Cambridgeshire & Peterborough Integrated Care System

NHS Cambridgeshire & Peterborough

Operational Plan 2025/26

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April 2025

Contents

Executive summary

We plan to:

1. Deliver a breakeven financial plan in 2025/26.
2. Deliver all quality and operational performance expectations within the national planning guidance.
3. Deliver 36% of the productivity opportunities identified from national benchmarking.
4. Deliver a 2.3% reduction in whole time equivalent roles, alongside expected bank and agency cost reductions, of 10% and more than 30%, respectively.
5. Continue our targeted work in areas of greatest need.

This operational plan delineates the strategic direction and commitments of the Cambridgeshire and Peterborough Integrated Care Board (ICB) for the financial year 2025/26, with an emphasis on enhancing health services and patient care. It highlights the transition from analogue to digital care models and the integration of services to improve accessibility and quality for the population served.

We will implement a person-centred care model that enhances patient access and equity through a unified planned waiting list and centralised referral management. This encompasses establishing a single point of access for planned care and urgent care services, facilitating better coordination and streamlined processes. A focus on shared decision-making and health navigation is also underscored as crucial for patient engagement and effective care management.

For planned care, we will endeavour to reduce waiting lists and improve referral to treatment times for all patients waiting for a first outpatient appointment or treatment. For unplanned care, the focus will be placed on providing urgent same-day services, bolstering community response capabilities, and improving the quality and experience of people waiting to receive care in Emergency Departments. We will implement the federated data platform for improved population health management and the utilisation of digital tools to streamline diagnostic ordering. It is essential we re-introduce robust contract management and strategic commissioning to ensure that services meet the evolving needs of the community.

In addition, the plan emphasises the importance of reducing health inequalities through targeted initiatives, such as the ‘Your Healthier Futures’ programme aimed at reversing risk factors for cardiovascular diseases. It also stresses the need for equitable access to services, particularly focusing on marginalised populations.

For this year, the financial context is challenging, necessitating strong stewardship and resource management to meet both operational and financial targets. Delivering our plan will ensure we live within our financial allocations and break even while delivering safe quality care. We will execute cost improvement programmes, targeting a 1% reduction in the overall cost base and at least 30% reduction in agency spending.

This plan holds considerable risk, with substantial clinical and operational productivity requirements critical to delivery. This is within the context of planned NHS reorganisation and the challenges of managing demand and costs effectively. Mitigation strategies will be developed to address these risks, ensuring that the local health and care system partnership remains responsive to both local and national healthcare needs.

In conclusion, the operational plan for 2025/26 represents a comprehensive approach to enhancing healthcare delivery in Cambridgeshire and Peterborough. By focusing on integration, efficiency, and equity, we aim to navigate the complexities of the healthcare landscape while achieving our strategic objectives.

Our approach

The Cambridgeshire and Peterborough ICB 2025/26 Operational plan considers and builds on the wider strategic context including:

- The Cambridgeshire & Peterborough Integrated Care System Outcomes Framework.
- Our Health & Well-Being Integrated Care Strategy, and our Joint Forward Plan.
- Health Utilisation Model: local and regional work to develop a common approach to tackling the current and future challenges we face.
- Our Strategic Commissioning plan 2025-2028.
- Our approach to tackling Health Inequalities.
- Work which our partners are developing such as the Cambridge University Hospital NHS FT Acute Clinical Strategy and North West Anglia NHS FT's Clinical Strategy, the recent Place-based Joint Strategic Needs Assessments and the Cambridgeshire & Peterborough Combined Authority State of the Region.
- National policy including Lord Darzi's Independent Investigation of the NHS in England, and early indications of the Governments intentions for its 10 Year Plan – from hospital to community services, from analogue to digital, and from treating sickness to preventing it. We see our Care Model and this Strategic Commissioning Plan as closely aligned to these themes but will review our Strategic Commissioning Plan when the national 10-year plan is published.

Our planning approach

The ICB set out its approach to operational planning for 2025/26 in September 2024, building on what had worked well and learning from previous years. Our core planning principles are:

- Think local - development and ownership at the right level
- Keep it simple – alignment between strategies
- Do it together – clear comms, shared ownership, and accountability
- Prove it -delivery focused, measurable and transparent

In preparing for the 2025/26 planning round, the ICB agreed a series of initial assumptions, planning methodology and governance structure to support a triangulated approach across quality, performance, finance, and workforce, with tactical, operational, and strategic multidisciplinary input.

Engaging with our stakeholders is a vital part of the development of our planning process. Throughout this process, we have been working with partners across the system to test, challenge and refine the position. Bringing different perspectives and experiences into the process to progress our thinking through shared endeavour.

Reflections on the last 12 months

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

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

We have mitigated this through delivering more activity that ever before, with elective activity 8% higher than the previous year, cancer activity 15% higher and diagnostics 27% higher. This has contributed to an improvement in our cancer performance with delivery of the 28-day Faster Diagnosis Standard for seven consecutive months. It has supported a 40% reduction in the number of patients waiting over 52 weeks for elective treatment and a 15% improvement in patients receiving diagnostics within 6 weeks from 65% (April 24) to 80% (Jan 25).

The Cambridgeshire and Peterborough system is on track to deliver its plan for 29 of the 34 national indicators at 2024/25-year end. The five areas of non-delivery against plan are shown in the table below and a full breakdown of performance in 24/25 is included as Appendix 1.

Key performance indicators	2023/24	2024/25 Plan	2024/25 Actual
Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025	59.5% (full year)	78%	67.0% (Mar 25 YTD)
Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25	33 min	30 mins	36.4 min (Feb 25 YTD)
Improve community services waiting times, with a focus on reducing long waits (>52 weeks) [1]	448	333	793 (Dec 24)
Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025	71.7%	75.0%	44.7% (Q3 24/25)
Increase the percentage of patients with hypertension treated according to NICE guidance	64.3%	77%	66.7% (Sept 24)

While focused plans are in place to support performance improvement against these indicators in 2025/26, there is a high level of risk, recognising that previous improvement interventions have not had the impact expected. We will continue to closely monitor our performance, drivers for variation and work proactively to mitigate risks to delivery in year.

The ICB will deliver a break-even financial plan in 2024/25, with all providers achieving break-even, though Cambridgeshire and Peterborough NHS FT have received non-recurrent system support with their financial recovery in 2024/25.

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

Our 2025/26 commitments

- ## Delivering a breakeven financial plan

We will deliver a breakeven financial plan in 2025/26, though there is much greater risk in the position this year than previously, outlined in more detail in appendix 6.2.

We will go further than in previous years on cost improvement programmes, recognising the expectation of a real terms cost base reduction of 1%, whilst protecting investment in primary care services. We will make changes to our workforce, building on our strong performance in 2024/25 to deliver the minimum requirement of 30% reduction on agency spend and 10% reduction on bank spend and we will focus on driving maximum efficiency from our corporate expenditure, consolidating and aligning at system level, where it makes sense to do so.

We will, in time, also need to reflect the NHS financial reset expectations of 50% reduction in ICB costs and Provider corporate running costs back to 2019/20 levels, which are not currently included in full within our plan position.

- ## Delivering quality and operational performance improvements

In the coming year, we will remain focused on improving those areas of current clinical and operational risk, investing in clinically led redesign of services to ensure sustainable high-quality outcomes for our population. **We will deliver all quality and operational performance expectations within the national planning guidance**, spanning urgent and emergency care, referral to treatment times, cancer, mental health, learning disabilities and autism, maternity, cardiovascular disease, and primary care.

Our neighbourhood and place-based teams are critical to improving outcomes for patients, as those who best understand local need, and in 2025/26, we will expand and enhance our neighbourhood health model.

We will continually review our commissioning approach and oversight arrangements across the ICB to ensure that we remain responsive to emerging risks, have robust contract management arrangements and are strategically commissioning the right services for improved population outcomes.

- ## Maximising productivity and efficiency across our services

Fundamental to our plan is maximising productivity and efficiency, generating cash releasing savings which support our financial position, and improving clinical and operational productivity to deliver key performance indicators. **We will deliver 36% of the productivity opportunities identified from national benchmarking**, which includes both cash releasing and productivity gains. In addition, we plan to deliver £172m of efficiencies across all organisations in the system which represents 8.9% of our core ICB allocation. We will do this through implementation of best practice pathways, streamlining interface arrangements between health services, and through focused activity to reduce unwarranted clinical variation, with robust oversight and performance arrangements.

Our plan is ambitious, and the scale and pace of change required should not be underestimated. We remain committed to driving a clinically led improvement culture within all organisations in Cambridgeshire and Peterborough, and through 2025/26, we will continue to support our staff with training on continuous improvement and through our focus on workforce, create the right culture in which they can succeed.

- ## Changing our workforce

Our three strategic priorities of retention, recruitment and optimising our workforce remain critical to how we deliver the best quality care for our patients. In C&P, 30% of our workforce belong to the global majority, and over the next 12 months, we are committed to implementing our anti-racism central, inclusion strategy to

engender an inclusive culture and ensure proportionate representation of our population, at all levels within our workforce. Improving equality will improve the culture and morale of our workforce, the quality and experience of care and reduce health inequalities.

We will need to make changes to the shape and size of our workforce in 2025/26, reversing growth seen in recent years, with an expectation of 3% reduction in whole time equivalent roles, alongside expected bank and agency cost reductions, of 10% and more than 30%, respectively. These changes will need to be supported through the adoption of different ways of working such as the use of automation and exploring shared services and functions, including unified payroll and occupational health services.

We are committed to improving the productivity and efficiency of our workforce, completing benchmarking and establishment reviews in line with plan expectations. To support us in maximising our performance, we will continue to systematically implement all elements of the people promise, providing leadership capacity and capability building for our teams, exploring options for innovative workforce approaches and new roles, and embedding our local 'I' statements, which set out the behaviours and commitments on how we work effectively together as a system.

