes and earlier death among people in inclusion health groups compared with the general population.

In November 2023, NHS England published a national inclusion health framework to help meet the healthcare needs of people in inclusion health groups. In 2024/25, Cambridgeshire & Peterborough ICB was successful in its application to be a part of the second wave of the national Inclusion Health Learning Programme in partnership with Pathway, Groundswell and NHS England. Seven systems were chosen from a total of 22 ICSs who applied. Six learning sessions took place throughout Q1 2024/25 with representation from across the ICS including the ICB, North/South Care Partnerships, local authorities, public health and the voluntary, community and social enterprise sector (VCSE).

In June 2024, building on the learning from the inclusion health learning programme, the ICB hosted an inclusion health knowledge sharing event for ICS partners to help develop a collective understanding of 'inclusion health' and the healthcare inequalities faced, to share the outcomes of the ICBs homeless health needs audit, as well as hearing directly from those with lived experience. The event showcased some of the projects and initiatives already in place which have been implemented to address healthcare inequalities amongst inclusion health groups such as the Wildflowers Project, the Cambridgeshire and Peterborough Changing Futures Programme, and the Peterborough Homeless Health Hub. A new inclusion health network has since been established to maintain momentum and to help facilitate connections across the system.

## Voluntary, Community and Social Enterprise sector (VCSE)

Significant progress has been made since the ICS VCSE Strategy launched in 2022. Highlights include development and expansion of the Voluntary Sector Network, including the establishment of a clear structure and strategic steering board; launch of the £2million Healthier Future's Fund and two rounds of the ICB/Assura Community Grants Programme; VCSE representation roles on all ICB committees and accountable business units; development of a VCSE data catalogue; approval of a research business case in partnership with Anglia Ruskin University to support the future sustainability and enhancement of our system-wide volunteering workforce; and ICB training and development offers made to the sector.

In March 2024, the ICB secured funding from NHS England to review the ICS VCSE Strategy and assess relationship maturity using the national VCSE Quality Development Tool. This involved facilitated workshops with diverse VCSE organisations and ICS partners to assess the six development areas and identify opportunities for future action. A broader consultation has since been launched to gather additional feedback. This included a survey, dedicated workshops, and discussions on the action plan at various forums, including North and South Place Partnership Boards, Health Inequalities Strategic Oversight Group, ICB Leadership and Culture Enabling Group, and the system Aligning Support to the VCSE steering group. The final action plan, aligned with the Strategy's four strategic goals, is currently going through the ICB governance for approval.

Our first Participation and Involvement Network Summit took place in September 2024, was attended by over 50 co-production experts from across the ICS. The purpose was to explore

how we further amplify and embed people's voices to lead change and inform decision making, so that co-production becomes common practice. The Network, established by the ICB in December 2023, has since expanded to include over 100 members from a diverse range of sectors and organisations, driven by collective challenges and a desire to collaborate.

## Health and wellbeing strategy

The ICB has been a key partner in the delivery of the four priorities of the Health and Wellbeing Integrated Care strategy. There are partnership actions plans with an identified system leader as Senior Responsible Officer (SRO) for each of the priorities.

### Priority 1: Children ready to enter and exit education, prepared for the next phase of their lives.

Implementation of the action plan across all deliverables is ongoing, with the involvement of District Councils, Primary Care, early years settings and schools. Over the last year partnership work has been focusing on increasing uptake of childhood immunisations and mental health support, including new commissioning to support emotionally based school avoidance.

ICB aligned delivery areas include:

- Integrated family approach across perinatal and early years,
- Emotional wellbeing and mental health; Special needs, disabilities and neurodiversity,
- Mental health transitions,
- Ensuring elective recovery for children and young people keeps pace with that of adults.

### Priority 2: Create an environment to give people the opportunities to be as healthy as they can be.

The Obesity Summit held in February 2024, explored the evidence and identified priorities for the next phase of strategy delivery with support from experts and system leaders. The primary care risk stratification model was launched in 2024, covering risk factors for cardiovascular disease and obesity. This will continue to be developed and expanded. ICB aligned delivery areas include:

- Identification of risk factors through primary care,
- Empowering people to manage and live well with their health conditions through personalised care and supported self-management,
- Regular medication reviews, social prescribing and shared decision-making,
- Identification and treatment of hypertension, high blood sugar and cholesterol,
- Waiting Well and other pre-operative programmes,
- Embedding the prevention offer in secondary care, stop before the operation, get fit before the operation, hospital smoking cessation support and onward referral to sustain quit, and
- Actions to deliver on environmental sustainability (including waste, travel and energy efficiency) are also critical for preventing ill health.

Supporting high risk groups is another key ICB intervention, including people with mental health problems, supporting pregnant smokers to quit and addressing inequalities.

Furthermore, the role of the ICB as an anchor institution and its wider influence within our system is aligned to this work.

Finally, actions to improve the management of long-term conditions including asthma, diabetes, epilepsy, mental health and oral health, in line with the Core20Plus5 priorities.

## Priority 3: Reduce poverty through better employment, skills, and better housing.

The ICB is a key partner in the Cambridgeshire and Peterborough Work, Health and Wellbeing Strategy Oversight group, which is well established and continues to grow. The group's work across the area has been identified nationally as an area of good practice. It supported our successful bid to be one of fifteen WorkWell national vanguard sites. This joint Department of Health and Social Care and Department for Work and Pensions initiative has brought funding into the system to establish an integrated service with a referral and pathway network that addresses the often-complex needs of people who have poor health or a disability, enabling them to secure and remain in work.

Other ICB aligned delivery areas include:

- The People Plan promise, workforce retention and training,
- Affordable housing for health workers,
- Integrated local approaches to provide person centred support.

## Priority 4: Promote early intervention and prevention measures to improve mental health and wellbeing.

As part of our ICS, there is a mental health oversight group that provides guidance on the development of the following three workstreams: motivation for mental health; information and communication; and relationships for mental wellbeing.

ICB aligned delivery areas include:

- Increasing access to Talking Therapies and community mental health services,
- Providing employment support to enable people with mental health conditions, learning disabilities and autism to return to the labour market,
- Improving dementia diagnosis and support,
- Development of the Learning Disabilities and Autism Partnership and implementation of its work programmes, with increasing focus on prevention and early intervention, particularly for children and young people.

## Financial review

NHS Cambridgeshire and Peterborough ICB was given a resource allocation for the year to 31 March 2025.

- Allocations have been set for ICBs and the system with a movement towards the national target allocation.
- The ICB had a requirement to achieve in year breakeven in 2024/25.
- A system covid testing allocation has been issued to fund related expenditure. This is at a much lower level than in previous years.

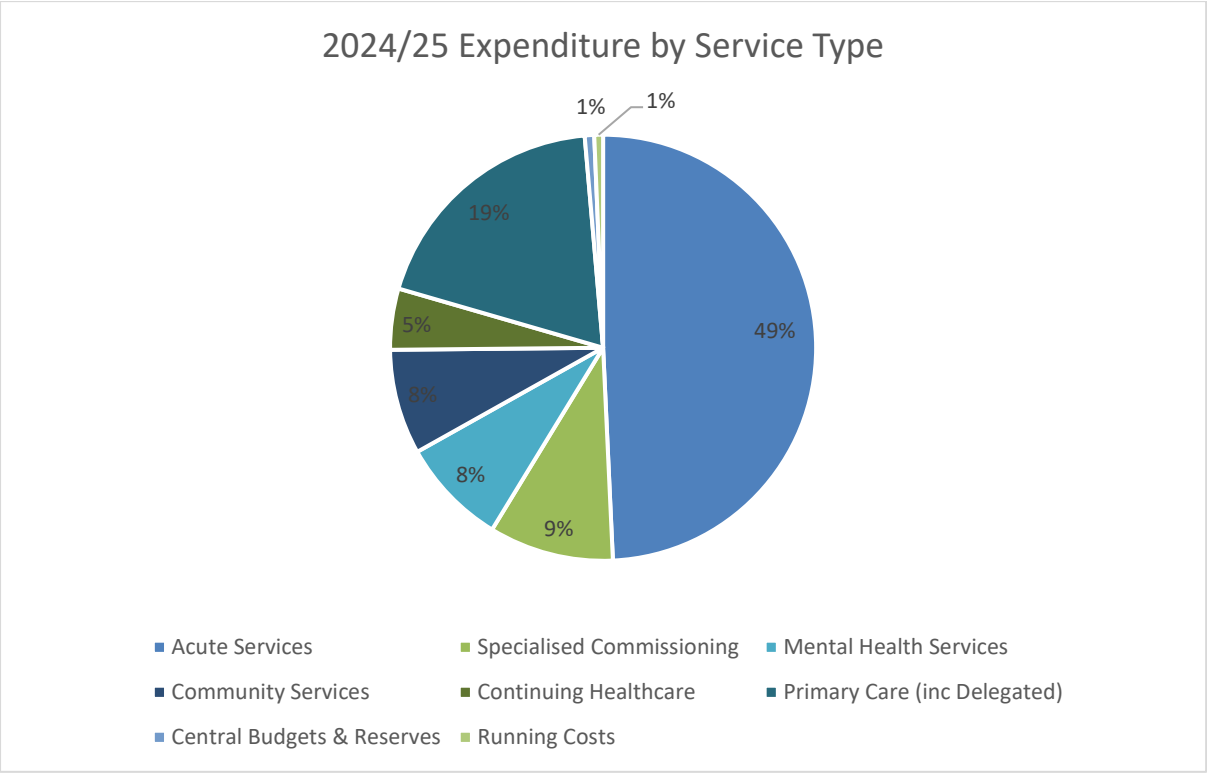
- Retrospective funding has also been issued by NHS England to fund the additional costs of Industrial Action, which were much lower than 2023/24.
- Elective recovery funding could also be earnt if activity exceeded target levels set by NHS England, up to a notified cap.
- The ICB took on the delegation of some Specialised Commissioning services contracts from NHS England in 2024/25.
- The ICB has achieved the breakeven requirement set by NHSE with a small surplus of £37k.
- As part of the national business rules, the net historical overspend for Cambridgeshire and Peterborough was written off, which meant the system could use all its funding to support the population, rather than repay historic debts.
- The ICB does not have its own capital resource limit to spend but is allocated primary care capital which is to be utilised for capital projects / schemes of an estates or IT nature. The expenditure does not impact on the ICB's accounts or reporting. The ICB publishes an annual joint capital resources uses plan which sets out the Integrated Care System plans for capital expenditure. The plan for 2024/25 can be found at joint-capital-resource-uses-plan-march-2024-published.docx

The table below shows the ICB financial position.

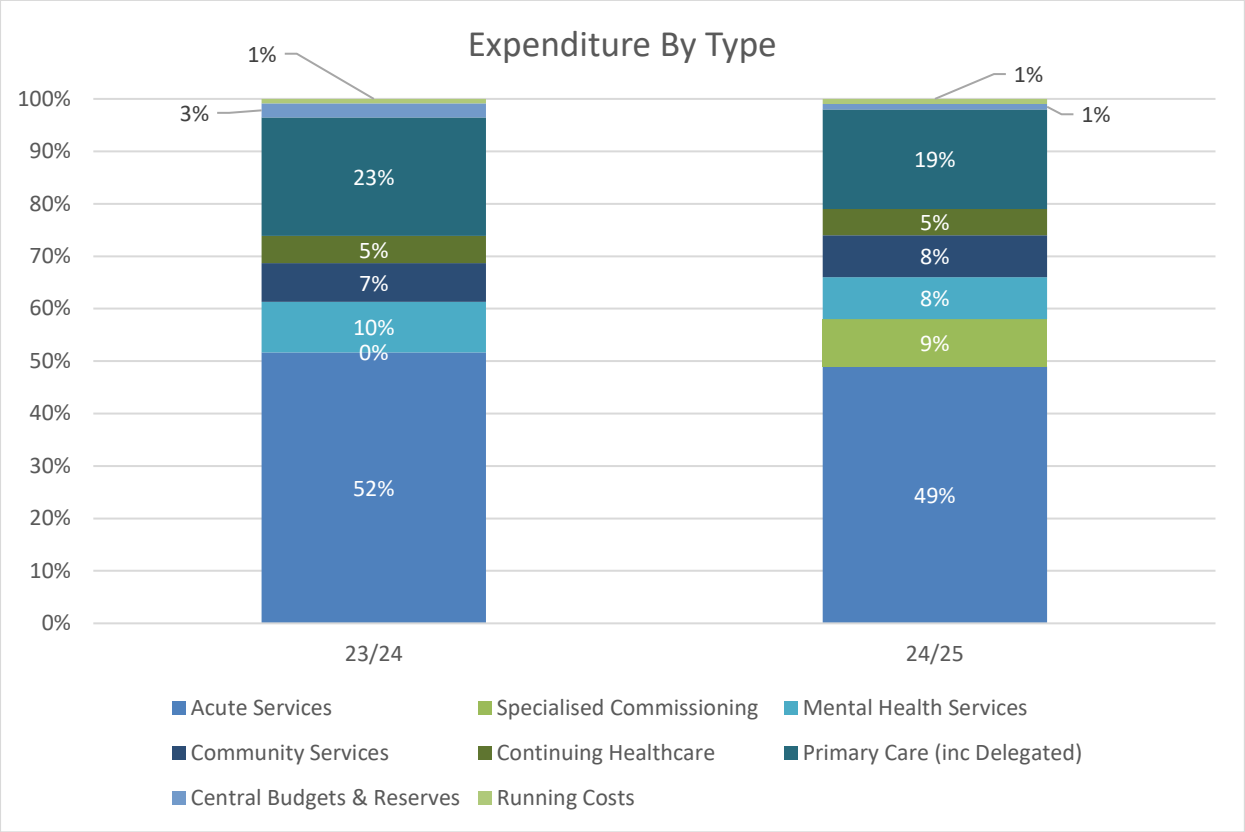
| ICB Financial Position | 2024/25 |
|---|---|
| | £'000 |
| **Total net operating costs** | 2,414,093 |
| **Revenue resource limit** | 2,414,130 |
| **Under/(over) spend** | **37** |

The ICB spent over 99% of its allocation on purchasing services for the population and less than 1% on administrative costs.

The Annual Report shows the in-year expenditure breakdown by service type for the ICB, the chart below shows the split for 2024/25.




The chart on the next page compares expenditure by service type from 2023/24 and 2024/25.



# Accountability Report

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

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April 2024 to 31 March 2025 including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

# Corporate Governance Report

# Directors' Report

# Composition of Board

John O'Brien was Chair throughout 2024/25.

The previous Board Member for Mental Health left in February 2024. Scott Haldane fulfilled the role from May to September 2024 and Steve Grange since January 2025.

Nicci Briggs the Chief Finance Officer left the ICB in February 2025. Jo Wright was acting CFO for February 2025, and Sarah Griffiths started in March 2025 as the substantive appointment.

