



**Cambridgeshire &
Peterborough**

NHS Cambridgeshire & Peterborough Integrated Care Board

Annual Report & Accounts

1 April 2025 – 31 March 2026

ICB Annual Report Template 1 April 2025 – 31 March 2026

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PERFORMANCE REPORT

Performance Overview

This section provides an outline of the performance of NHS Cambridgeshire and Peterborough Integrated Care Board (ICB) from 1 April 2025 to 31 March 2026. It gives an overview of how we have commissioned services and discharged our statutory functions on behalf of the population we serve.

Cambridgeshire & Peterborough ICB Annual Report Statement from Jan Thomas, Chief Executive Officer and Robin Porter, Chair

Welcome to our 2025/26 Annual Report.

The past year has brought significant challenges, alongside steady progress. Demand for services remained high, and we also worked through major organisational change, including plans to reduce running costs and reshape how we work. Throughout this period, partners across the system stayed focused on what matters most: delivering safe, effective care for our population.

Strong collaboration across the system helped more people receive care closer to home and avoid unnecessary hospital stays, easing pressure on hospitals. While demand for urgent and emergency care remained high, performance stabilised as more people were supported through community services and alternative care pathways.

The ICB also made progress in recovering planned care. Waiting lists stabilised, and cancer pathways continued to strengthen, with earlier diagnosis and faster treatment.

Alongside service recovery, we strengthened our focus on prevention and reducing health inequalities. A clear example is the work to increase vaccination uptake in communities facing the greatest disadvantages. By analysing vaccination data, the ICB funded additional nursing support through the Access and Inequality Nurse project, focusing on GP practices with the lowest uptake. Over the past 18 months, this resulted in more than 12,500 additional vaccinations, including over 2,000 MMR vaccinations, delivered through targeted outreach with homeless communities, asylum seekers, and Gypsy, Roma and Traveller communities.

Building on this targeted work, programmes such as Your Healthier Future and our High Intensity Use approach continue to support earlier help and more coordinated personalised care for people with complex needs. During 2025/26, the focus has been on making these ways of working part of everyday practice, while continuing to use data more effectively to reduce unfair differences in care and improve health outcomes across our population.

The WorkWell pilot also supported more than 2,500 people facing health-related barriers to employment through personalised support delivered with local partners and has been recognised nationally for its reach and impact.

Access to primary care continued to improve, with appointment numbers increasing by around 6%. This was supported by better patient experience and greater use of digital access.

Progress was also made in mental health services, including improvements in dementia diagnosis and early intervention in psychosis. However, demand for children and young people's mental health services remains high and improving access continues to be a key priority.

All of this has taken place during a time of significant change for colleagues across our organisations. We would like to thank staff for their professionalism, resilience and commitment throughout the year. During 2025/26, work progressed to establish Central East Integrated Care Board, bringing together Cambridgeshire & Peterborough with neighbouring systems as part of a new, larger ICB. This marks an important transition from the organisation reflected in this report.

From 1 April, we move forward as part of Central East, serving 3.5 million people. Guided by a clear purpose – to do what best serves our population – and supported by our strategy, *Our Way*, this creates an opportunity to work in a more joined-up way, improve outcomes, and experiences, and build a more sustainable health and care system for the future.

Accountable Officer: **Jan Thomas, Chief Executive**
Organisation: **NHS Cambridgeshire & Peterborough Integrated Care Board**

Signature:
Date: 18 June 2026

Purpose and Activities of the Organisation

NHS Cambridgeshire & Peterborough is a statutory NHS organisation 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, 85 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.](#)

2025/26 marks the final year of the ICB's existence. The new Central East ICB came into being on 1 April 2026.

Performance Summary and analysis

Set out in the tables below are the Key Performance Indicators (KPIs) relating to the national priorities and 2025/26 operational plan that the ICB has been tracking. It is recognised that, as well as our successes, there are some ongoing challenges that we continue to seek improvement against. Performance has been monitored against these indicators through ICB governance committees and through the Integrated Care Board.

There are seven national priorities, each underpinned by clearly defined success measures. Table 1 below outlines these priorities and indicates whether the ICS is on track to achieve the associated measures against its locally agreed targets. The ICS is on track to deliver its delivery plan for 14 of the 18 national indicators at 2025/26-year end, noting non-compliance with the plan in Elective Care, Mental Health and Dental.

Table 1 – national priorities.

National Priority	Success Measures	Delivery Expectation
1. Reduce the time people wait for elective care	Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement	X Achieved 61.60%
	Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement	X Achieved 66.8%
	Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026	✓ Achieved 1.00%
	Improve performance against the headline 62-day cancer standard to 75% by March 2026	X Achieved 71.1%
	Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026	✓ Achieved 85.4%
2. Improve A&E waiting times and ambulance response times	Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25	X Non Compliant 4hr: 71.9% 12hr: 10.7% v 7.5% plan
	Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26	✓ Achieved 30mins
3. Improve access to general practice and urgent dental care	Improve patient experience of access to general practice as measured by the ONS Health Insights Survey	✓ Forecasted to remain on track: Lasted point showed an improvement of 3.3 percentage points
	Increase the number of urgent dental appointments in line with the national ambition to provide 700,000 more	✓ Improvement of 6.9 percentage points v plan
4. Improve mental health and learning disability care	Reduce average length of stay in adult acute mental health beds	✓ Achieved 52 against a plan of 56
	Increase the number of Children and Young People (CYP) accessing services to achieve the national ambition for 345,000 additional CYP aged 0–25 compared to 2019	X Below plan by 15.6%
	Reduce reliance on mental health inpatient care for people with a learning disability and	X Not expected to deliver against local plans

	autistic people, delivering a minimum 10% reduction	
5. Live within the budget allocated, reducing waste and improving productivity	Deliver a balanced net system financial position for 2025/26	✓ £2.534m surplus
	Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems	X 0.5% below planned reduction
	Close the activity/ whole time equivalent (WTE) gap against pre-Covid levels (adjusted for case mix)	Data unavailable
6. Maintain our collective focus on the overall quality and safety of our Services	Improve safety in maternity and neonatal services, delivering the key actions of the 'Three year delivery plan'	✓ ICB delivery plan in progress.
7. Address inequalities and shift towards prevention	Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people	✓ ICS Outcomes Framework programmes in delivery.
	Increase the % of patients with hypertension treated according to NICE guidance, and the % of patients with GP recorded Cardiovascular Disease (CVD), who have their cholesterol levels managed to NICE guidance	✓ ICS Outcomes Framework programmes in delivery.

Delivery throughout 2025/26 has continued to be challenging, as the ICB and its partners progress recovery efforts and mitigate risks arising from industrial action, alongside increasing demand across both physical and mental health services.

Table 2 - Full breakdown of the latest validated operational plan performance in 2025/26. Note, the national priority success measures are highlighted in blue below.

Cancer Indicators	Latest period	Actual	Plan	Var to Plan	On Plan / Off Plan
National Priority: % of cancer patients seen within 62 days	Mar-26	71.1%	77.5%	-6.4pp	Off Plan
National Priority: % of referrals meeting 28-Day Faster Diagnosis standard (urgent suspected cancer only)	Mar-26	85.4%	82.6%	2.8pp	On Plan
% of Lower Gastrointestinal (GI) suspected cancer referrals with an accompanying FIT result (YTD Cumulative)	Mar-26	82.7%	80.0%	2.7pp	On Plan
% of people treated beginning first or subsequent treatment of cancer within 31 days of receiving a decision to treat/earliest clinically appropriate date	Mar-26	84.2%	93.3%	-9.1pp	Off Plan
Community Indicators	Latest period	Actual	Plan	Var to Plan	On Plan / Off Plan

Number of Urgent Community Response (UCR) referrals (All)	Mar-26	15,226	18,557	-18.0%	Off Plan
Number of community healthcare patients waiting over 52 weeks	Mar-26	1,244	1,269	-2.0%	On Plan
Number of people on waiting lists for adult services who are waiting over 52 weeks	Mar-26	8	120	-93.3%	On Plan
Number of people on waiting lists for CYP services who are waiting over 52 weeks	Mar-26	1,236	1,149	7.6%	Off Plan
Number of Community care contacts	Mar-26	1,187,055	1,248,221	-4.9%	Off Plan
Non-elective (NEL) Average length of stay - community beds	Sep-25	9	25	-63.7%	On Plan
Diagnostic Indicators	Latest period	Actual	Plan	Var to Plan	On Plan / Off Plan
Number of Diagnostic Procedures - Total	Mar-26	574,963	528,978	8.7%	On Plan
Elective Indicators	Latest period	Actual	Plan	Var to Plan	On Plan / Off Plan
Referral to Treatment (RTT) Completed Admitted Pathways	Mar-26	71,856	77,263	-7.0%	Off Plan
Number of 52+ week waits	Mar-26	1,373	1,396	-1.6%	On Plan
% of episodes moved or discharged to Patient Initiated Follow-up (PIFU) as an outcome of attendance	Mar-26	5.0%	7.0%	-2.0pp	Off Plan
New RTT Pathways (Clock Starts)	Mar-26	390,867	387,620	0.8%	Off Plan
Number of elective day case spells	Mar-26	172,893	159,937	8.1%	On Plan
Number of elective ordinary spells	Mar-26	25,809	28,421	-9.2%	Off Plan
RTT Completed Non-Admitted Pathways	Mar-26	281,200	296,274	-5.1%	Off Plan
RTT Waiting List	Mar-26	142,892	143,089	-0.1%	On Plan
% of all outpatient attendances that are for follow-ups without a procedure – Elective Recovery Fund (ERF) Scope	Mar-26	53.0%	54.0%	1.0pp	Off Plan
Open Pathways 52+ week waiting list for patients aged 18 or under	Mar-26	196	137	43.1%	Off Plan
Number of outpatient attendances (all TFC; consultant and non-consultant led)	Mar-26	2,136,361	1,977,112	8.1%	On Plan
Number of elective ordinary and day case spells	Mar-26	198,702	188,358	5.5%	On Plan
Total Waiting List for patients waiting less than 18 weeks	Mar-26	89,506	89,150	0.4%	Off Plan
National Priority: % of patients waiting for first attendance who have been waiting less than 18 weeks	Mar-26	66.8%	68.6%	-1.8pp	Off Plan
Total Waiting List for patients aged under 18 years and waiting less than 18 weeks	Mar-26	10,067	9,186	9.6%	Off Plan
Total Waiting List for patients aged under 18 years	Mar-26	16,238	14,818	9.6%	Off Plan
National Priority: % patients on waiting list waiting more than 52 weeks	Mar-26	1.0%	1.0%	0.0pp	On Plan
National Priority: % patients on waiting list waiting less than 18 weeks	Mar-26	62.6%	62.3%	0.3pp	On Plan
Mental Health Indicators	Latest period	Actual	Plan	Var to Plan	On Plan / Off Plan

% of people aged 14 and over with a learning disability (LD) on the GP register receiving an annual health check	Oct-25	20.0%	18.8%	-1.2pp	On Plan
Adult only learning disabilities inpatient rate per million population	Mar-26	40	0	+40	Off Plan
% of NHS Talking Therapies patients achieving reliable improvement	Mar-26	54.0%	68.0%	-14pp	Off Plan
% of NHS Talking Therapies patients achieving reliable recovery	Mar-26	37.0%	49.9%	-12.9pp	Off Plan
National Priority: Number of people with at least one contact with CYP Mental Health (MH) services in the past 12 months	Mar-26	140,505	166,428	-15.6%	Off Plan
Number of inappropriate out-of-area MH placements at the end of the period	Mar-26	0	2	-100.0%	On Plan
National Priority: Care (Education) and Treatment Reviews (CETR) - Number of Autism Spectrum Disorder (ASD) Inpatients at last day of month	Dec-25	15	5	200.0%	Off Plan
National Priority: CETR - Number of LD Inpatients at last day of month	Dec-25	9	7	28.6%	Off Plan
Individual Placement Support Access	Mar-26	580	403	43.9%	On Plan
National Priority: Average length of stay for adult acute mental health beds	Mar-26	52	56	-6.8%	On Plan
Primary Care Indicators	Latest period	Actual	Plan	Var to Plan	On Plan / Off Plan
National Priority: Units of dental activity delivered as a proportion of all units of dental activity contracted	Jan-Mar 26	90.9%	84.0%	6.9pp	On Plan
% of resident population seen by an NHS dentist - adult (24 month rolling)	Oct-Dec 25	25.8%	26.1%	-0.3pp	Off Plan
% of resident population seen by an NHS dentist - child (12 month rolling)	Oct-Dec 25	54.9%	52.2%	2.7pp	On Plan
Total Appointments in General Practice and Primary Care Networks	Mar-26	7,302,226	6,952,162	5.0%	On Plan
Number of Pharmacy First Consultations (oral contraception, BP, clinical pathways)	Mar-26	111,425	130,094	-14.4%	Off Plan
National Priority: Proportion of those surveyed whose experience with accessing primary care has improved in last 12 months	Nov-25	23.4%	<20.1%	3.3pp	On Plan
UEC Indicators	Latest period	Actual	Plan	Var to Plan	On Plan / Off Plan
Mean handover time for all ambulance conveyances	Mar-26	39	32	21.4%	Off Plan
Non-elective spells with a length of stay of one or more days	Mar-26	83,986	86,033	-2.4%	On Plan
% of Virtual Ward capacity utilised	Mar-26	86.5%	80.6%	-5.9pp	On Plan
National Priority: % of attendances at Type 1-3 A&E departments where the patient spent less than 4 hours from time of arrival to admission/discharge/transfer	Mar-26	71.9%	78.1%	-6.2pp	Off Plan
Non-elective spells with a length of stay of zero days	Mar-26	28,810	33,378	-13.7%	On Plan
Total Patients Arriving by Ambulance	Mar-26	79,583	75,147	5.9%	Off Plan
Same Day Emergency Care Attendances	Mar-26	45,259	42,365	6.8%	On Plan

% of attendances at all Type 2 & 3 A&E departments where the patient spent less than 4 hours from time of arrival to admission/discharge/transfer	Mar-26	97.3%	97.1%	0.2pp	On Plan
% of attendances at all Type 1 A&E departments where the patient spent less than 4 hours from time of arrival to admission/discharge/transfer	Mar-26	61.6%	69.4%	-7.8pp	Off Plan
Number of attendances at Type 1-3 A&E departments	Mar-26	447,032	465,341	-3.9%	On Plan
Number of attendances at all Type 2 & 3 A&E departments	Mar-26	129,964	141,796	-8.3%	On Plan
Number of attendances at all Type 1 A&E departments	Mar-26	317,068	323,545	-2.0%	On Plan
National Priority: % of attendances at Type 1 A&E departments where the patient spent more than 12 hours from time of arrival to admission/discharge/transfer	Mar-26	10.7%	7.5%	3.2pp	Off Plan
Non-elective spells with a length of stay of 7 or more days	Mar-26	30,127	32,100	-6.1%	On Plan
National Priority: Cumulative Annual Mean response time for category 2 ambulance calls (EEAST only)	Mar-26	30	30	-1.3%	On Plan
Finance Indicators	Latest period	Actual	Plan	Var to Plan	On Plan / Off Plan
National Priority: YTD Total Agency Expenditure £'000	Mar-26	10,117	17,758	-43.0%	On Plan
National Priority: YTD System Surplus/Deficit excluding Non-Recurrent Deficit Support Funding £'000	Mar-26	2,534	2,548	-0.5%	Off Plan

Operational Performance Overview

Throughout the 2025/26 period, the ICB has proactively managed a range of significant challenges across the healthcare system. These have included prolonged waiting times for patients requiring treatment, sustained pressures on urgent and emergency care services, and the ongoing effects of industrial action, which have disrupted both planned and unplanned care for our population.

The ICB remains steadfast in its commitment to delivering strategic initiatives designed to address these challenges and will continue this work within the new Central East ICB from 1 April 2026. This approach will ensure a sustained focus on providing high-quality, timely healthcare services that meet the needs of our communities.

Throughout 2025/26, ICB teams and healthcare providers have demonstrated exceptional adaptability in responding to evolving system pressures. At various points, this has required the prioritisation of resources and services towards urgent and emergency care to maintain essential support for patients. Our colleagues have worked tirelessly to strengthen service delivery and improve access, underpinned by a shared commitment to securing the best possible outcomes and experiences for our population.

Urgent and Emergency Care (UEC)

Demand for UEC services across the ICS has remained persistently high, driven by demographic factors such as an ageing population, frailty, and long-term conditions.

For context, comparing 2023/24 with 2024/25, attendances increased at the main providers. At Cambridge University Hospitals NHS Foundation Trust (CUH), total A&E attendances (Type 1 and Type 3)

rose by 4.44%. North West Anglia NHS Foundation Trust (NWAFT), which operates the emergency departments at Peterborough City Hospital and Hinchbrook Hospital, recorded a 6.4% increase in attendances. Royal Papworth Hospital NHS Foundation Trust (RPH) contributes only through low-volume specialist urgent transfers, with volumes remaining stable and minimal in the context of overall Type 1 demand. This resulted in overall emergency activity growth of approximately 5 to 8%, consistent with national trends showing around 4% growth in attendances for 2024/25.

Comparing 2024/25 with 2025/26 (year-to-date to early 2026, including data up to January/February 2026), demand has stabilised at these elevated levels without significant further escalation, though winter pressures have sustained high activity volumes. Monthly attendances and emergency admissions have remained similar. System performance has shown modest improvement, supported by primary care streaming, integrated urgent care pathways, and the UEC care coordination hub. Overall volumes continue to exceed pre-pandemic baselines, aligning with national patterns of sustained high demand into 2025/26.

Planned Care

Demand for planned elective care, as indicated by new referrals, clock starts, and waiting list volumes, has shown modest year-on-year growth, offset by increased delivered activity to support recovery and backlog reduction.

Comparing 2023/24 with 2024/25, new referrals at CUH increased by approximately 6.2%, with elective activity growing strongly: day cases by 8.2%, elective inpatients by 13%, and outpatient attendances by 9.3%. NWAFT saw a similar pattern, with referral and treatment volumes rising by 5 to 8%. RPH maintained high demand for specialist cardiothoracic procedures while initiating targeted waiting list reductions.

Comparing 2024/25 with 2025/26 (year-to-date to early 2026), referral demand has continued at a moderate rate (between 3% and 6% growth at providers) but waiting lists have stabilised and begun to decline. RPH has shown exceptional progress, achieving a 20% reduction in its waiting list and improving 18-week referral-to-treatment performance from around 63% to over 73%. Across the ICB, incomplete pathways have trended positively, leading to cumulative referral growth of over 6% since 2023/24 and treatment volumes up by 8% to 13%. This trend is in line with the national picture.

Mental Health

Demand for mental health services, primarily delivered by Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), has continued to increase steadily, reflecting post-pandemic recovery and local population needs.

Comparing 2023/24 with 2024/25, mental health referrals rose by 1.8%. Contacts attended increased by 3.3%, while admissions grew by 10.8%. Waiting lists expanded considerably, from around 6,700 to 11,600 patients, highlighting increased access pressures.