- **Reducing health inequalities**

Reducing health inequalities is a common strand through all our work programmes. It is our belief that embedding how we address health inequalities in our core programmes of work is the most effective method of delivery of unfair differences in access to services and health outcomes. We will also continue our targeted work in areas of greatest need, including our 'Your Healthier Futures' programme which focuses on reversible risk for cardiovascular disease, the most significant disease driver of inequalities in life expectancy, expand our high intensity user programme and roll out screening such as targeted lung health checks, to support earlier disease identification and intervention.

Further information on the C&P operational plan is included as appendix 6.2 including, key assumptions, full performance and data assessment, risks, and mitigations.

System transformation

We will deliver our 2025/26 plan commitments through prioritising work in four key areas. These are areas where, through partnership working, we believe we can have the biggest impact in the short and medium term, while creating the right infrastructure for long term sustainability, as per our strategic commissioning intentions. Our plan is evidence driven, using population health data, to underpin prioritisation of interventions and our approach to how we will deliver.

The principles that underpin our shared system priorities are:

- System wide change management programme and enabling PMO and governance
- Shared resource team with programme and project leads, as well as delivery leads – clinical and operational, from all partners
- Distributed ICS executive and senior leadership of programmes of work

Detailed delivery plans will be developed for each of the system priorities and managed through a system wide aligned Programme Management Office (PMO). Where plans have been developed and agreed, the assumptions have been embedded within our activity, performance, and financial plans for 2025/26.

Planned care

We will have one planned waiting list, improving equity and access for patients

- Single point of access for planned care advice and guidance / referral management including centralised patient helpdesk
- Shared decision making with health navigator approach central to deciding and waiting well
- Single PTL approach to support choice and equity of access, with a focus on robust waiting list validation
- Elective hub accreditation and implementation to maximise elective productivity and efficiency

- ✓ National strategy – Left shift & analogue to digital
- ✓ New care model – Person centred customer service, nerve centre & elective
- ✓ Ops guidance – RTT 65%

Unplanned care

We will manage care for those who need urgent same day services

- Single point of access for urgent care coordination operating 16/7and push model to manage onward treatment options
- Comprehensive and streamlined urgent community response services (all 9 pathways) operating 16/7 built around population need, including point of care diagnostics
- VW model focused on step up provision & flexible risk-based criteria
- At scale same day urgent access to primary care services
- Home First and discharge pathway redesign to reduce LoS

- ✓ National strategy – Left shift & prevention
- ✓ New care model – Managed care, nerve centre
- ✓ Ops guidance – UEC 4 & 12 hr, C2 response time

Enabling & infrastructure

We will consolidate and integrate, doing things once where it makes sense

- Single diagnostic ordering platform across C&P to enable shared PTL and maximise utilisation of all diagnostic capacity
- Federated Data Platform implementation – Population health management, Optica (discharge) and test bed for single PTL
- People enablers – staff passports, consolidation of functions i.e. Occupational health, use of AI and automation

- ✓ National strategy – Analogue to digital
- ✓ New care model – Digital front door & Federated Data Platform
- ✓ Ops guidance - Productivity and efficiency

Commissioning developments

We will strategically review and recommission services for sustainability

- Health optimisation approach that can scale to reverse risk
- Strategic review of cardiology services (community & acute)
- Mental health service review, focusing on Children and young people
- Community service review, aligned to future design of neighbourhood health model

- ✓ National strategy – Prevention
- ✓ New care model – Health optimisation
- ✓ Ops guidance –strategic commissioning

Prioritisation and assessment

In January 2025, the Cambridgeshire and Peterborough ICB Board approved strategic commissioning intentions for 2025-28, which set the framework through which prioritisation decisions would be made for the upcoming planning round. This document, alongside system agreed priorities for quality and performance, as well as early work on benchmarked productivity and efficiency opportunities in 2024/25, has supported our risk assessment and prioritisation approach.

Through the planning round, discussions have taken place at both an individual provider level and collective level, to understand interdependencies, trade-offs, and unintended consequences of prioritisation decisions. The ICB has been robust in its approach to considering all opportunities for improving efficiency before considering changes to pausing investment in improvement and sustainability initiatives or changes in services.

Providers across C&P have well established processes to assess the impact of local decisions. Each Trust has developed a quality impact tool which is broadly in line with the draft national framework for Quality and Equality impact assessments including multidisciplinary assessment of impacts.

Those decisions which have a system impact have been and will continue to be subject to scrutiny through our Joint Clinical Professional Executive Group (JCPEG) and Quality and Equality Impact Assessment process, the latter of which aligns to the recently published national framework. These can be summarised as follows:

Balancing short- and medium-term priorities

- Where financial allocations no longer remain ringfenced, including health inequalities funding, system development funding and capacity and demand funding, these allocations have been used to support the ICB and providers in achieving a breakeven financial position.
- We have paused some planned activity on transformational changes, including shifting care from reaction to prevention and left shift activity, such as expanding urgent community response teams. We have worked hard to protect transformational work, however, with a reduction in overall resources, we have had to prioritise efforts in a smaller number of high priority areas.

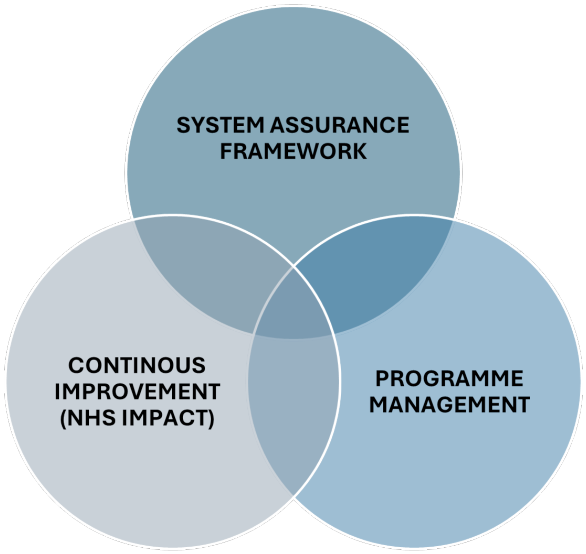
Operational and clinical risk prioritisation

- We have prioritised operational improvements to those areas of greatest clinical need, as articulated in our Board Assurance Framework and Corporate Risk Register, seeking to reduce these risks as far as reasonably practicable, and those aligned to operational plan indicators. We are clear that there are areas of service delivery we would wish to improve for our population, however, to achieve a balanced plan, we have had to target our resources in a small number of high priority areas, with the expectation that we broadly maintain performance in all other areas at current levels.
- We have reviewed contracts to ensure value for money, appropriate productivity and efficiency expectations, and contribution to improved outcomes in priority areas, though there remains more to do across all NHS services. This has led to some initial changes in funding allocations, for example, in the independent sector, where prioritisation of funding has been applied for Ophthalmology and diagnostic services, again based on clinical risk and contribution to improvement in referral to treatment times.

Delivery model

Our approach

To underpin our delivery in 2025/26, we will continue working to embed continuous improvement as a core part of our operating model, developing our staff to have the skills and autonomy to make decisions to improve care in their local areas.



We will ensure we plan effectively and collaboratively with partners, adopting a system programme management approach to coordinate oversight on delivery, recognising the complex interdependencies in a system with multiple stakeholders. We will keep our delivery plan under regular review, ensuring we are responsive to emerging risks in year and balanced in how we plan our resources to deliver both reactive and proactive programmes of work to improve quality, performance and effectiveness of healthcare services.

We will provide clarity on expectations, roles and responsibilities of all partners who have contributed to this plan through the implementation of our system assurance framework (SAF). This framework provides a transparent approach to management of risk and escalation, enabling peer and collective accountability for delivery.

Reporting and governance

Performance against the key operational performance indicators will be monitored on a regular basis through both provider and ICB governance structures. Delivery of our key programmes of work, will be tracked through our new system PMO with collective oversight at our ICB Board.

Risks

For this year, the context is challenging, necessitating strong stewardship and resource management to meet both operational and financial targets. There are several risks within the Cambridgeshire and Peterborough ICB operational plan for 2025/26 which cannot be mitigated by the ICB and providers alone. We have made several assumptions and identified mitigations to support a balanced plan, and we will continue collaborating with stakeholders to ensure that these can be resolved.

Scale of productivity and efficiency challenge: C&P have set a high ambition to deliver clinical and operational productivity across a range of areas. This scale of change requires significant engagement and cultural buy in from across organisations to achieve and the risk of non-delivery would impact on our performance and financial assumptions.

Drivers of demand and cost: There are high-risk areas of demand, activity, and cost, including NICE Technology Appraisal implementation, ADHD waiting list management and rising costs in Medicines Optimisation and Continuing Health Care (CHC). These have contributed significant pressure to the C&P financial position in 2024/25 and while the ICB has included 100% of identified efficiency savings in these areas within its 2025/26 plan as per the benchmarking opportunities, a national approach and solution to these demands is required.

Allocations outside of C&P: It is assumed in our plan that C&P providers receive contracts that align with national planning guidance assumptions on cost uplift, growth, capacity, Clinical Negligence Scheme for Trusts (CNST) and Elective Recovery Fund (ERF), for both specialised commissioning services and from those providers outside of the C&P geography. As a net inflow system, allocations below expected levels will impact significantly on the overall C&P position.

Elective caps: Our plan assumes that following the national payment rules consultation that mechanisms are established for ICBs to cap contract values and activity. If caps are not able to be applied, then there is an increased risk to the C&P financial plan position due to increased independent sector provision.