Kate Vaughton joined the ICB as Interim Chief Officer Strategy and Partnerships in September 2024 and subsequently appointed as substantive Chief Partnerships and Integration Officer in January 2025

## Members of Board (Voting Members)

| | |
|---|---|
| John O'Brien | ICB Chair |
| Saqhib Ali | ICB Non-Executive Member |
| Carol Anderson | ICB Chief Nurse |
| Nicci Briggs | ICB Chief Finance Officer (to February 2025) |
| Ged Curran | ICB Non-Executive Member |
| Matt Gladstone | Partner Member – Local Authorities (Chief Executive – Peterborough City Council) |
| Steve Grange | Board Member – Mental Health (from January 2025) (Chief Executive – Cambridgeshire and Peterborough NHS Foundation Trust) |

| | |
|---|---|
| Dorothy Gregson | ICB Non-Executive Member |
| Sarah Griffiths | ICB Chief Finance Officer (from March 2025) |
| Scott Haldane | Board Member – Mental Health (from May 2024 to September 2024) (Interim Chief Executive – Cambridgeshire and Peterborough NHS Foundation Trust) |
| Dr Simon Hambling | Partner Member – Primary Medical Services |
| Dr Fiona Head | ICB Medical Director |
| Sarah Hughes | ICB Non-Executive Member |
| Eilish Midlane | Partner Member – NHS Trust and Foundation Trusts (Chief Executive Royal Papworth Hospital NHS Foundation Trust) |
| Stephen Moir | Partner Member – Local Authorities (Chief Executive –Cambridgeshire County Council) |
| Jan Thomas | ICB Chief Executive Officer (CEO) |
| Vacant | Board Member – Voluntary and Community Sector (from March 2025) |

## Regular Participants and Observers – Non-Voting)

| | |
|---|---|
| Jyoti Atri | Director of Public Health Cambridgeshire & Peterborough *(to May 2025)* |
| Dr Sally Cartwright | Director of Public Health Cambridgeshire *(from January 2025)* |
| Hannah Coffey | North Place Representative |
| Stacie Coburn | Chief Operating Officer |
| Stewart Francis | Healthwatch Representative *(to December 2024)* |
| Dr Gary Howsam | Chief Clinical Improvement Officer |
| Dr Diana Hunter | Cambridgeshire Local Medical Committee Representative |
| Claudia Iton | Chief People Officer |
| Jonathan Jelley | Healthwatch Representative *(from December 2024)* |
| Louis Kamfer | Deputy CEO / Managing Director Strategic Commissioning |
| Mike Robinson | Interim Director of Public Health Peterborough (*from June 2024)* |
| Roland Sinker | South Place Representative |
| Val Thomas | Acting Director of Public Health Cambridgeshire *(from May 2024 to Dec 2024)* |
| Kate Vaughton | ICB Chief Officer Partnerships and Integration *(January 2025)* |
| Emmeline Watkins | Acting Director of Public Health Peterborough *(May 2025 only)* |
| Matthew Winn | Children and Maternity Collaborative Representative |

## Committee(s) – Members

## Audit & Risk Committee

| | |
|---|---|
| Saqhib Ali | Chair – Non-Executive Member. |
| Sarah Hughes | Non-Executive Member |
| Eilish Midlane | Partner member - NHS Trusts/Foundation Trusts |

## Remuneration Committee

| | |
|---|---|
| Sarah Hughes | Chair - Non-Executive Member |
| Saqhib Ali | Non-executive Member |
| Eilish Midlane | Partner Member – NHS Trust and Foundation Trusts |

| | |
|---|---|
| John O'Brien | Chair of the Board |

## Quality, Performance and Finance Committee

| | |
|---|---|
| Dorothy Gregson | Chair – Non Executive Member |
| Ged Curran | Non-Executive Member (Vice-Chair) |
| Carol Anderson | Chief Nurse |
| Nicci Briggs | Chief Finance Officer *(to February 2025)* |
| Adam Cayley | NHS England & NHS Improvement Representative |
| Stacie Coburn | Chief Operating Officer |
| John Gregg | Local Authority Representative: Peterborough City Council |
| Sarah Griffiths | Chief Finance Officer *(from March 2025)* |
| Dr Fiona Head | Medical Director |
| Michael Hudson | Local Authority Representative: Cambridgeshire County Council *(from February 2025)* |
| Miriam Martin | Voluntary, Community & Social Enterprise organisations *(to May 2024)* |
| Eilish Midlane | Partner Member: NHS Trusts and Foundation Trusts |
| Lynda Phillips | Voluntary, Community & Social Enterprise organisations *(from June 2024)* |
| Jess Slater | Healthwatch Senior Representative *(from May 2024)* |
| Patrick Warren Higgs | Local Authority Representative: Cambridgeshire County Council *(to February 2025)* |
| Faustina Yang | Voluntary, Community & Social Enterprise organisations *(from Feb 2025)* |
| *Primary Care Rep* | *Position remained vacant in-year* |
| *Patient Safety Partner* | *Position remained vacant in-year* |

## Commissioning & Investment and Improvement & Reform Committee *(From May 2023)*

| | |
|---|---|
| Ged Curran | Chair – Non-Executive Member |
| Dorothy Gregson | Non-Executive Member (Vice-Chair) |
| Ashley Bunn | Voluntary Sector Representative *(from October 2024)* |
| Carol Anderson | Chief Nurse |
| Nicci Briggs | Chief Finance Officer *(to February 2025)* |
| Michael Firek | Voluntary Sector Representative *(to August 2024)* |
| Dr Simon Hambling | ICB Partner Member – Primary Medical Services |
| Dr Gary Howsam | Chief Clinical Improvement Officer |
| Sarah Griffiths | Chief Finance Officer *(from March 2025)* |
| Dr Fiona Head | Medical Director |
| Louis Kamfer | Managing Director Strategic Commissioning |
| Miriam Martin | Voluntary Sector Representative |
| Chris Palmer | Healthwatch Representative |
| Stephen Taylor | Local Authority Representative: Peterborough City Council *(from March 2025)* |
| Jan Thomas | Chief Executive Officer |
| Patrick Warren-Higgs | Local Authority Representative: Cambridgeshire County Council *(from February 2025)* |
| *Primary Care Rep* | *Position remained vacant in-year* |

## People Board

| | |
|---|---|
| Sarah Hughes | Non-Executive Member (Chair) |
| Saqhib Ali | Non-Executive Member |
| Fiona Adley | Voluntary and Community Sector *(from March 2025)* |
| Tanie Brown | North West Anglia NHS Foundation Trust *(from March 2025)* |
| Carol Anderson | NHS Cambridgeshire & Peterborough ICB: Chief Nurse |
| Sharon Allen | Voluntary and Community Sector |
| Janet Atkin | Local Authority representative |
| Claudia Iton | NHS Cambridgeshire & Peterborough ICB Chief People Officer |
| Dr Simon Hambling | Cambridgeshire & Peterborough Primary Care |
| Stephen Legood | Cambridgeshire & Peterborough NHS Foundation Trust |
| Mariejke Maciejewski | North West Anglia NHS Foundation Trust *(to January 2025)* |
| Oonagh Monkhouse | Royal Papworth Hospital NHS Foundation Trust |
| Anita Pisani | Cambridgeshire Community Services NHS Trust |
| Marika Stephenson | East of England Ambulance Service NHS Trust |
| David Wherrett | Cambridge University Hospitals NHS Foundation Trust |

## Programme Executive

| | |
|---|---|
| Jan Thomas | Chief Executive – ICB (Chair) |
| Hannah Coffey | Chief Executive – North West Anglia NHS Foundation Trust |
| Steve Grange | Chief Executive – Cambridgeshire & Peterborough NHS Foundation Trust |
| Eilish Midlane | Chief Executive – Royal Papworth Hospital NHS Foundation Trust |
| Roland Sinker | Chief Executive – Cambridge University Hospitals NHS Foundation Trust |
| Matthew Winn | Chief Executive – Cambridgeshire Community Services NHS Trust |

## Register of interests

The ICB Conflicts of Interest register is published on our website.

### Personal data related incidents

The ICB is required to publish in its Annual Report all incidents relating to the loss of personal data or confidentiality breaches. See other sources of assurance section in the Annual Governance Statement on pages 63-64.

## Modern Slavery Act

NHS Cambridgeshire and Peterborough fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

## Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of NHS Cambridgeshire &

Peterborough 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, and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer, and that Officer shall be appointed by NHS England.

NHS England has appointed the Chief Executive to be the Accountable Officer of NHS Cambridgeshire & Peterborough. 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 NHS Cambridgeshire & Peterborough assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that Cambridgeshire and Peterborough'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 Cambridgeshire & Peterborough Integrated Care Board (ICB) is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

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

The ICB's general function is arranging the provision of services for people for the purposes of the health service in England. The ICB is required to arrange for the provision of certain health

services to such extent as it considers necessary to meet the reasonable requirements of its population.

Between 1 April 2024 and 31 March 2025, the ICB was not subject to any directions from NHS England issued under Section 14Z61 of the National Health Service Act 2006 (as amended).

## Scope of Responsibility

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

## Governance Arrangements and Effectiveness

The main function of the ICB Board is to ensure that the ICB has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently, and economically and complies with such generally accepted principles of good governance as are relevant to it.

The ICB Board met nine times during 2024-25 as follows:

10 May 2024
26 June 2024
12 July 2024
13 September 2024
15 November 2024
10 January 2025
7 February 2025
14 March 2025
25 March 2025

There was good attendance from all ICB Board Members. Attendance is recorded within the minutes for each meeting. The minutes of the meetings held in public are available on the ICB website - Board Meetings and Papers | CPICS Website

The ICB Board was served by the following Committees throughout this period:

**Audit & Risk Committee (Statutory Committee) – Chaired by a Non-Executive Member**, the Audit & Risk Committee is accountable to the board and provides it with an independent and objective view of the ICB's financial systems, financial information and compliance with laws, regulations and directions governing the ICB as far as they relate discharging their statutory

duties. The committee ensures that there is an effective system of internal control and provide an objective review of systems and reports presented by Internal and External Audit and provides the Board with an assurance that the ICB's governance, including financial, clinical and risk management processes are conducted within best practice guidelines set out in the Audit Committee Handbook published by the Healthcare Financial Management Association.

**Remuneration Committee (Statutory Committee)** – Chaired by a Non-Executive Member, the Remuneration Committee is responsible for consideration of the appropriate remuneration and terms of service for the Chief Executive Officer, Board Members, except for the Chair, Executive Directors and staff on Very Senior Managers terms and conditions. The composition of the committee ensures that only non-conflicted members of the Remuneration Committee will be involved in the decision-making process.

**Quality, Performance & Finance Committee (Non-Statutory Committee) –** Chaired by a Non-Executive Member, the Quality, Performance & Finance Committee provides assurance to the Board on delivery of operational performance, quality, safety, and finance within the ICB. The purpose of the committee will be framed against the ICB and the broader system building a clinically driven data-supported culture where clinicians and professionals are accountable and will lead innovation and sustainable improvement.

**People Board (Non-Statutory Committee)** – Chaired by a Non-Executive Member, the People Board contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the ICB on delivery of the ten people functions, building on the enduring ambitions set out in the People Plan and the People Promise, ensuring a one workforce approach within the ICB. The duties of the committee will be driven by the organisation's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year. However, this will be flexible to new local, regional, and national emerging priorities and risks.

**Commissioning & Investment and Improvement & Reform Committee** Chaired by a Non-Executive Member, the committee is responsible for: Providing oversight and assurance on the delivery of the ICS strategy, system wide transformation and improvement schemes and other priority reform items across the C&P population that support delivery of our objectives. Ensure alignment of system resources to achieve improved outcomes for our population. Opportunity to share learning across the system, working closely with our Accountable Business Units (ABUs) to support local delivery. Establishing a framework for effective commissioning and oversight of commissioned services for the local population (directly commissioned and delegated functions). Oversight and decision making on large scale investments to support improvement, reform and transformation of health and care services. Oversight of some system cross cutting enablers including estates, digital and procurement. Responsibility for oversight of the Delegation Agreement with NHS England for the commissioning of primary care medical, pharmacy, ophthalmic and dentistry services, and specialised commissioning.

**Integrated Care Partnership** - Each ICS is comprised of an Integrated Care Board (ICB) working with an Integrated Care Partnership (ICP) committee formed between health and care organisations, local government, and voluntary sector partners. ICPs are not statutory bodies. The role of the ICP Committee is to ensure that, within the resources available, local people experience the best possible care and are supported to access the services that best meet their needs. The ICP Committee will seek to use its position to influence the decisions of the ICB in

endeavour to ensure that decisions are made in the best interests of the circa one million people living in Cambridgeshire and Peterborough. The committee focuses on the person, rather than organisation and works with the ICB to protect those interests and promote co-production and collaboration as a core values.

**Programme Executive** - The Programme Executive is responsible for maintaining oversight and delivery of the ICS' Operational Plan and Joint Forward Plan, as well as ensuring strategic oversight of system finances and its impact on delivery.

There was good attendance at all ICB committee meetings which is recorded within the minutes of each meeting.

The ICB's constitution was approved by NHSE and came into force on 1 July 2022. It is published on the Governance page of our website.

The Committee structure was supported by the ICB's Governance Handbook which was last approved by the ICB board in March 2024 check date, and which is also published on the website.

The composition and named membership of the ICB Board and its committees, throughout the financial year, are set out in the corporate governance section on pages 50-53

The gender distribution of the board, senior managers and all other employees is set out in the staff report section on page 88.

## UK Corporate Governance Code

NHS bodies are not required to comply with the UK Code of Corporate Governance. Whilst the detailed provisions of the UK corporate governance code are not mandatory for public sector bodies, compliance is considered good practice.

In line with the UK corporate governance code, we conducted a committee effectiveness survey in Quarter 3 of 24/25. Key themes arising from the survey were:

- **Theme 1 – Challenge -** The feedback generally was supportive of the level of debate as well as the openness and inclusiveness of the environment. Opportunities were identified to strengthen the level of challenge in certain areas and ensure that members/attendees were clear on purpose and roles. A key element of effective challenge is ensuring that inputs process are fed into the discussions, at the appropriate point, for example highlighting issues raised during feeder group discussions or engagement with stakeholders.

- **Theme 2 – Members and attendance –** Feedback was generally supportive of consistent attendance and membership. Some logistical issues were raised about the timing of certain meetings. There was general support around the breadth and diversity of membership and attendance, however specific points were raised in respect of representation of primary care and to a lesser extent local authorities, both of which are actively being addressed. The feedback highlighted the importance of ensuring that all participants were fully engaged in the discussions, rather than defaulting to ICB voices only.

- **Theme 3 – Effective business planning –** All the responses acknowledged the range of content within the remit of each committee and generally were supportive of the view that this was being effectively managed. The feedback highlighted the importance of papers being appropriately tailored to the specific meetings and continuing to focus on ensuring that attachments and appendices are minimised as far as practical. There were a number of comments about working within the agreed business cycle, and whilst there was a recognition of the occasional need for additional meetings, that these should be seen as the exception. Specific areas for development into 2025/26 and beyond were identified.
    - Ensuring equity of access to and providing clarity on the agenda setting process.
    - Balancing most effectively the utilisation of Committee time vs. level of resource required.
    - Ensuring that as far as possible the Committees are working within the agreed business programme and minimising the need for additional meetings.

- **Theme 4 –Committee Development Sessions** – All of the Committees were strongly supportive of development sessions being organised for each Committee. The sessions will enable each Committee to work through the themes in more detail. To minimise the impact on individuals who may be expected to attend multiple sessions it may be necessary to phase these in a prioritised manner, particularly if additional time slots are required to be identified.

**Committee development sessions during Quarter 1 of 2025/26.**

Terms of Reference for each Committee will be reviewed during this time, ahead of submission to the Board for formal approval.

## Discharge of Statutory Functions

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

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

## Risk Management Arrangements and Effectiveness

Within the ICB, risk management is demonstrated by:

- Adopting an integrated approach to risk management, whether the risk relates to clinical, organisational, health and safety, or financial risk, through the processes and structures detailed in the ICB's Risk Management Policy.
- Managing risk as part of the routine line management responsibilities and consideration of funding to address 'risk' issues (based on a risk assessment) as part of the normal business planning process.
- Undertaking risk assessments on existing, new, and proposed activities to ensure that:

- Significant risks are identified in accordance with the Risk Management Policy which provides full details on what constitutes a hazard or risk, and how it should be identified and assessed,
- Assessments are made of their potential frequency and severity,
- Control measures are implemented in accordance with the Risk Management Policy,
- Risks are always assessed and reduced or minimised where possible,
- Strategic risks are recorded on the Board Assurance Framework (BAF) in line with the Risk Scoring Matrix,
- Risks are recorded on the Directorate Risk Registers (DRR) and are escalated as appropriate,
- A Corporate Risk Register (CRR) is now in place which includes High risks escalated by Directorates. This is regularly reviewed by the ICB Executive Team and is presented to the Audit & Risk Committee on a regular basis.

Staff at all levels of the organisation contribute to the identification and assessment of risk and at the Main Provider Meetings and Contract and Clinical Quality Review meetings. The risk management actions that have been taken this year include:

- Refresh of the ICB Risk Management Policy,
- Continued development of the DRR,
- Further development of the ICB's BAF,
- Further development of the CRR,
- Compliance with NHS England's Emergency Preparedness Resilience and Response (EPRR) Framework and subsequent delivery against the annual EPRR Core Standards self-assessment. For 2024, the ICB declared full compliance against these standards,
- Further development of our compliance against the Data Security and Protection Toolkit,
- A new framework was developed to deliver an effective Impact Assessment process for completion of the impact assessments to support business case development, project management, and service transformation/reductions requiring public consultation, where these documents form part of the overall process.

The control environment is supported by regular review of our ICB Constitution, including Standing Orders, Scheme of Delegation and Standing Financial Instructions, directions on fraud, programme of Internal Audit, budgetary control systems, and information to support performance and risk monitoring processes.

## Capacity to Handle Risk

The ICB Board provides leadership to ensure that risk management is embedded within the organisation. This includes continuous development of the BAF which identifies the key objectives and related risks.

As Accountable Officer, I ensure that sufficient resources are invested in managing risk and I am supported in this task by the Chief Nurse (Caldicott Guardian) who holds ICB board level responsibility for clinical risks. The ICB Executive Team takes executive level responsibility for non-clinical risks supported by the Corporate Governance Team led by the Director of Governance. The Managing Director Strategic Commissioning is the ICB's Senior Information Risk Owner (SIRO). The Head of Governance holds the role of the ICB Data Protection Officer.

Leadership across the organisation is given to the risk management process through the ICB Executive Team, Senior Leadership Team and ICB board members via the committees of the ICB board. Each committee regularly reviews strategic risks set out in the BAF.