Comparing 2024/25 with 2025/26 (year-to-date to early 2026), referral and contact volumes have remained high, though with trends stable rather than accelerating further. Cumulative growth in contacts and admissions from earlier baselines remains approximately 10% and 11% respectively, consistent with ongoing demographic and post-pandemic demand influences, particularly in children, young people and adolescent services.

Primary Care

General Practice:

Demand for General Practice, measured by the national GP Appointments Data (GPAD), has been consistently high and resilient across the ICB.

Comparing 2023/24 with 2024/25, the ICB saw cumulative growth of approximately 6% over the period (in line with national increases in total appointments offered).

Comparing 2024/25 with 2025/26 (year-to-date to early 2026), volumes have stabilised at elevated levels, with recent monthly figures (e.g. 761,254 appointments offered in October 2025) showing flat changes driven by population growth and persistent access requirements. Same-day and urgent appointments remain primary demand drivers, supported by workforce expansion and digital tools.

Online consultations have increased sharply, following the implementation of the national GP contract changes during 2025/26 reaching record proportions nationally by late 2025. Face-to-face consultations continue to account for 65 to 70% of all appointments. Around 80% of all appointments continue to be delivered within 2 weeks of contact.

Patients experience of access appears to be improving, when comparing the monthly ONS Health Insights Survey report, patients are reporting that services at their practice are improving or remain consistent.

NHS Oversight Framework

NHS England assesses NHS Trusts against a range of performance criteria and publish the results. This assessment determines the support individual NHS trusts need to improve with those in the middle of the pack supported by NHS England to improve and those demonstrating persistently low performance, receiving prompt intervention. Those performing at the top may be rewarded with additional freedoms.

The table below summarises the ICB's acute provider Q4 segmentation and rankings, published 11 June 2026. Royal Papworth ranked as the best performing acute provider in the country in Q2 and Q4. At Q4, NWAFT was in segment 3 (79/134), CUHFT was in segment 2 (28/134) and RPHFT was in segment 1 (1/134).

Table 3 – acute provider Q4 NOF segmentation

Acute Providers	NOF Q4 Segment	Rank / 134	In Financial Deficit?	Access to Services	Finance & Productivity	Effectiveness & Experience	Patient Safety	People & Workforce
North West Anglia NHS Foundation Trust	3	79	No	3 – Below average	2- Above average	2- Above average	4 – Low performing	3 – Below average
Cambridge University Hospitals NHS Foundation Trust	2	28	No	3 – Below average	1 – High performing	3 – Below average	2- Above average	1 – High performing

Royal Papworth Hospital NHS Foundation Trust	1	1	No	1 – High performing	1 – High performing	1 – High performing	1 – High performing	1 – High performing
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The table below summarised the ICB's non-acute provider Q4 segmentation and rankings. Cambridgeshire Community Services ranked as the best performing non-acute provider in the country in Q2. At Q4, CPFT was in segment 3 (37/61) and CCS was in segment 2 (18/61).

Table 4 – non-acute provider Q4 NOF segmentation

Non-Acute Providers	NOF Q4 Segment	Rank / 61	In Financial Deficit?	Access to Services	Finance & Productivity	Effectiveness & Experience	Patient Safety	People & Workforce
Cambridgeshire and Peterborough NHS Foundation Trust	3	37	Yes	4 – Low performing	4 – Low performing	1 – High performing	2- Above average	2- Above average
Cambridgeshire Community Services	2	18	No	4 – Low performing	2- Above average	1 – High performing	1 – High performing	2- Above average

The table below summarised the ICB's emergency ambulance provider Q4 segmentation and rankings. Neither the East of England Ambulance Service NHS Trust (EEAST) nor the East Midlands Ambulance Service (EMAS) was in financial deficit but the ICB's primary ambulance provider EEAST was in segment 4 (ranked bottom nationally) while EMAS was in segment 3 (ranked 7th).

Table 5 – emergency ambulance provider Q4 NOF segmentation

Emergency Ambulance Providers	NOF Q4 Segment	Rank / 10	In Financial Deficit?	Access to Services	Finance & Productivity	Effectiveness & Experience	Patient Safety	People & Workforce
East of England Ambulance Service NHS Trust	4	10	No	4 – Low performing	3 – Below average	4 – Low performing	4 – Low performing	4 – Low performing
East Midlands Ambulance Service NHS Trust	3	7	No	4 – Low performing	1 – High performing	2- Above average	3 – Below average	4 – Low performing

Urgent and Emergency Care Services

During 2025/26, urgent and emergency care services across Cambridgeshire and Peterborough continued to experience sustained pressure, reflecting high and complex demand across the system. While overall activity levels stabilised compared to the previous year, demand remained significantly

above pre-pandemic baselines, driven by an ageing population, increasing frailty, and higher prevalence of long-term conditions.

Performance against national UEC standards showed mixed progress. The system is expected to deliver against the national ambition for Category 2 ambulance response times, achieving an average of 30 minutes across the year. In addition, improvements have been seen in same day emergency care (SDEC) utilisation and virtual ward capacity, both of which have supported flow and reduced unnecessary admissions.

However, the percentage of patients admitted, discharged or transferred within four hours in Type 1–3 emergency departments remained below plan at 68.1% against a target of 74.1%. Performance within Type 1 emergency departments was particularly challenged at 56.9%, reflecting ongoing pressure within acute hospital pathways. In parallel, the proportion of patients experiencing waits of over 12 hours remained above planned levels at 13.9%, highlighting continued challenges in patient flow and timely admission or discharge.

Ambulance handover delays also remained a key pressure point, impacting ambulance availability and wider system responsiveness. In addition, variation in performance across providers, particularly in ambulance services, presents a system-level risk. The East of England Ambulance Service NHS Trust continues to face significant operational challenges, as reflected in national oversight ratings, which impacts response times and handover performance across the system.

The primary risk to delivery continues to be system capacity constraints, particularly within acute hospital settings. High bed occupancy, delays in discharge, and poor patient flow. This directly impacts emergency department performance, ambulance handovers, and patient experience. Despite this, non-elective length of stay metrics showed some improvement, with reductions in longer stays (7+ days), indicating progress in elements of discharge and flow.

Workforce pressures across urgent and emergency care services, including within ambulance services and acute providers, present an ongoing risk to performance sustainability. These pressures are compounded during periods of peak demand, particularly over winter.

In response to these challenges, the ICB has continued to prioritise urgent and emergency care through a range of system-wide interventions. Integrated urgent care pathways have been strengthened, including the development of the UEC care coordination hub and additional primary care streaming capacity in community to ensure patients are directed to the most appropriate care setting. Significant progress has been made in expanding same day emergency care and virtual ward provision, improving alternatives to admission and supporting earlier discharge. These models have contributed to improved patient flow and reduced pressure on acute beds.

The ICB has worked closely with system partners to improve discharge processes, including strengthening collaboration with local authorities and community providers to increase capacity and reduce delays. Targeted initiatives to reduce length of stay and improve patient flow have supported reductions in longer hospital stays.

Ambulance handover improvement plans have been implemented in collaboration with acute providers and ambulance services, focusing on reducing delays and improving turnaround times. System escalation processes have been strengthened to ensure a coordinated response during periods of peak pressure.

Looking ahead, the ICB will continue to focus on embedding neighbourhood-based models of care, expanding community capacity, and further developing integrated urgent care pathways. These actions will be critical in managing demand, improving patient experience, and delivering sustainable improvements in urgent and emergency care performance.

Cancer Care

The 62-day cancer referral-to-treatment performance deteriorated in Q1 of 2025/26 to a low of 66.8% with challenges seen particularly in skin and breast pathways, driven by a combination of demand increases and workforce constraints. Focussed recovery work across the system has resulted in the latest performance of 75.1% in November 2026 which was 5% above the England average. December and January proved to be more challenging but good recovery was seen in February 2026 with all providers predicting to be above plan by March 2026. Performance against the 28-day performance standard also deteriorated to a low of 71.4% in September 2025. However, focus on early diagnostics led to a full turnaround with the end of year aim being achieved and sustained from October 2025.

The most challenged area of cancer performance has remained the numbers of patients treated within 31 days of the decision to treat. Access to cancer surgery across the system and radiotherapy treatments at CUHFT have been the main constraint. Additional surgical capacity has been identified throughout the year, focussed on those challenged specialties supported by SDF funding. Limited radiotherapy capacity at CUHFT has been to the difficulty in recruiting therapeutic radiographers as well as the replacement of two linear accelerators. Recruitment to these key roles has now improved, but the capital replacement programme will not be completed until Winter 2026. Additional radiotherapy capacity is now being sourced from other providers to support.

Lung Cancer Screening Programme

The Lung Cancer Screening Programme (previously known as the Targeted Lung Health Checks) went live in Peterborough in February 2025, and in Cambridge from June 2025. By the end of March 2026, it is expected 31,200 eligible patients will have been invited to have a Lung Health Check, with almost 17,000 checks completed, and 6,168 scans completed for patients who were identified as high risk. To the end of February 2026 47 cancers had been identified, with 60% of these at stage 1. The programme has been promoted throughout the year at a range of community events and will continue to be rolled out across the ICB footprint, as part of the four-year national programme roll-out.

Cambridge Cancer Research Hospital

Progress towards the new Cambridge Cancer Research Hospital continues well with DHCS the Treasury responding positively to funding. The design work is progressing with the RIBA 4 design now signed off.

The full business case continues to be developed with further review from NHP, NHSE and the National Infrastructure and Service Transformation Authority.

Preconstruction work has started on site including the installation of hoardings, land excavation and archaeological dig. The new hospital is expected to open in 2029.

Dermatology Pathway Review

The C&P Dermatology redesign group produced a new pathway for dermatology care across Primary, community and secondary care. The work was clinically led, and coproduced through stakeholder engagement with patient focus groups, clinicians, operational staff, national and regional subject matter

experts. This work is now being taken forward by Central East ICB as one of the key strategic commissioning objectives, as outlined in 'Our Way' strategy. [Our Way - strategy to delivery - Central East ICB](#)

Electives

The overall referral to treatment (RTT) waiting list was 120,190 in January 2026, an increase from 118,730 in April 2025.

During 2025/26, we treated all patients who had been waiting over 78 weeks, reducing the number to zero.

By the end of January 2026, we had 59 patients waiting over 65 weeks, compared to 54 in March 2025. Whilst this is a year on year increase, this is focused in a small number of high volume specialties, where a combination of new demand growth, high overall wait lists and capacity constraints have compounded difficulties in balancing risk across the overall waiting list. We remain focused on supporting patients to be seen as quickly as possible.

52+ week waiters have shown a big reduction (in terms of the RTT position), reducing from 4,088 in April 2025 to 1,870 in January 2026 (even though the overall waiting list has increased). This is as a result of targeted efforts by providers.

The percentage of people waiting less than 18 weeks for treatment has also increased from 56.4% in April 2025 to 59.4% in January 2026.

CUH was placed into national NHS England tiering during 2025/26 – Tier 1 for elective in July 2025 and Tier 2 for Diagnostics in February 2026. This enhanced oversight on performance recovery is reviewed quarterly.

Diagnostics

The proportion of patients waiting over six weeks for diagnostic procedures increased from 24.9% in April 2025 to 35.7% in January 2026. This equates to c8,000 more patients seen monthly within the 6-week period than at the start of the year. The overall waiting list increased from 24,297 to 32,721 during this period, with population demand for diagnostics increasingly significant. Activity has also increased during this period, with waiting list procedures performed increasing from 21,758 in April 2025 to 25,125 in January 2026, alongside an increase in planned procedures, which rose from 5,232 to 5,389 over the same timeframe. Demand for diagnostics is only going to increase both as a result of population growth but also as the NHS focuses on earlier intervention and direct access, with diagnostic first pathways, which drive overall efficiency, productivity and experience of care pathways. A strategic review of diagnostic needs, aligned to delivery of our strategy will be undertaken to ensure appropriate commissioned diagnostic capacity is in place to further improve outcomes for our population. Monitoring of system wide performance and key deliverables has been through the ICS System Diagnostic Board.

Mental Health, Learning Disabilities & Autism

The NHS operational target for the number of people who have received a course of psychological therapy via NHS Talking Therapies for depression and anxiety disorders is on track to be met. However, the percentage of patients who have achieved reliable improvement and/or reliable recovery has declined during the year. A year-to-date position recorded in January 2026 shows 45.6% of patients achieved reliable recovery while 65% achieved reliable improvement, marginally below the national

targets. A review of year-to-date data demonstrates that the associated 6-week and 18-week waiting time targets are on track to be met.

Improving the average length of stay for adult acute mental health inpatient services for patients aged 18+ has been an operational priority throughout the year. An analysis of performance shows initial progress with sustained improvements leading to operational targets being met towards the end of 2025. However, performance has declined with the average length of stay increasing again by January 2026. Initial analysis suggests this is due to some inpatients with particularly lengthy stays being discharged during this period. The ICB is continuing to work with partners to improve purposeful admission and the quality of inpatient care. It is also working to provide robust community mental health services to support safe discharge and suitable housing and social care to support sustained shorter length of stays.

Inappropriate Out of Area Placements (OAPs) are associated with poor patient experience, poor clinical outcomes and high financial costs. They also often result in longer hospital stays. To reduce our reliance on OAPs, work has been undertaken across the whole pathway to address barriers to discharge and to reduce re-admission rates. As a result, the number of inappropriate OAPs has decreased throughout the year and is on track to meet our operational plan target.

Significant reductions in OAPs and improvements in the average length of stay have been achieved through revised care delivery models. Concurrently, ICB-led work has been ongoing to enhance the mental health crisis response. This addresses a pathway that is considered excessively complex and challenging for patients and carers to navigate, particularly during a mental health crisis. Integrated into our system's approach to enhancing mental health crisis management is the national Right Care, Right Person (RCRP) programme. This programme aims to eliminate the inappropriate and avoidable involvement of the police in responding to incidents involving individuals with mental health needs. Last year's annual report referenced the programme's implementation and now it is fully embedded across our system through collaboration with the Police East of England Ambulance Service (EEAST), acute hospitals, mental health and social services. The system collaboration has led to better outcomes for people supported, perhaps most evident through significant reductions in conveyance to A&E and the Section 136 suite.

People living with severe mental illness (SMI) experience significant health inequalities. Their life expectancy is 15–20 years shorter than that of the general population largely due to preventable physical illnesses. This necessitates a robust SMI physical health check programme. Locally the percentage of patients receiving a SMI physical health check has increased throughout the year. In December 2025 68% of the SMI population had received a health check a significantly higher percentage than the national ambition of 60%. This places the ICB among the top five performing ICBs in England. However, there remains an opportunity to further enhance services within neighbourhoods for people living with SMI which will be advanced in the coming year.

A comprehensive redesign of all-age Neurodiversity provision has been progressed. The demand for diagnostic assessments for both attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) has experienced a substantial increase nationally and locally. This has resulted in prolonged waiting times for commissioned services leading to an increasing reliance on private providers delivering services through Right to Choose without the requisite quality assurance or financial control required by the ICB. To mitigate these risks the ICB has collaborated with Norfolk and Waveney ICB to develop a local Accreditation Framework for adult ADHD services to provide the quality assurance required for our patients while embedding local tariffs to improve financial control. Further work is being progressed to establish similar Frameworks for all-age ASD provision and children and young people's ADHD provision. In addition, targeted work with our lead mental health trust provider is bringing

continual improvements to our NHS provider services including an anticipated reduction in adult ADHD waiting list numbers by over 1,000 patients in March 2026.

Mental Health Expenditure

Financial Years	Current year (2025/26) £'000	Prior year (2024/25) £'000
Mental Health Spend	192,485	196,742
ICB Programme Allocation	2,525,923	2,397,114
Mental Health Spend as a proportion of ICB Programme Allocation	7.62%	8.21%

Primary Care

General Practice performance in Cambridgeshire & Peterborough has largely met expectations. The ONS Health Insights Survey has provided a consistent, independent source of patient experience data across the ICS, enabling a clearer understanding of how residents perceive access, booking processes, waiting times, and overall satisfaction.

The survey results have:

- Captured patient reported experience across the ICS population.
- Provided a stable evidence base for understanding perceptions of booking processes, waiting times, and overall satisfaction.
- Enabled comparison with national and regional trends.
- Provided comparable data that supports monitoring of access trends over time.
- Highlighted variation in patient experience that aligns with known demographic and demand pressures.

The response rate is modest ~1500 per month for Cambridgeshire & Peterborough. The survey design does not support granular analysis, meaning insights cannot be reliably attributed to specific localities, PCNs, or practices and some demographic groups are underrepresented. Despite these constraints, the survey remains a valuable tool for understanding broad patient sentiment and identifying system-wide themes.

In general, the perception of access to GP appointments and feedback has been improving following the implementation of nationally informed contract changes. However, there are some issues and potential risks that the ICB should remain cognisant of when planning for future delivery.

The 2026/27 GP Contract Changes seek to further support patient access by increasing capacity to manage urgent on the day demand. To enable this funding will be repurposed from the Primary Care Network (PCN) Directed Enhanced Service (DES) into practice level reimbursement and a cash uplift of 3.6% will be paid to practices.

- Moving funding to practice level may reduce the ability to coordinate system-wide access improvements. *Risk:* Variation between practices may widen, and system-level interventions may become harder to resource.
- Cambridgeshire & Peterborough has high population growth and existing workforce shortages. A limited uplift may not be sufficient to expand capacity in line with demand. *Risk:* Patient reported access may decline even if practices are working efficiently.

- Monitoring will increase at practice level to accurately pinpoint demand and inform future interventions. Practices will be required to deal with all clinically urgent requests on the same day. Practices across the area who already experience high demand may struggle to meet this requirement without additional workforce whilst recruitment is undertaken. *Risk:* Increased pressure on triage systems, potential diversion of capacity away from routine appointments, and, patient frustration if expectations rise faster than capacity.
- The 2026/27 contract was unilaterally imposed and has been rejected by the BMA GP Committee, with potential for collective action. Cambridgeshire & Peterborough already faces recruitment challenges in several areas. Contractual disputes may worsen morale and retention. *Risk:* Reduced continuity, fewer available appointments, and lower patient satisfaction.
- The contract's focus on same day urgent access and improved responsiveness may raise public expectations. If expectations rise faster than capacity, patient dissatisfaction may increase. *Risk:* ONS survey results may reflect unmet expectations rather than service deterioration. Triangulation will be required to ensure that all available patient experience data is analysed and to identify factors which are influencing patient experience so that it can be addressed.

To address the referenced risks, the ICB will need to:

- Continue to support workforce planning and Additional Roles Reimbursement Scheme (ARRS) deployment, with a focus on maintaining what has worked well such as social prescribers.
- System level population health data and modelling to identify areas of high demand enabling proactive capacity planning and management.
- Support resilience at practice level, through neighbourhood working models and appropriate investment.
- Continued use of digital triage and optimisation to ensure urgent requests can be managed safely and efficiently.