Risks	£m	Additional information
Other commissioner income risk	16.3	Plans are reliant on contract offers aligning to national planning guidance for appropriate uplifts and growth.
Income reduction risk	10.1	Linked to NHSE Genomic contract and HWE pathology contract
Inflation risk	7.5	Inflation (CHC, CPI, PFI, Electricity and Rates) is above the levels set in national planning assumptions.
Pay cost risk	15.0	Nationally determined pay award allocation does not fully cover the local implementation. Additional risk linked to workforce re-banding initiatives (bands 2-3, bands 5-6).
Prescribing risk	11.6	NICE recommendations, growth due to Right to Choose (ADHD and obesity), price concessions and impact of medication shortages.
Efficiency risk	43.1	Due to operational performance targets and the NHS re-organisation, identification/delivery of efficiency plans may slip.
Service re-design	10.7	Re-design of CDC and Genomics services to accommodate lower funding expectations.
Risk total	**114.3**	

Mitigations	£m	Additional information
Contract negotiation support	15.0	Support from ICB and NHSE in support of contract discussions with other commissioners.
Enhanced cost control & non-recurrent mitigations	39.1	Assessment and removal of costs where there is no identified funding source. Enhanced cost controls over discretionary/ uncommitted funds. Use of non-recurrent resources.
Prescribing efficiencies and control	11.6	Increased control, waste reduction and increased efficienty opportunities (switches, over-prescribing).
Efficiency plan focus	43.1	Increased delivery focus on efficiency plans in particular emphasis on key milestones for achieving cost reductions. Support and engagement across all disciplines particularly for workforce changes. ICB and providers have track record of delivering over 95% of efficiency targets.
Elective recovery funding	5.5	Redistribution of elective recovery funding from ISPs into the system.
Mitigations total	**114.3**	

In addition, recent announcements on changes to the role, functions and capacity of Department of Health and Social Care, NHS England and Integrated Care Boards, as well as Provider corporate resources, is likely to create some distraction from delivery, with a reduction in overall resources, staff disengagement and low morale, while future form and functions are developed and implemented.

As part of the final planning submission, ICBs and Provider Boards have completed Board assurance templates, the purpose of which is to provide assurance that all considerations around finance, workforce and activity have been addressed, whilst ensuring that the ambitions for 2025/26 can be met and that quality of care is prioritised.

Appendices

- Appendix 1: 2024/25 Operational plan delivery summary
- Appendix 2: Cambridgeshire & Peterborough ICB 2025/26 Operational plan detail

Appendix 1: 2024/25 Operational plan delivery summary

Area	Objective	2023/24	2024/25 Actual	2024/25 Plan	Performance vs. 24/25 submitted plan
Quality and patient safety	Implement the Patient Safety Incident Response Framework (PSIRF)	N/A	Implemented	N/A	✓ expected to meet
Urgent and emergency care	Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025	59.5%	67.0% (YTD)	78%	X not expected to meet
	Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25	33 min	36.4 min (YTD)	30 min	X not expected to meet
Primary and community services	Improve community services waiting times, with a focus on reducing long waits (>52 weeks)[2]	448	793	N/A	X not expected to meet
	Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need	81.6%	82.1% (Jan)	81.6%	✓ expected to meet
	Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels	67.8%	74.7% (Apr)	80%	✓ expected to meet
Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	62%	80% (Jan)	82%	✓ expected to meet

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

Area	Objective	2023/24	2024/25 Actual	2024/25 Plan	Performance vs. 24/25 submitted plan
Elective	Eliminate waits of over 65 weeks for elective care as soon as possible (except where patients choose to wait longer or in specific specialties)	2,057	89 (Jan) *46 capacity	0	✓ expected to meet
	Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%	120%	128% (Nov YTD)	>107%	✓ expected to meet
	Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25	N/A	45.8% (Jan)	46%	✓ expected to meet
	Improve patients' experience of choice at point of referral – implement PIDMAS	N/A	Implemented	N/A	✓ expected to meet
Cancer	Improve performance against the headline 62-day standard to 70% by March 2025	59.4%	68.7% (Jan)	70%	✓ expected to meet
	Improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026	70.3%	79.9% (Jan)	77%	✓ expected to meet
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	40.3%	48.5% (Sep)	N/A	✓ expected to meet
Mental health	Improve patient flow and work towards eliminating inappropriate out of placements	30	6 (Jan)	10	✓ expected to meet
	Increase the number of people accessing transformed models of adult community mental health (to 400,000), perinatal mental health (to 66,000) and children and young people services (345,000 additional CYP aged 0–25 compared to 2019)	Adult: New Perinatal:790 CYP: 16,085	Adult: 5,900 Perinatal: 850 CYP: 14,240 (Dec)	Adult: 5,900 Perinatal:790 CYP: 13,546	✓ expected to meet
	Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement and 48% reliable recovery	New	Access: 67% Recovery: 46% (Jan)	Access: 67% Recovery: 48%	✓ expected to meet
	Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025	60.2%	65.3% (Dec)	75%	✓ expected to meet
	Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate	58.7%	60.2% (Dec)	63.4%	✓ expected to meet

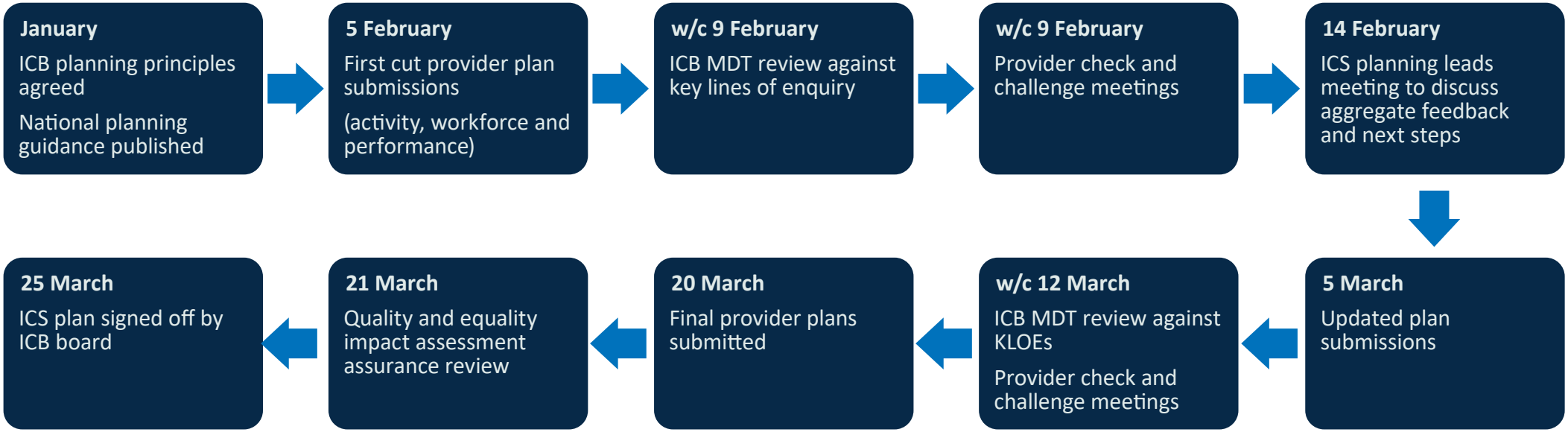
Area	Objective	2023/24	2024/25 Actual	2024/25 Plan	Performance vs. 24/25 submitted plan
Learning disabilities and autism	Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025	71.7%	44.7% (Q3 24/25)	75%	X not expected to meet
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12–15 under 18s for every 1 million population.	19	15 (Jan)	19	✓ expected to meet
Maternity, neonatal and women's health	Continue to implement the Three-year delivery plan for maternity and neonatal services, including making progress towards the national safety ambition and increasing fill rates against funded establishment	N/A	Implemented	N/A	✓ expected to meet
	Establish and develop at least one women's health hub in every ICB by December 2024, working in partnership with local authorities	N/A	Implemented	N/A	✓ expected to meet
Workforce	Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of the People Promise retention interventions	N/A N/A	Implementation underway	N/A	✓ expected to meet
	Improve the working lives of doctors in training by increasing choice and flexibility in rotas, and reducing duplicative inductions and payroll errors		Implementation underway	N/A	✓ expected to meet
	Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan	N/A	Implementation underway	N/A	✓ expected to meet
Resource	Deliver a balanced net system financial position for 2024/25	N/A	On track	Breakeven	✓ expected to meet
	Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25	2.7%	2.2% (Oct)	2.4%	✓ expected to meet
Health inequalities	Increase the % of patients with hypertension treated according to NICE guidance	64.3%	66.7% (Sep)	77%	X not expected to meet
	Increase the percentage of patients aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025	58.6%	61.5% (Sep)	65%	✓ expected to meet
	Increase vaccination uptake for children and young people year on year towards WHO recommended levels	New	Implementation underway	N/A	✓ expected to meet
	Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people	N/A	Implementation underway	N/A	✓ expected to meet

Appendix 2: Cambridgeshire & Peterborough ICB 2025/26 Operational plan detail

Our plan sets out that we will:

- Deliver a breakeven financial plan
- Deliver all quality and operational performance expectations within the national planning guidance
- Deliver 36% of the productivity opportunities identified from national benchmarking
- Deliver a 2.3% reduction in whole time equivalent roles, alongside expected bank and agency cost reductions, of 10% and more than 30% respectively
- Continue our targeted work in areas of greatest need

The process through which we have developed our plans is summarised below. Plans have been triangulated to ensure balanced delivery across quality, performance, workforce and finance and decisions made during the plan process have been subject to Quality and equality impact assessment processes at both Provider and ICB level.