Risk registers are maintained at a directorate level and all staff are required to adhere to the ICB's Risk Management Policy which requires them to assess, identify and manage risks in a way that is appropriate to their authority and duties. Guidance is provided to staff by the Corporate Governance Team who provide templates on how to undertake risk assessments, produce risk registers and business continuity plans, and embed risk management in the activity of the organisation. The Corporate Risk Register (CRR) has been developed further this year and brings together escalated risks from the Directorate Risk Registers (DRRs) alongside corporate risks identified by the ICB Executive Team. The CCR is reviewed by the ICB Executive Team and presented to the Audit & Risk Committee, alongside the BAF.

The ICB is supported by risk management resources within Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) which provides expert advice, development, and training around health and safety, fire safety and claims management.

*Risk Assessment*

The BAF identifies the ICB's strategic objectives and risks, the controls that are currently in place to minimise the risk, and the sources of assurance to those controls. The system of regular review of the BAF by the ICB board provides evidence to the Annual Governance Statement. The ICB board has overseen regular assessment of the risks associated with achieving the ICB's strategic objectives and risks, has reviewed gaps in key controls and assurance to address those risks, and monitored management actions to address the gaps. The BAF assesses the likelihood of an event occurring combined with the possible consequences to provide a standard approach to the assessment of risk. Calculating the risk supports the prioritisation of action plans and the reduction of risks is therefore managed through this process. Organisational risks are included in Directorate Risks Registers and escalated to the Corporate Risk Register.

The internal audit review of the BAF and our risk management processes was completed in March 2025. Reasonable Assurance was received.

The BAF is regularly reviewed by the key committees of the ICB board. It is also scrutinised at each Audit & Risk Committee and presented to the ICB board meeting in public throughout the year.

The BAF identified several risks to achieving our strategic aims which are being managed through actions linked to the BAF to mitigate these risks. These are as follows as of 31 March 2025:

## High Level Risks (Risk Scores 15-25)

BAF01 **Health inequalities and outcomes** – There is a risk that Health inequalities will widen. As a result, population health outcomes will worsen for our 'Core20PLUS' population.

BAF04 **Service quality** – There is a risk that with services under increasing demand, clinical workforce gaps and access delays, service quality can be impacted.

## Significant Risks (Risk Score 8 - 12)

BAF02 **Listening to residents** – There is a risk that future models of care are not built through listening and understanding what people need to maximise their health and wellbeing.

BAF03 **Valuing our workforce** – There is a risk that we don't focus on our culture and the challenges that staff currently face to ensure that they feel valued and activated to respond to the increasing pressure of working in health and care.

BAF05 **Getting the basics right** – There is a risk that we don't deliver the basic NHS statutory standards that have been put in place to maximise the outcomes for our residents.

BAF06 **Respecting the public pound** – There is a risk that we do not take effective decisions through the lens of best use of the public money and financial sustainability which will impact on the organisation's ability to achieve its statutory financial duty.

BAF07 **Building for the future** – There is a risk that we do not get ahead and build services for the future meaning we adapt what we have rather than considering new care models.

BAF08 **Recruitment and retention** – There is a risk that we are unable to recruit and retain staff across the system.

BAF09 **Industrial action** – There is a risk that sustained industrial action will impact on the ability of the ICB and wider ICS to deliver services to patients, compromising patient experience and potentially leading to the deterioration of patient's health and wellbeing. The ability of the ICB to deliver its Operational Plan for 2024/25 and its Joint Forward Plan, alongside meeting the statutory duties set out in the ICB's Constitution including quality, patient safety, finance, health inequalities and delivery may also be impacted.

## Moderate Risks (Risk Score 4 – 6)

Nil

Through the assessment of these risks, the BAF sets out the gaps in controls and the management actions that are required to mitigate the risk. Where risks remain high, additional scrutiny is set out below:

- Continued review of finance, patient safety, quality, and performance risks through the Integrated Performance Report (IPR) presented to the Quality Performance & Finance Committee.

- Review of governance risks via the Audit & Risk Committee and associated sub-groups of the Quality Performance & Finance Committee.
- Review of workforce risks via the People Board.
- The BAF is now fully reviewed six times per year, ahead of each board meeting by the Executive Team of the ICB.

## Other Sources of Assurance

## Internal Control Framework

A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively, and economically. The system of Internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness. The internal audit plan is agreed annually by the Audit & Risk Committee and combines a range of internal audit reviews to meet national requirements and local areas identified by the executive. This provides the basis of assurance to the Audit & Risk Committee.

## Annual Audit of Conflicts of Interest Management

The revised statutory guidance on managing conflicts of interest requires commissioners to undertake an annual internal audit review of conflicts of interest management.

The Internal Audit Review of the ICB's conflicts of interest arrangements has been conducted in line with the NHS England template and achieved Substantial Assurance in 2024/25. The findings and recommendations from this review will be reflected in the review of the Conflicts of Interest and Standards of Business Conduct Policy.

As of 31 March 2025, the ICB declared no breaches to its Conflicts of Interest Policy. This position is recorded in the Conflicts of Interest Breaches Register published on the ICB's website at the following link: https://www.cpics.org.uk/conflict-of-interest

## Data Quality

Data quality is reviewed at various levels within the ICB across the various data sources we use. For our main commissioning datasets, we have the service of a Data Service for Commissioners Regional Office (DSCRO) which validates the information we use to monitor contracts and pathways. These validation checks include data quality checks e.g. missing information (NHS number, dates), incorrect information (date mismatch, incorrect prices, invalid admissions e.g. an 85-year-old admitted under paediatrics). For more aggregate information e.g. performance against targets (18 weeks, cancer, A&E) we triangulate information from multiple sources e.g. provider reporting and national reporting. We also compare different views e.g. commissioner level and provider level to ensure consistency. The ICB reviews the quality of the data it

receives on a regular basis. The monthly Integrated Performance Report (IPR) provides the basis for this review.

## Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information. The Framework is supported by a Data Security and Protection Toolkit (DSPT) and the annual submission process provides assurances to the Integrated Care Board, other organisations and to individuals that personal information is dealt with legally, securely, efficiently, and effectively.

The Data Security and Protection Toolkit Is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 Data Security Standards. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security, and that personal information is managed correctly.

The ICB Cyber & Information, Assurance & Governance Steering Group reports directly, by exception, to the Audit & Risk Committee. The Steering Group's membership includes the Caldicott Guardian, Senior Information Risk Owner (SIRO) and Data Protection Officer. The ICB's Data Protection Registration is renewed annually through the Information Commissioner's Office. There are established processes in place for incident reporting and the investigation of serious incidents. Data Security Awareness training is mandated annually for all staff.

The ICB is required to publish all Serious Incidents (SI) involving confidentiality and data security breaches, including any that have been reported to the Information Commissioner's Office (ICO). During 2024/25 one incident was reported to the ICO.

| Date of incident (month) | Nature of incident | Number affected | How patients were informed | Lesson learned |
|---|---|---|---|---|
| February 2025 | Loss of connection to systems accessed via HSCN network. | Unknown | Not informed | ICB spoken with network provider and agreed further control measures when a change is going to be made. |

Table: ICB Summary of other incidents including data security breaches (using the CIA Triad below, introduced by NHS Digital) for 2024/25

| Category | Nature of incident | 2023/24 | 2024/25 |
|---|---|---|---|
| **I** | **Confidentiality** breaches (unauthorised or accidental disclosure of or access to personal data) | 22 | 31 |
| **II** | **Integrity** breaches (unauthorised or accidental alteration of personal data) | 9 | 4 |
| **III** | **Availability** breaches (unauthorised or accidental loss of access to, or destruction of, personal data) | 110 | 83 |
| **IV** | Other | 10 | 5 |
| **Total** | | 151 | 123 |

## Business Critical Models

Modelling and forecasting form a fundamental part of the process between providers and commissioners. Each year, contracts are constructed to forecast spend and activity values for the following year. These are then monitored in year with forecasts updated monthly to identify position against plans and year-end outturn. Quality assurance of this process is given by the involvement of providers and commissioners in the construction and monitoring process. This peer review ensures models are built on robust assumptions with the most up-to-date and accurate data. The different perspectives ensure that plans are realistic but still give challenge in relation to system transformation.

## Third Party Assurances

The ICB receives some of its support services through contracts with various providers. This includes ICT and IT services, risk management including claims management, and some HR and financial transactions. The ICB ensures that providers are compliant and provide assurance to support our own compliance levels as part of the contract management process. The ICB continues to seek assurance from our third-party providers through the contract management route.

The ICB's accounts payable, receivable, general ledger, and payroll systems are provided by NHS Shared Business Services (SBS). The systems of internal control within SBS are audited by their independent auditors and are reported through the ISAE3402 Performance Assurance.

## Control Issues / Pressures

Set out in the table below are the significant control issues and pressures that were identified by the ICB within the Month 9 Governance Statement submitted in January 2024, together with the remedial action that has been undertaken or is in progress. An update on the current progress is included.

| Control Issue | M9 Position (31 December 2024) | Position at 31 March 2025 |
|---|---|---|
| Finance, Governance and Control – Finance and Procurement | The ICB position for M9 is a £4m deficit which is a £3.5m improvement largely driven by reduction in month deficits in VOID costs, and improvements on CIP and reduced community independent sector costs. These reductions are partially offset by increases in S117 costs and shortfalls in the prescribing recovery plan (approximately £2m to end of the year) due to lack of engagement from GPs making switches to more cost-efficient products, despite being incentivised to do so. M9 saw marked improvement again for the fourth month in a row in the CHC run rates and an overall reduced the forecast risk by £2m. The ICB is now in a position where its base and worst-case scenarios are fully mitigated and | The financial position for the ICB and organisations within the ICS for 2024/25 has now landed *(subject to audit).* This shows a position in line with the financial plan at breakeven. We will continue to work on delivering recurrent efficiencies in 2025/26 to maintain financial sustainability for the ICB and across the system. |

| | | |
|---|---|---|
| | the only risk unmitigated at a system level is CPFT non delivery of recovery plan and Las not passing through pay award funding. To manage these risks; NHS England East of England's finance team have asked providers to escalate where Las are not passing on pay award funding, and, the ICB has a formal commitment from the CPFT Executive Team and Board to deliver its recovery plan. | |
| Quality and Performance - Accident and Emergency | Acute Trusts' activity levels remain significantly high which is in line with the regional and national picture. A&E attendances are also high with significant impact on ambulance delays, compounded by issues with flow across the hospitals. We continue to focus on initiatives to address the sustained and significant demand across the system which continues to impact on 111 and A&E departments. | As of 31 March, C&P continues to see urgent and emergency care demand above planned levels. Across the course of the year, 7.4% more people have attended a minor injury unit, urgent treatment centre or Emergency department, than in 23/24.<br><br>We continue to see ambulance handover delays at some of our hospitals, with Peterborough City the most challenged, though we remain committing to working towards no ambulance waiting more than 45 minutes to handover. Initiatives such as our urgent care coordination hub is also supporting to remain in their own homes, with >4,000 patients supported since its launch in December. This has reduced ambulance attendances and conveyances to hospital.<br><br>A&E four hour waiting time performance is below the national target of 78%, with 68.3% (unvalidated) achieved across 24/25. This is an improvement from 58% for 23/24, in the context of significantly more demand.<br><br>In 25/26, we continue to focus on pathway improvements to manage demand, improve A&E processes and reduce length of stay to improve wider flow, through focused work on Home First and discharge models. |
| Quality and Performance - RTT/52 week wait | As of 1 December 2024, there were 150,692 patients on an open referral-to-treatment (RTT) pathway, 2.2% above plan. The average wait in the system was 19.1wks, meaning 56% of patients were waiting below 18-weeks. 5,353 patients across the system were waiting over 52wks, 87 over 65wks, 7 over 78wks and 1 over 104wks. Positively, waits over 52 | The overall elective recovery position in C&P is better than expected, with strong performance through the course of the year, despite an ongoing increase in referrals.<br><br>As of 1 March 2025, there were 149,539 patients on an open RTT pathway, over plan by 3% (4,573). The median waiting time in the system was 14.9 weeks, meaning 56% of patients (83,440) waiting within 18-weeks |

| | | |
|---|---|---|
| | weeks are 44% lower than our planned position. | and 44% (66,099) more than 18-weeks. 4,643 patients across the system were waiting over 52-weeks, 70 over 65-weeks, 6 over 78-weeks and 1 over 104-weeks. Positively, waits over 52-weeks were 13% below the planned position, with children and young people long waits 50% better than expected, with only 247, of the 4,643 total. Completed admitted pathways YTD were 2% (1,510) above plan whereas completed non-admitted pathways YTD were 1% (1,836) below plan. RTT clock starts were 4% (12,745) over plan YTD.<br><br>We remain focused on the wider work required to maximise advice and guidance available to primary care to support demand management, consistent clinical triage and prioritisation of elective activity, as well as utilising approaches such as patient initiated follow ups to release capacity for 1st outpatient appointments to improve overall waiting times. |
| Quality and Performance - Regulators (inc. patient safety) | The ICB has been informed of an Ofsted/CQC SEND Local Area Inspection, for Cambridgeshire which runs until 31 January 2025 | Cambridgeshire<br>The CQC/OFSTED Area Special Educational Needs and/or Disabilities (SEND) inspection of Cambridgeshire Local Area Partnership took place between the 27 January 2025 to 31 January 2025. The inspection outcome was the local area partnership's arrangements lead to inconsistent experiences and outcomes for children and young people with SEND. As a result, the local area partnership must work jointly to make improvements and, update and publish its strategic plan based on the recommendations set out in the report. The report detail five areas for improvement the local area partnership will be monitored on before the next full area SEND inspection, which will take place within three years. The ICB is leading on 1 area of improvement related to neurodevelopmental and mental health services.<br><br>Peterborough<br>The Peterborough area SEND partnership monitored every 6 months by the Department for Education and NHS England following the SEND Written Statement of Action revisit carried out by Ofsted and CQC on 24-26th January 2022. Leaders last met with the Department for Education and NHS |

| | | |
|---|---|---|
| | | England on the 20th of November 2024 to provide evidence of progress against the Peterborough Area SEND Accelerated Progress Plan. The monitoring team noted the significant progress made by the partnership, working under difficult circumstances, since the last review in February 2024. However, there are still some areas that require attention so the area will continue to be monitored. If sufficient progress has been made at the next visit in June 2025, the area will move into the sustainability period which precedes the lifting of the Accelerated Progress Plan. |

## Review of Economy, Efficiency, and Effectiveness of the Use of Resources

The ICB Board is accountable for ensuring that the ICB has mechanisms in place to ensure that the organisation uses its resources economically, efficiently, and effectively. The ICB board approved the ICB's Financial Plan and associated Savings Plan on an annual basis. The responsibility for monitoring this has been delegated to the Quality Performance & Finance Committee. This Committee also provided scrutiny of the ICB's financial planning, in year performance monitoring, and central running costs.

The Quality Performance & Finance Committee oversaw the ICB's financial risks and reviewed the risks on the BAF at each meeting. The committee reported to the ICB board at each meeting, where an overview of committee business was provided, alongside the Integrated Performance Report (IPR), which provided a comprehensive suite of data covering quality, finance, contract, activity, complex cases, project management office, population outcomes and other performance data into a single accessible source.

## Commissioning of delegated specialised services

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

To the best of the ICB Leadership's knowledge, the commissioning of all delegated services has been compliant with the 10 core commissioning requirements, as set out in the 2024/25 Delegated Commissioning Assurance Guidance, published by NHS England, including the requirement that all conditions set out in the DA are being met.

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

The ICB leadership is able to provide the necessary evidence of core commissioning requirements compliance should NHS England or a third party (e.g. external auditors) ask for such evidence.

## Delegation of Functions

The management of research related excess treatment costs is delegated to Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) as lead for the Eastern Local Clinical Research Network. No further delegation of functions has been agreed this year.

## Counter Fraud Arrangements

The ICB's Audit & Risk Committee oversaw the counter fraud arrangements for the organisation in line with the NHS Counter Fraud Authority Standards for Commissioners: Fraud, Bribery and Corruption. An accredited counter fraud specialist is contracted to undertake counter fraud work proportionate to identified risks. The Chief Finance Officer is the executive lead on the ICB Board who is responsible for counter fraud arrangements. The ICB received regular reports on counter fraud activities in line with guidance.

## Better payment

## Public Sector Payment Policy (Confederation of British Industry (CBI) Better Payment Practice Code)

The ICB, as with all NHS and public sector organisations, aims to pay a minimum of 95% of valid invoices by the due date or within 30 days of receipt, whichever is the later.

The table below shows that for 2024/25 this was not achieved for both NHS and non-NHS organisations in terms of the number of invoices, and non-NHS organisations in terms of value of invoices. The target was achieved for NHS organisations in terms of value of invoices.

*Table : Better Payment Practice Code – measure of compliance*

| Better Payment Practice Code – measure of compliance | 2024/25 | |
|---|---|---|
| | Number | £000s |
| **Non NHS Creditors** | | |
| Total bills paid in year | 19,891 | 360,394 |
| Total bills paid within target | 15,041 | 321,629 |
| Percentage of bills paid within target | 75.62% | 89.24% |
| **NHS Creditors** | | |
| Total bills paid in year | 2,111 | 1,623,114 |
| Total bills paid within target | 1,694 | 1,598,212 |
| Percentage of bills paid within target | 80.25% | 98.47% |

## Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness

of the clinical commissioning group's system of risk management, governance, and internal control.