NHS Dental Services

Increase the number of urgent dental appointments in line with the national ambition to provide 700,000 more

Funding was allocated from the ICB Dental Allocation to commission 24,424 additional urgent dental care appointments across the system, C&P's national allocation was 14,195. The outcome of this is still unknown as contractors have until June 2026 to submit their final FP17 submissions for 2025/26 and to submit the local data that is being collected.

Units of dental activity delivered as a proportion of all units of dental activity contracted

The units of dental activity as a proportion of all units of dental activity contracted activity is off plan. In accordance with the National Contractual Framework, all providers that deliver an NHS Dental Contract are expected to deliver 96% of their contract by 31 March 2026. However, there is a 2-month lag with the data as Contract Holders have until 30 June 2026 to submit their final data.

A Contract Year End process is undertaken from the following July onwards. If a Contract does not deliver its full contract, the provider is expected to pay back any under delivered Units of Dental Activity (UDA) to the ICB.

The following initiatives were implemented and delivered through 2025/26 to support increasing access to NHS Dental services across the system.

National initiative

Dental Recruitment Incentivisation Scheme – 12 placements offered to C&P, four of these are filled in Cambridgeshire, in Fenland and East Cambridgeshire.

Depending on the entry level of the dentist recruited, there will be an expectation that this additional workforce will individually deliver up to 6,000 units of dental activity against the contract, for the provider that they have been recruited to. The recruitment to four of the placements has enabled 12,560 units of contracted dental activity being delivered per annum, in areas of the system where access to dental services is the most challenging during 2025 - 2028.

Local initiatives

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. The test phase was delivered from 1 April 2025 – 31 March 2026 within the parameters set out below:’

- IQVIA Test phase: a tiered reimbursement payment system was devised for each of the 21 contracts involved in the test phase. The tier that is anticipated that they will achieve in 2025 / 26 has been determined upon the current delivery against their contracted activity.
- There is an expectation to deliver at least 10% more of their contracted activity than they did the previous year. The minimum expectation of delivery is 75% of contracted activity. If the tier determined is achieved, the contract will be paid the associated tier payment.
- Special Care Dental Service: additional funding given to the Special Care Dental (SCD) Service to support legacy patients, was put in place to ensure that vulnerable patients in the system receive dental support whilst a discharge pathway into high street dental services is designed.
- Oral Health and prevention: additional funding was provided by the ICB to the SCD service for two years, 2025 – 2027, to support the Local Authority element of the contract for Dental Public Health Improvement, which includes Oral Health Promotion, Epidemiology and Screening. To enhance the service oral health provision delivered in areas of highest dental need; supervised tooth-brushing, increasing the supply of health visitor packs, family hub resources, fluoride varnish and care home training. The ICB is working collaboratively with Local Authority Public Health colleagues and the provider to deliver this additionality.

The ICB also actively reallocates unused activity to maximise delivery and ensure available funding supports the greatest possible number of patient appointments.

% of resident population seen by an NHS dentist - adult (24-month rolling)

Percentage of adults seen by an NHS Dentist is below plan for 2025 / 26.

Risk: Dental practices are independent providers who hold a contract to provide NHS dental services. Dental providers manage their own practice including capacity and determine whether they can accept

additional/new patients and therefore their lists can open and close on a frequent basis. Under the current contractual framework, the ICB cannot mandate who the contractor holders see as part of their provision.

Children and Young People (CYP) and Adults Safeguarding

Safeguarding children, young people and adults at risk remains a core priority for ICB. This work is undertaken in partnership with statutory agencies including Cambridgeshire Constabulary, Cambridgeshire County Council and Peterborough City Council. The Integrated Care System (ICS) continues to develop its safeguarding arrangements to ensure individuals accessing services are protected from abuse, neglect and harm. Effective safeguarding relies on strong partnership working across statutory organisations, health providers, professionals and voluntary sector partners to protect vulnerable individuals and groups within the community.

The ICB maintains executive oversight alongside our statutory partners of both the Cambridgeshire Adults and Children's Safeguarding Partnership Boards and the Peterborough Adults and Children Safeguarding Partnership Boards. Multi-agency safeguarding arrangements have been agreed and are published within the Safeguarding Arrangements Document ([Safeguarding Arrangements Document \(updated 2024\) | Cambridgeshire and Peterborough Safeguarding Partnership Board](#)) Annual reports produced by the Safeguarding Partnership Boards outline key achievements and areas of focus during the reporting period and can be located at [Annual Reports | Cambridgeshire and Peterborough Safeguarding Partnership Board](#).

Independent chairs and independent scrutineers provide oversight and constructive challenge to support continuous improvement in multi-agency safeguarding practice at all levels of partnership board activity.

The Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence Partnership (DASV) has been restructured within this financial year to align with local authority boundaries and has maintained a shared strategic board at which the ICB has representation. The strategic documents can be accessed at [Cambridgeshire County Council DASV Partnership - Strategic Documents](#). The ICB also contributes to the County Wide High Harms Board, which coordinates statutory responsibilities and system-wide priorities including drugs, serious violence, violence against women and girls, and serious and organised crime alongside attendance at the six Community Safety Partnership Boards and the Prevent strategic boards. The ICB is represented at all levels of these partnership arrangements. Despite organisational changes across partner agencies, safeguarding remains a shared priority across the system.

Safeguarding governance within the ICB is supported by a robust assurance framework. Safeguarding activity is reported through the ICB Quality, Performance and Finance Committee and is underpinned by statutory legislation and national guidance including the Children Act 2004, Children and Social Work Act 2017, Working Together to Safeguard Children 2023, Mental Capacity Act 2005, Care Act 2014 and Domestic Abuse Act 2021.

The Safeguarding Accountability and Assurance Framework (SAAF) and associated protocols defines safeguarding responsibilities for commissioning and providing NHS-funded services. Safeguarding assurance is embedded within contractual arrangements through Special Conditions 32 of the NHS Standard Contract and through established monitoring processes with commissioned providers. The ICB Executive ensures the discharge of statutory safeguarding duties. Please see the table below.

AREA	STANDARD	RAG RATING
Leadership and Organisational Accountability	A clear line of accountability for safeguarding, reflected in the ICB governance arrangements, i.e., a named Executive Lead to take overall leadership responsibility for the organisation's safeguarding arrangements. In addition, a team made up of designated professionals for safeguarding children, children in care, care leavers and adults.	Green
Training	Training all ICB staff to recognise and report safeguarding issues supported by a training strategy and compliance percentage in line with Intercollegiate Documents and national guidance for Prevent.	Green
Safer Recruitment	Clear policies describing the commitment and approach to safeguarding, including safe recruitment practices and arrangements for dealing with allegations against people who work with children and adults, as appropriate.	Green
Inter-agency Working	Effective inter-agency working with Local Authorities, the Police and third sector organisation's, including appropriate arrangements to co-operate with Local Authorities in the operation of safeguarding children's partnerships, Corporate Parenting Boards, Safeguarding Adults Boards and Health and Wellbeing Boards.	Green
Implementation	Appropriately engaged with all safeguarding investigations, multi-agency case reviews or safeguarding practice reviews and that the evidence of learning has been embedded into practice.	Amber
Patient Engagement	Ensures appropriate and accessible information is provided for its population in relation to how it discharges its duties for safeguarding.	Green
Supervision	Safeguarding supervision is available to staff in line with Intercollegiate Guidance.	Green
Assurance	As a commissioner of local health services, the ICB must be assured that there are effective safeguarding arrangements in place in the services and gain assurance throughout the year to ensure continuous improvement.	Green

Position on Amber ratings:

Implementation: The team has been fully engaged with all safeguarding investigations, multi-agency case reviews and safeguarding practice reviews. There have been challenges in evidence that learning has been embedded, a system learning assurance approach is required to understand how effective change has been implemented and assess impact. This is recognised as an area for development across safeguarding partnerships.

The ICB has remained compliant with national safeguarding assurance tools including the NHS England Safeguarding Integrated Data Dashboard (SIDD), the Safeguarding Case Review Tracker (SCRT) and the Safeguarding Clinical Assurance Tool (S-CAT). Members of the safeguarding team also participated in regional and national forums facilitated by NHS England to support shared learning and alignment with national developments. The ICB has supported the facilitation of the expansion of the Child Protection Information System within directed clinical areas.

Ensuring the workforce has the knowledge and skills required to identify and respond to safeguarding concerns remains a key priority. During the year, the safeguarding team updated key policies relating to Prevent, safeguarding supervision and safeguarding training strategy which are aligned to the Intercollegiate Documents, all policies are monitored and reviewed to ensure that they align to national and local policies, best practice and learning from reviews. A training programme to ensure compliance with Prevent was implemented, with required compliance achieved.

Safeguarding supervision arrangements remain well established. The All Age Continuing Healthcare (CHC) team receives safeguarding supervision to strengthen awareness of potential organisational safeguarding issues within care providers. Supervision is also available to Named Nurses and relevant staff, supported by a quarterly health safeguarding and executive groups which facilitates shared learning and discussion of complex safeguarding issues.

During 2025, we have maintained the Mental Capacity Act Health Leads Group and the Prevent Health Leads Steering Group. Both groups meet quarterly, receive direction from regional networks and provide system oversight to ensure legislation, guidance and best practice are reflected in local arrangements and training. The Mental Capacity group has also facilitated a system wide self-assessment audit on the Mental Capacity Act facilitating assurance and areas for development to the safeguarding partnership board to enable further multi-agency development in this area.

The ICB safeguarding team has led on a national project to develop a safeguarding multi-agency Level 3 apprenticeship programme, this has received accreditation and was presented at the Safeguarding Adult National Network.

The ICB Safeguarding People Team continues to contribute to a range of statutory review processes including Child Safeguarding Practice Reviews, Safeguarding Adult Reviews, the Child Death Overview Panel (CDOP), Learning from Lives and Deaths (LeDeR) reviews and domestic abuse related death reviews. The team are also compliant with their devolved role of NHS England in reviewing domestic abuse related deaths for Home Office quality assurance panels.

The Designated Doctor for Safeguarding Children leads the Child Sexual Abuse sub-group of the safeguarding partnership board and continues to review the impact of the local sexual abuse strategy. This work is aligned with national learning from the safeguarding practice review into sexual abuse within the family environment.

Following a review of the ICS multi-agency safeguarding hubs (MASH) health function and the child protection medical service last year. The ICB has continued to support development in this area with evidence of a significant increase in compliance by the provider.

A Section 11 and Adult Safeguarding Self-Assessment audit was completed across general practice in 2025. The electronic audit combined both adult and children's safeguarding requirements. 58 responses were received, with some covering multiple sites.

The audit reviewed core safeguarding arrangements and included additional questions informed by practice learning reviews, such as routine enquiry, contraception, and domestic abuse. Key areas for improvement included cultural competency, recording who attends patient appointments, considering routine enquiry for low mood presentations, and documenting relationship histories. These themes differ from the 2022 audit, which focused on service user voice, learning from safeguarding reviews, the Multi-Agency Risk Management (MARM) process, and Mental Capacity. This shift reflects progress in several areas; however, domestic abuse awareness and practice require further strengthening. Learning from the audit has been shared through GP Safeguarding Lead Forums, Safeguarding Matters webinars, and two half day safeguarding training sessions delivered this year.

The child death review team have continued to ensure that the ICB meets its statutory responsibility to review all deaths of children who die prior to their 18th birthday. The Child Death Overview Panel (CDOP) has met six times during the financial year, reviewing 54 cases.

Learning and themes from the CDOP were shared via a quarterly newsletter, as well as by each organisations panel representatives. During 2025/26 the CDOP membership was reviewed to ensure adequate multi-disciplinary expertise, introducing a learning disability Nurse, and a Neonatologist as substantive members.

One of the cases reviewed in this period has prompted work with the National Child Mortality Database (NCMD) and will see an update made to the statutory and operational guidance around how CDOP's manage a no body homicide review, with Cambridgeshire and Peterborough CDOP being the first in England to manage such a case.

The CDOP have also supported colleagues in Public Health and Education to raise awareness around the risks of cold-water shock and drowning when entering open bodies of water, this was following an increase in drowning deaths amongst young males during the warmer months.

The full CDOP annual report is published via the [Safeguarding Partnership Board website](#).

The Designated Nurse and Designated Doctor for Children in Care and Care Leavers have overarching strategic responsibility for all health matters relating to this cohort of children and young people. They contribute to Corporate Parenting Boards and play a key role in strengthening communication and partnership working between health and social care professionals. In 2025, service specifications and commissioning arrangements for children in care health services were reviewed and updated to improve delivery models, strengthen performance oversight, and promote equitable access to services. The service is now commissioned through a single provider across Cambridgeshire and Peterborough. Since the implementation of this model, there has been a significant improvement in performance, particularly in previously underperforming areas, with more children in care receiving health assessments within required timescales.

The Health of Children in Care Partnership is a multi-agency forum bringing together representatives from health organisations, care providers, and the local authority. Its purpose is to promote and enhance health outcomes for children in care and care leavers. Chaired by the Designated Nurse for Children in Care, the partnership meets every month (alternating between Local Authorities) and supports collaborative pathway development. It also leads on key priorities, including the co-production of guidance to improve the timeliness of health notifications when a child enters care and ensuring services are aligned with the updated Coram BAAF documentation.

Research

The ICB hosted Research Office provides a specialist R&D function for National Institute for Health and Care Research (NIHR) portfolio research in primary care and wider care settings. It also hosts and manages selected NIHR grants for primary care and population health research; and supports and promotes research and the use of research evidence across the ICS.

In 2025-26, we received £454,000 in Research Capability Funding (RCF). Over 75% of this was used to fund strategic research capacity and capability building awards across our local system. Applications included development of new research to support improvements in primary care and community services for mental health in people with obesity; palliative and end-of-life care for people with housing insecurity; multimorbidity management; eye health in prisons; and the use of health navigators to reduce health inequalities. We also funded a new Community of Practice in academic primary care research led by the University of Cambridge.

A total of £100,000 in Research Engagement Network (REN) programme funding awarded by NHS England has supported ongoing work to boost research access and inclusion for underserved groups. Community-based research engagement activity has supported recruitment and retention to research studies and sign-ups to the Be Part of Research service via VCSE partners and selected primary care practices.

This year we also actively supported winning applications from two of our most research-active primary care practices (previous recipients of RCF and REN to trial inclusive expansion of research capacity and capability) to become NIHR Commercial Research Delivery Centres (Primary Care). They are now part of a national cohort of 14 centres and will pioneer expansion of commercial research across linked practices.

Research Office staff have been pleased to contribute to national strategic thinking on research policy in relation to metrics, finance, workforce and Model ICB and Region blueprints. We also held a summit for local health and care leaders: *Shifting the dial? How research supports the 10 Year Health Plan*.

Environmental Matters

The Department of Health and Social Care (DHSC) General Accounting Manual (GAM) set out a phased approach to incorporating the recommended Task Force on Climate-related Financial Disclosure (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.

The phased approach incorporates the disclosure requirements of the following 'pillars': Governance, Strategy, Risk management, and Metrics and targets. These disclosures are provided below with

appropriate cross referencing to relevant information elsewhere in this report and in other external publications.

Governance and Risk Management

The ICS Green Plan was due to be refreshed in 25/26, and work had commenced on redrafting. A Programme Board had been operational to oversee delivery, focus on measuring implementation, identifying blockers to progress and opportunities. A specialist transport sub-group was established, alongside existing groups (estates and pharmacy) to take on the responsibility of delivery against our targets. These groups and revision work were paused, in light of the restructure announced, and anticipated, and the Blueprint issued as to future ICB responsibilities. In the interim a 'Plan on a Page' has been developed setting out the commitments in line with the Green Plan guidance issues by the national team. Notwithstanding this, work continued in several areas, in line with the aims of the existing Green Plan, programmes of work and relationships developed over previous years.

Risk associated with climate change continue to be regularly monitored through the Divisional and Corporate Risk Registers.

Work continues to look at adaptation and how we can work with partners to raise the issue at the highest levels across the system. In particular working through the Cambridgeshire and Peterborough Local Resilience Forum (CPLRF) and the Future Fens grouping.

The Impact Assessment Panel continues to assess the environmental impact of all proposals that seeks ICB funding (decommissioning, transformation of services, or is predicted to have an impact on a sizeable fraction of the population) and provide advice and guidance to those involved.

We continue to input to major strategies and consultations, to ensure an environmental sustainability thread is woven through same. In this period this included:

- Natural England Nature Recovery Strategy consultation
- ICB Behavioural framework
- ICB Outcomes framework
- ICB Operational Plan
- Environmental Policy for Central East
- Environmental Impact Assessment process for Central East
- Commissioning intentions

As part of the new structural arrangements for delivering ICB functions, the Sustainability Leads for the three ICBs in our cluster met regularly since April to look at alignment and future support and integration of this agenda.

Workforce and leadership

We continue to sit on local, regional and national groups, to gather information, share our experience and advice.

- Eastern Region ICS Sustainability Leads Forum
- Eastern Region Sustainable Procurement, Transport and Estates groups
- EEAST (Ambulance Service)
- NHS Biodiversity working group
- NHS Greener By Design Focus Group (IT and AI)

- Local Joint Strategic Needs Assessment (JSNA), Community Energy, Warm Homes events and Older Persons Panel

All new staff this year received environmental sustainability in the NHS, as part of their induction programme. Training sessions were also provided to the Sustainability Clinical Fellows national Programme and by our Clinical Fellows to clinicians and wider NHS audiences (Local and National). Our second Clinical Fellow finished her secondment in August, having delivered in the areas of Sustainable Surgery, Sustainable Travel across the system and nationally the Green Radiotherapy Framework. We were again successful and secured a third Clinical Fellow who is working on Sustainable Travel and Transport, AI and the opportunities and impacts and reuse of Walking Aids working with the Prison Service and Design For Life.

A Primary Care network was set up connecting GPs and Pharmacists, with an interest in this agenda.

Travel and transport

ICS partnership work continued (working across Trusts, local authority and transport provider bodies). The ICB Clean Air Framework was presented and shared across our system. Work has commenced on a Sustainable Travel and Transport Strategy for Central East ICB.

Estates

An information leaflet and guide was produced for Primary Care to assist in improving environmental sustainability in the management of the General Practice estate.

Procurement

Bespoke Procurement training was provided to ICB and NHS staff across the system. We also inputted into Strategic Commissioning planning and Commissioning Intentions documents and continued to provide support for tenders.

Sustainable are pathways and digital

With the appointment of a second Sustainability Clinical Fellow, we have continued to build on the work of the previous two secondments. The focus areas to date include

- AI and the digital realm
- Recycling of Walking aids in partnership with the prison project
- Participation in the Greener by Design (Digital and IT) forum
- Design For Life

Improve quality

A core responsibility of the ICB is to maintain oversight of the quality and safety of commissioned services, ensuring that high standards of safe, effective and compassionate care are delivered to our population. Alongside this assurance role, the ICB supports providers and system partners in driving continuous improvement in the quality of care.