National operational plan key performance indicators

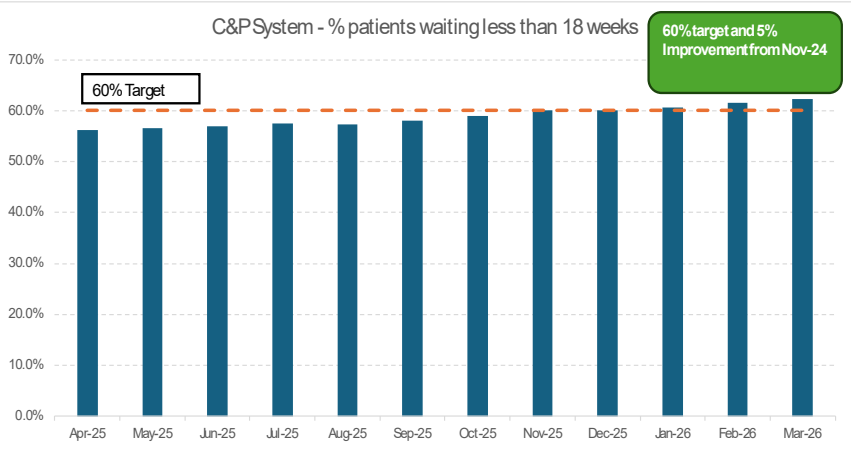
	CCS	CPFT	CUHFT	NWAFT	RPHFT	ICB
Live within the budget allocated, reducing waste and improving productivity						
Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spend	Met	Met	Met	Met	Met	n/a
Deliver a balanced net system financial position for 2025/26	Breakeven	Breakeven	Breakeven	Breakeven	Breakeven	Breakeven
Improve A&E waiting times and ambulance response times						
Achieve >78% A&E four-hour performance	n/a	n/a	78.3%	78.0%	n/a	78.2%
Reduce the number of patients spending more than 12 hours in the Emergency Department vs 24/25	n/a	n/a	-2.4%	-2.0%	n/a	-2.1%
Improve C2 ambulance response times to an average of 30 minutes across 2025/26	n/a	n/a	n/a	n/a	n/a	Met
Reduce the time people wait for elective care						
Provide patients with more choice with at least 70% of elective care appointments available to view & manage via NHS App	To be confirmed					
Validate patients on a referral to treatment (RTT) waiting list after 12 weeks and every 12 weeks thereafter	n/a	n/a	Met	Met	Met	n/a
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	n/a	n/a	68.6% (target 68.5%)	67.3% (target 67%)	83.7% (target 88.7%)	68.6% (target 63.8%)
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	n/a	n/a	64.1% (target 64.1%)	60.0% (target 60.0%)	70.5% (target 69.5%)	62.3% (target 60.9%)
Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of total waiting list by March 2026	n/a	n/a	0.99%	1.0%	0.64%	0.98%
Improve performance against headline 62-day cancer standard to 75% by March 2026	n/a	n/a	79.9%	75.3%	75.0%	77.5%
Improve performance against the 28-day cancer faster diagnosis standard to 80% by March 2026	n/a	n/a	84.4%	80.5%	83.3%	82.%

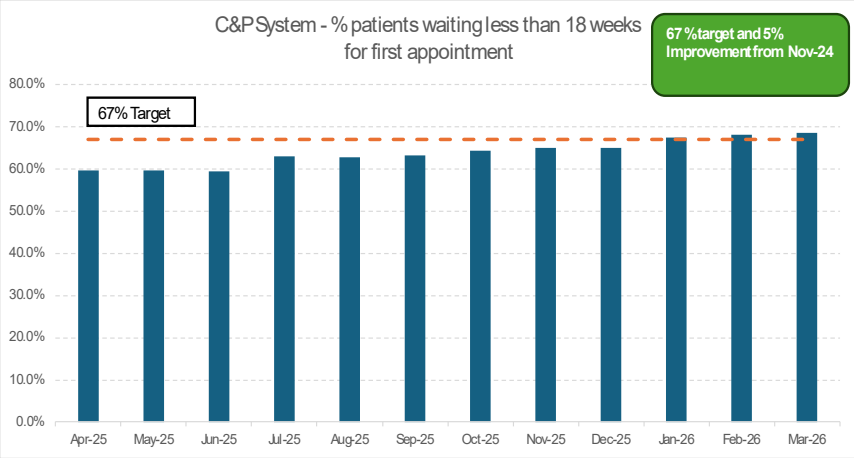
	CCS	CPFT	CUHFT	NWAFT	RPHFT	ICB
Improve access to general practice and urgent dental care						
Improve access to dental care by commissioning urgent appointments to meet governments manifesto commitment of additional 700,000 C&P proportion of this = 14,195 additional appointments in 2025/26	n/a	n/a	n/a	n/a	n/a	Met
Improve patient experience of access to general practice as measured by the ONS health insights survey	n/a	n/a	n/a	n/a	n/a	Met
Improve mental health and learning disability care						
Reduce average length of stay in adult acute mental health beds	n/a	-3days	n/a	n/a	n/a	n/a
Increase the number of CYP accessing services to achieve the national ambition for 345,000 additional CYP aged 0-25 compared to 2019 C&P proportion of this = total 13,525 contacts	n/a	n/a	n/a	n/a	n/a	Met 14,664
Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, delivering a minimum 10% reduction Reduce from 15 total	n/a	n/a	n/a	n/a	n/a	10
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 3-year delivery plan	n/a	n/a	Met	Met	n/a	Met
Address inequalities and shift towards prevention						
Reduce inequalities in line with the CORE20PLUS5 approach for adults and children and young people	n/a	n/a	n/a	n/a	n/a	Met
Increase the % of patients with hypertension treated according to NICE guidance, and the % of patients with GP recorded GCVD, who have their cholesterol levels managed to NICE guidance	n/a	n/a	n/a	n/a	n/a	Met

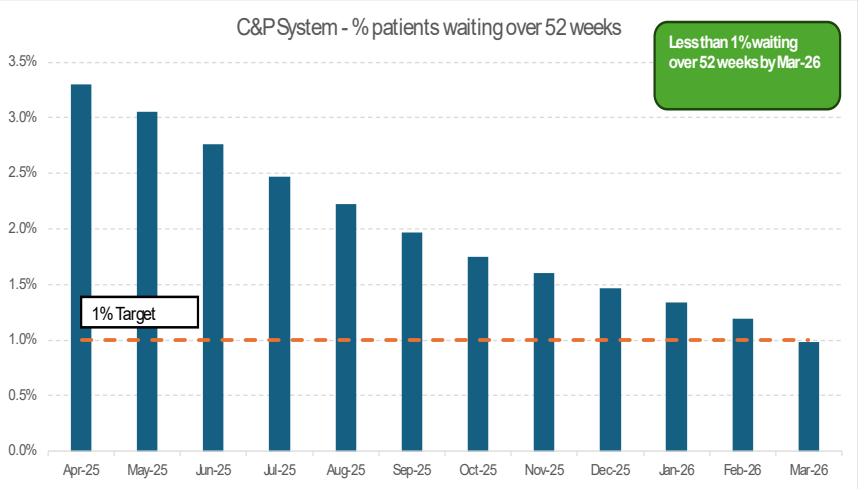
Patient safety, quality, and operational performance