In 2024/25 the Head of Internal Audit concluded that the organisation had an adequate and effective framework for risk management, governance, and internal control. However, their work identified further enhancements to the framework of risk management, governance, and internal control to ensure that it remained adequate and effective.

The ICB's internal auditors operated a process whereby they apply one of four assurance ratings, namely:

- Substantial Assurance,
- Reasonable Assurance,
- Partial Assurance,
- No Assurance.

During 2024/25 internal audit has issued the following audit reports:

| Area of Audit | Level of Assurance Given |
|---|---|
| Raising Concerns including Fit and Proper Persons | **Substantial** Assurance |
| Financial Planning and Reporting | **Substantial** Assurance |
| Conflicts of Interest | **Substantial** Assurance |
| Commissioning and Contract Management | **Substantial** Assurance |
| Primary Care Services | **Substantial** Assurance |
| Medicines Optimisation | **Reasonable** Assurance |
| Specialist Commissioning | **Reasonable** Assurance |
| System Partnerships | **Reasonable** Assurance |
| Risk Management / Board Assurance Framework | **Reasonable** Assurance |
| Key Financial Controls | **Reasonable** Assurance |

## 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 Audit, Executive Directors, and Clinical Leads within the ICB who have the responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me.

The BAF itself provides me with the evidence that the effectiveness of controls that manage the risks to the organisation achieving its corporate objectives have been reviewed. My review is also informed by internal and external audit. I have been advised of the implications of the result of my review of the effectiveness of the system of internal control by the ICB Board and the Audit & Risk Committee. A plan to address weaknesses and ensure continuous improvements of the system of internal control will be put in place. The ICB Board and its associated committees, together with internal audit, maintain a regular review of the effectiveness of the process of internal control.

My review is also informed by:

- The Data Security and Protection Toolkit,

- Our Research Governance Framework,
- Any external reviews,
- My attendance at key governance meetings,
- Reports from internal audit and the head of internal audit opinion,
- NHS Resolution Membership and Risk Management Assessment,
- Full Compliance against the Emergency Preparedness Resilience and Response (EPRR) core standards for 2024,
- External audit's assessment of the ICB's arrangements for economy, efficiency, and effectiveness in the use of its resources,
- Regular meetings with NHSE including touchpoint and quarterly oversight meetings.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the following:

- The ICB Board, which had responsibility for setting the overall direction, agreeing the ICB's strategic aims, corporate objectives, assessing and managing strategic risks to the delivery of those objectives, and monitoring progress through regular performance monitoring reports at each ICB Board meeting in public,
- Scrutiny and assurance provided by the ICB's committees:
- The Audit & Risk Committee which works to a well-developed audit plan and provides assurance to the ICB Board,
- The Remuneration Committee, which is responsible for recommending Very Senior Managers' pay to the ICB Board,
- The Primary Care Commissioning Sub Committee reporting to the Commissioning & Investment Committee and Improvement & Reform Committee which oversees delegated commissioning of primary care services in line with the Delegation Agreement with NHS England East of England,
    - The Quality Performance & Finance Committee which provides scrutiny of delivery of quality, finance, performance, and contracts management including activity,
    - The People Board, which contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the ICB on delivery of the ten people functions, building on the enduring ambitions set out in the People Plan and the People Promise, ensuring a one workforce approach within the ICS.
    - The Commissioning & Investment and Improvement & Reform Committee which provides assurance to the board on the delivery of the objectives set out in improvement and reform plans as approved by the management executive and laid out within the workstream plans within the ICB.
- ICB Board Members, Executive Directors and associated Senior Managers (Associate Directors/Deputy Directors) who lead on specific areas of responsibility,
- The ICB Executive Team which meets weekly to support delivery of the Operational Plan, Strategic Plan, and deals with day-to-day risk,
- The command, control and co-ordination structures established to support the incident response in line with our duties under the Civil Contingencies Act 2004,
- Internal audit has reviewed the effectiveness of the design and operation of the controls in the areas covered by its risk-based Operational Plan. As described above, the Head of Internal Audit Opinion concluded that:
    - The organisation has an adequate and effective framework for risk management, governance, and internal control. However, our work has identified further enhancements to the framework of risk management,

governance, and internal control to ensure that it remains adequate and effective.

- Any weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk, and this will be addressed via management action plans agreed between internal audit and executive director leads for each area. The Audit & Risk Committee reviews progress against implementation of all internal audit recommendations.

## Conclusion

The ICB has continued to face a number of challenges during 2024/25 but has also made some significant improvements to enhance the care we provide to our local population, as well as maintaining strong and effective governance which is reflected in the Internal Audit Review outcomes and the Head of Internal Audit Opinion.

2024/2025 was a challenge financially to manage the continued impact of Industrial Action, rising inflation and prescribing pressures but the ICB delivered a break-even position and more importantly the ICS which constitutes over £4bn of services delivered a system break-even position for the third year in a row. This has been achieved through increased robust grip and control measures on areas of identified pressure alongside assured delivery of the efficiency plans, and additional efficiencies being identified. This achievement means that a further incentive will be awarded in 2025/26 with upwards of £12.3m capital and £12.3m revenue being provided to the system.

In addition, our historic debt of £132.6m has now officially been written off by NHS England. This is a significant milestone and one that reflects sustained effort, careful management, and system working over the last three years. This outcome means we are now able to move forward with a clean slate and renewed focus on the future.

The context for health and care delivery has presented several new challenges in recovering and improving services in 2024/2025. Timely access to urgent and emergency care remains a challenge across our area. We have taken pro-active steps to invest in primary and community care, as well as other acute alternatives to the Emergency Department to keep as many people well and supported in their own homes as possible.

We have maintained our commitment to learning, with a structured After-Action Review (AAR) into the events leading up to the situation at Maple Surgery with the findings and recommendations reported to the ICB Board. Several themes emerged during the review, which are consistent with the findings of from the Priors Field Surgery AAR completed in 2023. The recommendations from the review have been endorsed by the Board and actions are being taken forward to address these.

During 2024/25, we have finalised our Single Assessment Framework which sets out our approach to ICB oversight and assurance of performance to bring in the totality of the ICB responsibilities including primary care, delegated Pharmacy, Optometry and Dental services, and arrangements with Accountable Business Units (ABUs).

The importance of developing and clarifying the role and accountability arrangements for place base working and ABUs has been a focus for the ICB during 2024/25. We have engaged an

external consultancy to review the role of Place, North and South Partnerships, the Mental Health and Learning Disabilities and the Children's and Maternity Partnerships and their systemwide relationships. Alongside the outcomes of the Internal Audit Review on System Partnership Working, we will be taking forward the findings of the wider review to ensure that we strengthen our governance arrangements to support collective accountability across the system.

As I conclude our Annual Governance Statement for 2024/5, the NHS is facing a period of significant change, with the integration of NHS England with the Department of Health and Social Care, reduction in staff that will transition into the Department of Health and Social Care, and the impact of these changes at a local level with the reduction of ICB running costs by 50%. Whilst I recognise the challenges that staff are facing and we will support them through this transition period, the organisation will continue to maintain focus on maintaining effective governance arrangements, delivering our Operational Plan and our Strategic Commissioning Plan, which will ensure that the local health and care system partnership remains responsive to the needs of our local population.

**Jan Thomas**
Chief Executive

June 2025

# Remuneration Report

## Membership of Remuneration Committee

| Name | Position |
|---|---|
| John O'Brien | ICB Chair |
| Sarah Hughes | Non-executive Member (Chair) |
| Saqhib Ali | Non-executive Member |
| Eilish Midlane | Partner Member - NHS Trusts and Foundation Trusts |

## Policy on the remuneration of senior managers

"Remuneration payments made to the Lay Members and GP Board Members are proposed to the Board by the ICB's Remuneration Committee, taking into consideration relevant Conflicts of Interests. The Committee reviews benchmarking data from other ICBs to support any proposed changes to remuneration of these members. No remuneration was waived by members and no compensation was paid for loss of office. No payments were made to co-opted members and no payments were made for golden hellos."

"Where individual national review bodies govern salaries, then the national rates of increase have been applied. Where national review bodies do not cover staff, then increases have been in line with the percentage notified by the NHS Chief Executive and approved by the Remuneration Committee. For 2024/25 this was 0% (2023/24 0%). Any increases above that limit have been on the basis of increased responsibilities or promotion."

The cost of a session paid to a GP for attendance at a meeting remained unchanged at £285 (2023/24 0% increase).

## Policy on Performance Conditions

"The ICB's Remuneration Committee set standards in conjunction with the Chief Clinical Officer, Chief Operating Officer and Lay Chair, who has held regular appraisals and 1:1 supervision session with the individuals concerned. The Lay Chair sets individual targets for the Chief Operating Officer and Chief Clinical Officer based on the performance of the ICB in relation to national and local targets set out in the ICB service plans. The Remuneration Committee takes the financial circumstances of the organisation into consideration in making pay awards, as well as Advance letters advice from the Department of Health. All uplifts were discussed with and decided by the Remuneration Committee and its relevant Sub-Groups, which is supported by a Human Resource (HR) professional. Middle managers receive their targets through cascade of organisational objectives with advice and support from HR. The annual cost of living uplift is awarded by the Remuneration Committee based on National Guidance."

"Policy on duration of contracts, notice periods and termination payments"

"Senior manager contracts are subject to 3 - 6 months' contractual notice due to the time it takes to replace a senior manager. Termination payments are in accordance with NHS policy and negotiated with trades unions. Contracts, where possible, are permanent except for project work, due to the legislation giving fixed term contracts similar employment rights. During times of change the organisation resorts to fixed term contracts and secondments, but this is becoming increasingly regulated."

## Service Contracts

| Name | Position | Date of Contract | Unexpired term (if applicable) | Early termination terms |
|---|---|---|---|---|
| Jan Thomas | Accountable Officer | 24 April 2018 | N/A | N/A |
| Louis Kamfer | Deputy CEO / Managing Director Strategic Commissioning | 17 September 2018 | N/A | N/A |
| Carol Anderson | Chief Nurse | 7 January 2019 | N/A | N/A |
| Dr Fiona Head | Medical Director | 19 March 2020 | N/A | N/A |
| Claudia Iton | Chief People Officer | | N/A | N/A |
| Stacie Coburn | Chief Operating Officer | | N/A | N/A |
| Nicci Briggs (to 16/02/2025) | Chief Finance Officer | | N/A | N/A |
| Kate Vaughton (from 03/01/2025 | Chief Officer Partnerships and Integration | | N/A | N/A |
| Sarah Grifftiths (from 03/03/2025) | Chief Finance Officer | | N/A | N/A |

GPs are elected by Member Practices to serve on the GP Governing Body through a process agreed by the Cambridgeshire Local Medical Committee.

# Remuneration Report (audited information)

| | | 2024-25 | | | | 2023-24 | | | |
|---|---|---|---|---|---|---|---|---|---|
| Name | Title | Salary and Fees (Bands of £5,000) £000 | Taxable Benefits (Rounded to the nearest £100) £ | Pension related benefits (Bands of £2,500) £000 | Total (Bands of £5,000) £000 | Salary and Fees (Bands of £5,000) £000 | Taxable Benefits (Rounded to the nearest £100) £ | Pension related benefits (Bands of £2,500) £000 | Total (Bands of £5,000) £000 |
| Executive Directors | | | | | | | | | |
| Jan Thomas | Accountable Officer | 195 - 200 | - | 50 – 52.5 | 245 - 250 | 185 - 190 | - | 50 - 52.5 | 240 - 245 |
| Carol Anderson | Chief Nurse (Nurse Member) | 140 - 145 | - | 0 - 2.5 * | 110 – 115 | 140 - 145 | - | 0 - 2.5 * | 110 - 115 |
| Louis Kamfer | Deputy Chief Executive Officer and Managing Director of Strategic Commissioning | 160 - 165 | - | 45 – 47.5 | 205 - 210 | 150 - 155 | - | 37.5 - 40 | 190 - 195 |
| Jane Webster (to 28/06/23) | Commissioning Director | - | - | - | - | 30 - 35 | - | 0 - 2.5 * | 0 - 5 * |
| Fiona Head | Medical Director | 125 - 130 | - | 0 - 2.5 * | 75 - 80 | 110 - 115 | - | 10 - 12.5 | 120 - 125 |
| Nicci Briggs (to 16/02/25) | Chief Financial Officer | 155 - 160 | - | 27.5 - 30 | 185 – 190 | 165 - 170 | - | 37.5 - 40 | 200 - 205 |
| Kit Connick (to 28.03.24) | Chief Officer Partnerships & Strategy | - | - | - | - | 145 - 150 | - | 0 - 2.5 * | 80 - 85 |
| Kate Vaughton (from 03/01/25) | Chief Officer Partnerships and Integration | 35 - 40 | - | 20 - 22.5 | 55 – 60 | - | - | - | - |
| Claudia Iton | Chief People Officer | 155 - 160 | - | 45 - 47.5 | 200 – 205 | 145 - 150 | - | 35 - 37.5 | 180 - 185 |
| Barbara Brafman-Price (to 26/05/23) | Chief of Staff | - | - | - | - | 15 - 20 | - | - | 15 - 20 |
| Sarah Griffiths (from 03/03/25) | Chief Financial Officer | 10 - 15 | - | 2.5 - 5 | 10 - 15 | - | - | - | - |
| Dr Gary Howsam | Chief Clinical Improvement Officer | 135 - 140 | - | 0 - 2.5 | 135 - 140 | 130 - 135 | - | 0 - 2.5 * | 0 - 5 * |
| Stacie Coburn | Chief Operating Officer | 135 - 140 | - | 35 - 37.5 | 170 - 175 | 125 - 130 | - | 30 - 32.5 | 155 - 160 |
| Chair and Lay Members | | | | | | | | | |
| John O'Brien | Chair | 60 - 65 | - | - | 60 - 65 | 60 - 65 | - | - | 60 - 65 |
| Saqhib Ali | Non Executive Member | 15 - 20 | - | - | 15 - 20 | 15 - 20 | - | - | 15 - 20 |
| Gerard Curran | Non Executive Member | 15 - 20 | - | - | 15 - 20 | 15 - 20 | - | - | 15 - 20 |
| Dr Dorothy Gregson | Non Executive Member | 15 - 20 | - | - | 15 - 20 | 15 - 20 | - | - | 15 - 20 |
| Dr Sarah Hughes | Non Executive Member | 15 - 20 | - | - | 15 - 20 | 15 - 20 | - | - | 15 - 20 |

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the ICB in the financial year 2024/25 was £195k to £200k (2023/24 £185k to £190k). This was 4.07 times (2023/24 4.08 times) the median remuneration of the workforce, which was £48,526 (2023/24 £45,996). Remuneration ranged from £23,615 to £210,000 (2023/24 £22,383 to £189,263). In 2024/25, one employee (working on behalf of National and Regional programmes) received remuneration in excess of the highest paid director (2023/24: none).

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.

## Pension related benefits

No pensions contributions are made on behalf of lay members.

* The 2024/25 pension related benefits value for Carol Anderson and Fiona Head are negative. Manual for Accounts guidance requests negatives are replaced by zero value however, the negative value is included when calculating the total for the year.