In the previous year, the ICS refreshed its system-wide Improving Quality Strategy, aligning it with the National Quality Board's Shared Commitment to Quality. This work established a shared framework and set of principles for how partners across the system collaborate to improve patient safety, experience and clinical outcomes.

While the formal strategy programme concluded during the year, the principles and relationships developed through this work continue to underpin how organisations across the ICS work together to address quality challenges, share learning and support improvement across services.

Although the strategy provides a coordinated system approach to quality improvement, individual organisations remain responsible for maintaining their own organisational quality strategies, governance arrangements and benchmarking processes. The ICS approach strengthens opportunities for organisations to collaborate, share best practice and address common challenges collectively.

Strengthening Quality Oversight Across the System

During the year, the ICB has continued to strengthen its approach to quality oversight across commissioned services through a structured contractual assurance process.

All providers holding NHS contracts are required to meet a set of locally agreed quality requirements as part of their contractual obligations. Compliance with these requirements is monitored through a robust assurance framework which brings together a range of intelligence, including provider quality reports, contractual performance data, patient safety information, and findings from quality assurance visits.

Quality intelligence is reviewed through the ICB's contractual governance processes prior to formal contract meetings. For larger providers this includes the Clinical Quality Review Meeting (CQRM), which operates under a formal Terms of Reference and includes multidisciplinary clinical representation from across the ICB. The CQRM provides a structured forum to review provider performance against quality standards, consider emerging themes in patient safety and quality, monitor improvement plans, and recognise areas of good practice and innovation.

Quality assurance visits form an important part of this contractual assurance framework. These visits enable the ICB to gain direct insight into the quality of care and patient experience, providing an opportunity to triangulate provider-reported information with observations from clinical environments and discussions with staff and patients.

During the year, the programme of quality assurance visits expanded to include independent sector providers delivering NHS-funded services. This has strengthened the ICB's ability to gain assurance across the full range of commissioned services. Findings from these visits are reviewed alongside contractual and performance data and inform the discussions held through CQRM and contract review meetings.

Together, these arrangements provide a comprehensive picture of quality across commissioned services and support the ICB in maintaining effective oversight of provider performance, recognising areas of good practice and ensuring appropriate monitoring of improvement actions where required.

Patient Safety and the Implementation of Patient Safety Incident Response Framework (PSIRF)

The Patient Safety Incident Response Framework (PSIRF) is now embedded across acute and community providers within the system. The ICB maintains oversight through established governance arrangements, including monitoring providers' patient safety priorities, reviewing themes and learning

arising from incident investigations, and seeking assurance that improvement actions are being delivered.

During the year, a significant area of work has been supporting independent sector providers delivering NHS-funded services to implement PSIRF. The ICB has worked closely with these providers to support the development of PSIRF policies and response plans, helping ensure that patient safety learning approaches are aligned across the system.

To support shared learning and continuous improvement, the ICB facilitates a system-wide PSIRF Community of Practice. This forum brings together patient safety leads from across organisations to share learning from investigations, discuss emerging themes and promote best practice approaches to patient safety improvement.

Supporting quality improvement and the spread of learning across the system remains a priority. During the year, the ICB facilitated a number of learning events and collaborative forums to enable organisations to share improvement initiatives, reflect on patient safety themes and develop approaches to quality improvement. These events have strengthened system collaboration and supported organisations to learn from each other's experiences in improving patient safety and quality of care.

The role of Patient Safety Partners (PSPs) continues to develop across the system, strengthening the involvement of patients and the public in safety governance. PSPs contribute valuable insight and challenge to patient safety work and are supported through a Community of Practice that enables shared learning and development across organisations.

Primary care providers have also been supported to understand the framework and the principles of patient safety learning. National guidance for primary care has been implemented differently and is not mandated in the same way as for larger providers, and the ICB continues to support practices to develop their understanding of patient safety approaches.

System leadership and CQC readiness

As a central system partner, the ICB has strengthened its leadership role in driving a culture of continuous improvement, regulatory readiness, and collective accountability across Cambridgeshire and Peterborough.

Strategic quality leadership

Providing system-wide leadership for CQC readiness through a structured, person-centred approach, placing individuals, outcomes, and lived experience at the heart of assurance processes. This approach is explicitly aligned to statutory duties and the CQC Single Assessment Framework, ensuring that preparation is grounded in legislation, evidence, and demonstrable impact.

- Leading the coordination of system readiness through the establishment and chairing of a high-impact System CQC Steering Group, enabling partners to align approaches, share intelligence, and maintain a consistent state of inspection preparedness across organisations.
- Supporting system partners to adopt the same principles and methodology, providing advice, constructive challenge, and practical support to strengthen local readiness, evidence capture, and continuous improvement.

- Maintaining a proactive and transparent relationship with CQC through regular engagement and intelligence-sharing, enabling early identification of risks, themes, and areas of focus, and ensuring the system is well-positioned to respond collectively.
- Representing the system at East of England regional CQC forums, contributing to regional alignment, sharing best practice, and escalating cross-system challenges to influence wider improvement.

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

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 Collaborative Group meets monthly to share best practice and lessons learned from the previous month. It 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 also provides system awareness of new and emerging threats, offers peer review and supports a level of standardising practice across sites.

Following a national incident declaration for *Clostridioides difficile* (C.diff) in January 2025, a quality improvement initiative was undertaken throughout the year. This resulted in the development of a C.diff toolkit where providers contributed useful tools for the management of this infection. The toolkit was shared with all organisations, who signed a commitment to support the initiative. At the end of 2025 Acute Trusts within Cambridgeshire and Peterborough showed a total reduction in cases of 30% over the year (January to December 2025).

When comparing calendar years 2024 to 2025 case numbers:

- CUHFT has seen a 21% reduction in case numbers (169 to 137 cases)
- NWAFT has seen a 17% reduction in case numbers (156 to 132 cases)
- RPH has seen a 38% reduction in case numbers (20 to 14 cases).

Total *C-difficile* cases in Cambridgeshire and Peterborough for 2025, including acute and community cases showed a 42% reduction in cases overall, January to December 2025.

Collaborative working with the local authorities of Peterborough City Council and Cambridgeshire County Council continues and the ICB hosts the local authority IPC nurse. 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. Biweekly meetings are held with Public Health and UK Health Security Agency to discuss any ongoing public health or IPC issues across Cambridgeshire and Peterborough, with support offered by the ICB IPC team as required.

Training study days for Practice Nurses were conducted in 2025/26. This year also saw the introduction of IPC study days for care homes, jointly hosted by the Local Authority and ICB. Study days have been well attended, and positive feedback has been received.

Following feedback at the winter debrief meetings for 2024/25, over the 2025/26 winter season the ICB IPC team has been collating and circulating weekly reports into the status of winter pressures in provider organisations across the area. The providers have been engaged with this initiative, providing data promptly each week that has been circulated across the system and used to inform risk assessment and identify where additional support may be required.

The IPC team has supported organisations across the system with incident management in 2025/26, including TB in prisons, nosocomial malaria, outbreak management and surgical site infections.

2025/26 also saw the launch of a project to introduce a standardised IPC audit program across the system using digital technology to benchmark across all organisations. Still in early stages, work will continue throughout 2026/27.

Engaging people and communities

Listening to the experiences of our local people and communities is at the heart of everything we do. It's a simple, but powerful belief that 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 Community and Mental Health provision to setting up our new Community Participation Group, our approach has continued to be rooted in openness, curiosity, and collaboration.

A large part of our engagement activities this year has been with staff and partners as we move from Cambridgeshire & Peterborough ICB to become the new Central East ICB as part of a nation-wide programme of changes for Integrated Care Boards. Ensuring our partners were informed and our staff could be actively involved the change process has been an incredibly important part of our work this year and will continue to be so into the new financial year as we become Central East ICB. Our Senior

Leaders have met with key stakeholders across the area on a regular basis, and we have set up a range of staff forums, engagement channels and information sources to support everyone throughout the change process.

Beyond the change process, we have successfully launched our NHS Community Participation Group, with facilitation support from Healthwatch Cambridgeshire and Peterborough. The model combines a diverse core membership with flexible, topic-specific participation from individuals with lived experience, ensuring a broader range of voices can shape key programmes such as mental health, community services redesign and neighbourhood health.

The feedback received from these sessions has helped to shape our work in these key areas and enabled rich, in-depth discussions. Next year we will be undertaking a review of the effectiveness of the group and looking at how we can take those learnings into the new Central East ICB.

Another focus for this year has been our engagement work for the Community and Mental Health Review, which was designed to assess how community and mental health services are currently delivered across Cambridgeshire & Peterborough, and how they align with wider strategic objectives, including those set out in the ICB Strategic Commissioning Plan and national 10-year plan.

We wanted to hear from the wide range of professionals who worked within this field, and the people who use or have experienced these services. To do this effectively we undertook a combined engagement approach which includes one to one conversations with key stakeholders, focus groups with service users and larger events where we undertook deep dives into key themes with our providers, including NHS and voluntary sector.

The feedback we have received has helped to shape the review process and will be used in the future to help guide decisions about commissioning arrangements in the future.

On a more local basis, we have continued to undertake focused engagement work with communities about the General Practice services they receive in their local area. In Bar Hill, we held another community event to understand how the improvements made to their local practice have supported better access to care; and in Parnwell we worked with local Councillors and residents to provide insights into when a branch practice would reopen following works.

Over the past year, we have strengthened our approach to VCSE engagement and co-production, working alongside communities, partners and people with lived experience to shape more inclusive, preventative and community-led health and care.

A key area of focus has been building the evidence base for community impact. Our partnership with Anglia Ruskin University is delivering a multi-phase research programme to better understand and strengthen the volunteering landscape across Cambridgeshire and Peterborough - exploring who is currently engaged, where gaps exist, and how volunteering can support improved health, wellbeing and employment pathways. Alongside this, our research with Support Cambridgeshire and The Gather Movement has deepened our understanding of the faith sector, highlighting its significant contribution to children and families, food security and mental health, and strengthening links into neighbourhood health models.

Building on our £2 million Healthier Future's Fund, launched in 2023, we are now seeing clear and measurable impact from sustained investment in VCSE-led prevention and early intervention. Across 21 funded projects, over 5,400 people have already benefited, with strong outcomes emerging in children

and young people's emotional wellbeing, family relationships, and support for people living with dementia.

For example, the majority of children receiving bereavement or domestic abuse support are achieving improved wellbeing and relationships, while targeted counselling support is enabling young people to successfully return to education. This impact is being strengthened through our hyper-local community grants programme, delivered in partnership with Assura Plc, which invested in grassroots organisations responding to locally identified health needs.

We have also made significant progress in embedding co-production across the system. Our Participation and Involvement Network, jointly led by NHS, local authority and VCSE partners, is driving cultural change through the development of a co-production charter, expanding access to training and support, and beginning to shape a shared framework for measuring impact. Practical learning has been supported through shared sessions, including innovative engagement approaches with children and families to inform neighbourhood planning.

Finally, we have continued to strengthen and embed strategic VCSE leadership through the Voluntary Sector Network, ensuring the sector remains an equal partner in shaping and delivering ICB priorities.

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 these services, and the outcomes they receive. Inequalities in health generally reflect the inequalities in society, with many of those most in need often facing the biggest barriers to accessing support.

We recognise health inequalities exist across the country, and within Cambridgeshire and Peterborough is no exception. The ICB is committed to reducing health 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. Average healthy life expectancy rates, which is the average number of years a person can expect to live in good health, 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 are lowest for those people living in more deprived areas. This means those living in the more deprived areas of Cambridgeshire and Peterborough not only tend to die earlier but also spend a greater proportion of their lives in poor health. 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.

Health Inequality Focus

Our overarching aim is to increase the number of years people live in good health and reduce premature mortality. To achieve this, there has been a continued 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 are outlined in our [Joint Forward Plan](#) (2025-30) and our [Strategic Commissioning Plan](#). Both focus on the following key principles:

- Using our data and wider insights so we are evidence-led in our approaches.
- Promoting healthy behaviours and increase access to early intervention services.
- Improving access to healthcare services for vulnerable and marginalised populations.
- Working with local people and communities to better understand the challenges they experience and coproduce solutions that best meet their needs.
- Embedding a 'Core20PLUS' approach.

To deliver on these principles, the ICB's Population Health Improvement (PHI) Board brought together the ICB's prevention, population health management and health inequalities programmes. Throughout 2025/26 the Board provided accountability for the Health Inequalities Strategic Oversight Group (HISOG), a core group of system leaders from a range of partner organisations with responsibility for tackling healthcare inequalities and for delivering against [NHS England's strategic priorities](#).

Data & Reporting

To help measure the whole system's success in keeping the population well and reducing illness, the ICS' Outcomes Framework was developed based on the overarching aims of the Health & Wellbeing Integrated Care Strategy, and which is now hosted on the [Cambridgeshire & Peterborough Insight](#) webpages. The Outcomes Framework is used to monitor several healthcare inequality metrics, aligned to the [NHS England's Core20PLUS5 approach](#), as well as broader metrics to help track how the ICB is reducing inequalities in deaths in under 75s and measure how the broader social, economic and environmental factors also shape people's lives through the inclusion of wider determinant proxy measures.

Alongside the Outcomes Framework, the ICB has produced an health inequalities data pack in response to NHS England's Information Statement ([NHS England's statement on information on health inequalities](#)). The health inequalities data pack is available on the ICB's website and provides an overview of some of the key metrics the ICB monitors to ensure it commissions services that tackle identified inequalities. The production of robust data and subsequent analysis enables the ICB, NHS bodies and wider system partners to better understand inequalities within the population and between specific groups in the access they have to health services, and the experiences and outcomes they receive.

For example, the reporting and analysis of vaccine uptake data has enabled the ICB to commission additional capacity through its Access and Inequality Nurse project. This project has helped to address unwarranted variation and engagement in GP practices with the lowest vaccine uptakes, supporting the NHSE-commissioned Community and School-Aged Immunisation Service (CSAIS) programme through the commissioning of additional nurses in some of our most deprived practices. The project has helped deliver a total of 12,574 additional vaccinations in the last 18-months, with an additional 2,028 MMR vaccinations. This has been possible through additional engagement events, promoting vaccinations amongst groups at risk of experiencing health inequalities, including homeless communities, asylum seekers housed in temporary hotel accommodation, ethnic minority groups such as the Gypsy, Roma and Traveller group as well as other tailored events such as during University 'Fresher's Week', Family Event Days and Pride events across the system.

An enabler to tackling inequalities: ICB's impact assessment process

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

As such, one of the priority areas of focus for the ICB in 2025/26 was to continue to embed a new, consolidated two-stage impact assessment process and align this to the ICB's wider governance framework. This approach ensures compliance with the ICB's statutory duty under the Health Care Act 2012, the Equality Act 2010 and the Public Sector Equality Duty to effectively evaluate the impacts of its decisions, while paying particular attention to those population groups most at risk of experiencing health inequalities.

By embedding our robust impact assessment process, all proposals seeking funding, decommissioning or in the transformation of commissioned services, the ICB has been able to identify negative impacts and mitigate these where possible to reduce the risk of widening the health inequalities gap. It is the intention of the transition committee to ensure progress in this space is not lost as Cambridgeshire & Peterborough ICB becomes a part of Central East ICB from 1 April 2026. In doing so, and ensuring every decision is scrutinised appropriately through the domains of equity and inequality

Health and wellbeing strategy

The ICB's priorities and outcomes framework are directly aligned to the ambitions of the Health and Wellbeing Integrated Care Strategy. We have continued to work in partnership with our local authority partners, health and care delivery partners and voluntary sector stakeholders to facilitate joint programmes of work with a focus on prevention and inequalities. Specific examples of delivery aligned to the four priorities of the Health and Wellbeing Integrated Care Strategy are provided below.

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

- Integrated family approaches across perinatal and early years
- Uptake of immunisations
- Support pathways for emotional wellbeing for children and young people, including through education and transition into adult services

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

- Promoting 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, including for example regular medication reviews, social prescribing and shared decision-making
- Embedding the prevention offer in secondary care
- Supporting high risk groups and addressing inequalities
- Improving 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.

- Delivery of the WorkWell programme as one of 15 national pilots. Since its establishment in 2024, this joint Department of Health and Social Care and Department for Work and Pensions initiative has supported more than 3,000 individuals to overcome health related barriers to work and provides an integrated pathway to person-centred support
- 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 have been workstreams to support this priority. There is a stocktake of position of the workstreams undertaken to be clear of completed actions and progress against the workstreams and identified actions for 26/27.

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.

As part of this process, the contents of the draft annual report was shared with the Cambridgeshire and Peterborough Health and Wellbeing Board for review and comment.

Joint Forward Plan

Each Integrated Care Board in England is required to have a Joint Forward Plan. In Cambridgeshire & Peterborough, our plan has been written by a wide range of health and care professionals and partners from across the county, who have spent time listening to local communities about what they want from health and care services. The ICB delivered its [Joint Forward Plan](#) (JFP) objectives through its operational plans for 25/26, with clear alignment between the short-term actions required in year one and delivery of its strategic objectives. Therefore, the two plans should be read and considered in conjunction. Oversight of delivery of JFP objectives was routinely reported through ICB Board and sub-board committees and overseen by the Joint Health and wellbeing partnership board.

Delivery against the JFP priorities is reported throughout the annual report rather than as a standalone section. For example, under 'focus on the basics' the ICB committed to improving cancer care and as demonstrated in the performance section of the report, strong in year recovery led the ICB to exceeding the national target for Faster Diagnostic Standard performance. Another example is work delivered as part of 'Reform' and 'Make Big Moves' priorities, with our work well programme actively engaging with and supporting proactively high users of health services to coordinate their care and support them back into work. This delivery is against the backdrop of the ICB reconfiguration announcements in March 2025 and publication of the ICB Model Blueprint in May 2025.

Financial review

NHS Cambridgeshire and Peterborough ICB was given a resource allocation for the year to 31 March 2026.