Performance trajectories

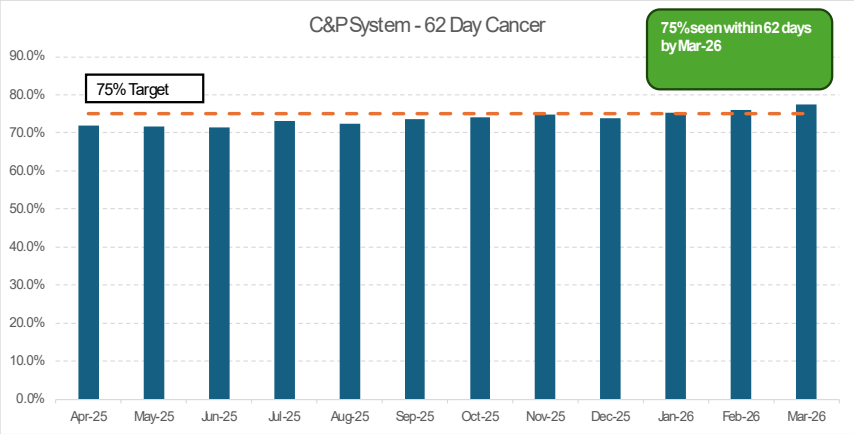
Elective care

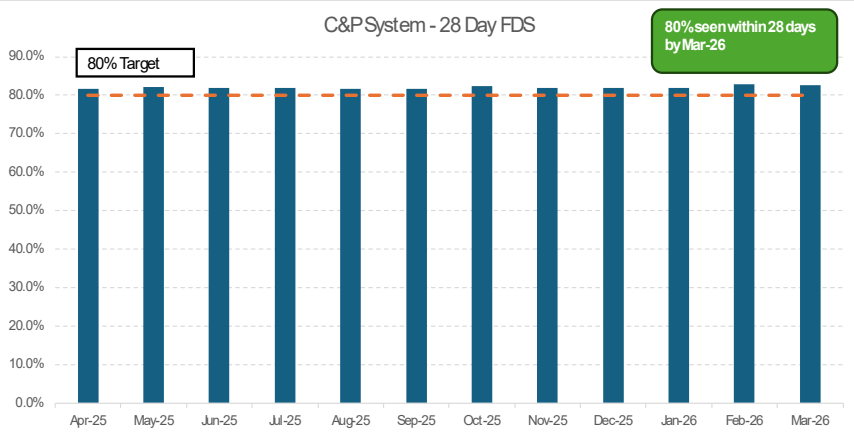




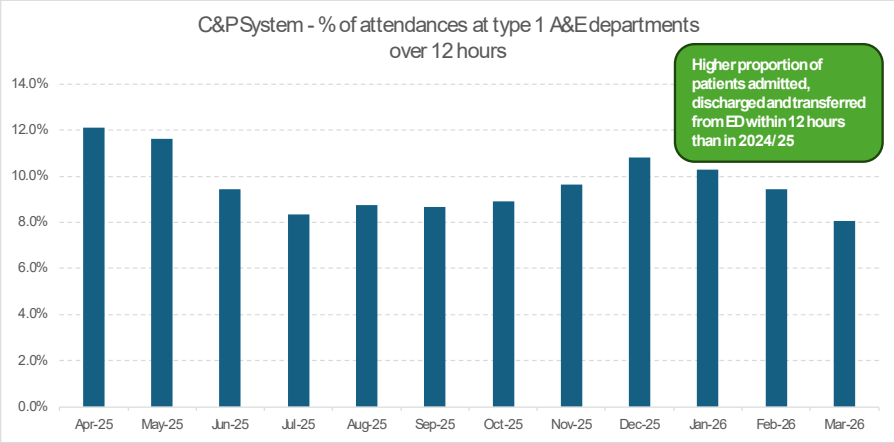


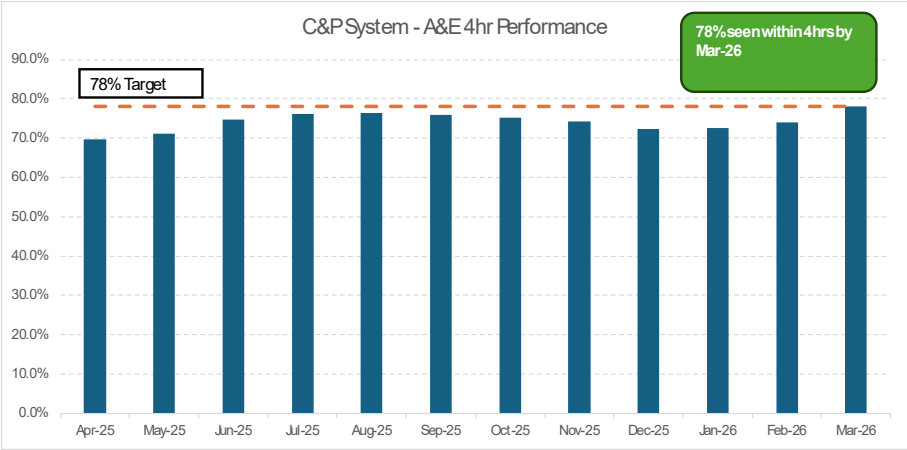
Cancer

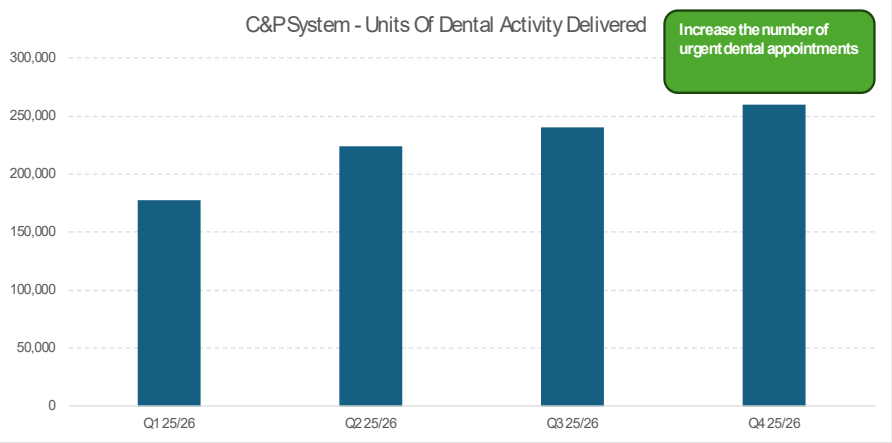

C&P System - 62 Day Cancer
75% seen within 62 days by Mar-26
75% Target
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26


C&P System - 28 Day FDS
80% seen within 28 days by Mar-26
80% Target
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26

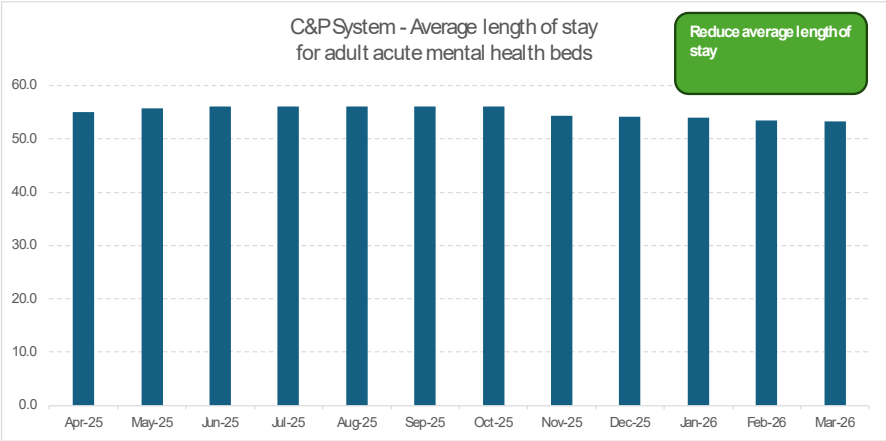
Urgent and emergency care & Dental

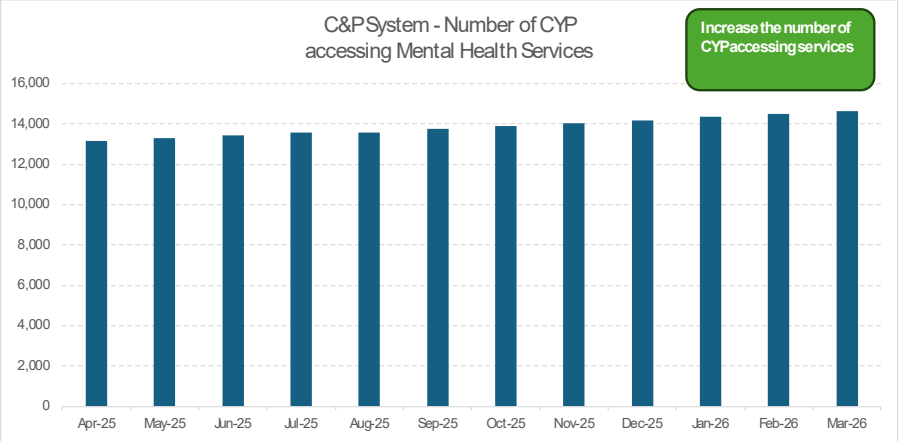


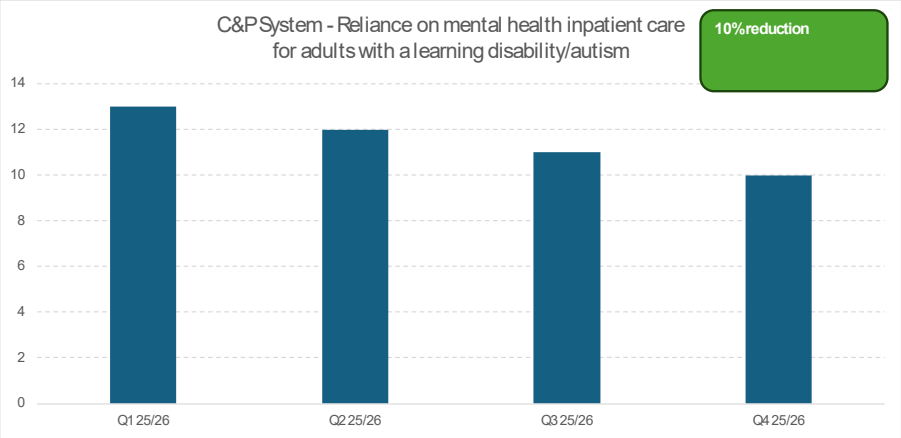




Mental health and learning disabilities



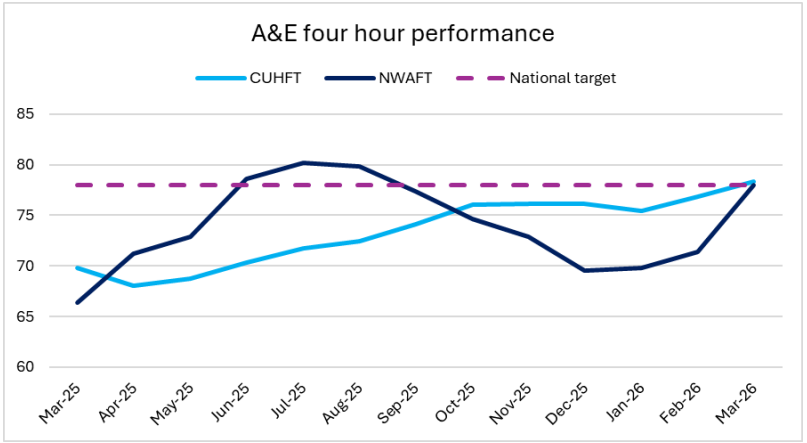




Improve A&E waiting times

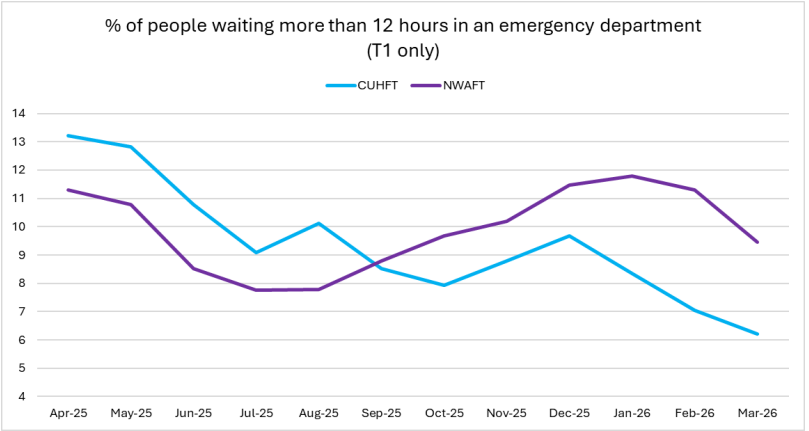
Summary

- Providers are planning to meet the national standard of >78% of people being seen, treated, and discharged or admitted within four hours by March 2026. Average performance through the year, 73.7% at CUHFT and 74.7% at NWAFT.
- Providers are planning to reduce the number of patients waiting more than 12 hours in an emergency department through the year, from 11.7% to 6.2% at CUHFT and 11.3% to 9.4% at NWAFT.
- The ICB has committed to average ambulance handovers of 30 mins, with no handovers exceeding 45 minutes (in line with Handover 45 EEAST policy), supporting Category 2 response performance of 30 minutes.