## Remuneration Report - Pension entitlements (audited information)

| Name and title | Real increase in pension at pension age (bands of £2,500) Apr 2024 - Mar 2025 £000 | Real increase in pension lump sum at pension age (bands of £2,500) Apr 2024 - Mar 2025 £000 | Total accrued pension age at 31 March 2025 (bands of £5,000) £000 | Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000) £000 | Cash Equivalent Transfer Value at 31 March 2025 £000 | Cash Equivalent Transfer Value at 31 March 2024 £000 | Real increase in Cash Equivalent Transfer Value *** Apr 2024- Mar 2025 £000 | Employer's contribution to stakeholder pension (rounded to nearest £00) £00 | Pension Accrued 31 March 2024 £ | Lump Sum 31 March 2024 £ | CETV 31 March 2024 £ | Pension Accrued 31 March 2025 £ | Lump Sum 31 March 2025 £ | CETV 31 March 2025 £ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Carol Anderson, Director of Quality (Nurse Member)* | 0 - 2.5 | 0 - 2.5 | 50 - 55 | 130 - 135 | 1,174 | 1,111 | -29 | - | 48,778 | 130,465 | 1,110,935 | 51,840 | 130,465 | 1,174,388 |
| Louis Kamfer, Chief Financial Officer | 2.5 - 5 | 0 - 2.5 | 30 - 35 | - | 466 | 386 | 34 | - | 28,922 | - | 386,365 | 34,166 | - | 465,875 |
| Jan Thomas, Accountable Officer* | 2.5 - 5 | 0 - 2.5 | 40 - 45 | 25 - 30 | 690 | 233 | 416 | - | 36,121 | 25,675 | 233,332 | 42,374 | 26,614 | 689,747 |
| Fiona Head, Medical Director* | 0 - 2.5 | 70 - 72.5 | 50 - 55 | 130 - 135 | 1,225 | 966 | 178 | - | 52,844 | 56,436 | 966,216 | 51,119 | 131,833 | 1,224,833 |
| Nicci Briggs, Chief Financial Officer (to 16/02/25) | 0 - 2.5 | 0 - 2.5 | 40 - 45 | - | 576 | 501 | 17 | - | 36,828 | - | 501,271 | 42,085 | - | 575,533 |
| Claudia Iton, Chief People Officer | 2.5 - 5 | 0 - 2.5 | 5 - 10 | - | 0 | 94 | -119 | - | 4,967 | - | 93,616 | 8,558 | - | - |
| Stacie Coburn, Chief Operating Officer | 2.5 - 5 | 0 - 2.5 | 5 - 10 | - | 86 | 52 | 13 | | 4,692 | - | 52,202 | 7,649 | - | 86,304 |
| Kate Vaughton, Chief Officer Partnerships and Integration (from 03/01/25) | 0 - 2.5 | 0 - 2.5 | 40 - 45 | 105 - 110 | 874 | 725 | 20 | | 35,923 | 93,241 | 725,086 | 43,007 | 106,542 | 874,339 |
| Sarah Griffiths, Chief Financial Officer (from 03/03/25) | 0 - 2.5 | 0 - 2.5 | 5 - 10 | - | 123 | 87 | 1 | | 7,056 | 0 | 86,645 | 9,881 | 0 | 123,090 |
| Dr Gary Howsam, Clinical Chief Improvement Officer * | 0 - 2.5 | 0 - 2.5 | 30 - 35 | 70 - 75 | 687 | 629 | -2 | - | 28,909 | 70,916 | 629,389 | 32,002 | 71,197 | 686,615 |

No pensions contributions are made on behalf of the chairman and lay members.

The calculation of real increases values may be negative. Manual for Accounts guidance requests negatives are replaced by zero value.

The Real increase calculations are proportionate for the time in post.

The prior year pensions figures included in the above table may be different from those reported in the 2023/24 Annual Report and Accounts where NHS Pensions have provided revised information after completion of the 2023/24 Accounts.

* The calculation of real increases in the value of the Lump Sum and/ or Pension Accrued are negative. As per the Manual for Accounts, negatives are replaced by zero value.

## Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's 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 effectively 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).

## Off-payroll engagements

For all off-payroll engagements as of 31 March 2025, for more than £245 per day and that last longer than six months:

| Number of existing engagements | Number |
|---|---|
| as of 31 March 2024 | 14 |
| Of which, the number that have existed: | |
| for less than one year at the time of reporting | 3 |
| for between one and two years at the time of reporting | 6 |
| for between two and three years at the time of reporting | 3 |
| for between three and four years at the time of reporting | 0 |
| for four or more years at the time of reporting | 2 |

The ICB has undertaken a risk-based assessment as to whether assurance is required that the individual is paying the correct amount of Tax and NI. The ICB has concluded that the risk of significant exposure in relation to these individuals is minimal.

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

| Number of new engagements | Number |
|---|---|
| between 1 April 2024 and 31 March 2025 | 4 |
| Of which: | |
| No. assessed as caught by IR35 | - |
| No. assessed as not caught by IR35 | - |
| No. engaged directly (via PSC contracted to department) and are on the departmental payroll | - |
| No. of engagements reassessed for consistency / assurance purposes during the year. | - |
| No. of engagements that saw a change to IR35 status following the consistency review. | - |

The ICB has undertaken a risk assessment and concluded that engagement without contractual clauses allowing it to seek assurance on individuals tax obligations would not result in significant exposure for the ICB.

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

| 1 April 2024 and 31 March 2025 | Number |
|---|---|
| No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year | - |
| Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year | 10 |

The above disclosure has not been audited and there is no requirement for the information to be audited.

## Pay Ratio Information

Figures subject to audit.

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

The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

| **2024/25** | 25th percentile | Median pay ratio | 75th percentile pay ratio |
|---|---|---|---|
| Total remuneration (£) | £36,483 | £48,526 | £60,504 |
| Salary component of total remuneration (£) | £36,483 | £48,526 | £60,504 |
| Pay ratio information | 5.41:1 | 4.07:1 | 3.26:1 |
| **2023/24** | 25th percentile | Median pay ratio | 75th percentile pay ratio |
| Total remuneration (£) | £32,529 | £45,996 | £57,349 |
| Salary component of total remuneration (£) | £32,529 | £45,996 | £57,349 |
| Pay ratio information | 5.76:1 | 4.08:1 | 3.27:1 |

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.

The percentage change in remuneration of the highest paid director from the previous financial year was 5.33% (2023/24 2.74%). This is calculated using the midpoint of the salary band.

The average change from the previous financial year in respect of employees of the entity was 9.52% (2023/24 10.53%). This is calculated using the midpoint of the salary band based on the average salary (total salary costs excluding the highest paid director, divided by the full-time equivalent number of employees).

# Staff Report

## Number of senior managers

## Senior Managers in Post at the start of the period (1 April 2024).

The table below shows the number of Senior Managers in post at the start of the period (1 April 2024), where Senior Manager is taken to be managers that are paid at Band 8 or above.

The figures exclude Non-Executive Members and the ICB Chair but include Executive Board Members and staff recharged by other Department of Health and Social Care (DHSC) group bodies.

| Pay grade | Head count | Full Time Equivalent (FTE) | Employment Status |
|---|---|---|---|
| Personal Salary including Very Senior Manager (VSM) | 26 | 12.44 | Permanent |
| NHS\|YC72\|Consultant (post 31 Oct) | 2 | 1.60 | Permanent |
| NHS\|XR12\|Review Body Band 9 | 7 | 7.00 | Permanent |
| NHS\|XR11\|Review Body Band 8 - Range D | 19 | 18.30 | Permanent |
| NHS\|XR10\|Review Body Band 8 - Range C | 29 | 28.26 | Permanent |
| NHS\|XR09\|Review Body Band 8 - Range B | 29 | 28.00 | Permanent |
| NHS\|XR08\|Review Body Band 8 - Range A | 62 | 59.09 | Permanent |
| Sub total (Permanent) | 174 | 154.69 | Permanent |
| Personal Salary including Very Senior Manager (VSM) | 6 | 2.13 | Other |
| NHS\|YC72\|Consultant (post 31 Oct) | 1 | 1.00 | Other |
| NHS\|XR12\|Review Body Band 9 | 1 | 0.51 | Other |
| NHS\|XR11\|Review Body Band 8 - Range D | 0 | 0.00 | Other |
| NHS\|XR10\|Review Body Band 8 - Range C | 1 | 1.00 | Other |
| NHS\|XR09\|Review Body Band 8 - Range B | 3 | 3.00 | Other |
| NHS\|XR08\|Review Body Band 8 - Range A | 5 | 4.20 | Other |
| Sub total (Other) | 17 | 11.84 | Other |
| Overall Total | 191 | 166.53 | All |

The "Personal Salary" pay grade comprises the following, that are paid “personal salary” amounts in accordance with the organisation’s Remuneration Framework as opposed to being on “Agenda for Change” bands:

- 7 headcount Very Senior Managers (VSM) including the Chief Executive Officer and Executive Directors.
- 21 headcount GP Clinical Leads.
- 4 other general staff.

‘Permanent’ refers to members of senior management with a permanent (UK) employment contract directly with the organisation.

‘Other’ refers to any senior manager engaged by the ICB on 1 April 2024 that does not have a permanent (UK) employment contract with the organisation. This includes employees on short

term contracts of employment, agency/temporary staff, locally engaged staff overseas, and inward secondments from other entities where the whole or majority of the employees' costs are met locally.

## Senior Managers in Post at the end of the period (31 March 2025).

The table below shows the number of Senior Managers in post at the end of the period (31 March 2025), where Senior Manager is taken to be managers that are paid at Band 8 or above).

The figures exclude Non-Executive Members and the ICB Chair but include Executive Board Members and staff recharged by other Department of Health and Social Care (DHSC) group bodies.

| Pay grade | Head count | Full Time Equivalent (FTE) | Employment Status |
|---|---|---|---|
| Personal Salary including Very Senior Manager (VSM) | 28 | 13.19 | Permanent |
| NHS\|YC72\|Consultant (post 31 Oct) | 3 | 2.60 | Permanent |
| NHS\|XR12\|Review Body Band 9 | 7 | 7.00 | Permanent |
| NHS\|XR11\|Review Body Band 8 - Range D | 16 | 15.40 | Permanent |
| NHS\|XR10\|Review Body Band 8 - Range C | 26 | 25.30 | Permanent |
| NHS\|XR09\|Review Body Band 8 - Range B | 31 | 29.70 | Permanent |
| NHS\|XR08\|Review Body Band 8 - Range A | 63 | 59.94 | Permanent |
| Sub total (Permanent) | 174 | 153.13 | Permanent |
| Personal Salary including Very Senior Manager (VSM) | 3 | 2.05 | Other |
| NHS\|YC72\|Consultant (post 31 Oct) | 0 | 0.00 | Other |
| NHS\|XR12\|Review Body Band 9 | 1 | 0.51 | Other |
| NHS\|XR11\|Review Body Band 8 - Range D | 3 | 2.60 | Other |
| NHS\|XR10\|Review Body Band 8 - Range C | 2 | 2.00 | Other |
| NHS\|XR09\|Review Body Band 8 - Range B | 6 | 5.80 | Other |
| NHS\|XR08\|Review Body Band 8 - Range A | 0 | 0.00 | Other |
| Sub total (Other) | 15 | 12.96 | Other |
| **Overall Total** | **189** | **166.09** | **All** |

The "Personal Salary" pay grade comprises the following, that are paid "personal salary" amounts in accordance with the organisation's Remuneration Framework as opposed to being on "Agenda for Change" bands:

- 8 headcount Very Senior Managers (VSM) including the Chief Executive Officer and Executive Directors.
- 19 headcount Clinical Leads.

- 4 other general staff.

'Permanent' refers to members of senior management with a permanent (UK) employment contract directly with the organisation.

'Other' refers to any senior manager engaged by the ICB on 31 March 2025 that does not have a permanent (UK) employment contract with the organisation. This includes employees on short term contracts of employment, agency/temporary staff, locally engaged staff overseas, and inward secondments from other entities where the whole or majority of the employees' costs are met locally.

## Staff numbers and costs

At the start of the period, 1 April 2024, excluding Non-Executive Members and Chair but including Executive Members and staff seconded in from other entities and Agency Workers, there were 444 people engaged in work activity by the ICB amounting to a Full Time Equivalent (FTE) of 398.72 FTE.

At the end of the period, 31 March 2025, the total number of staff engaged by the ICB (as above), comprised a headcount of 451 amounting to a Full Time Equivalent (FTE) of 403.63 FTE. Across the reporting period commencing 1 April 2024 and ending 31 March 2025, the ICB had an average weekly workforce of 401.50 FTE.

The table below identifies the split between permanent staff and temporary staff engaged by the ICB at the close of the reporting period (31 March 2025).

| Figures subject to audit | Headcount | Full Time Equivalent (FTE) | Cost (in £000s) |
|---|---|---|---|
| Permanent staff on payroll on 31 March 2025 | 408 | 366.87 | 27,872 |
| **Other (temporary) staff on 31 March 2025** | **Headcount** | **Full Time Equivalent (FTE)** | **Cost (in £000s)** |
| Fixed Term Contract (FTC) staff on payroll (excluding non-executive members/Chair x5) | 20 | 16.71 | 866 |
| Staff engaged on Contracts for Services | 2 | 0.60 | 23 |
| ICB Staff seconded out to other organisations | (7) | (5.80) | (385) |
| ICB staff on unpaid career break | 0 | 0.00 | 0 |
| Staff seconded into the ICB from other organisations | 10 | 8.45 | 524 |
| Agency and Bank workers engaged by the organisation | 11 | 11.00 | 1,948 |
| **Total staff engaged by the organisation on 31 March 2025** | **451** | **403.63** | **30,848** |

The cost of total staff engaged by the ICB is higher than the figure (£30,301k) detailed in Note 4.1.1 as it includes staff seconded into the ICB and staff engaged on Contracts for Services which are not included in Note 4.1.1.

The functional categories breakdown of the staff on ICB payroll (excluding Non-Executive Members and Chair) as at 31 March 2025 (as defined in NHS Digital's NHS Occupation Code Manual) is as follows:

| PERMANENT STAFF ON PAYROLL | | | Occupation Code | Headcount |
|---|---|---|---|---|
| Administration and Estates staff | Senior Manager | Central Functions | G0A | 23 |
| | Manager | Central Functions | G1A | 126 |
| | Clerical and Administrative | Central Functions | G2A | 139 |
| Nursing, Midwifery and Health Visiting Staff | Manager | Community Services | N0H | 3 |
| | Children's Nurse | Community Services | N1H | 2 |
| | Other 1st level (Level 1 – Sub Part 1) | Other Mental Health | N6E | 2 |
| | | Community Learning Disabilities | N6F | 1 |
| | | Community Services | N6H | 61 |
| Qualified Allied Health Professionals | Manager | Pharmacy | S0P | 3 |
| | Scientist | Pharmacy | S2P | 15 |
| | Technician | Pharmacy | S4P | 8 |
| | Therapist | Dietetics | S1B | 1 |
| Qualified Other Scientific, Therapeutic & Technical | Manager | Social Services | SOU | 2 |
| Medical and Dental | Other Specialities | | 099 | 1 |
| | General Medical Practitioner | | 921 | 19 |
| | Public Health Medicine | | 930 | 2 |
| | | | | **408** |

| OTHER (TEMPORARY) STAFF | | | Occupation Code | Headcount |
|---|---|---|---|---|
| Administration and Estates staff | Senior Manager | Central Functions | G0A | 6 |
| | Manager | Central Functions | G1A | 7 |
| | Clerical and Administrative | Central Functions | G2A | 15 |
| Nursing, Midwifery and Health Visiting Staff | Other 1st level (Level 1 – Sub Part 1) | Community Services | N6H | 13 |
| Medical and Dental | Other Specialities | | 099 | 2 |
| | | | | **43** |

Of the total number of staff engaged by the ICB at the end of the period (a headcount of 451 amounting to a Full Time Equivalent (FTE) of 403.63 FTE on 31 March 2025), 408 staff (366.87 FTE) were employed on permanent contracts of employment with the ICB and 20 staff (16.71 FTE) were employed by the ICB on short (fixed) term contracts of employment and 2 on a Contract for Services basis.

7 staff (5.81 FTE) were seconded out to other organisations.
10 staff (8.45 FTE) were seconded in from NHS Trusts and the Local Authority to work in roles with the organisation.

On 31 March 2025, there were 11 agency workers, amounting to 11.00 FTE being engaged by the organisation. 6 of the agency workers were working in clinical roles, 5 agency workers were supporting administrative and managerial functions for the organisation.

*Staff composition*

*Gender Analysis*

The ICB entered the period as of 1 April 2024 with a gender distribution of 77.03% females and 22.97% males.

Since 31 March 2017 all public sector organisations in England employing 250 or more staff have been required to publish annually their gender pay gap information.

The ICB Gender Pay Gap for the snapshot date of 31 March 2025 20.59% (mean) and 10.52% (median) (figures not yet published) with the following proportion of males and females in the ICB in each quartile pay band as of 31 March 2025 (snapshot date):

| | Male | Female |
|---|---|---|
| Lower Quartile Pay Band | 18.00% | 82.00% |
| Lower Middle Quartile Pay Band | 16.67% | 83.33% |
| Upper Middle Quartile Pay Band | 20.72% | 79.28% |
| Upper Quartile Pay Band | 33.64% | 66.36% |

Figures from 31 March 2025

At the end of the reporting period (31 March 2025) the gender distribution of ICB staff was 77.83% females and 22.17% males.

Of those occupying a role as Executive Director (31 March 2025), 77.78% were female and 22.22% identified as male. Senior Managers (excluding those in a director role) comprised 72.78% female and 27.22% male. The remaining staff cohort comprised 81.3% females and 18.7% males.

*Sickness absence data*

The ICB recorded an average sickness absence rate during the period of 4.85%
The table below splits the absence into short term and long term (where long term is any absence of greater than or equal to 28 days' duration).

| | Absence % FTE |
|---|---|
| Short Term | 1.35 |
| Long Term (lasting 28 days or more) | 3.50 |
| | 4.85 |

More detailed information (by month data) can be found in the NHS Digital publication series on NHS Sickness Absence Rates at:
https://digital.nhs.uk/data-and- information/publications/statistical/nhs-sickness-absence-rates

*Staff turnover percentages*

For the reporting period 1 April 2024 to 31 March 2025 an overall staff turnover rate of 11.31% was recorded (numbers leaving during the period (headcount 51) divided by the average number of staff in post over the period (headcount 451)).