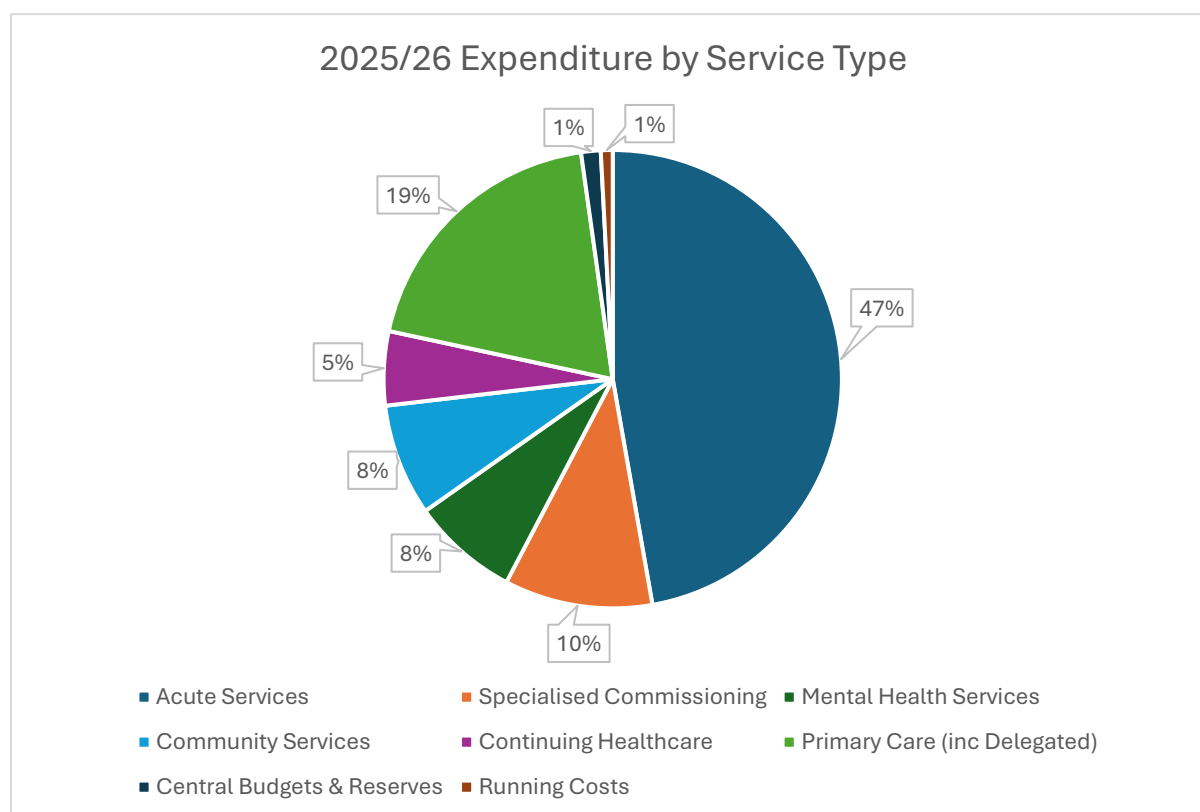
- Allocations have been set for ICBs and the system with a movement towards the national target allocation.
- The ICB had a requirement to achieve in year breakeven in 2025/26.
- Cambridgeshire and Peterborough ICS (of which the ICB is a part) is also required to breakeven in total across the 6 organisations.
- Retrospective funding has also been issued by NHS England to fund the additional costs of Industrial Action, which were much lower than in previous years.
- Elective recovery funding was allocated in contracts agreed in 2025/26 based on a set allocation from NHS England.
- The ICB took on the delegation of some additional Specialised Commissioning services contracts from NHS England in 2025/26.
- The ICB is undertaking a large-scale reorganisation and will form part of Central East ICB from 1 April 2026. This has resulted in additional one-off costs relating to staffing.
- The ICB has achieved the breakeven requirement set by NHSE with a surplus of £3,846k. This off-sets the deficit position reported by Cambridgeshire and Peterborough NHS Foundation Trust and ensures the ICS reports breakeven.
- 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 2025/26 can be found at [Joint Capital Resource Use Plans 2025/26](#).
- Delivery against the joint capital use resource plan has been monitored through the ICB Quality, Performance and Finance committee, as part of the finance function. Providers also report delivery of their strategic capital programmes through their own governance arrangements, with provider funding making up most of the System Capital Departmental Expenditure Limit (CDEL) allocations in 2025/26. For 2026/27, arrangements for the distribution and oversight of capital has changed, with ICBs no longer having system CDEL responsibilities.

The table below shows the ICB financial position.

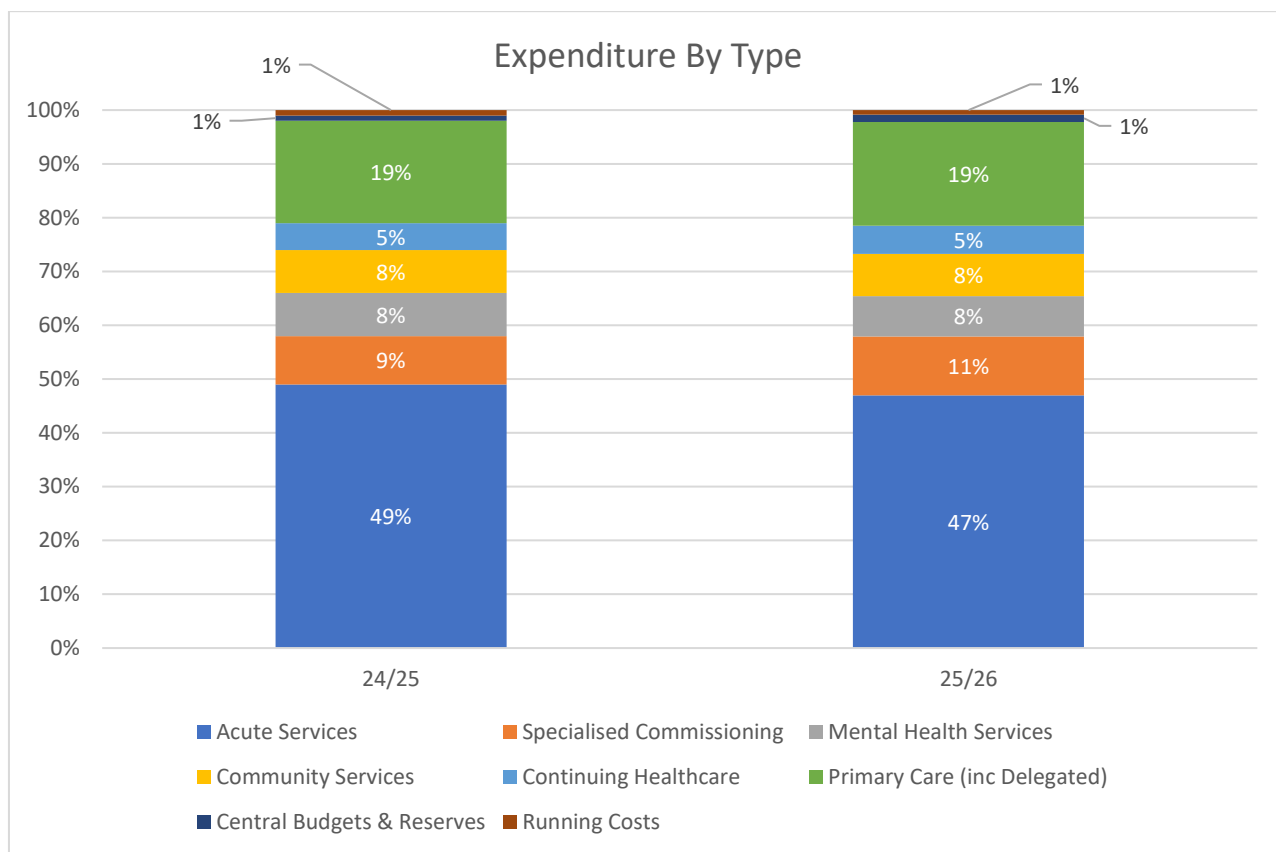
ICB Financial Position	2025/26
	£'000
Total net operating costs	2,543,786
Revenue resource limit	2,547,632
Under/(over) spend	3,846

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 2025/26.



The chart on the next page compares expenditure by service type from 2024/25 and 2025/26.



ACCOUNTABILITY REPORT

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 2025 to 31 March 2026 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 policies 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

Composition of Board

From 1 October 2025 to 31 March 2026 the ICB, working in partnership with Bedfordshire Luton & Milton Keynes ICB and Hertfordshire and West Essex ICB, operated transitional governance arrangements which were approved by the Boards of all three organisations. The arrangements required changes to both the ICB's Constitution, which was approved by NHS England, and the ICB's Governance Handbook.

These changes brought together the ICB Boards and Committees of each ICB, whilst maintaining the statutory obligations as independent legal entities. From 1 October 2025, we operated Boards and Committees in Common or as Joint Committees. Whilst statutory Committees were retained, the Board established several new Joint Committees. These transitional arrangements have been reflected within the composition of both the Board and Committees set out below for 2025/26. Refer to Annual Governance Statement for more information about the roles of each Committee (p49).

From 1 April – 30 September 2026

John O'Brien was Chair up to 30 September 2025. Robin Porter was appointed Chair of the new ICB cluster from 1 October 2025.

Dr Simon Hambling, Partner for Primary Care resigned from the Board in July 2025. Ged Curran, Non-Executive member and Chair of the Commissioning & Investment and Improvement and Reform Committee stepped down from his role in August 2025.

Integrated Care Board

Members of Board (Voting Members)

John O'Brien	ICB Chair
Saqhib Ali	ICB Non-Executive Member
Carol Anderson	ICB Chief Nurse
Ged Curran	ICB Non-Executive Member (<i>To August 2025</i>)
Matt Gladstone	Partner Member – Local Authorities (Chief Executive – Peterborough City Council)
Steve Grange	Board Member – Mental Health (Chief Executive – Cambridgeshire and Peterborough NHS Foundation Trust)
Dorothy Gregson	ICB Non-Executive Member
Sarah Griffiths	ICB Chief Finance Officer
Dr Simon Hambling	Partner Member – Primary Medical Services (<i>to July 2025</i>)
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)

Regular Participants and Observers – Non-Voting

Sharon Allen	Voluntary Community and Social Enterprise (VCSE)
Dr Sally Cartwright	Director of Public Health, Cambridgeshire County Council
Hannah Coffey	North Place Representative
Stacie Coburn	Chief Operating Officer
Dr Gary Howsam	Chief Clinical Improvement Officer
Dr Diana Hunter	Cambridgeshire Local Medical Committee Representative
Claudia Iton	Chief People Officer
Jonathan Jelley	Healthwatch Representative
Louis Kamfer	Deputy CEO / Managing Director Strategic Commissioning
Dr Raj Lakshman	Interim Director of Public Health, Peterborough City Council
Roland Sinker	South Place Representative
Kate Vaughton	ICB Chief Officer Partnerships and Integration
Matthew Winn	Children and Maternity Collaborative Representative

Committee(s), including Audit & Risk Committee

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) (<i>to August 2025</i>)
Carol Anderson	Chief Nurse
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
Dr Fiona Head	Medical Director
Michael Hudson	Local Authority Representative: Cambridgeshire County Council
Eilish Midlane	Partner Member: NHS Trusts and Foundation Trusts
Lynda Phillips	Voluntary, Community & Social Enterprise organisations
Jess Slater	Healthwatch Senior Representative
Faustina Yang	Voluntary, Community & Social Enterprise
<i>Primary Care Rep</i>	<i>Position remained vacant in-year</i>
<i>Patient Safety Partner</i>	<i>Position remained vacant in-year</i>

Commissioning & Investment and Improvement & Reform Committee

Ged Curran	Chair – Non-Executive Member (<i>to August 2025</i>)
Dorothy Gregson	Non-Executive Member (Vice-Chair) – (<i>Chair from August 2025</i>)
Ashley Bunn	Voluntary Sector Representative
Carol Anderson	Chief Nurse
Dr Simon Hambling	ICB Partner Member – Primary Medical Services (<i>To July 2025</i>)
Dr Gary Howsam	Chief Clinical Improvement Officer
Sarah Griffiths	Chief Finance Officer
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
Jan Thomas	Chief Executive Officer
Patrick Warren-Higgs	Local Authority Representative: Cambridgeshire County Council
<i>Primary Care Rep</i>	<i>Position remained vacant in-year</i>

People Board

Sarah Hughes	Non-Executive Member (Chair)
Saqhib Ali	Non-Executive Member

Fiona Adley	Voluntary, Community and Social Enterprise
Tanie Brown	North West Anglia NHS Foundation Trust
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
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

From 1 October – 31 March 2026: Transition Governance arrangements

Integrated Care Board

Members of Board (Voting Members)

Robin Porter	Non-Executive Chair
Jan Thomas	Chief Executive
Karen Barker	Transition Director and Executive Director of Corporate Services
Alison Borrett	Non-Executive Member
Dorothy Gregson	Non-Executive Member
Sarah Griffiths	Executive Director of Finance, Resources and Contracting
Dr Fiona Head	Executive Clinical Director Utilisation Management (Medical Director)
James Howard	GP Partner – Primary Medical Services Provider Partner Member
Sarah Hughes	Non-Executive Member
Louis Kamfer	Executive Director of Strategy, Planning and Evaluation
Vineeta Manchanda	Non-Executive Member
Eilish Midlane	Chief Executive, Royal Papworth Hospitals NHS Foundation Trust – NHS Trust Partner Member
Stephen Moir	Chief Executive, Cambridgeshire County Council – Local Authority Partner Member
Prof. Gurch Randhawa	Non-Executive Member
Sarah Stanley	Executive Clinical Director Total Quality Management
Jan Thomas	Chief Executive Officer
Kate Vaughton	Executive Director for Neighbourhood Health, Place and Partnerships

Committee(s), including Audit & Risk Committee

Audit & Risk Committee

Alison Borrett	Non-Executive Member
Dorothy Gregson	Non-Executive Member
Vineeta Manchanda	Non-Executive Member (Chair)

Remuneration and Workforce Committee

Alison Borrett	Non-Executive Member (Chair)
Sarah Hughes	Non-Executive Member
Robin Porter	Non-Executive Member

Finance Planning and Payer Function Committee

Karen Barker	Transition Director & Executive Director of Corporate Services
Alison Borrett	Non-Executive Member
Dorothy Gregson	Non-Executive Member (Chair)
Sarah Griffiths	Executive Director of Finance, Resources and Contracting
Dr Fiona Head	Executive Clinical Director Utilisation Management (Medical Director)
Louis Kamfer	Executive Director of Strategy, Planning and Evaluation
Prof Gurch Randhawa	Non-Executive Director
Sarah Stanley	Executive Director Total Quality Management (Nursing Director)
Jan Thomas	Chief Executive Officer
Kate Vaughton	Executive Director Neighbourhood Health, Places & Partnerships

Utilisation Management and Quality Improvement Committee

Prof Natalie Hammond	Director of Safeguarding & Complex Care (<i>Until March 2026</i>)
Dr Fiona Head	Executive Clinical Director Utilisation Management (Medical Director)
Sarah Hughes	Non-Executive Director (Chair)
Louis Kamfer	Executive Director of Strategy, Planning and Evaluation
Prof Gurch Randhawa	Non-Executive Director
Vineeta Manchanda	Non-Executive Director
Sarah Stanley	Executive Director Total Quality Management (Nursing Director)

Management Executive Committee

Karen Barker	Transition Director & Executive Director of Corporate Services
Stacie Coburn	Director of Contracts and Performance
Elizabeth Disney	Director of Strategic Planning and Commissioning (<i>from March 2026</i>)
Beverly Flowers	Director of Strategic Planning and Commissioning (<i>Until December 2025</i>)
Pam Green	Director of Neighbourhood Health Places and Partnerships for Cambridgeshire & Peterborough
Sarah Griffiths	Executive Director of Finance, Resources and Contracting

Prof Natalie Hammond	Director of Safeguarding & Complex Care (<i>Until March 2026</i>)
Dr Fiona Head	Executive Clinical Director Utilisation Management (Medical Director)
Louis Kamfer	Executive Director of Strategy, Planning and Evaluation
Ed Knowles	Director of Neighbourhood, Place and Partnerships for Hertfordshire (<i>From February 2026</i>)
Emma Kriehn-Morris	Director of Finance
Tania Marcus	Director of People and Culture
Andrew Palmer	Director of Population Health, Analytics and Evaluation
Sarah Stanley	Executive Director Total Quality Management (Nursing Director)
Jan Thomas	Chief Executive Officer
Pól Toner	Director of Safeguarding and Complex Care (<i>From March 2026</i>)
Kate Vaughton	Executive Director Neighbourhood Health, Places & Partnerships
Maria Wogan	Director of Neighbourhood Health Places and Partnerships BLMK

Register of Interests

The ICB [Conflicts of Interest register](#) is published on the 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 (p58 refers)

Modern Slavery Act

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

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Cambridgeshire & 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 2025 and 31 March 2026, the ICB was not subject to any directions from NHS England issued under Section 14Z61 of the National Health Service Act 2006 (as amended).

From 1 October 2025 to 31 March 2026 the ICB, working in partnership with Bedfordshire Luton & Milton Keynes ICB and Hertfordshire and West Essex ICB, operated transitional governance arrangements which were approved by the Boards of all three organisations. The arrangements required changes to both the ICB's Constitution, which was approved by NHS England, and the ICB's Governance Handbook which was approved by the ICB Board.

These changes brought together the ICB Boards and Committees of each ICB, whilst maintaining the statutory obligations as independent legal entities. From 1 October 2025, we operated Boards and Committees in Common or as Joint Committees. Whilst statutory Committees were retained, the Board established several new Joint Committees. These transitional arrangements have been reflected within this Annual Governance Statement.

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 2025-2026 as follows:

9 May 2025
2 June 2025
20 June 2025
11 July 2025
19 September 2025
17 October 2025 (in Common)
28 November 2025 (in Common)
6 February 2026 (in Common)
27 March 2026 (in Common)

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:

From 1 April 2025 to 30 September 2025

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.

1 October 2025 to 31 March 2026

Audit & Risk Committee (Statutory) – Chaired by a Non-Executive Member. The Committee's purpose is to provide independent assurance on governance, risk management, internal control, and financial reporting. Key responsibilities of the Committee are to oversee internal and external audit processes; monitor risk management frameworks including deep dives on system-wide risks; review financial statements and governance reports; ensure compliance with statutory and regulatory requirements (Information Governance, Cyber Security, EPRR, Annual Report & Annual Accounts including Annual Governance Statement, Freedom to Speak Up), provide Integrated Care Partnership assurance.

Remuneration & Workforce Committee (Statutory [Remuneration]) – Chaired by a Non-Executive Member, the Committee's purpose is to oversee Executive and Director (VSM) pay, performance, and workforce strategy aligned with NHS People Plan. Key responsibilities of the Committee are to set remuneration and terms for senior executives; monitor workforce planning, recruitment, and wellbeing; compliance with the Fit and Proper Persons Test (FPPT); promote equality, diversity and, inclusion and compliance with Workforce Race Equality Standards (WRES)/Workforce Disability Equality Standard (WDES).

Finance Planning and Payer Function Committee (Non-Statutory) – Chaired by a Non-Executive Member. The Committee's purpose is to ensure financial sustainability and value-based commissioning aligned with population health needs. Key responsibilities of the Committee are to oversee the payer function; oversee financial planning, budget setting and monitoring financial performance; approve major investments and business cases; monitor commissioning outcomes and contract performance; align resources with strategic priorities; approve Health Care Partnership assurance investment; oversee utilisation of research opportunities.

Utilisation Management & Quality Improvement Committee (Non-Statutory) – Chaired by a Non-Executive Member. The Joint Committee's purpose is to provide assurance on the quality, safety, and performance of commissioned services. The Committee's key responsibilities are to monitor clinical effectiveness, patient safety, and patient experience across all ICB

Commissioned services including primary care; oversee safeguarding, serious incidents, utilisation management and quality improvement; review outcomes against NHS constitutional standards; assure Equality impact and consideration of population health risk of ICB commissioned services; review and monitor those risks on the Board Assurance Framework and Corporate Risk Register which relate to quality, safety, effectiveness, access, equity, acceptability, and relevance.