Key actions

- Development of frailty hub and frailty SDEC in Peterborough, extended medical SDEC and surgical SDEC capacity
- Implementation of new IUC model to increase patients redirected to appropriate out of hospital settings, with enhanced clinical assessment and full validation of 111-999 referrals (Category 2- Category 5) reducing conveyance
- Increased activity through urgent care coordination hub and UCR services, expansion of UCCH model to include MH practitioners
- Changes to virtual ward model to focus on more step-up capacity
- Flow and length of stay improvement, through changes to medical model, new integrated health, and care pathway 1 capacity, and implementation of single digital discharge platform (Optica – FDP) across the ICB
- Targeted interventions for high intensity users, with expansion and enhancement of neighbourhood teams



Risks and mitigations

- ***R*** **-** Demand is above expected planning levels ***M*** – Demand management schemes in place, including admission avoidance and additional general practice capacity to stream appropriate patients away from the Emergency department. System OPEL and in-extremis actions in place to support periods of significant demand
- ***R*** - Interventions planned to reduce length of stay do not have the expected impact resulting in ongoing delays for T1 admitted patients ***M*** – Strong clinical leadership and engagement in changes to medical model, focus on clinical productivity within UEC footprints and robust Executive oversight.

Reduce the time people wait for elective wait

Summary

- Providers are planning to meet elective KPIs including improvements in referral to treatment times, reduction in long waits over 52 weeks and cancer diagnosis and waiting time standards
- RPH are not meeting the minimum 5% improvement in waits to first outpatient appointment, as they are already delivering above the national target of 72%, with 83.1% performance in November 24.

Key actions

- Adoption of best practice GIRFT advice and guidance templates
- Implementation of referral management centre model to manage demand, reduce unwarranted clinical triage variation and increase advice and guidance
- Adherence to ICB threshold policies and lower clinical priority policies
- Waiting list validation – improvement sprints, centralisation of activity to improve productivity and use of digital automation
- Enhanced direct access diagnostics, increase straight to test pathways and increase theatre productivity
- Elective hub implementation to drive productivity for high volume low complexity procedures
- Identification of improvement opportunities to reduce Did Not Attends (DNAs) – digitally enabled predictor analytics and intervention
- Cancer - increased use of tele dermatology, review of breast and urology pathways, maintenance of high FIT test compliance in primary care

	Providers			
Success Measure	CUHFT	NWAFT	RPH	ICB
Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026,	64.1%	60.0%	70.5%	62.3%
Every trust expected to deliver a minimum 5% point improvement	5.0%	7.7%	6.0%	6.4%
Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026	68.6%	67.3%	83.7%	68.6%
Every trust expected to deliver a minimum 5% point improvement	5.0%	14.3%	0.6%	9.8%
Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026	0.99%	1.00%	0.64%	0.98%
Improve performance against the headline 62-day cancer standard to 75% by March 2026	79.9%	75.3%	75.0%	77.5%
Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026	84.4%	80.5%	83.3%	82.6%

Risks and mitigations

- ***R*** **–** Demand management through referral management centre approach is not sufficient to reduce elective referrals ***M*** – Learning from best practice existing models nationally, commencing quickly with individual specialties to test and scale.
- ***R*** – Reduction in admin and clerical resources and overall workforce changes impact on capacity and efficiency of scheduling, validation, and effective management of RTT pathways ***M*** – Focus on use of digital enablers to support some tasks i.e. automated waiting list validation and AI enabled scheduling.

Improve access to general practice and urgent dental care

Summary

- The ICB will meet the expectations to increase access to urgent dental care, with 14,195 additional appointments planned for 2025/26. This is our share of the national 700,000 additional appointments committed to in the government manifesto.
- The ICB will work closely with general practice to improve the experience of patients accessing services as per the ONS health insights survey.

Key actions

- Continued delivery of C&P 5-year dentistry reform plan, approved by ICB Board in September 2024. This reform plan sets out 4 work streams to transform dentistry access for the local population, reducing inequalities in access and ensuring sustainability of services with a revised commercial model.
- Agreement on additional sessions for urgent dental care, through existing providers with 10% flex on current commissioned services.
- Development of our neighbourhood health teams including same day urgent care provision and managed care approach to those with high intensity needs
- Continue with our Health optimisation approach – 'Your Healthier Futures' programme to reverse risk for cardiovascular disease
- Procure a new Digital front door for primary care access, enabling greater patient access to digital records, health services, advice, and support
- Implementation of population health management tool, working with general practice to enhance data coding and quality to support strategic commissioning
- Implementation of a new contracting, performance, and quality assurance framework across primary care
- Changes to local enhanced services approach and commitment to levelling up funding, recognising limitations in Carhill formula, resulting in additional investment in general practice to reduce health access inequalities

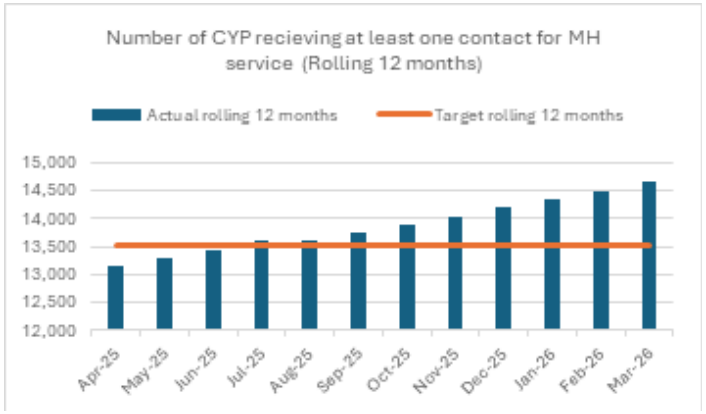
Risks and mitigations

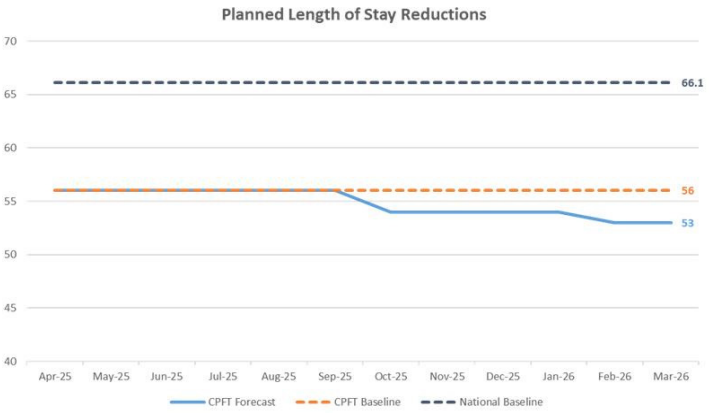
- ***R*** **-** Limited engagement with general practice in developing system wide solutions to increase patient access to same day and routine appointments ***M –*** Shared learning from positive practice level access, end to collective action due to 2025/26 contract agreement, development of single solutions such as digital front door to release GP capacity for patients who most require continuity of care
- ***R*** **-** Public expectation of accessing general practice with changing models of delivery including increased virtual capacity and multidisciplinary team approach ***M –*** Working closely with patient participation groups, HealthWatch and other patient organisations to support the local population to understand benefits of right professional, right time. Increase direct access, self-referral and enhanced self-management support for patients
- ***R –*** Current dental provision across C&P does not meet demand and increase in appointment capacity cannot be delivered in a sustainable way ***M*** – Continued implementation of C&P dental reform plan, prioritising sustainable commercial model and creating flexibility in contracted services.

Improve mental health and learning disability care

Summary

- The ICB is committed to reducing reliance on inpatient mental health capacity for people with a learning disability and those with autism, from an average of 15 people to no more than 10, exceeding the minimum 10% reduction
- CPFT as the main Mental health provider plan to meet the expected reduction in average length of stay for adult acute mental health beds to 53 days
- Providers plan to increase the number of CYP accessing mental health services in 2025/26, meeting the expected target





Key actions

- Use of 3-3-3 model in adult inpatient MH units to improve length of stay and support timely discharge, introduction of high impact actions for MH discharges and inclusion of MH capacity within the ICS Transfer of Care hub
- Minimising out of area placements through continued work on operational processes, governance, and flow management. There has been significant progress with performance improvement in 24/25 reducing from a peak of 35 OOA placements in May 2025, to 6 in January 25 (latest data).
- Maintaining timely care and treatment reviews, as well as meeting requirements for emergency C(e) TR prior to admission
- Review and redesign of Learning Disabilities model of care is underway with planned implementation from Q3. This follows the disaggregation of the current section 75 with Cambridgeshire County Council on 31 March 2025, with will see the transition of existing LD services back to the ICB as lead commissioner.
- Formal evaluation of Mental health support teams to understand current provision, effectiveness of national model and value for money, to shape future commissioning for children and young people.