*Staff engagement percentages*

This was our second year of completing the NHS Staff Survey and, in a challenging year with a vacancy freeze in the ICB, we saw our survey response rate decline from 86% in 2023 to 74% in 2024. The average response rate for similar organisations (ICBs) for 2024 was 76%.

The NHS Staff survey is aligned to the NHS People Promise to help improve staff experiences in support of delivering improved patient care.
A review of the responses received from staff led us to undertake a review of the appraisal process and we continue to use the results as a foundation, through the engagement of staff groups and our directorates within the ICB and ICS.

In response to the survey, the ICB has implemented an 'Allyship' forum with a number of individuals from across the organisation volunteering as allies as a support network to staff. The 'allies' complement the Health & Wellbeing, Freedom to Speak Up and Mental Health Ambassador support teams.

*Staff policies*

The ICB operates the guaranteed interview scheme and uses tools to ensure adverts and products are accessible. The end-to-end recruitment process has been reviewed and updated. Requests for additional support are taken seriously and adjustments made where it is reasonable.

A new supporting neurodivergent colleagues' policy has been produced and is currently being consulted on.

All ICB policies are subject to a phased review programme. Those linked to legislative changes have been completed to date as part of phase one. This has included maternity, paternity and adoption leave, carers and special leave, flexible working, supporting attendance and menopause. The policy review is focused on embracing diversity and inclusivity within the workforce. All reviewed policies are being equality impact assessed and the outcomes are shared with staff side during the consultation phases.

The next phase of the review will include refreshing the Equality, Diversity and Inclusion policy. The plan is also to introduce a focus on women and men's health policies.

The ICB has published its 2024 gender pay figures and analysed disability and global majority pay gaps to inform an action plan that aims to reduce the pay gaps. The interventions include implementing inclusive recruitment approaches (anonymous screening diverse interview panels), monitoring pay and workforce data, introducing non-discriminatory policies around pay and training.

The ICB has introduce allyship roles to support colleagues. It has also launched its squaring the triangle initiative which is the ICB's system approach to reducing ethnic inequality in our workforce. The focus of this approach is:

- Change the shape of representation so that people of all backgrounds have the opportunity to develop and excel at every level in our organisations
- Engender the inclusive culture that will allow us to realise our vision for new models of care from cohesive, inclusive teams that support each other to deliver with excellence

The ICB has published its workforce protected characteristics data and how it compares with the Cambridgeshire and Peterborough population.

*Trade Union Facility Time Reporting Requirements*

The Trade Union (Facility Time Publication Requirements) Regulations 2017 (Regulation 8), requires the ICB to publish annually the following information:

- The total number of ICB employees that were relevant union officials during the relevant period.
- The percentage of time spent on facility time.
- The percentage of the ICB pay bill spent on facility time.
- The percentage of Paid trade union activities.

The information for the ICB for the period commencing 1 April 2024 and ending 31 March 2025 is set out in the tables below:

*Relevant Union Officials:*

| | |
|---|---|
| Number of ICB employees that were relevant union officials during the period. | 1 |
| Full time equivalent number. | 0.60 |

*Percentage of time spent on facility time:*

| Percentage of time spent on facility time. | Number of employees |
|---|---|
| 0% | 0 |
| 1-50% | 1 |
| 51-99% | 0 |
| 100% | 0 |

*Percentage of pay bill spent on facility time:*

| | |
|---|---|
| Total cost of facility time (£). | 1910 |
| Total pay bill (£). | 30,301,429 |
| Percentage spent on facility time. | 0.0063 |

*Percentage of Paid trade union activities*

| | |
|---|---|
| Time spent on paid trade union activities (hours) | 6 |
| Total paid facility time (hours) | 80 |
| Percentage of facility time spent on union activities. | 7.5% |

*Other employee matters*

The ICB is reviewing its appraisal approach with a view to producing a more holistic approach to regular conversations around wellbeing, career aspirations, learning and development and delivery of agreed objectives.

Staff side are involved in ICB job matching activities. We consult with trade union partners on all policy changes and proposals. Topics such as EDI, reward, health and safety, display screen equipment assessments are included in the ICB's induction and Manager's training programmes.

### *Expenditure on consultancy*

The ICB did not have any expenditure on consultancy during the period 1 April 2024 to 31 March 2025.

### *Off-payroll engagements*

Refer to Remuneration report – page 83 Refers.

*Exit packages, including special (non-contractual) payments*

**Table 1: Exit Packages**

| Exit package cost band (inc. any special payment element | Number of compulsory redundancies | Cost of compulsory redundancies | Number of other departures agreed | Cost of other departures agreed | Total number of exit packages | Total cost of exit packages | Number of departures where special payments have been made | Cost of special payment element included in exit packages |
|---|---|---|---|---|---|---|---|---|
| | WHOLE NUMBERS ONLY | £s | WHOLE NUMBERS ONLY | £s | WHOLE NUMBERS ONLY | £s | WHOLE NUMBERS ONLY | £s |
| **Less than £10,000** | 1 | 7,921 | 1 | 2,035 | 2 | 9,956 | - | - |
| **£10,000 - £25,000** | 1 | 15,126 | - | - | 1 | 15,126 | - | - |
| **£25,001 - £50,000** | 1 | 42,171 | - | - | 1 | 42,171 | - | - |
| **£50,001 - £100,000** | - | - | - | - | - | - | - | - |
| **£100,001 - £150,000** | - | - | - | - | - | - | - | - |
| **£150,001 – £200,000** | - | - | - | - | - | - | - | - |
| **>£200,000** | - | - | - | - | - | - | - | - |
| TOTALS | 3 | 65,218 | 1 | 2,035 | 4 | 67,253 | - | - |

Redundancy and other departure cost have been paid in accordance with the provisions of the NHS Pension Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the ICB has agreed early retirements, the additional costs are met by the 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.

**Table 2: Analysis of Other Departures**

| | Agreements Number | Total Value of agreements £000s |
|---|---|---|
| Voluntary redundancies including early retirement contractual costs | - | - |
| Mutually agreed resignations (MARS) contractual costs | - | - |
| Early retirements in the efficiency of the service contractual costs | - | - |
| Contractual payments in lieu of notice* | **1** | **2** |
| Exit payments following Employment Tribunals or court orders | - | - |
| Non-contractual payments requiring HMT approval** | - | - |
| **TOTAL** | **1** | **2** |

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 4.3 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.

# Parliamentary Accountability and Audit Report

Cambridgeshire and Peterborough Integrated Care Board 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 at note 4.3 and note 28. An audit certificate and report are also included in this Annual Report at page 94.

## INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS CAMBRIDGESHIRE AND PETERBOROUGH INTEGRATED CARE BOARD

### Opinion

We have audited the financial statements of NHS Cambridgeshire and Peterborough Integrated Care Board ("the ICB") for the year ended 31 March 2025 which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 37, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by the HM Treasury's Financial Reporting Manual: 2024-25 as contained in the Department of Health and Social Care Group Accounting Manual 2024 to 2025, and the Accounts Direction issued by NHS England in accordance with the National Health Service Act 2006.

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Cambridgeshire and Peterborough Integrated Care Board as at 31 March 2025 and of its net expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2024 to 2025; and
- have been properly prepared in accordance with the National Health Service Act 2006, as amended by the Health and Care Act 2022.

### Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

### Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of 12 months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the ICB's ability to continue as a going concern.

## Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements, or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

## Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- other information published together with the audited financial statements is consistent with the financial statements; and
- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2024 to 2025.

## Matters on which we are required to report by exception

We are required 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 (as amended); or

- we make a written recommendation to the ICB under Section 24 and Schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 (as amended) 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; or

- we are not satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025; or

- in our opinion the governance statement does not comply with the guidance issued in the Department of Health and Social Care Group Accounting Manual 2024 to 2025.

We have nothing to report in these respects.

## Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's Responsibilities in respect of the Accounts, set out on page 58, the Accountable Officer is responsible for the preparation of the

financial statements and for being satisfied that they give a true and fair view and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is also responsible for ensuring the regularity of expenditure and income.

In preparing the financial statements, the Accountable Officer is responsible for 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 the Accountable Officer either intends to cease operations, or has no realistic alternative but to do so.

As explained in the Annual Governance Statement, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the ICB's resources.

## Auditor's responsibility for the audit of the financial statements

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 an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a 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 the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

***Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud***

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant are the National Health Service Act 2006, Health and Social Care Act 2012 and Health and Care Act 2022, and other legislation governing NHS ICBs, as well as relevant employment laws of the United Kingdom. In addition, the ICB has to comply with laws and regulations in the areas of anti-bribery and corruption and data protection.

- We understood how NHS Cambridgeshire and Peterborough Integrated Care Board is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of Management, Head of Internal Audit, Those Charged With Governance and the Local Counter Fraud Specialist and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance.

- We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur by planning and executing a journal testing strategy, testing the appropriateness of relevant entries and adjustments. We have considered whether judgements made are indicative of potential bias and considered whether the ICB is engaging in any transactions outside the usual course of business. We identified two specific fraud risks, relating to the risk of fraud in expenditure recognition through key estimates/judgements and misstatements due to fraud or error in relation to the classification of Admin and Programme costs.

- Based on this understanding we designed our audit procedures to identify noncompliance with such laws and regulations. Our procedures involved enquiry of Management, Those Charged With Governance, Internal Audit and the Local Counter Fraud Specialist, reading and reviewing

relevant meeting minutes of those charged with governance and the Governing Body and understanding the internal controls in place to mitigate risks related to fraud and non-compliance with laws and regulations.

- We addressed our fraud risks related to management override through implementation of a journal entry testing strategy, assessing accounting estimates for evidence of management bias and evaluating the business rationale for significant unusual transactions.

  To address our risk of fraud in expenditure recognition, we tested the appropriateness of expenditure recognition accounting policies and that they had been applied correctly during our detailed testing. We also tested a sample of accruals based on our established testing threshold for reasonableness, performed cut-off testing of transactions both before and after year-end to ensure that they were accounted for in the correct year, and performed sample testing on expenditure, including expenditure outside of contract arrangements. In addition, we have reviewed the Department of Health and Social Care (DHSC) Agreement of Balances data and investigated significant differences (outside of DHSC tolerances) and considered the completeness of liabilities included in the financial statements by performing unrecorded liability testing.

  To address our fraud risk in relation to the classification of Admin and Programme costs we performed journal testing on transactions moving expenditure from admin cost centres to programme cost centres; and tested judgements made by management on the classification of programme and admin expenditure, ensuring the classification is compliant with relevant guidance.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

## Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice 2024, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in November 2024 as to whether the ICB had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the ICB put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the ICB had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 (as amended) to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 (as amended) requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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.

## Report on Other Legal and Regulatory Requirements

### Regularity opinion

In our opinion, in all material respects the expenditure and income reflected 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 are responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Local Audit and Accountability Act 2014 (as amended).

We conducted our work in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) issued by the Public Audit Forum. We are required to obtain evidence sufficient to give an opinion on whether 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.

### Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until the NAO, as group auditor, has confirmed that no further assurances will be required from us as component auditors of NHS Cambridgeshire and Peterborough Integrated Care Board.

### Use of our report

This report is made solely to the members of the Governing Body of NHS Cambridgeshire and Peterborough Integrated Care Board in accordance with Part 5 of the Local Audit and Accountability Act 2014 (as amended) and for no other purpose. Our audit work has been undertaken so that we might state to the members of the Governing Body of the ICB 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 as a body, for our audit work, for this report, or for the opinions we have formed.


David Riglar (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Cambridge
20 June 2025

# Annual Accounts

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

| | Note | 2024-25 £'000 | 2023-24 £'000 |
|---|---|---|---|
| Income from sale of goods and services | 2 | (28,931) | (26,998) |
| **Total operating income** | | **(28,931)** | **(26,998)** |
| Staff costs | 4 | 30,686 | 26,240 |
| Purchase of goods and services | 5 | 2,408,897 | 1,997,607 |
| Depreciation and impairment charges | 5 | 120 | 120 |
| Provision expense | 5 | - | (114) |
| Other operating expenditure | 5 | 3,318 | 737 |
| **Total operating expenditure** | | **2,443,022** | **2,024,592** |
| **Net Operating Expenditure** | | **2,414,091** | **1,997,594** |
| Finance expense | 10 | 2 | 3 |
| **Net expenditure for the Year** | | **2,414,093** | **1,997,597** |
| **Total Net Expenditure for the Financial Year** | | **2,414,093** | **1,997,597** |
| **Comprehensive Expenditure for the year** | | **2,414,093** | **1,997,597** |

**Statement of Financial Position as at 31 March 2025**

| | Note | 2024-25 £'000 | 2023-24 £'000 |
|---|---|---|---|
| **Non-current assets:** | | | |
| Right-of-use assets | 13 | 120 | 241 |
| **Total non-current assets** | | **120** | 241 |
| **Current assets:** | | | |
| Inventories | 16 | 182 | 182 |
| Trade and other receivables | 17 | 23,613 | 19,702 |
| Cash and cash equivalents | 20 | 86 | (4,529) |
| **Total current assets** | | **23,881** | **15,355** |
| **Total current assets** | | **23,881** | 15,355 |
| **Total assets** | | **24,002** | 15,596 |
| **Current liabilities** | | | |
| Trade and other payables | 22 | (175,046) | (141,770) |
| Lease liabilities | 13 | (169) | (108) |
| **Total current liabilities** | | **(175,215)** | (141,878) |
| **Non-Current Assets plus/less Net Current Assets/Liabilities** | | **(151,213)** | (126,282) |
| **Non-current liabilities** | | | |
| Lease liabilities | 13 | - | (166) |
| **Total non-current liabilities** | | **-** | **(166)** |
| **Assets less Liabilities** | | **(151,213)** | (126,448) |
| **Financed by Taxpayers' Equity** | | | |
| General fund | | (151,213) | (126,448) |
| **Total taxpayers' equity:** | | **(151,213)** | (126,448) |

The notes on pages 108 to 124 form part of this statement

The financial statements on pages 104 to 107 were approved by the Board on 20 June 2025 and signed on its behalf by:

Jan Thomas
Chief Accountable Officer
20 June 2025

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

| | General fund £'000 | Total reserves £'000 |
|---|---|---|
| **Changes in taxpayers' equity for 2024-25** | | |
| **Balance at 01 April 2024** | (126,448) | (126,448) |
| **NHS Integrated Care Board balance at 31 March 2024** | **(126,448)** | **(126,448)** |
| **Changes in NHS Integrated Care Board taxpayers' equity for 2024-25** | | |
| **Net Recognised Expenditure for the Financial year** | **(2,414,093)** | **(2,414,093)** |
| Net funding | 2,389,328 | **2,389,328** |
| **Balance at 31 March 2025** | **(151,213)** | **(151,213)** |

| | General fund £'000 | Total reserves £'000 |
|---|---|---|
| **Changes in taxpayers' equity for 2023-24** | | |
| **Balance at 01 April 2023** | (128,467) | **(128,467)** |
| **Adjusted balance at 31 March 2024** | **(128,467)** | **(128,467)** |
| **Changes in NHS Integrated Care Board taxpayers' equity for 2023-24** | | |
| **Net Recognised NHS Integrated Care Board Expenditure for the Financial Year** | **(1,997,597)** | **(1,997,597)** |
| Net funding | 1,999,615 | 1,999,615 |
| **Balance at 31 March 2024** | **(126,448)** | **(126,448)** |

The notes on pages 108 to 124 form part of this statement

**Statement of Cash Flows for the year ended 31 March 2025**

| | Note | **2024-25 £'000** | 2023-24 £'000 |
|---|---|---|---|
| **Cash Flows from Operating Activities** | | | |
| Net operating expenditure for the financial year | | (2,414,093) | (1,997,597) |
| Depreciation and amortisation | 5 | 120 | 120 |
| Interest paid / received | | 2 | 3 |
| (Increase)/decrease in trade & other receivables | 17 | (3,911) | (8,982) |
| Increase/(decrease) in trade & other payables | 22 | 33,276 | 2,205 |
| Provisions utilised | 27 | - | (455) |
| Increase/(decrease) in provisions | 27 | - | (114) |
| **Net Cash Inflow (Outflow) from Operating Activities** | | **(2,384,606)** | (2,004,820) |
| **Cash Flows from Investing Activities** | | | |
| **Net Cash Inflow (Outflow) from Investing Activities** | | **-** | - |
| **Net Cash Inflow (Outflow) before Financing** | | **(2,384,606)** | (2,004,820) |
| **Cash Flows from Financing Activities** | | | |
| Grant in Aid Funding Received | | 2,389,328 | 1,999,615 |
| Repayment of lease liabilities | | (107) | (107) |
| **Net Cash Inflow (Outflow) from Financing Activities** | | **2,389,221** | 1,999,508 |
| **Net Increase (Decrease) in Cash & Cash Equivalents** | 20 | **4,615** | (5,311) |
| **Cash & Cash Equivalents at the Beginning of the Financial Year** | | **(4,529)** | 783 |
| **Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year** | | **87** | (4,529) |

The notes on pages 108 to 124 form part of this statement

**Notes to the financial statements**

1 **Accounting Policies**

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

1.1 **Going Concern**

These accounts have been prepared on a going concern basis.
Public sector bodies are assumed to be a going concern where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

1.2 **Accounting Convention**

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

1.3 **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.