Management Executive Committee – Chaired by the ICB Chief Executive (CEO) (Non-Statutory). The Joint Committee's purpose is to be responsible for the operational leadership and delivery of the ICB's strategic objectives. It ensures effective coordination across executive functions and supports the CEO in discharging their responsibilities to the Board. The Committee provides executive leadership and oversight of day-to-day operations including performance, finance, workforce, and quality metrics; ensures delivery of the ICB's strategic and operational plans; coordinates cross-functional initiatives and transformation programmes; supports the development of Committee/Board papers and assurance reports; oversees the Board Assurance Framework and Corporate Risk Register and ensures alignment with NHS priorities and statutory obligations.

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.

Joint Transition Committee – In line with NHSE Guidance, the Boards of Bedfordshire Luton & Milton Keynes ICB, Cambridgeshire & Peterborough ICB, and Hertfordshire and West Essex ICB established a Joint Transition Committee which met from August 2025. The purpose of the Committee was to oversee the transitional arrangements, close down of three ICBs alongside the development of the new Central East ICB which is anticipated to be established from 1 April 2026.

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 October 2025, 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 (p42-47).

The gender distribution of the board, senior managers and all other employees is set out in the staff report section on pages 80-81.

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 Board and Statutory Committee Effectiveness Survey in Quarter 4 of 2025/26. This was based on the transitional governance arrangements described above which were in place from 1 October 2025. Key themes from the survey are set out below:

- Strategic focus and leadership – Boards and Statutory Committees demonstrate strong strategic intent and leadership, with recognised need for sufficient time to explore complex and high-risk issues in depth.
- Governance roles and clarity – Governance arrangements are broadly understood, with some ongoing need for clarity around roles, responsibilities as decision-making arrangements continue to evolve.
- Papers and agenda management – The volume timing and length of papers can limit effective scrutiny across Boards and Committees with members seeking more concise, purpose-drive reporting.
- Culture, challenges, and relationships – Culture is generally seen as open and respectful, though the size of meetings held in common and the pace of changes can affect consistent participation and challenge.
- Governance development and maturity – There is strong support for structured development to build shared understanding, role clarity and effective challenge as arrangements move forward to a single ICB.

The outcomes of the effectiveness survey were reported to the ICB Boards in Common at the end of March 2026. A small number of actions were proposed as a result of the Survey, and these will be taken forward by the new Central East ICB.

Regular review of the new Governance Framework and continuing effectiveness monitoring will continue to be a priority for the new ICB. Board Development will be incorporated into the overall new Central East ICB Organisational Development Programme. The Organisational Development & Delivery Team is responsible for building organisational capability, culture and performance structures to keep promises and sustain delivery and will be responsible for taking forward the ICB's organisational development programme, including Board Development. Specific focus for the Board will include ensuring mandatory Board training is undertaken, recognising the new ICB's statutory responsibilities, as well Board oversight and involvement on the delivery of Central East ICBs Strategy 'Our Way'. There will be strong focus on effective appraisals for all staff, Executive and Non-Executive Directors. The new ICB will also embark on a series of Orientation Days for all those appointed to the new ICB. These will commence in June and July 2026.

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
 - Implementation of Healthcare Guardian (InPhase) providing a more consistent approach to risk management through the Directorate Risk Registers
 - A Corporate Risk Register (CRR) is now under development which includes High risks escalated by Directorates through the Healthcare Guardian (InPhase) tool
 - A Transition Risk Register is in place monitored by the Joint Transition Committee

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:

- Continued development of the DRR, and the implementation of Healthcare Guardian (In Phase)
- Maintenance of the ICB's BAF and CRR
- Establishment of a Transition Risk Register,
- 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, including delivery against the DSPT Improvement Plan which has been overseen by a Task and Finish Group chaired by the ICB's Senior Information Risk Owner.

In addition, the ICB has continued 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. This framework was introduced during 2024/2025.

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 Caldicott Guardian (Chief Nurse until 30 September 2025 and Executive Clinical Director from 1 October 2025) who holds ICB board level responsibility for clinical risks. The ICB Executive Team (until 30 September 2025) and the Management Executive Committee (from 1 October 2025) 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 (until 30 September 2025) and the Executive Director of Strategy, Planning and Evaluation (from 1 October 2025) is the ICB's Senior Information Risk Owner (SIRO). The Head of Governance holds the role of the ICB Data Protection Officer (until 30 September 2025) and the Director of Strategic Planning & Commissioning (from 1 October 2025).

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 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 2026. Reasonable Assurance was received.

The BAF is reviewed by the Board and key Committees of the ICB at each meeting, including scrutiny by the Audit & Risk Committee, which also looks for assurance around the risk management framework. At Board level, there is strong representation from the wider NHS, through our Partner Members, as well as our Local Authority members and public stakeholders such as Healthwatch. All members are able to contribute to the discussion around the management of risk and assurance on mitigations.

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 2026:

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.
- 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.
- BAF04 **Service quality** – There is a risk that with services under increasing demand, clinical workforce gaps and access delays, service quality can be impacted.
- 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.
- BAF10 **Organisational Change** – There is a risk that the pace and scale of the proposed national changes to ICB structures and functions, as outlined in the ICB Model Blueprint, will affect the ICB's ability to deliver its statutory duties, operational and financial plans, and wider system objectives. There is also a risk of legal challenge due to workforce issues and inadequate engagement across the ICS due to tight timescales.

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.
- 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 2025/26 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 until 30 September 2024⁵ and the Finance Planning and Payer Function Committee and Utilisation Management & Quality Improvement Committee (from 1 October 2025).
- Review of governance risks via the Audit & Risk Committee and associated sub-groups of the Quality Performance & Finance Committee (until 30 September 2025) and the Joint Transition Committee from 1 October 2025.
- Review of workforce risks via the People Board (until 30 September 2025) and the Joint Transition Committee (from 1 October 2025).
- The BAF is 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 ordinarily expects commissioners - although not a specified requirement - to carry out an annual internal audit review of conflicts of interest management. The Internal Audit Review of the ICB's conflicts of interest arrangements was last conducted in 2024/25 and received an opinion of Substantial Assurance. Due to the prioritised transitional arrangements and after discussion with our internal auditors it was agreed not to undertake a specific Audit in-year. The ICB did however work with its Local Counter Fraud Service provider to populate the NHS Counter Fraud Authority (NHSCFA) Conflict of Interest checklist.

As of 31 March 2026, 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. A Joint Steering Group has been in place reflecting the transitional governance arrangements since October 2025. 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 2025/2026 no incidents were reported to the ICO.

Business Critical Models

Modelling and forecasting form a fundamental part of the contracting 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 expected year-end outturn. Quality assurance of this process is given through the involvement of both providers and commissioners in the construction and monitoring stages. This peer review approach ensures that models are built on robust assumptions using the most up-to-date and accurate data, enabling plans to remain realistic while still providing challenge in relation to system transformation.

In addition, the NHS Standard Contract sets out specific Activity Management requirements under *Service Condition 29: Managing Activity and Referrals*. This sets out how providers and commissioners should jointly monitor, manage, and respond to activity levels during the contract year. The terms set expectations for processes such as handling overperformance, managing demand, and reviewing referral patterns to maintain financial balance and ensure efficient service delivery.

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 2026, 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 2025)	Position as of 31 March 2026
Finance, Governance and Control – Finance and Procurement	The transition to the new NHS financial system (ISFE2) in Autumn 2025 has been challenging. CPICB, in common with other ICBs, have experienced a challenging go-live period. The ICB has experienced payment issues impacting providers (with potential BPPC compliance impacts) and issues with some ISFE2 functionality and reporting. The ICB is working with NHS SBS to support improvements.	The transition to the new NHS financial system (ISFE2) in Autumn 2025 was challenging. CPICB, in common with other ICBs, experienced a difficult go live period. The ICB experienced delays in making payments to Providers and issues with some ISFE2 functionality and reporting. Although some improvements have been seen, there remain a number of issues still to be resolved. The ICB continues to work with NHS SBS and NHS England to support improvements.
Finance, Governance and Control - Other	The ICB has been asked to reduce its running costs to £19 per head of population from April 2026. Accordingly, the ICB is currently undertaking both voluntary and compulsory redundancy schemes. This will result in a significant number of staff leaving the organisation in the coming months. The ICB considers there is a risk as due to the number of staff leaving in a short space of time and the impact this could have on the business of the ICB, whilst all staff are re-organised. The ICB has mitigations in place regarding this risk which include clear timelines and handover processes for staff who are leaving. The ICB also has its senior management team in place who are not affected by this change, having already been re-organised during 2025.	As of 31 March 2026, and the dissolution of CPICB, the organisational reconfiguration continues into the new Central East ICB. The ICB is currently continuing to recruit to the new structure, with slotting in finalised and interviews for competitive slot ins concluding over the next few weeks. An Assessment Centre is in place to manage to the next stages of the reconfiguration. Voluntary redundancy arrangements have been finalised. The ICB will be in a better position to understand the number of compulsory redundancies that will be required by the end of Quarter 1 (2026/27). The new Central East ICB will continue to have mitigations in place to manage the business which includes clear timelines and handover processes for staff that are leaving.

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 (to 30 September 2025) and the Finance Planning and Payer Function Committee (from 1 October 2025). 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 to 30 September 2025) and the Finance Planning and Payer Function Committee (from 1 October 2025). 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 services (primary care services and specialised services)

Cambridgeshire & Peterborough ICB signed delegation agreements with NHS England for the commissioning of delegated primary care services and specialised services and held full commissioning responsibilities for delegated services during the 2025/26 reporting period.

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

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

To support this, the Specialised Commissioning Team has completed a **self-assessment** against the core commissioning domains (from 2024/25 core commissioning requirements). This document provides assurance that East of England delegated specialised commissioning remained compliant during 2025/26.

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 (to 30 September 2025) and the Executive Director of Finance, Resources & Contracts (from 1 October 2025) 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 2025/26 this was not achieved for both NHS and non-NHS organisations in terms of the number of invoices. The target was achieved for both NHS and non-NHS organisations in terms of value of invoices.

Table : Better Payment Practice Code – measure of compliance

Better Payment Practice Code – measure of compliance	2025/26	
	Number	£000s
Non NHS Creditors		
Total bills paid in year	16,503	356,466
Total bills paid within target	15,524	343,261
Percentage of bills paid within target	94.07%	96.30%
NHS Creditors		
Total bills paid in year	2,105	1,759,451
Total bills paid within target	1,687	1,738,658
Percentage of bills paid within target	80.14%	98.82%

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 2025/26 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 2025/26 internal audit has issued the following audit reports:

Area of Audit	Level of Assurance Given
Specialist Commissioning	Substantial
Transition Processes – Contracts Register	Minimal
Financial Reporting and Budgetary Control	Reasonable
Risk Management and Assurance Framework	Reasonable
Continuing Healthcare	Reasonable
CAF Framework	N/a - advisory
Key Financial Controls (Preparedness for ISFE2)	N/a – Advisory

Any outstanding management actions not completed by year end will, where adjudged to be pertinent to the new organisation, be transferred to NHS Central East ICB for completion. In particular four high level actions arising from the *Transition Process – Contracts Register* audit report have been carried over and assigned to the relevant directorate for implementation by the end of June 2026.

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
- Substantial Compliance against the Emergency Preparedness Resilience and Response (EPRR) core standards for 2025/26
- 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 (Joint from 1 October 2025) which works to a well-developed audit plan and provides assurance to the ICB Board
 - The Remuneration Committee (Joint from 1 October 2025), 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 (to 30 September 2025) and the Finance Planning and Payer Function Committee from 1 October 2025 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 (to 30 September 2025) and the Utilisation Management & Quality Improvement Committee) from 1 October 2025) which provides scrutiny of delivery of quality, finance (to 30 September), performance, and contracts management including activity
 - The People Board (to 30 September 2025), 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 to 30 September 2025) and the Finance Planning and Payer Function Committee from 1 October 2025 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
 - Joint Transition Committee which provides assurance to the three ICBs which provides assurance on transitional arrangements, ICB close down and establishment of the new Central 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 2025/26 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.

2025/2026 was a challenge financially to manage the continued impact of Industrial Action and other related pressures together with closing down the current organisation and preparing for inception of the new Central East ICB from 1 April 2026. Despite this the ICB has achieved the breakeven requirement set by NHSE with a surplus of £3,846k. This off-sets the deficit position reported by Cambridgeshire and Peterborough NHS Foundation Trust and ensures the ICS reports a breakeven position.

The new Central East ICB will continue to have mitigations in place to manage the business which includes clear timelines and handover processes for staff that are leaving.

2025/26 has also seen the transition to the new NHS financial system (ISFE2) in Autumn 2025 has been challenging. CPICB, in common with other ICBs, has experienced a challenging go-live period. The ICB has experienced payment issues impacting providers (with potential BPPC compliance impacts) and issues with some ISFE2 functionality and reporting. The ICB continues to work NHS SBS to support improvements.

2025/26 has also been the year when the ICB has been asked to reduce its running costs to £19 per head of population in preparation for 1 April 2026. Accordingly, the ICB embarked on a significant reconfiguration programme during this year, and as we move into the new financial year, and the creation of a new Central East ICB, we are concluding the outcomes of the staff consultation and the creation of a new Organisational Structure. This has/will resulted in a significant number of staff leaving the organisation as we conclude the end of the financial year and move into 2026/2027. The ICB considers there is a risk as due to the number of staff leaving in a short space of time and the impact this could have on the business of the ICB, whilst all staff are re-organised. The ICB has mitigations in place with regard to this risk which include clear timelines and handover processes for staff who are leaving. The ICB also has its Executive Management Team in place who are not affected by this change, having already been re-organised during 2025.

As I conclude our Annual Governance Statement for 2025/26, I recognise that this will be the last one for Cambridgeshire & Peterborough ICB. During times of significant change, staff have continued 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.

Accountable Officer:
Organisation:

Jan Thomas, Chief Executive
NHS Cambridgeshire & Peterborough Integrated Care Board

Signature:
Date:

18 June 2026

Remuneration and Staff 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
From 1st October (Transition Governance arrangements)	
Alison Borrett	Non-executive Member (Chair)
Sarah Hughes	Non-executive Member
Robin Porter	Non-executive Member

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 2025/26 this was 0% (2024/25 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 (2024/25 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
Kate Vaughton	Chief Officer Partnerships and Integration		N/A	N/A
Sarah Griffiths	Chief Finance Officer		N/A	N/A
Karen Barker	Transition Director & Executive Director of Corporate Services		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)

Name	Title	2025-26				2024-25			
		Salary and Fees (Bands of £5,000)	Taxable Benefits (Rounded to the nearest £100)	Pension related benefits (Bands of £2,500)	Total (Bands of £5,000)	Salary and Fees (Bands of £5,000)	Taxable Benefits (Rounded to the nearest £100)	Pension related benefits (Bands of £2,500)	Total (Bands of £5,000)
		£000	£	£000	£000	£000	£	£000	£000
Executive Directors									
Jan Thomas	Chief Executive Officer	235 - 240	-	67.5 - 70	305 - 310	195 - 200	-	50 - 52.5	245 - 250
Carol Anderson (to 30/09/25)	Chief Nurse (Nurse Member)	70 - 75	-	22.5 - 25	95 - 100	140 - 145	-	0 - 2.5 *	110 - 115
Louis Kamfer	Managing Director Strategic Commissioning (to 30/09/25); Executive Director Strategy Planning and Evaluation (from 01/10/25)	155 - 160	1,600	42.5 - 45	200-205	160 - 165	-	45 - 47.5	205 - 210
Fiona Head	Chief Medical Officer (to 30/09/25); Executive Clinical Director Utilisation Management (from 01/10/25)	130 - 135	-	197.5 - 200	325 - 330	125 - 130	-	0 - 2.5 *	75 - 80
Nicci Briggs (to 16/02/25)	Chief Financial Officer	-	-	-	-	155 - 160	-	27.5 - 30	185 - 190
Kate Vaughton	Chief Officer - Strategy & Partnerships (to 30/09/25); Executive Director Neighbourhood Place and Partnerships (from 01/10/25)	155 - 160	-	80 - 82.5	235 - 240	35 - 40	-	20 - 22.5	55 - 60
Claudia Iton (to 30/09/25)	Chief People Officer	80 - 85	-	7.5 - 10	90 - 95	155 - 160	-	45 - 47.5	200 - 205
Sarah Griffiths	Chief Finance Officer (to 30/09/25); Executive Director Finances, Resources and Contracts (01/10/25)	155 - 160	1,600	37.5 - 40	195 - 200	10 - 15	-	2.5 - 5	10 - 15
Dr Gary Howsam (to 30/09/25)	Chief Clinical Improvement Officer	70 - 75	-	12.5 - 15	85 - 90	135 - 140	-	0 - 2.5	135 - 140
Stacie Coburn	Chief Operating Officer (to 30th Sep 2025); Director of Contracts and Procurement (From 1st Oct 2025)	145 - 150	-	35 - 37.5	180 - 185	135 - 140	-	35 - 37.5	170 - 175
Karen Barker (from 15/09/25)	Executive Director Corporate Services	85 - 90	100	50 - 52.5	135 - 140	-	-	-	-
Chair and Lay Members									
John O'Brien (to 30/09/25)	Chair	30 - 35	-	-	30 - 35	60 - 65	-	-	60 - 65
Saqhib Ali (to 30/11/25)	Non Executive Member	10 - 15	-	-	10 - 15	15 - 20	-	-	15 - 20
Gerard Curran (to 31/07/25)	Non Executive Member	5 - 10	-	-	5 - 10	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

On 1st October 2025, the executive teams of NHS Cambridgeshire and Peterborough ICB, NHS Bedfordshire Luton and Milton Keynes ICB and NHS Hertfordshire and West Essex ICB joined together and undertook the executive functions of all three organisations prior to the commencement of NHS Central East ICB on 1st April 2026. Executive pay costs were shared equally and during this period, NHS Cambridgeshire and Peterborough ICB received contributions of £363,825 from each of NHS Bedfordshire Luton and Milton Keynes ICB and NHS Hertfordshire and West Essex ICB for the pay costs of the Executive Directors employed by the ICB.

NHS Cambridgeshire and Peterborough ICB contributed £85,413 to the pay costs of Beverley Flowers (Director of Strategy Planning and Commissioning from 1st October 2025 to 31st December 2025), Natalie Hammond (Director of Safeguarding and Complex Care from 1st October 2025 to 31st March 2026) and Tania Marcus (Director of People and Culture from 1st October 2025 to 31st March 2026) employed by NHS Hertfordshire and West Essex ICB and £86,200 to the pay costs of Maria Wogan (Director for Neighbourhood Health and Partnerships from 1st

October 2025 to 31st March 2026), Sarah Stanley (Executive Clinical Director Total Quality Management from 1st October 2025 to 31st March 2026) and Robin Porter (Chair from 1st October 2025 to 31st March 2026) employed by NHS Bedfordshire Luton Milton Keynes ICB.