Risks and mitigations

- ***R*** – Transition of LD services following dissolution of the current section 75 arrangement with the Local Authority will impact on pace of transformation change for services. ***M*** – Additional resources in place to mitigate short term transition requirements and shared resource between ICB and CPFT as lead provider of services being explored to progress pathway redesign and implementation.
- ***R*** – Demand for children and young people mental health services continues to exceed available capacity ***M*** – Focus on appropriate clinical risk stratification of waiting lists, complete review of mental health services to support future commissioning arrangements and targeted evidence-based interventions in areas of greatest need.

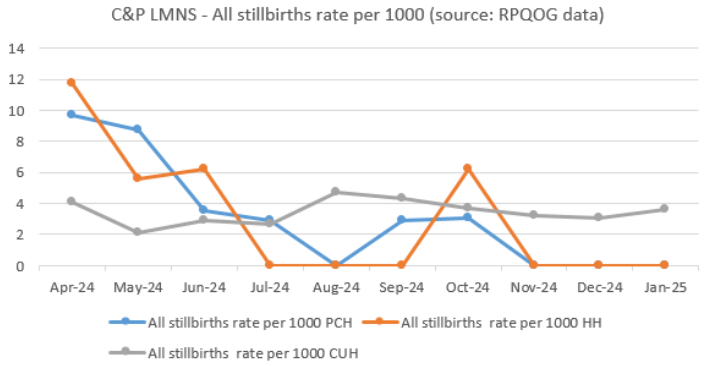
Improve safety in maternity and neonatal services

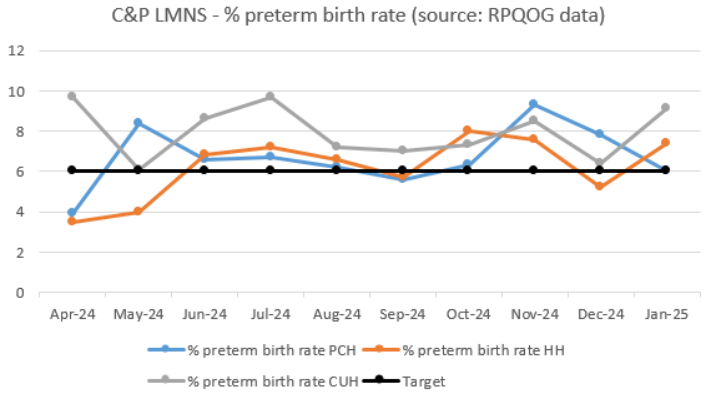
Summary

- System focus remains on ensuring the reduction in stillbirths, neonatal mortality, maternal mortality, and serious brain injury.
- Reducing the number of preterm births below 6% and optimising perinatal care.
- Addressing inequality, complexity, discrimination and exclusion

Key actions

- The required 50% reduction in stillbirths by 2025 equates to 2.6 stillbirths per 1000 births with CUH at 3.6%, PCH at 3.1% and HH at 3.0%.
- Preterm births national threshold set at 6% with CUH at 8%, PCH at 6.7% and HH at 6.2%.
- Increasing percentage of bookings by 10 weeks with a particular focus on health inequalities.
- Face to face, digital and non-digital communication to support informed choice and personalisation of care.
- Evidencing safety improvements across maternity and neonatal services will be measured by aligned reporting, incorporating all 10 Standards of the Maternity Incentive Scheme.
- Demonstrating quality improvements with the maternity and neonatal voice partnerships providing the service user voice on the experienced quality of care.
- Continue to embed a positive culture across all staffing levels as per the findings from the Ockenden and Kirkup reports.
- Delivering equitable access to perinatal pelvic health services and maternal mental health support as per the Three-Year Delivery plan.
- Valuing, retaining and developing a skilled workforce to deliver high quality care.





Risks and mitigations

- ***R*** **–** Workforce development and retention ***M*** – Annual training needs analysis and training available to all staff via the core competency framework.
- ***R*** – Quality and Safety measures not implemented as required. ***M*** – Assurance processes in line with the Maternity Incentive Scheme, incorporating Saving Babies Lives Care Bundle versions continually assess quality and safety.

Activity

Metric Description		2024/25 Plan	2024/25 FOT (published date)	2024/25 variance to plan	2025/26 Plan	2025/26 Plan Variance to 2024/25 FOT
Total OP	Outpatient attendaces (all TFC, Consultant and Non Consultant led) - Total	1,932,873	1,961,296	1.5%	1,913,278	**-2%**
OP Transformation	Number of episodes moved or discharged to patient initiated outpatient follow-up pathway as an outcome of their attendance.	82,833	83,563	0.9%	120,698	**44%**
	PIFU as percentage of total outpatient attendances	4.3%	4.3%	0.0%	6.3%	**48%**
Consultant led OP	Consultant-led first outpatient attendances (Spec Acute)	534,574	462,827	-13.4%	479,804	**4%**
	Consultant-led follow-up outpatient attendances (Spec Acute)	757,572	740,921	-2.2%	741,219	**0%**
Outpatients - ERF Scope	Outpatient procedures - ERF Scope	258,354	248,554	-3.8%	257,159	**3%**
	Outpatient first attendances without a procedure - ERF Scope	573,547	530,170	-7.6%	550,110	**4%**
	Outpatient follow-up attendances without a procedure - ERF Scope	1,004,150	939,149	-6.5%	961,289	**2%**
	Percentage outpatients follow-up without a procedure	54.7%	54.7%	0.0%	54.4%	**-1%**
	Percentage of all outpatient attendances that are for first appointments, or follow-up appointments attracting a procedure tariff	45.3%	45.3%	0.0%	45.6%	**1%**
Electives	Total number of specific acute elective day cases spells in the period	155,865	166,318	6.7%	159,937	**-4%**
	Total number of specific acute elective ordinary spells in the period	28,963	26,831	-7.4%	28,421	**6%**
	Total number of specific acute elective spells in the period	184,828	193,149	4.5%	188,358	**-2%**
	Total number of specific acute elective day case spells in the period of which children under 18 years of age	7,569	9,980	31.9%	10,322	**3%**
	Total number of specific acute elective ordinary spells in the period in which children under 18 years of age	3,003	3,108	3.5%	3,287	**6%**
A&E	Total number of attendances at A&E departments, excluding planned follow-ups, departing in less than 4 hours (4 hour performance)	242,850	297,123	22.3%	345,644	**16%**
	Total number of attendances at A^E departments, excluding planned follow-up attendances	408,234	437,048	7.1%	465,341	**6%**
	Percentage of attendances at type 1, 2 and 3 A&E departments, excluding planned follow-up attendances, departing in less than 4 hours	59.5%	68%	8.5%	74.3%	**9%**
	Number of attendances at type 1 A&E departments over 12 hours	N/A	35,722	N/A	31,232	**-13%**
	Number of attendances at type 1 A&E departments	N/A	302,717	N/A	323,545	**7%**
	Percentage of attendances at type 1 A&E departments over 12 hours	N/A	12%	N/A	9.7%	**-18%**

Metric Description		2024/25 Plan	2024/25 FOT (published date)	2024/25 variance to plan	2025/26 Plan	2025/26 Plan Variance to 2024/25 FOT
Non-electives	Number of specific acute non-elective spells in the period with a length of stay of zero days	33,620	30,776	-8.5%	33,378	**8%**
	Number of specific acute non-elective spells in the period with a length of stay of one or more days	77,446	84,504	9.1%	86,033	**2%**
	Number of specific acute non-elective spells in the period	111,066	115,280	3.8%	119,411	**4%**
RTT	The number of completed admitted RTT pathways in the reporting period	69,329	70,481	1.7%	77,263	**10%**
	The number of completed non-admitted pathways in the reporting period	281,024	277,120	-1.4%	296,274	**7%**
	The number of new RTT pathways in the reporting period	364,974	378,656	3.7%	378,620	**2%**
Diagnostics - Activity	Total Diagnostic Tests	498,564	493,689	-1.0%	476,822	**-3%**

The table above summarises the expected activity movement year on year. Notable changes include:

- Significant increase in planned patient initiated follow up (PIFU) improvement, from 4.3% to 6.3% overall. This exceeds the national planning requirement of achieving 5% by 2029 as outlined in the elective reform strategy.
- Despite a reduction in elective recovery funding in 2025/26, through productivity and efficiency changes, providers are planning to deliver activity levels broadly in line with the previous year, except for diagnostics, where, because of changes to CDC funding, CT and MRI capacity previously available has been withdrawn, resulting in an overall reduction of activity year on year of 3%.
- Providers are planning to significantly improve A&E performance (9%) despite continued increases in demand (6% year on year increase). This mirrors the position in 2024/25 which saw a 7% increase in demand and a 9% improvement in A&E four-hour performance.

Productivity and efficiency

National productivity and efficiency benchmarking packs were shared with all providers and ICBs in February 24. These documents set out a series of cash releasing and productivity savings. While acknowledging the methodology used to calculate each provider position was one approach, it did allow a consistent national assessment of cost of provision. As part of the planning round, all organisations have been asked to assess its expected delivery against these areas.

For C&P, £236m of potential opportunity was identified across national priority areas, as broken down in Table 1: Productivity and efficiency. In our plan submission, we are committing to delivery of £53.1m (35.7%) of the total productivity opportunities. In addition, we plan to deliver £172m of efficiencies which considers the nationally identified opportunities as well as other local schemes. This is across both cash releasing schemes which support delivery of our breakeven plan, and efficiencies in operational and clinical processes, supporting delivery of constitutional standards.