1.4 **Employee Benefits**

1.4.1 **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.

1.4.2 **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.

1.4.3 **Local Government Pensions**

Some employees are members of the Local Government Pension Scheme (LGPS), which is a defined benefit pension 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.

1.5 **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.

1.6 **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.

1.7 **Property, Plant & Equipment**

1.7.1 **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.

**Notes to the financial statements**

1.7.2 **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.

1.7.3 **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.

1.8 **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.

1.9 **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.

1.9.1 **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.

1.10 **Inventories**

Inventories are valued at the lower of cost and net realisable value.

1.11 **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.

**Notes to the financial statements**

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.

1.12 **Provisions**

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

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

• A nominal short-term rate of 4.03% (2023-24: 4.26%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 4.07% (2023-24: 4.03%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 4.81% (2023-24: 4.72%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 4.55% (2023-24: 4.40%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

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

1.13 **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.

1.14 **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.

1.15 **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.

1.16 **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.

1.16.1 **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.

1.16.2 **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.

1.16.3 **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.

1.16.4 **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).

**Notes to the financial statements**

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.

1.17 **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.

1.17.1 **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.

1.18 **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.

1.19 **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.

1.20 **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).

1.21 **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.

1.21.1 **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 ICB has entered into a partnership agreement and a pooled budget with Cambridgeshire County Council, Peterborough City Council, Hertfordshire County Council and North Northamptonshire Council in respect of the Better Care Fund. This is a national policy initiative and the funds involved are material in the ICB accounts. Having reviewed the terms of the partnership agreement, the DHSC GAM and the appropriate financial reporting standards, the ICB has determined that there are two elements to the Better Care Fund and they are accounted for as follows:

- the first element is controlled by the Councils which commission services from various non-NHS providers. Whilst the services are determined in partnership, the risks and rewards of the contracts remain wholly with the council. The ICB accounts for this as expenditure with the local authority.

- the second element is controlled by the ICB which commissions various services from NHS and non-NHS providers. The risks and rewards of these contracts are the responsibility of the ICB, which it considers to be acting as a lead commissioner for those services on behalf of the partnership. The ICB accounts for these costs as healthcare purchased from NHS and non-NHS providers.

As a result of the above, the ICB have accounted for the arrangements as jointly controlled operations.

1.21.2 **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.

The in-year liability relating to the Cambridgeshire Local Government Pension Scheme is immaterial and full IAS19 accounting and related disclosures are not warranted.

Material accounting estimates include Prescribing, whereby the NHS Business Services Authority provide a report which forecasts final Prescribing spend for each GP Practice and is used to calculate a year-end accrual of £21,531k (2023/24 £22,384k).

The continuing healthcare accrual as at 31 March 2025 is £4,687k (2023/24 £2,414k). The accrual is calculated by comparing ledger costs with the costs forecast from Adam, a database of clients' agreed funding.

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

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted.

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

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

The impact of the adoption of the above accounting standards has been reviewed and is not material to the Accounts.

1.23 **Transfer of functions**

As public sector bodies are deemed to operate under common control, business reconfigurations within the DHSC group are outside the scope of IFRS 3 Business Combinations. From the 1st April 2024, the ICB took on delegated commissioning responsibilities for specialised commissioning from NHS England.

## 2 Other Operating Revenue

| | 2024-25 Total | 2023-24 Total |
|---|---|---|
| | £'000 | £'000 |
| **Income from sale of goods and services (contracts)** | | |
| Non-patient care services to other bodies | **5,991** | 5,113 |
| Prescription fees and charges | **10,755** | 10,235 |
| Dental fees and charges | **8,808** | 8,534 |
| Other Contract income | **2,992** | 2,764 |
| Recoveries in respect of employee benefits | **385** | 352 |
| **Total Income from sale of goods and services** | **28,931** | **26,998** |
| **Total Other operating income** | **-** | **-** |
| **Total Operating Income** | **28,931** | **26,998** |

## 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 |
|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Source of Revenue** | | | | | |
| NHS | 4,965 | - | - | 543 | 201 |
| Non NHS | 1,026 | 10,755 | 8,808 | 2,449 | 184 |
| **Total** | **5,991** | **10,755** | **8,808** | **2,992** | **385** |

| | Non-patient care services to other bodies | Prescription fees and charges | Dental fees and charges | Other Contract income | Recoveries in respect of employee benefits |
|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Timing of Revenue** | | | | | |
| Point in time | 5,991 | 10,755 | 8,808 | 2,992 | 385 |
| Over time | - | - | - | - | - |
| **Total** | **5,991** | **10,755** | **8,808** | **2,992** | **385** |

## 4. Employee benefits and staff numbers

### 4.1.1 Employee benefits

| | 2024-25 Permanent Employees £'000 | Other £'000 | Total £'000 |
|---|---|---|---|
| **Employee Benefits** | | | |
| Salaries and wages | 21,371 | 1,948 | **23,319** |
| Social security costs | 2,433 | - | **2,433** |
| Employer Contributions to NHS Pension scheme | 4,774 | - | **4,774** |
| Apprenticeship Levy | 95 | - | **95** |
| Termination benefits | 65 | - | **65** |
| **Gross employee benefits expenditure** | **28,738** | **1,948** | **30,686** |
| Less recoveries in respect of employee benefits (note 4.1.2) | (385) | - | **(385)** |
| **Total - Net admin employee benefits including capitalised costs** | **28,353** | **1,948** | **30,301** |
| **Net employee benefits excluding capitalised costs** | **28,353** | **1,948** | **30,301** |

### 4.1.1 Employee benefits

| | 2023-24 Permanent Employees £'000 | Other £'000 | Total £'000 |
|---|---|---|---|
| **Employee Benefits** | | | |
| Salaries and wages | 18,934 | 1,331 | **20,265** |
| Social security costs | 2,200 | - | **2,200** |
| Employer Contributions to NHS Pension scheme | 3,679 | - | **3,679** |
| Apprenticeship Levy | 89 | - | **89** |
| Termination benefits | 8 | - | **8** |
| **Gross employee benefits expenditure** | 24,910 | 1,331 | **26,240** |
| Less recoveries in respect of employee benefits (note 4.1.2) | (352) | - | **(352)** |
| **Total - Net admin employee benefits including capitalised costs** | 24,558 | 1,331 | **25,888** |
| **Net employee benefits excluding capitalised costs** | **24,558** | **1,331** | **25,888** |

### 4.1.2 Recoveries in respect of employee benefits

| | 2024-25 Permanent Employees £'000 | Total £'000 | 2023-24 Total £'000 |
|---|---|---|---|
| **Employee Benefits - Revenue** | | | |
| Salaries and wages | (385) | (385) | (352) |
| **Total recoveries in respect of employee benefits** | **(385)** | **(385)** | **(352)** |

### 4.2 Average number of people employed

| | 2024-25 Permanently employed Number | Other Number | Total Number | 2023-24 Permanently employed Number | Other Number | Total Number |
|---|---|---|---|---|---|---|
| Total | 389.05 | 14.2 | 403.25 | 378.48 | 16 | 393.98 |
| Of the above: | | | | | | |
| Number of whole time equivalent people engaged on capital projects | - | - | - | - | - | - |

### 4.3 Exit packages agreed in the financial year

| | 2024-25 Compulsory redundancies Number | £ | 2024-25 Other agreed departures Number | £ | 2024-25 Total Number | £ |
|---|---|---|---|---|---|---|
| Less than £10,000 | 1 | 7,921 | 1 | 2,035 | 2 | 9,956 |
| £10,001 to £25,000 | 1 | 15,126 | - | - | 1 | 15,126 |
| £25,001 to £50,000 | 1 | 42,171 | - | - | 1 | 42,171 |
| £50,001 to £100,000 | - | - | - | - | - | - |
| £100,001 to £150,000 | - | - | - | - | - | - |
| £150,001 to £200,000 | - | - | - | - | - | - |
| Over £200,001 | - | - | - | - | - | - |
| **Total** | **3** | **65,218** | **1** | **2,035** | **4** | **67,253** |

| | 2023-24 Compulsory redundancies Number | £ | 2023-24 Total Number | £ |
|---|---|---|---|---|
| Less than £10,000 | 1 | 7,667 | 1 | 7,667 |
| £10,001 to £25,000 | - | - | - | - |
| £25,001 to £50,000 | - | - | - | - |
| £50,001 to £100,000 | 2 | 165,333 | 2 | 165,333 |
| £100,001 to £150,000 | - | - | - | - |
| £150,001 to £200,000 | 1 | 160,000 | 1 | 160,000 |
| Over £200,001 | - | - | - | - |
| **Total** | **4** | **333,000** | **4** | **333,000** |

### Analysis of Other Agreed Departures

| | 2024-25 Other agreed departures Number | £ |
|---|---|---|
| Contractual payments in lieu of notice | 1 | 2,035 |
| **Total** | **1** | **2,035** |

* As a single exit package can be made up of several components each of which will be counted separately in this table, the total number will not necessarily match the total number in the table above, which will be the number of individuals.
These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.
Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pension scheme.
Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.
Where the ICB has agreed early retirements, the additional costs are met by the ICB 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.
The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

### 4.4 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:

#### 4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.
The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

#### 4.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.
The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 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

For 2024/25, employers' contributions of £4,774k were payable to the NHS Pension Scheme at the rate of 23.7% of pensionable pay. These costs are included in the NHS pension line of note 4.1.

## 5. Operating expenses

| | 2024-25 Total £'000 | 2023-24 Total £'000 |
|---|---|---|
| **Purchase of goods and services** | | |
| Services from other ICBs and NHS England | 663 | 667 |
| Services from foundation trusts | 1,546,087 | 1,195,348 |
| Services from other NHS trusts | 113,466 | 94,754 |
| Purchase of healthcare from non-NHS bodies | 283,565 | 256,435 |
| General Dental services and personal dental services | 46,300 | 44,234 |
| Prescribing costs | 160,822 | 157,134 |
| Pharmaceutical services | 31,311 | 31,196 |
| General Ophthalmic services | 8,428 | 8,289 |
| GPMS/APMS and PCTMS | 209,601 | 198,065 |
| Supplies and services – clinical | 5,845 | 3,857 |
| Supplies and services – general | (5,753) | (1,213) |
| Establishment | 5,193 | 5,830 |
| Transport | 804 | - |
| Premises | 434 | 440 |
| Audit fees | 277 | 342 |
| Other non statutory audit expenditure | | |
| · Internal audit services | 153 | 133 |
| · Other services | 49 | 13 |
| Other professional fees | 973 | 1,591 |
| Legal fees | 459 | 290 |
| Education, training and conferences | 220 | 202 |
| **Total Purchase of goods and services** | **2,408,897** | **1,997,607** |
| | | |
| **Depreciation and impairment charges** | | |
| Depreciation | 120 | 120 |
| **Total Depreciation and impairment charges** | **120** | **120** |
| | | |
| **Provision expense** | | |
| Provisions | - | (114) |
| **Total Provision expense** | **-** | **(114)** |
| | | |
| **Other Operating Expenditure** | | |
| Chair and Non Executive Members | 137 | 139 |
| Grants to Other bodies | 472 | 20 |
| Expected credit loss on receivables | 2,709 | 578 |
| **Total Other Operating Expenditure** | **3,318** | **737** |
| | | |
| **Total operating expenditure** | **2,412,336** | **1,998,351** |

**6 Payment Compliance Reporting**

**6.1 Better Payment Practice Code**

| **Measure of compliance** | **2024-25 Number** | **2024-25 £'000** | 2023-24 Number | 2023-24 £'000 |
|---|---|---|---|---|
| **Non-NHS Payables** | | | | |
| Total Non-NHS Trade invoices paid in the Year | 19,891 | 360,394 | 33,922 | 318,555 |
| Total Non-NHS Trade Invoices paid within target | 15,041 | 321,629 | 28,797 | 271,057 |
| **Percentage of Non-NHS Trade invoices paid within target** | **75.62%** | **89.24%** | **84.89%** | **85.09%** |
| **NHS Payables** | | | | |
| Total NHS Trade Invoices Paid in the Year | 2,111 | 1,623,114 | 1,687 | 1,297,899 |
| Total NHS Trade Invoices Paid within target | 1,694 | 1,598,212 | 1,196 | 1,166,771 |
| **Percentage of NHS Trade Invoices paid within target** | **80.25%** | **98.47%** | **70.90%** | **89.90%** |

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

The ICB had no costs for the late payment of commercial debts (Interest) Act 1998.

**7 Income Generation Activities**

The ICB did not undertake any income generation activities.

**8. Investment revenue**

The ICB had no investment revenue.

**9. Other gains and losses**

The ICB had no other gains and losses.

**10.1 Finance costs**

| | **2024-25 £'000** | 2023-24 £'000 |
|---|---|---|
| **Interest** | | |
| Interest on lease liabilities | 2 | 3 |
| **Total finance costs** | **2** | **3** |

**10.2 Finance income**

The ICB had no finance income.

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

There were no transferred functions that gave rise to a recognised gain or loss.

**12 Property, plant and equipment**

| **2024-25** | **Plant & machinery £'000** | **Information technology £'000** | **Furniture & fittings £'000** | **Total £'000** |
|---|---|---|---|---|
| **Cost or valuation at 01 April 2024** | 49 | 965 | 51 | 1,064 |
| **Cost/Valuation at 31 March 2025** | **49** | **965** | **51** | **1,064** |
| **Depreciation 01 April 2024** | 49 | 965 | 51 | 1,064 |
| **Depreciation at 31 March 2025** | **49** | **965** | **51** | **1,064** |
| **Net Book Value at 31 March 2025** | **-** | **-** | **-** | **-** |
| **Total at 31 March 2025** | **-** | **-** | **-** | **-** |

## 13 Leases

### 13.1 Right-of-use assets

| 2024-25 | Buildings excluding dwellings £'000 |
|---|---|
| **Cost or valuation at 01 April 2024** | 482 |
| **Cost/Valuation at 31 March 2025** | **482** |
| | |
| **Depreciation 01 April 2024** | 241 |
| Charged during the year | 120 |
| **Depreciation at 31 March 2025** | **361** |
| | |
| **Net Book Value at 31 March 2025** | **120** |
| | |
| **NBV by counterparty** | |
| Leased from other group bodies | 120 |
| **Net Book Value at 31 March 2025** | **120** |

### 13.2 Lease liabilities

| 2024-25 | 2024-25 £'000 | 2023-24 £'000 |
|---|---|---|
| **Lease liabilities at 01 April 2024** | (274) | (378) |
| | | |
| Interest expense relating to lease liabilities | (2) | (3) |
| Repayment of lease liabilities (including interest) | 107 | 107 |
| **Lease liabilities at 31 March 2025** | **(169)** | **(274)** |

### 13.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

| | 2024-25 £'000 | Of which: leased from DHSC group bodies £000 | 2023-24 £'000 | Of which: leased from DHSC group bodies £000 |
|---|---|---|---|---|
| Within one year | (176) | (176) | (107) | (107) |
| Between one and five years | - | - | (170) | (170) |
| After five years | - | - | - | - |
| **Balance at 31 March 2025** | **(176)** | **(176)** | **(277)** | **(277)** |

### 13.4 Amounts recognised in Statement of Comprehensive Net Expenditure

| 2024-25 | 2024-25 £'000 | 2023-24 £'000 |
|---|---|---|
| Depreciation expense on right-of-use assets | 120 | 120 |
| Interest expense on lease liabilities | 2 | 3 |

### 13.5 Amounts recognised in Statement of Cash Flows

| | 2024-25 £'000 | 2023-24 £'000 |
|---|---|---|
| Total cash outflow on leases under IFRS 16 | 107 | 107 |

**14 Intangible non-current assets**
The ICB did not hold any intangible non-current assets.

**15 Investment property**
The ICB had no investment property as at 31 March 2025.

**16 Inventories**

| | **Other £'000** | **Total £'000** |
|---|---|---|
| **Balance at 01 April 2024** | 182 | **182** |
| **Balance at 31 March 2025** | **182** | **182** |

**17.1 Trade and other receivables**

| | **Current 2024-25 £'000** | Current 2023-24 £'000 |
|---|---|---|
| NHS receivables: Revenue | 5,924 | 9,553 |
| NHS prepayments | 77 | - |
| Non-NHS and Other WGA receivables: Revenue | 6,099 | 3,503 |
| Non-NHS and Other WGA prepayments | 1,305 | 1,116 |
| Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice | 12,782 | 5,689 |
| Expected credit loss allowance-receivables | (3,331) | (622) |
| VAT | 756 | 424 |
| Other receivables and accruals | 1 | 39 |
| **Total Trade & other receivables** | **23,613** | **19,702** |
| **Total current and non current** | **23,613** | **19,702** |
| Included above: | | |
| Prepaid pensions contributions | - | - |