The following compulsory redundancy payments to Executive Directors were made for loss of Office. These amounts are included in Note 4.3 (Exit packages agreed in the financial year):-

Executive Directors	£
Carol Anderson	160,000
Claudia Iton	20,000
Dr Gary Howsam	140,800

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 2025/26 was £235k to £240k (2024/25 £195k to £200k). This was 4.34 times the median remuneration of the workforce, which was £54,710 (2024/25 £48,526). Remuneration ranged from £24,937 to £238,108 (2024/25 £22,383 to £189,263). In 2025/26, no employee received remuneration in excess of the highest paid director (2024/25 one employee received remuneration in excess of the highest paid director).

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.

Remuneration Report - Pension entitlements (audited information)

Name and title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension age at 31 March 2026 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2026	Cash Equivalent Transfer Value at 31 March 2025	Real increase in Cash Equivalent Transfer Value *** Apr 25- Mar 26	Employer's contribution to stakeholder pension (rounded to nearest £00)							
	(bands of £2,500) Apr 25- Mar 26	(bands of £2,500) Apr 25- Mar 26							Pension Accrued 31/03/2025	Lump Sum 31/03/2025	CETV 31/03/2025	Pension Accrued 31/03/2026	Lump Sum 31/03/2026	CETV 31/03/2026	
	£000	£000	£000	£000	£000	£000	£000	£00	£	£	£	£	£	£	£
Carol Anderson, Director of Quality (Nurse Member) *	0 - 2.5	0 - 2.5	55 - 60	130 - 135	1,263	1,174	25	-	51,840	130,465	1,174,388	55,969	132,551	1,263,369	
Louis Kamfer, Chief Financial Officer	3 - 3.5	0 - 2.5	35 - 40	-	529	466	35	-	34,166	-	465,875	37,964	-	528,670	
Jan Thomas, Accountable Officer	2.5 - 5	0 - 2.5	45 - 50	25 - 30	784	690	53	-	42,374	26,614	689,747	48,007	27,068	784,251	
Fiona Head, Medical Director	7.5 - 10	20 - 22.5	60 - 65	155 - 160	1,489	1,225	227	-	51,119	131,833	1,224,833	61,650	155,004	1,489,369	
Claudia Iton, Chief People Officer	0 - 2.5	0 - 2.5	10 - 15	-	0	0	-7	-	8,558	-	-	10,284	-	-	
Stacie Coburn, Chief Operating Officer	2.5 - 5	0 - 2.5	10 - 15	-	121	86	15		7,649	-	86,304	10,550	-	120,794	
Kate Vaughton, Chief Officer Partnerships and Integration (from 03/01/25)	2.5 - 5	2.5 - 5	45 - 50	110 - 115	974	874	66		43,007	106,542	874,339	48,539	112,359	973,853	
Sarah Griffiths, Chief Financial Officer (from 03/03/25)	2.5 - 5	0 - 2.5	10 - 15	-	163	123	19		9,881	0	123,090	12,898.56	-	163,086.16	
Karen Barker, Executive Director Corporate Services (from 15/09/25)	2.5 - 5	0 - 2.5	35 - 40	-	503	412	34		29,670.40	0.00	412,061.76	35,853.03	-	502,740.34	
Dr Gary Howsam, Clinical Chief Improvement Officer	0 - 2.5	0 - 2.5	30 - 35	70 - 75	747	687	16	-	32,002	71,197	686,615	34,871	73,511	747,486	

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 2024/25 Annual Report and Accounts where NHS Pensions have provided revised information after completion of the 2024/25 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 2026, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2026	8
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	1
for between two and three years at the time of reporting	2

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 2025 and 31 March 2026, for more than £245 per day:

	Number
Number of new engagements between 1 April 2024 and 31 March 2025	9
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 2025 and 31 March 2026:

	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.

2025/26	25 th percentile	Median pay ratio	75 th percentile pay ratio
Total remuneration (£)	£39,217	£54,710	£68,631
Salary component of total remuneration (£)	£39,217	£54,710	£68,631
Pay ratio information	6.06:1	4.34:1	3.46:1
2024/25	25 th percentile	Median pay ratio	75 th 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

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 20.25% (2024/25 5.33%). 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 12.74% (2024/25 9.52%). 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 2025).

The table below shows the number of Senior Managers in post at the start of the period (1 April 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.

Table One: Senior Managers in post at the start of the period (1 April 2025)

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	17	16.40	Permanent
NHS XR10 Review Body Band 8 - Range C	27	26.30	Permanent
NHS XR09 Review Body Band 8 - Range B	31	29.30	Permanent
NHS XR08 Review Body Band 8 - Range A	62	59.14	Permanent
Sub total (Permanent)	175	153.93	Permanent
Personal Salary including Very Senior Manager (VSM)	5	3.12	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	2	1.60	Other
NHS XR10 Review Body Band 8 - Range C	2	2.00	Other
NHS XR09 Review Body Band 8 - Range B	7	6.80	Other
NHS XR08 Review Body Band 8 - Range A	0	0.00	Other
Sub total (Other)	17	14.03	Other
Overall Total	192	167.96	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.
- 20 headcount GP Clinical Leads.

- 5 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 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.

Senior Managers in Post at the end of the period (31 March 2026).

The table below shows the number of Senior Managers in post at the end of the period (31 March 2026), 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.

Table Two: Senior Managers in post at the end of the period (31 March 2026)

Pay grade	Head count	Full Time Equivalent (FTE)	Employment Status
Personal Salary including Very Senior Manager (VSM)	32	18.72	Permanent
NHS YC72 Consultant (post 31 Oct)	3	2.60	Permanent
NHS XR12 Review Body Band 9	6	6.00	Permanent
NHS XR11 Review Body Band 8 - Range D	18	17.80	Permanent
NHS XR10 Review Body Band 8 - Range C	24	23.30	Permanent
NHS XR09 Review Body Band 8 - Range B	30	28.70	Permanent
NHS XR08 Review Body Band 8 - Range A	57	54.03	Permanent
Sub total (Permanent)	170	151.15	Permanent
Personal Salary including Very Senior Manager (VSM)	3	1.72	Other
NHS YC72 Consultant (post 31 Oct)	1	0.40	Other
NHS XR12 Review Body Band 9	2	1.69	Other
NHS XR11 Review Body Band 8 - Range D	1	0.60	Other
NHS XR10 Review Body Band 8 - Range C	0	0.00	Other
NHS XR09 Review Body Band 8 - Range B	3	3.00	Other
NHS XR08 Review Body Band 8 - Range A	1	0.90	Other
Sub total (Other)	11	8.31	Other
Overall Total	181	159.46	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.
- 17 headcount Clinical Leads.
- 11 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 2026 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 2025, excluding Non-Executive Members and Chair but including Executive Members and staff seconded in from other entities and Agency Workers, there were 452 people engaged in work activity by the ICB amounting to a Full Time Equivalent (FTE) of 404.38 FTE.

At the end of the period, 31 March 2026, the total number of staff engaged by the ICB (as above), comprised a headcount of 415 amounting to a Full Time Equivalent (FTE) of 373.08 FTE. Across the reporting period commencing 1 April 2025 and ending 31 March 2026, the ICB had an average weekly workforce of 387.51 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 2026).

Figures subject to audit	Headcount	Full Time Equivalent (FTE)	Cost (in £000s)
Permanent staff on payroll on 31 March 2026	390	351.67	44,274
Other (temporary) staff on 31 March 2026	Headcount	Full Time Equivalent	Cost
Fixed Term Contract (FTC) staff on payroll (excluding non-executive members/Chair)	7	6.09	534
Staff engaged on Contracts for Services	2	1.20	187
ICB Staff seconded out to other organisations	4	3.80	-120

ICB staff on unpaid career break	0	0.00	0
Staff seconded into the ICB from other organisations	6	4.12	181
Agency workers engaged by the organisation	10	10.00	1,895
Total staff engaged by the organisation on 31 March 2026	415	373.08	46,951

The cost of total staff engaged by the ICB is higher than the figure (£46,582k) 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 2026 (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	26
	Manager	Central Functions	G1A	124
	Clerical and Administrative	Central Functions	G2A	130
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	1
		Community Learning Disabilities	N6F	1
		Community Services	N6H	56
Qualified Allied Health Professionals	Manager	Pharmacy	S0P	1
	Scientist	Pharmacy	S2P	15
	Technician	Pharmacy	S4P	8
	Therapist	Dietetics	S1B	1
	Therapist	Occupational Therapist	S1C	1
Qualified Other Scientific, Therapeutic & Technical	Manager	Social Services	SOU	1
Medical and Dental	Other Specialities		099	1
	General Medical Practitioner		921	17
	Public Health Medicine		930	2
				390

OTHER (TEMPORARY) STAFF			Occupation Code	Headcount
Administration and Estates staff	Senior Manager	Central Functions	G0A	3
	Manager	Central Functions	G1A	5
	Clerical and Administrative	Central Functions	G2A	4
Nursing, Midwifery and Health Visiting Staff	Other 1st level (Level 1 – Sub Part 1)	Community Services	N6H	16
Medical and Dental	Other Specialities		099	1
Medical and Dental	General Medical Practitioner		921	1
				30

Of the total number of staff engaged by the ICB at the end of the period (a headcount of 415 amounting to a Full Time Equivalent (FTE) of 373.08 FTE on 31 March 2026), 390 staff (351.67 FTE) were employed on permanent contracts of employment with the ICB and 7 staff (6.09 FTE) were employed by the ICB on short (fixed) term contracts of employment and 2 (1.20 FTE) on a Contract for Services basis.

4 staff (3.80 FTE) were seconded out to other organisations.

6 staff (4.12 FTE) were seconded in from NHS Trusts and the Local Authority to work in roles with the organisation.

On 31 March 2026, there were 10 agency workers, amounting to 10.00 FTE being engaged by the organisation. 9 of the agency workers were working in clinical roles, 1 agency worker was supporting administrative functions for the organisation.

Staff composition

Gender Analysis

The ICB entered the period as of 1 April 2025 with a gender distribution of 77.83% females and 22.17% 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 2026 was 19.47% (mean) and 6.46% (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 2026 (snapshot date):

31 March 2026 snapshot	Male	Female
Lower Quartile Pay Band	17.39%	82.61%
Lower Middle Quartile Pay Band	15.56%	84.44%
Upper Middle Quartile Pay Band	21.50%	78.50%
Upper Quartile Pay Band	31.19%	68.81%

Figures from 31 March 2026

At the end of the reporting period (31 March 2026) the gender distribution of ICB staff was 77.62% females and 22.38% males.

Of those occupying a role as Executive Director (31 March 2026), 71.43% were female and 28.57% identified as male. Senior Managers (excluding those in a director role) comprised 73.56% female and 26.44% male. The remaining staff cohort comprised 80.83% females and 19.17% males.

Sickness absence data

The ICB recorded an average sickness absence rate during the period of 4.96%

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	0.99
Long Term (lasting 28 days or more)	3.97
	4.96

More detailed information (by month data) can be found in the NHS Digital publication series on NHS Sickness Absence Rates at: [NHS Sickness Absence Rates - NHS England Digital](#) And [NHS Sickness Absence - Interactive Dashboard](#)

Staff turnover percentages

For the reporting period 1 April 2025 to 31 March 2026 an overall staff turnover rate of 14.32% was recorded (numbers leaving during the period (headcount 60) divided by the average number of staff in post over the period (headcount 419)).

Other employee matters

We reviewed our appraisal approach in response to staff feedback and introduced a revised process with updated guidance and training for managers and staff, to build confidence in holding high-quality appraisal conversations consistently.

Following national announcements requiring ICBs to deliver significant cost savings, much of the focus shifted to supporting staff through a period of uncertainty and organisational change. A Transition Programme offering a broad suite of training and support including upskilling, wellbeing and resilience support, accredited project management qualifications, interview

skills, problem solving, leadership for change, stakeholder influencing, effective workplace communication, change management, and planning for retirement was rolled out to staff.

The programme was delivered through a variety of formats—face-to-face, virtual, classroom-based, online, blended, and mobile learning to support diverse learning needs and to strengthen individual, team and organisation capability. 40 different types of training, over 70 sessions and more than 1,000 staff bookings were completed.

Twice-weekly HR drop-in sessions were available to staff as a safe space to ask questions or to raise concerns.

Expenditure on consultancy

The ICB did not have any expenditure on consultancy during the period 1 April 2025 to 31 March 2026.

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	6,669	11	66,324	12	72,993	0	0
£10,000 - £25,000	2	41,485	21	403,512	23	444,997	0	0
£25,001 - £50,000	1	28,000	34	1,215,507	35	1,243,507	0	0
£50,001 - £100,000	0	0	45	3,403,313	45	3,403,313	0	0
£100,001 - £150,000	2	247,467	12	1,495,894	14	1,743,361	0	0
£150,001 – £200,000	1	160,000	6	957,753	7	1,117,753	0	0
>£200,000	0	0	1	223,066	1	223,066	0	0
TOTALS	7	483,621	130	7,765,369	137	8,248,990	0	0

Redundancy and other departure cost have been paid in accordance with the provisions of the NHS Pensions 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	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	127	7,678
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	3	87
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
TOTAL	130	7,765

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

NHS Cambridgeshire and Peterborough ICB is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at note 4.3 and note 29. An audit certificate and report are also included in this Annual Report at page 86.

AUDIT REPORT

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS CENTRAL EAST INTEGRATED CARE BOARD AS THE SUCCESSOR 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 2026 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 38, 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: 2025-26 as contained in the Department of Health and Social Care Group Accounting Manual 2025 to 2026, 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 2026 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 2025 to 2026; 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.

Emphasis of Matter – Transition to NHS Central East ICB

We draw attention to Note 35 - Events After the Reporting Period, which describes the reorganisation of NHS Cambridgeshire and Peterborough Integrated Care Board and the formation of NHS Central East Integrated Care Board. Our opinion is not modified in respect of this matter.

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.

In evaluating the Accountable Officer's conclusions, we have considered the requirement of the DHSC Group Accounting Manual for entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services they provide will continue into the future, and had regard to the guidance provided in Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) regarding the application of ISA (UK) 570 Going Concern to public sector entities.

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 2025 to 2026.

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 2026; 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 2025 to 2026.

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 pages 47 to 48, 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 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, Internal Audit, the Local Counter Fraud Specialist and Those Charged with Governance 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, specifically those entries and adjustments that understate expenditure

accruals balances at the year end, 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, Internal Audit, the Local Counter Fraud Specialist and Those Charged with Governance, reading and reviewing relevant meeting minutes of those charged with governance and the Board and understanding the internal controls in place to mitigate risks related to fraud and non-compliance with laws and regulations.

We addressed our fraud risk 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. This included testing journals posted in the general ledger that fell outside of the standard transaction process flow.

We addressed our fraud risk related to the understatement of expenditure accruals through undertaking testing to gain assurance over the completeness and valuation of 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.

We addressed our fraud risk in relation to the classification of Admin and Programme costs through journal testing on transactions moving expenditure from admin cost centres to programme cost centres; and testing 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 March 2026 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 2026.

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) (the "Code of Audit Practice").

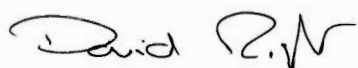
We conducted our work in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) issued by the Public Audit Forum. We are required to obtain evidence sufficient to give an opinion on whether in all material respects the 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 Board of NHS Central East Integrated Care Board as the successor 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 Board of NHS Central East Integrated Care Board 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.



ERNST & YOUNG LLP

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

18 June 2026

ANNUAL ACCOUNTS

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

	Note	2025-26 £'000	2024-25 £'000
Income from sale of goods and services	2	(27,642)	(28,931)
Other operating income	2	(1,248)	-
Total operating income		(28,890)	(28,931)
Staff costs	4	46,702	30,686
Purchase of goods and services	5	2,528,107	2,408,897
Depreciation and impairment charges	5	149	120
Other operating expenditure	5	(2,283)	3,318
Total operating expenditure		2,572,675	2,443,022
Net Operating Expenditure		2,543,785	2,414,091
Finance expense	10	1	2
Net expenditure for the Year		2,543,786	2,414,093
Total Net Expenditure for the Financial Year		2,543,786	2,414,093
Comprehensive Expenditure for the year		2,543,786	2,414,093

**Statement of Financial Position as at
31 March 2026**

		2025-26	2024-25
	Note	£'000	£'000
Non-current assets:			
Right-of-use assets	13	822	120
Total non-current assets		822	120
Current assets:			
Inventories	16	182	182
Trade and other receivables	17	19,310	23,613
Cash and cash equivalents	20	-	86
Total current assets		19,492	23,881
Total assets		20,314	24,002
Current liabilities			
Trade and other payables	22	(142,473)	(175,046)
Cash and cash equivalents	20	(3,149)	-
Lease liabilities	13	(170)	(169)
Total current liabilities		(145,792)	(175,215)
Non-Current Assets plus/less Net Current Assets/Liabilities		(125,478)	(151,213)
Non-current liabilities			
Lease liabilities	13	(652)	-
Total non-current liabilities		(652)	-
Assets less Liabilities		(126,130)	(151,213)
Financed by Taxpayers' Equity			
General fund		(126,130)	(151,213)
Total taxpayers' equity:		(126,130)	(151,213)

The notes on pages 97 to 114 form part of this statement

The financial statements on pages 93 to 96 were approved by the Governing Body on 16 June 2026 and signed on its behalf by:

Jan Thomas
Chief Accountable Officer
18 June 2026

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

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2025-26		
Balance at 01 April 2025	(151,213)	(151,213)
Adjusted NHS Integrated Care Board balance at 31 March 2025	<u>(151,213)</u>	<u>(151,213)</u>
Changes in NHS Integrated Care Board taxpayers' equity for 2025-26		
Net Recognised Expenditure for the Financial year	(2,543,786)	(2,543,786)
Net funding	2,568,870	2,568,870
Balance at 31 March 2026	<u>(126,130)</u>	<u>(126,130)</u>

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2024-25		
Balance at 01 April 2024	(126,448)	(126,448)
Adjusted NHS Integrated Care Board balance at 31 March 2025	<u>(126,448)</u>	<u>(126,448)</u>
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	<u>(151,213)</u>	<u>(151,213)</u>

The notes on pages 97 to 114 form part of this statement

**Statement of Cash Flows for the year ended
31 March 2026**

	Note	2025-26 £'000	2024-25 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(2,543,786)	(2,414,093)
Depreciation and amortisation	5	149	120
Interest paid / received		1	2
(Increase)/decrease in trade & other receivables	17	4,303	(3,911)
Increase/(decrease) in trade & other payables	22	(32,573)	33,276
Net Cash Inflow (Outflow) from Operating Activities		(2,571,907)	(2,384,606)
Cash Flows from Investing Activities			
Net Cash Inflow (Outflow) from Investing Activities		-	-
Net Cash Inflow (Outflow) before Financing		(2,571,907)	(2,384,606)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		2,568,870	2,389,328
Repayment of lease liabilities		(198)	(107)
Net Cash Inflow (Outflow) from Financing Activities		2,568,672	2,389,221
Net Increase (Decrease) in Cash & Cash Equivalents	20	(3,235)	4,615
Cash & Cash Equivalents at the Beginning of the Financial Year		86	(4,529)
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		(3,149)	87

The notes on pages 97 to 114 form part of this statement

Notes to the financial statements

1 Accounting Policies

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

1.1 Going Concern

These accounts have been prepared on a going concern basis.

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, 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.

1.40 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.

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.

Notes to the financial statements**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 3.64% (2024-25: 4.03%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 4.22% (2024-25: 4.07%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- A nominal long-term rate of 5.32% (2024-25: 4.81%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
- A nominal very long-term rate of 5.07% (2024-25: 4.55%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

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

1.13 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).

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.

Notes to the financial statements

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 £22,448k (2024/25 £21,531k).

The continuing healthcare accrual as at 31 March 2026 is £6,677k (2024/25 £4,687k). 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 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.

2 Other Operating Revenue

	2025-26 Total £'000	2024-25 Total £'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	6,345	5,991
Prescription fees and charges	11,024	10,755
Dental fees and charges	9,830	8,808
Other Contract income	323	2,992
Recoveries in respect of employee benefits	120	385
Total Income from sale of goods and services	27,642	28,931
Other operating income		
Other non contract revenue	1,248	-
Total Other operating income	1,248	-
Total Operating Income	28,890	28,931

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

	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Source of Revenue					
NHS	6,110	-	-	217	64
Non NHS	235	11,024	9,830	106	56
Total	6,345	11,024	9,830	323	120

	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Timing of Revenue					
Point in time	6,345	11,024	9,830	323	120
Over time	-	-	-	-	-
Total	6,345	11,024	9,830	323	120

4. Employee benefits and staff numbers**4.1.1 Employee benefits**

	Total		2025-26
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	22,202	1,895	24,096
Social security costs	3,017	-	3,017
Employer Contributions to NHS Pension scheme	4,868	-	4,868
Apprenticeship Levy	100	-	100
Termination benefits	14,621	-	14,621
Gross employee benefits expenditure	44,808	1,895	46,702
Less recoveries in respect of employee benefits (note 4.1.2)	(120)	-	(120)
Total - Net admin employee benefits including capitalised costs	44,688	1,895	46,582
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	44,688	1,895	46,582

	Total		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

4.1.2 Recoveries in respect of employee benefits

	2025-26 Total £'000	2024-25 Total £'000
Employee Benefits - Revenue		
Salaries and wages	(120)	(385)
Total recoveries in respect of employee benefits	(120)	(385)

4.2 Average number of people employed

	2025-26			2024-25		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	377.06	12.42	389.48	389.05	14.20	403.25

Of the above:

Number of whole time equivalent people engaged on capital projects	-	-	-	-	-	-
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4.3 Exit packages agreed in the financial year

	2025-26		2025-26		2025-26	
	Compulsory redundancies		Other agreed departures		Total	
	Number	£	Number	£	Number	£
Less than £10,000	1	6,669	11	66,324	12	72,993
£10,001 to £25,000	2	41,485	21	403,512	23	444,997
£25,001 to £50,000	1	28,000	34	1,215,507	35	1,243,507
£50,001 to £100,000	-	-	45	3,403,313	45	3,403,313
£100,001 to £150,000	2	247,467	12	1,495,894	14	1,743,361
£150,001 to £200,000	1	160,000	6	957,753	7	1,117,753
Over £200,001	-	-	1	223,066	1	223,066
Total	7	483,621	130	7,765,369	137	8,248,990

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

Analysis of Other Agreed Departures

	2025-26		2024-25	
	Other agreed departures		Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	127	7,678,193	-	-
Contractual payments in lieu of notice	3	87,176	1	2,035
Total	130	7,765,369	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 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.5.2 Full actuarial (funding) valuation

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

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

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

For 2025/26, employers' contributions of £4,868k 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

	2025-26 Total £'000	2024-25 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	1,105	663
Services from foundation trusts	1,603,558	1,546,087
Services from other NHS trusts	116,874	113,466
Purchase of healthcare from non-NHS bodies	313,778	283,565
General Dental services and personal dental services	52,568	46,300
Prescribing costs	158,737	160,822
Pharmaceutical services	36,597	31,311
General Ophthalmic services	8,919	8,428
GPMS/APMS and PCTMS	226,801	209,601
Supplies and services – clinical	6,209	5,845
Supplies and services – general	(4,279)	(5,753)
Establishment	4,789	5,193
Transport	-	804
Premises	520	434
Audit fees	256	277
Other non statutory audit expenditure		
· Internal audit services	129	153
· Other services	(0)	49
Other professional fees	474	973
Legal fees	752	459
Education, training and conferences	321	220
Total Purchase of goods and services	2,528,107	2,408,897
Depreciation and impairment charges		
Depreciation	149	120
Total Depreciation and impairment charges	149	120
Other Operating Expenditure		
Chair and Non Executive Members	104	137
Grants to Other bodies	-	472
Expected credit loss on receivables	(2,388)	2,709
Total Other Operating Expenditure	(2,283)	3,318
Total operating expenditure	2,525,973	2,412,336

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6 Payment Compliance Reporting**6.1 Better Payment Practice Code**

Measure of compliance	2025-26 Number	2025-26 £'000	2024-25 Number	2024-25 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	16,503	356,466	19,891	360,394
Total Non-NHS Trade Invoices paid within target	15,524	343,261	15,041	321,629
Percentage of Non-NHS Trade invoices paid within target	94.07%	96.30%	75.62%	89.24%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,105	1,759,451	2,111	1,623,114
Total NHS Trade Invoices Paid within target	1,687	1,738,658	1,694	1,598,212
Percentage of NHS Trade Invoices paid within target	80.14%	98.82%	80.25%	98.47%

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

	2025-26 £'000	2024-25 £'000
Interest		
Interest on lease liabilities	1	2
Total finance costs	1	2

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

	Plant & machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
2025-26				
Cost or valuation at 01 April 2025	49	965	51	1,064
Cost/Valuation at 31 March 2026	49	965	51	1,064
Depreciation 01 April 2025	49	965	51	1,064
Depreciation at 31 March 2026	49	965	51	1,064
Net Book Value at 31 March 2026	-	-	-	-
Total at 31 March 2026	-	-	-	-

13 Leases**13.1 Right-of-use assets**

	Buildings excluding dwellings £'000
2025-26	
Cost or valuation at 01 April 2025	482
Additions	850
Cost/Valuation at 31 March 2026	1,332
Depreciation 01 April 2025	361
Charged during the year	149
Depreciation at 31 March 2026	510
Net Book Value at 31 March 2026	822
NBV by counterparty	
Leased from other group bodies	822
Net Book Value at 31 March 2026	822

13.2 Lease liabilities

	2025-26 £'000	2024-25 £'000
2025-26		
Lease liabilities at 01 April 2025	(169)	(274)
Additions purchased	(850)	-
Interest expense relating to lease liabilities	(1)	(2)
Repayment of lease liabilities (including interest)	198	107
Lease liabilities at 31 March 2026	(822)	(169)

13.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2025-26 £'000	Of which: leased from DHSC group bodies £'000	2024-25 £'000	Of which: leased from DHSC group bodies £'000
Within one year	(170)	(170)	(176)	(176)
Between one and five years	(652)	(652)	-	-
After five years	-	-	-	-
Balance at 31 March 2026	(822)	(822)	(176)	(176)

13.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	2025-26 £'000	2024-25 £'000
2025-26		
Depreciation expense on right-of-use assets	149	120
Interest expense on lease liabilities	1	2

13.5 Amounts recognised in Statement of Cash Flows

	2025-26 £'000	2024-25 £'000
2025-26		
Total cash outflow on leases under IFRS 16	198	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	Total
	£'000	£'000
Balance at 01 April 2025	182	182
Balance at 31 March 2026	182	182

17.1 Trade and other receivables

	Current 2025-26 £'000	Current 2024-25 £'000
NHS receivables: Revenue	4,095	5,924
NHS prepayments	(185)	77
Non-NHS and Other WGA receivables: Revenue	3,708	6,099
Non-NHS and Other WGA prepayments	1,843	1,305
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	9,376	12,782
Expected credit loss allowance-receivables	(944)	(3,331)
VAT	1,416	756
Other receivables and accruals	1	1
Total Trade & other receivables	19,310	23,613
Total current and non current	19,310	23,613

Included above:

Prepaid pensions contributions	-	-
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17.2 Receivables past their due date but not impaired

	2025-26 DHSC Group Bodies £'000	2025-26 Non DHSC Group Bodies £'000	2024-25 DHSC Group Bodies £'000	2024-25 Non DHSC Group Bodies £'000
By up to three months	239	502	397	534
By three to six months	-	-	17	4
By more than six months	37	202	(179)	462
Total	276	704	235	1,000

17.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000
Balance at 01 April 2025	(3,331)
Lifetime expected credit losses on trade and other receivables-Stage 2	2,388
Total	(943)

18 Other financial assets

The ICB had no other financial assets as at 31 March 2026.

19 Other current assets

The ICB had no other current assets as at 31 March 2026.

20 Cash and cash equivalents

	2025-26 £'000	2024-25 £'000
Balance at 01 April 2025	86	(4,529)
Net change in year	(3,235)	4,615
Balance at 31 March 2026	(3,149)	86
Made up of:		
Cash with the Government Banking Service	(3,150)	86
Cash in hand	1	1
Cash and cash equivalents as in statement of financial position	(3,149)	86
Balance at 31 March 2026	(3,149)	86

21 Analysis of impairments and reversals

There were no impairments or reversals during 2025/26.

22 Trade and other payables

	Current 2025-26 £'000	Current 2024-25 £'000
NHS payables: Revenue	5,214	4,922
NHS accruals	24,026	56,309
Non-NHS and Other WGA payables: Revenue	7,739	25,254
Non-NHS and Other WGA accruals	101,857	79,212
Non-NHS and Other WGA deferred income	382	3,940
Social security costs	341	289
Tax	425	388
Other payables and accruals	2,491	4,731
Total Trade & Other Payables	142,473	175,046
Total current and non-current	142,473	175,046

23 Other financial liabilities

The ICB had no other financial liabilities as at 31 March 2026.

24 Other liabilities

The ICB had no other liabilities as at 31 March 2026.

25 Borrowings

The ICB had no borrowing as at 31 March 2026.

26 Mental Health expenditure

	Current 2025-26 £'000	Current 2024-25 £'000
Minimum expenditure in mental health services to meet the Mental Health Investment Standard as notified by NHS England	175,557	160,001
Eligible mental health expenditure	175,641	162,298
Mental health expenditure above/(below) minimum investment required	84	2,297
Mental health expenditure as a proportion of total expenditure (%)	7%	7%

The mental health expenditure as a proportion of the total ICB Expenditure for the year was 7%. This is comparable with the last financial year (2024/25 7%).

27 Finance lease receivables

The ICB had no finance lease receivables.

28 Provisions

Legal claims are calculated from the number of claims currently lodged with the NHS Resolution and the probabilities provided by them. £44.4k (2024/25 £0) is included in the provisions of NHS Resolution as at 31 March 2026 in respect of clinical negligence liabilities of the ICB. £46.5k (2024/25 £15k) is included in the provisions of NHS Resolution as at 31 March 2026 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.

29 Contingencies

The ICB had no contingencies.

30 Commitments

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

31 Financial instruments

31.1 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.

31.1.1 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.

31.1.2 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.

31.1.3 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.

31.1.4 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.

31.1.5 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.

31 Financial instruments cont'd**31.2 Financial assets**

	Financial Assets measured at amortised cost 2025-26 £'000	Total 2025-26 £'000
Trade and other receivables with NHSE bodies	2,180	2,180
Trade and other receivables with other DHSC group bodies	1,915	1,915
Trade and other receivables with external bodies	13,085	13,085
Total at 31 March 2026	17,180	17,180

31.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2025-26 £'000	Total 2025-26 £'000
Trade and other payables with NHSE bodies	367	367
Trade and other payables with other DHSC group bodies	28,873	28,873
Trade and other payables with external bodies	112,086	112,086
Private Finance Initiative and finance lease obligations	822	822
Cash and cash equivalents	3,149	3,149
Total at 31 March 2026	145,296	145,296

32 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.

33 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 £56,689k (2024/25 £50,731k) to the Cambridgeshire fund and £18,621k (2024/25 £16,196k) to the Peterborough fund.

The ICB also contributed into a pooled budget agreement with Cambridgeshire County Council for Integrated Community Equipment Services (ICES) during 2025-2026. Under the arrangements, funds are pooled under S75 of the NHS Act 2006. As a commissioner of healthcare services, the ICB makes contributions to the pool, 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 ICES for the year was £3,271k (2024/25 £2,645k), which represents a share of 51.8% with the remaining contribution of 48.2% made by Cambridgeshire County Council.

34 Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr Gary Howsam, Partner, Nene Valley Hodgson Medical Practice	2,875	-	-	-
Dr Gary Howsam, Non-Executive Director, Eastern Academic Health Science Network	152	-	-	-
Fiona Head, Retained GP, East Barnwell Health Centre	6,891	-	-	-
Dr Diana Hunter, Chair of Cambridgeshire Local Medical Committee	722	-	-	-
Sarah Hughes, Chief Executive, Mind	1,520	-	-	-
Steve Grange, Chief Executive, Cambridgeshire & Peterborough NHS FT	254,535	235	3,853	677
Matthew Winn, Chief Executive, Cambridgeshire Community Services NHS Trust	29,929	47	3,024	398
Eilish Midlane, Chief Executive, Royal Papworth Hospital NHS Foundation Trust	79,776	0	3,634	0
Matt Gladstone, Chief Executive, Peterborough City Council	28,379	1,005	9,584	407
Stephen Moir, Chief Executive, Cambridgeshire County Council	42,399	1,625	3,950	317
Dr Gary Howsam, stepson employee of North West Anglia NHS FT	560,173	34	7,301	0
Dr Gary Howsam, brother in law employed part time by Cambridgeshire Community Services NHS Trust	29,929	47	3,024	398

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	642,922	263	10,058	124
North West Anglia NHS Foundation Trust	560,173	34	7,301	0
Cambridgeshire & Peterborough NHS Foundation Trust	254,535	235	3,853	677
East of England Ambulance Service NHS Trust	56,590	0	0	0
Cambridgeshire Community Services NHS Trust	29,929	47	3,024	398
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	42,698	144	156	95
Royal Papworth Hospital NHS Foundation Trust	79,776	0	3,634	0
West Suffolk NHS Foundation Trust	4,390	0	0	124
NHS England	213	5,764	48	1,810
East & North Hertfordshire NHS Trust	4,093	0	0	31
Department of Health	0	3,320	0	0
NHS Property Services	3,118	0	269	0

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	42,399	1,625	3,950	317
Hertfordshire County Council	2,622	1	277	0
Peterborough City Council	28,379	1,005	9,584	407

* 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 Related party transactions (Comparables)

Details of related party transactions with individuals are as follows:

		31 March 2025		
	Payments to	Receipts	Amounts	Amounts
	Related Party	from	owed to	due from
	Related Party	Related	Related	Related
	£'000	Party	Party	Party
	£'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	Receipts	Amounts	Amounts
	Related Party	from	owed to	due from
	Related Party	Related	Related	Related
	£000	Party	Party	Party
	£000	£000	£000	£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.

35 Events after the end of the reporting period

In September 2025, NHS England confirmed that Cambridgeshire & Peterborough ICB, Bedfordshire, Luton and Milton Keynes Integrated Care Board, and Hertfordshire & West Essex ICB will be abolished and a new organisation - Central East ICB will be created with effect from 1 April 2026. This decision represents a nationally mandated structural change to the commissioning landscape. The decision does not affect the recognition or measurement of assets, liabilities, income or expenditure in the 2025/26 financial statements and is therefore treated as a non adjusting event.

As part of the transition, NHS England has required all ICBs to reduce running costs by up to 50% from 2026/27. The three ICBs have progressed the design of the future operating model and organisational structure for the Central East ICB. As a result of this work, management has identified roles at risk and determined that a legal or constructive obligation for redundancy costs exists at the reporting date. Accordingly, expenditure for redundancy costs has been recognised in the 2025/26 financial statements in line with IAS 37. The costs reflects management's best estimate of the costs expected to be incurred as part of the organisational change programme.

There are no adjusting events after the reporting period which will have a material effect on the financial statements of NHS Cambridgeshire & Peterborough ICB.

36 Third party assets

The ICB did not hold any cash or cash equivalents on behalf of other parties as at 31 March 2026.

37 Financial performance targets

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

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

	2025-26 Target £000	2025-26 Performance £000	Achieved? Yes/ No	2024-25 Target £000	2024-25 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	2,547,632	2,543,786	Yes	2,414,130	2,414,093	Yes
Revenue administration resource use does not exceed the amount specified in Directions	21,709	21,238	Yes	17,016	16,069	Yes

When the expenditure of £2,543,786k is deducted from the Revenue Resource Limit of £2,547,632k, it shows a surplus of £3,846k (2024-25 surplus of £37k). The ICB has achieved the financial performance target in 2025/26 with an in year surplus of £3,846k against the revenue resource Limit. When the cumulative surplus of £2,372k is added to the 2025-26 in year surplus of £3,842k, it shows a cumulative surplus of £6,218k.

38 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 2025/26, 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:

The ICB reported a surplus of £3,846k as shown in Note 36 – Financial Performance Targets.

NHS England has required all Integrated Care Boards (ICBs) to reduce running costs by up to 50% from 2026/27. As part of the national response, three ICBs in the East of England - Cambridgeshire & Peterborough ICB, Bedfordshire Luton & Milton Keynes ICB, and Hertfordshire & West Essex ICB are progressing a planned merger to form the Central East ICB. NHS England confirmed in September 2025 that the Central East ICB will formally replace the three existing ICBs from 1 April 2026, at which point the current statutory bodies will be abolished.

Management has assessed the implications of this transition and concluded that the merger does not indicate an intention to liquidate or cease operations. It represents a nationally mandated structural realignment, with uninterrupted service delivery and continued statutory funding throughout the assessment period.

In forming this judgement, management has considered the operational and strategic context of the ICB, financial performance and medium term financial plans, published allocations and cash flow expectations and the continuity of statutory functions within the successor body. No material uncertainties have been identified that cast significant doubt on the ability of NHS Cambridgeshire and Peterborough ICB, or its successor body, to continue as a going concern.

Conclusion

Our considerations cover the period through to 19 June 2027, being 12 months beyond the date of authorisation of these financial statements. Considering these factors the Board has a reasonable expectation that the ICB has sufficient resources, statutory authority and operational capacity to meet its obligations through to 31 March 2026, and that services will continue within the new statutory body thereafter. Accordingly, we continue to adopt the going concern basis in preparing these financial statements.