**17.2 Receivables past their due date but not impaired**

| | **2024-25 DHSC Group Bodies £'000** | **2024-25 Non DHSC Group Bodies £'000** | 2023-24 DHSC Group Bodies £'000 | 2023-24 Non DHSC Group Bodies £'000 |
|---|---|---|---|---|
| By up to three months | 397 | 534 | 944 | 945 |
| By three to six months | 17 | 4 | 309 | 4 |
| By more than six months | (179) | 462 | 225 | 300 |
| **Total** | **235** | **1,000** | **1,478** | **1,249** |

**17.3 Loss allowance on asset classes**

| | **Trade and other receivables - Non DHSC Group Bodies £'000** |
|---|---|
| Balance at 01 April 2024 | **(622)** |
| Lifetime expected credit losses on trade and other receivables-Stage 2 | (2,709) |
| **Total** | **(3,331)** |

**18 Other financial assets**
The ICB had no other financial assets as at 31 March 2025.

**19 Other current assets**
The ICB had no other current assets as at 31 March 2025.

**20 Cash and cash equivalents**

| | **2024-25** | 2023-24 |
|---|---|---|
| | **£'000** | £'000 |
| **Balance at 01 April 2024** | (4,529) | 783 |
| Net change in year | 4,615 | (5,311) |
| **Balance at 31 March 2025** | **86** | **(4,529)** |
| | | |
| Made up of: | | |
| Cash with the Government Banking Service | 86 | (4,529) |
| Cash in hand | 1 | 1 |
| **Cash and cash equivalents as in statement of financial position** | **86** | **(4,529)** |
| | | |
| **Balance at 31 March 2025** | **86** | **(4,529)** |

**21 Analysis of impairments and reversals**

There were no impairments or reversals during 2024/25.

| **22 Trade and other payables** | **Current 2024-25 £'000** | Current 2023-24 £'000 |
|---|---|---|
| NHS payables: Revenue | 4,922 | 10,379 |
| NHS accruals | 56,309 | 16,509 |
| Non-NHS and Other WGA payables: Revenue | 25,254 | 22,230 |
| Non-NHS and Other WGA accruals | 79,212 | 86,457 |
| Non-NHS and Other WGA deferred income | 3,940 | 3,746 |
| Social security costs | 289 | 290 |
| Tax | 388 | 321 |
| Other payables and accruals | 4,731 | 1,837 |
| **Total Trade & Other Payables** | **175,046** | **141,770** |

**23 Other financial liabilities**

The ICB had no other financial liabilities as at 31 March 2025.

**24 Other liabilities**

The ICB had no other liabilities as at 31 March 2025.

**25 Borrowings**

The ICB had no borrowing as at 31 March 2025.

**26 Finance lease receivables**

The ICB had no finance lease receivables.

## 27 Provisions

Legal claims are calculated from the number of claims currently lodged with the NHS Resolution and the probabilities provided by them.

£0k (2023/24 £0k) is included in the provisions of NHS Resolution as at 31 March 2025 in respect of clinical negligence liabilities of the ICB. £15k (2023/24 £15k) is included in the provisions of NHS Resolution as at 31 March 2025 in respect of the Liabilities to Third Parties Scheme (LTPS).

Pension payments are made quarterly and amounts are known. The pension provision is based on life expectancy.

## 28 Contingencies

The ICB had no contingencies.

## 29 Commitments

The ICB had no capital or financial commitments (which are not leases, private finance initiative contracts or other service concession arrangements).

## 30 Financial instruments

### 30.1 Financial risk management

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

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

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

#### 30.1.1 Currency risk

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

#### 30.1.2 Interest rate risk

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

#### 30.1.3 Credit risk

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

#### 30.1.4 Liquidity risk

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

#### 30.1.5 Financial Instruments

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

**30 Financial instruments cont'd**

**30.2 Financial assets**

| | Financial Assets measured at amortised cost 2024-25 £'000 | Total 2024-25 £'000 |
|---|---|---|
| Trade and other receivables with NHSE bodies | 3,714 | 3,714 |
| Trade and other receivables with other DHSC group bodies | 2,210 | 2,210 |
| Trade and other receivables with external bodies | 18,881 | 18,881 |
| Cash and cash equivalents | 86 | 86 |
| **Total at 31 March 2025** | **24,892** | **24,892** |

**30.3 Financial liabilities**

| | Financial Liabilities measured at amortised cost 2024-25 £'000 | Total 2024-25 £'000 |
|---|---|---|
| Trade and other payables with NHSE bodies | 615 | **615** |
| Trade and other payables with other DHSC group bodies | 60,894 | **60,894** |
| Trade and other payables with external bodies | 108,920 | **108,920** |
| Private Finance Initiative and finance lease obligations | 169 | **169** |
| **Total at 31 March 2025** | **170,597** | **170,597** |

**31 Operating segments**

The ICB has considered the definition of an operating segment contained within IFRS 8 in determining its operating segments, in particular considering the internal reporting to the Governing Body, considered to be the 'chief operating decision maker' of the ICB, which was used for the purpose of resource allocation and assessment of performance. All activity performed by the ICB relates to its role as a commissioner of healthcare for its relevant population. As a result, the ICB considers that it has only one operating segment, being the commissioning of healthcare services. An analysis of both the income and expenditure and net assets relating to the segment can be found in the Statement of Comprehensive Net Expenditure and Statement of Financial Position respectively.

**32 Pooled budgets**

The ICB contributed to a pooled budget with Cambridgeshire County Council, Peterborough City Council and Hertfordshire County Council in respect of the Better Care Fund. The contributions include £50,731k (2023/24 £48,013k) to the Cambridgeshire fund and £16,196k (2023/24 £15,328k) to the Peterborough fund.

The ICB contributed into two other pooled budget agreements with Cambridgeshire County Council during 2024-2025. Under the arrangements, funds are pooled under S75 of the NHS Act 2006 for Integrated Community Equipment Services (ICES) and the Learning Disability Partnership (LDP).

The ICES and LDP are hosted by Cambridgeshire County Council. As a commissioner of healthcare services, the ICB makes contributions to the pools, which are then used to purchase healthcare services. The ICB accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreement.
The contribution to the LDP for the year was £29,622k (2023/24 £28,340k), which represents a share of 23.2% with the remaining contribution of 76.8% made by Cambridgeshire County Council.

The contribution to the ICES for the year was £2,645k (2023/24 £2,545k), which represents a share of 51.8% with the remaining contribution of 48.2% made by Cambridgeshire County Council.

**33 Related party transactions**

**Details of related party transactions with individuals are as follows:**

| | 31 March 2025 | | | |
|---|---|---|---|---|
| | Payments to Related Party £'000 | Receipts from Related Party £'000 | Amounts owed to Related Party £'000 | Amounts due from Related Party £'000 |
| | £'000 | £'000 | £'000 | £'000 |
| Dr Gary Howsam, Partner, Nene Valley Hodgson Medical Practice | 2,775 | - | - | - |
| Dr Gary Howsam, Non-Executive Director, Eastern Academic Health Science Network | 446 | - | - | - |
| Fiona Head, Retained GP, East Barnwell Health Centre | 1,092 | - | - | - |
| Dr Simon Hambling, Partner, Fenland Group Practice | 4,092 | - | - | - |
| Dr Diana Hunter, Chair of Cambridgeshire Local Medical Committee | 674 | - | 56 | - |
| Steve Grange, Chief Executive, Cambridgeshire & Peterborough NHS FT (from Oct 2024) | 118,065 | 356 | 5,261 | 59 |
| Matthew Winn, Chief Executive, Cambridgeshire Community Services NHS Trust | 25,601 | - | 311 | - |
| Matthew Winn, Chief Executive, Norfolk Community Health and Care NHS Trust | 1,799 | - | - | - |
| Eilish Midlane, Chief Executive, Royal Papworth Hospital NHS Foundation Trust | 68,685 | - | - | 852 |
| Dr Gary Howsam, stepson employee of North West Anglia NHS FT | 536,945 | 20 | 17,217 | 27 |
| Dr Gary Howsam, brother in law employed part time by Cambridgeshire Community Services NHS Trust | 25,601 | - | 311 | - |
| Saqhib Ali, Non Executive Member, Queen Elizabeth Hospital NHS FT | 41,560 | 4 | 175 | 4 |
| Jonathon Jelley, Board member, Peterborough City Council's Towns Fund Board | 10,902 | 771 | 15,343 | 682 |

The Department of Health is regarded as a related party. During the year the ICB has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. These entities with material values are listed below:

| | Payments to Related Party £000 | Receipts from Related Party £000 | Amounts owed to Related Party £000 | Amounts due from Related Party £000 |
|---|---|---|---|---|
| Cambridge University Hospitals NHS Foundation Trust | 594,186 | 197 | 36,561 | - |
| North West Anglia NHS Foundation Trust | 536,945 | 20 | 17,217 | 27 |
| Cambridgeshire & Peterborough NHS Foundation Trust | 236,129 | 711 | 5,261 | 59 |
| East of England Ambulance Service NHS Trust | 59,802 | - | 201 | - |
| Cambridgeshire Community Services NHS Trust | 25,601 | - | 311 | - |
| The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust | 41,560 | 4 | 175 | 4 |
| Royal Papworth Hospital NHS Foundation Trust | 68,685 | - | - | 852 |
| West Suffolk NHS Foundation Trust | 4,207 | - | - | 197 |
| NHS England | - | 5,628 | 310 | 3,495 |
| East & North Hertfordshire NHS Trust | 3,788 | - | 102 | - |
| Department of Health | - | 2,439 | - | - |
| NHS Property Services | 1,929 | - | 1,057 | - |

In addition, the ICB has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with local County Councils, see below for values.

| | | | | |
|---|---|---|---|---|
| Cambridgeshire County Council | 54,983 | 2,372 | 15,925 | 1,466 |
| Hertfordshire County Council | 1,975 | - | 439 | 1 |
| Peterborough City Council | 10,902 | 771 | 15,343 | 682 |

* Related Party transactions have been calculated on a cash and not an accruals basis, as the headings provided by the Department of Health imply.

**33 Related party transactions (Comparables)**

**Details of related party transactions with individuals are as follows:**

| | 31 March 2024 | | | |
|---|---|---|---|---|
| | Payments to Related Party £'000 | Receipts from Related Party £'000 | Amounts owed to Related Party £'000 | Amounts due from Related Party £'000 |
| | £'000 | £'000 | £'000 | £'000 |
| Dr Gary Howsam, Partner, Nene Valley Hodgson Medical Practice | 2,497 | - | - | - |
| Dr Gary Howsam, Non-Executive Director, Eastern Academic Health Science Network | 441 | - | - | - |
| Fiona Head, Retained GP, East Barnwell Health Centre | 987 | - | - | - |
| Nicci Briggs, Trustee, Healthcare Financial Management Association | 14 | - | - | - |
| Dr Simon Hambling, Partner, Fenland Group Practice | 4,097 | - | - | - |
| Dr Diana Hunter, Chair of Cambridgeshire Local Medical Committee (from Nov 2023) | 264 | - | 53 | - |
| Scott Haldane, Interim Chief Executive, Cambridgeshire & Peterborough NHS FT (from Feb 2024) | 36,965 | 214 | 5,052 | 652 |
| Matthew Winn, Chief Executive, Cambridgeshire Community Services NHS Trust | 31,157 | 10 | - | 1,608 |
| Eilish Midlane, Chief Executive, Royal Papworth Hospital NHS Foundation Trust | 30,228 | - | - | 2,082 |
| Dr Gary Howsam, stepson employee of North West Anglia NHS FT | 474,216 | 86 | 5,041 | 20 |
| Dr Gary Howsam, brother in law employed part time by Cambridgeshire Community Services NHS Trust | 31,157 | 10 | - | 1,608 |
| Sharon Fox, Sibling works at Queen Elizabeth Hospital NHS FT | 38,666 | - | 31 | - |
| Saqhib Ali, Audit Chair, Northamptonshire Healthcare NHS FT | 778 | - | - | - |

The Department of Health is regarded as a related party. During the year the ICB has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. These entities with material values are listed below:

| | Payments to Related Party £000 | Receipts from Related Party £000 | Amounts owed to Related Party £000 | Amounts due from Related Party £000 |
|---|---|---|---|---|
| Cambridge University Hospitals NHS Foundation Trust | 405,141 | 208 | 15,473 | 197 |
| North West Anglia NHS Foundation Trust | 474,216 | 86 | 5,041 | 20 |
| Cambridgeshire & Peterborough NHS Foundation Trust | 221,790 | 1,286 | 5,052 | 652 |
| East of England Ambulance Service NHS Trust | 56,266 | - | 554 | - |
| Cambridgeshire Community Services NHS Trust | 31,157 | 10 | - | 1,608 |
| The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust | 38,666 | - | 31 | - |
| Royal Papworth Hospital NHS Foundation Trust | 30,228 | - | - | 2,082 |
| West Suffolk NHS Foundation Trust | 4,152 | - | - | 253 |
| NHS England | -22 | 5,696 | 67 | 3,794 |
| East & North Hertfordshire NHS Trust | 3,119 | - | 141 | - |
| Department of Health | - | 2,118 | - | - |
| NHS Property Services | 2,589 | - | 474 | - |

In addition, the ICB has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with local County Councils, see below for values.

| | | | | |
|---|---|---|---|---|
| Cambridgeshire County Council | 49,591 | 2,153 | 23,918 | 1,506 |
| Hertfordshire County Council | 2,851 | 1 | 59 | - |
| Peterborough City Council | 17,379 | 304 | 6,773 | 572 |

* Related Party transactions have been calculated on a cash and not an accruals basis, as the headings provided by the Department of Health imply.

**34 Events after the end of the reporting period**

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

**35 Third party assets**

The ICB did not hold any cash or cash equivalents on behalf of other parties as at 31 March 2025.

**36 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:

| | **2024-25 Target £000** | **2024-25 Performance £000** | **Achieved? Yes/ No** | 2023-24 Target £000 | 2023-24 Performance £000 | Achieved? Yes/ No |
|---|---|---|---|---|---|---|
| Capital resource use does not exceed the amount specified in Directions | - | - | Yes | - | - | Yes |
| Revenue resource use does not exceed the amount specified in Directions | 2,414,130 | 2,414,093 | Yes | 1,997,645 | 1,997,597 | Yes |
| Revenue administration resource use does not exceed the amount specified in Directions | 17,016 | 16,069 | Yes | 18,854 | 17,091 | Yes |

When the expenditure of £2,414,093k is deducted from the Revenue Resource Limit of £2,414,130k, it shows a surplus of £37k (2023-24 surplus of £48k). The ICB has achieved the financial performance target in 2024/25 with an in year surplus of £37k against the revenue resource Limit. When the cumulative surplus of £2,335k is added to the 2024-25 in year surplus of £37k, it shows a cumulative surplus of £2,372k.

**37 Going concern**

NHS Cambridgeshire and Peterborough Integrated Care Board's annual report and accounts have been prepared on a going concern basis, in accordance with the definition as set out in Section 4 of the Department of Health and Social Care (DHSC) Group Accounting Manual 2024/25, which outlines the interpretation of IAS1 'Presentation of Financial Statements' as 'anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents'.
For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision (funding allocation) for that service in published documents, is normally sufficient evidence of going concern.

DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up.
In carrying out its assessment, the Governing Body has taken into account the following key considerations:

**NHS contracting and payment framework during 2024/25**

NHS Cambridgeshire and Peterborough ICB has been given a resource allocation for the year to 31 March 2025. The financial regime for ICBs has largely returned to the pre-covid allocation system. Allocations have been set for ICBs and the system with a movement towards the national target allocation.
The ICB reported a small surplus of £37k as shown in Note 36 – Financial Performance Targets.

**2025/26 Indicative financial planning**

In March 2025 the ICB was notified of its full year allocation for 2025/26.
As in previous years, the ICB will be permitted to draw down sufficient cash from NHS England to meet expenditure levels even if these exceed the resource allocation issued.
As previously stated, the ICB has been notified formally of the level of allocations it will receive from the Department of Health, through NHS England, for 2025/26 as shown in the table below.

| ICB Notified Funding | 2025/26 £'000 |
|---|---|
| ICB Recurrent Allocation | £2,241,486 |

The ICB has not been notified of the level of allocations for 2026/27, except for confirmation of the running cost allocation. Informal planning by the ICB indicates that the ICB will plan for a breakeven position in 2026/27, but this is dependent upon the actual allocation and planning guidance that will be received for that year. The ICB has received no indication that the financial framework, within which it operates, will change significantly in 2026/27.

**Conclusion**

Our considerations cover the period through to 23 June 2026, being 12 months beyond the date of authorisation of these financial statements. Considering these factors the Board has a reasonable expectation that the ICB will have adequate resources to continue in operational existence for the foreseeable future. For this reason, we continue to adopt the going concern basis in preparing these financial statements.