Table 1: Productivity and efficiency

Productivity and efficiency area	CCS		CPFT		CUH		NWAFT		RPH		ICB		Total	
	Opportunity	Planned delivery	Opportunity	Planned delivery	Opportunity	Planned delivery	Opportunity	Planned delivery	Opportunity	Planned delivery	Opportunity	Planned delivery	Opportunity	Planned delivery
Non-elective activity					9.8	2.6	22.6	17.6	2.0	0			34.4	20.2
A&E and SDEC					2.3	0	3.3	6.4	0.1	0			5.7	6.4
Elective					31.7	6.6	16.7	6.5	1.5	0			49.9	13.1
Outpatient					35.5	0.9	1.4	5.9	0.3	0			37.2	6.8
Other acute activity					4.4	2.3	1.6	0	1.2	0			7.2	2.3
Length of stay			14.1	0.0									14.1	0.0
Out of area placements			0.0	2.9									0.0	2.9
Other local opportunities										1.4			0.0	1.4
Total productivity	**0.0**	**0.0**	**14.1**	**2.9**	**83.7**	**12.4**	**45.6**	**36.4**	**5.2**	**1.4**	**0.0**	**0.0**	**148.6**	**53.1**
Delivery as %	**n/a**		**20.4%**		**14.8%**		**79.8%**		**26.7%**		**n/a**		**35.7%**	
Temp staffing	0.7	0.1	6.7	2.8	14	0	12.9	13.5	1.7	0.95			35.9	17.3
Corporate services	4.1	0.4	9.5	4.5	16.8	0	4.3	7.3	3.1	0.4			37.8	12.6
Medicines					1.9	1.1	1.6	1.6	0.0				3.5	2.7
Commercial	0.9	0.1	1.4	1.4	1.5	3.7	2.6	3.8	1.2	0.9			7.7	9.8
Continuing healthcare											2.1	2.1	2.1	2.1
Primary care prescribing											0.8	2.5	0.8	2.5
Other local opportunities		8.0		9.0		88.0		8.8		7.3		3.9	0.0	125.0
Total efficiency	**5.8**	**8.6**	**17.6**	**17.6**	**34.2**	**92.8**	**21.4**	**35.0**	**5.9**	**9.6**	**2.9**	**8.5**	**87.8**	**172.0**
Delivery as %	**147.7%**		**100.4%**		**271.3%**		**163.6%**		**161.5%**		**293.1%**		**196.0%**	

Finance

C&P has built on 4 successive years of delivering its financial plan through openness, transparency and an effective use of system resources. We have developed plans in line with national guidance, with a focus on the delivery of improved patient outcomes and living within the resources available. We have a breakeven plan as a system with the ICB and all hosted providers in financial balance.

The 2025/26 planning round has marked a financial reset across the NHS. The plans have been developed within an affordable financial envelope, maximising opportunities to improve productivity, efficiency and taking appropriate decisions on how to utilise resources to best meet the health needs of the Cambridgeshire and Peterborough population. Additional financial flexibilities have been provided by releasing most funding ring fences. This has resulted in a prioritisation and rationalisation exercise to ensure funding is being channelled to support local priorities and the remaining un-ringfenced allocations being used to support the overall system breakeven position.

The financial environment facing the NHS remains challenging. There is a clear emphasis on maximising productivity and efficiency opportunities, removing costs and limiting growth where this is unaffordable. There will be some reliance on non-recurrent resources in the year to deliver the balanced position and in year focus on delivering recurrent cost improvements. Overall, the plan carries a higher level of risk than in previous years but sets out clear and deliverable ambitions on the priority national performance asks to balance patient safety, quality, and affordability.

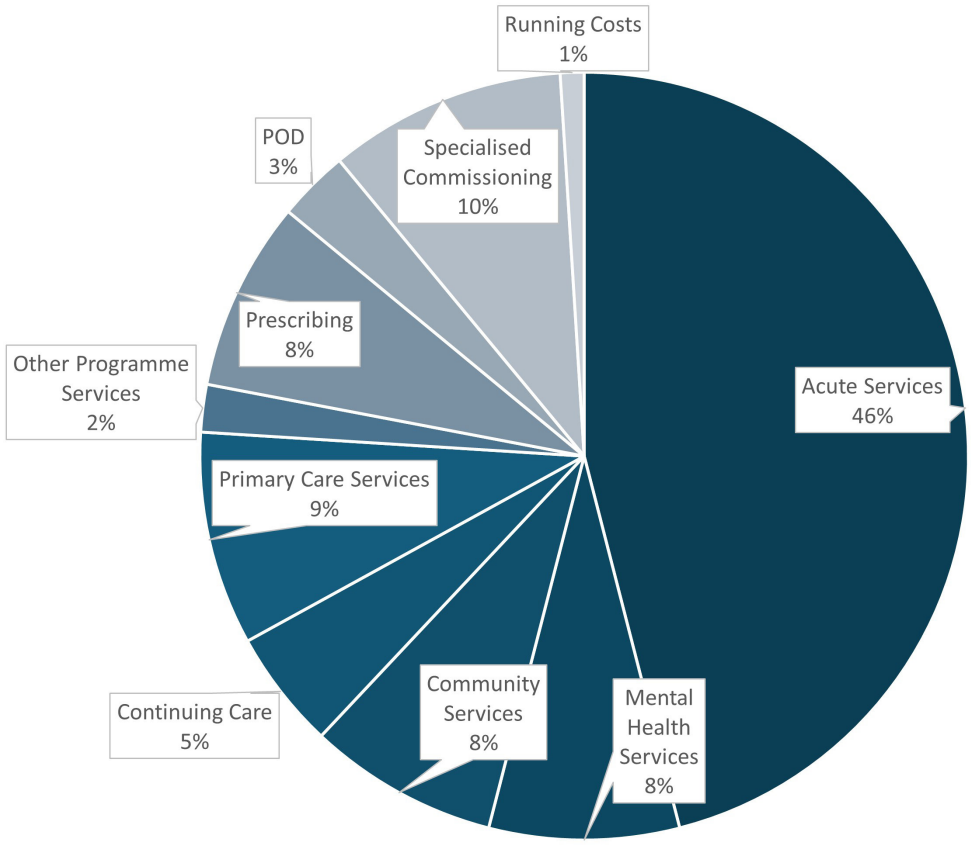
Financial assumptions

A strong delivery focus will be required to meet our plan ambitions for the year which is implied across the following assumptions:

- Efficiency delivery – our plans include £172m of financial efficiencies across the system to be delivered in 2025/26. This represents 8.9% of our core allocation and is significantly higher than the £136m planned for 2024/25. This is indicative of the level of ambition in our plan but also carries some risk of non-delivery.
- Productivity delivery – the plans include planned productivity gains across several operational areas. The delivery of these productivities will be key to meeting the required performance standards within an affordable financial envelope.
- Strong financial stewardship to ensure costs are managed within the allocations and for all organisations to address their recurrent run rate position in year to mitigate the impact of non-recurrent resources and exit 2025/26 in a financially sustainable position.
- Other commissioner income - C&P is a complex system with a large net inflow of activity and funding from other commissioners. In the current financial environment, C&P is highly exposed to decisions made by other commissioners. Plans are built on the assumption that all commissioners adhere to the national planning guidance in relation to appropriate contractual uplifts in recognition of patient flows.
- Workforce - the plans include a net Whole Time Equivalent (WTE) workforce reduction of approximately 935 positions across the system providers. This reverses some of the growth observed in provider corporate areas since 2019/20 as well as addresses the requirement for lower levels of temporary staffing use across the system. We plan to exceed the target of a 30% reduction in agency spend and meet the target of a 10% reduction in bank spend.
- Prescribing – our plans assume that NICE recommendations are mitigated via national support alongside controlled implementation, clear cashable benefits, increased efficiencies and reduction of waste and duplication.
- Reduction in the costs of running ICBs - the recent requirement for a 50% reduction in the costs of running an ICB is **not** currently captured within our plans. This includes any staff redundancy costs which have not been quantified.

The C&P financial plan covers £2.45bn direct allocation of which £1.25bn is passed over to in-system NHS providers. This represents 40% of the aggregate provider turnover and we therefore have collective responsibility for a total of £4.4bn of spend. Our ICB allocation now includes £248m of specialised commissioned services delegated from NHS England as well as the funding for the East of England hosted Cancer Alliance (within other Programme services).

	Provider turnover	C&P ICB allocation	% of turnover
Cambridge University Hospitals NHS Foundation Trust (CUH)	1,570	449	29%
North West Anglia NHS Foundation Trust (NWAFT)	743	504	68%
Royal Papworth Hospital NHS Trust (RPH)	329	35	11%
Cambridgeshire & Peterborough NHS Foundation Trust (CPFT)	352	237	67%
Cambridgeshire Community Services NHS Trust	177	29	16%
C&P provider totals	**3,172**	**1,253**	**40%**
ICB Core		375	
Continuing Healthcare (CHC)		143	
Prescribing		164	
Primary care		189	
POD		69	
Specialised commissioning		248	
Running costs		14	
Other ICB allocations		**1,202**	
Total ICB allocation 2025/26		**2,456**	



Financial risks and mitigations

The plan carries financial risks across the following areas:

- **Income risk** – that commissioners will not apply the relevant national guidance for contractual uplifts for services being provided. In addition, there is the risk of income reduction in some areas. The mitigations include ICB and NHSE support in contract negotiations as well as assessment of costs where there is no identified funding source.
- **Expenditure risk** – there are a number of cost pressures being managed linked to inflationary cost pressures above standard national assumptions, potential workforce re-banding (bands 2-3 and bands 5-6), drug / prescribing costs and high-cost packages of care. This is in addition to lower provider expenditure assumptions aligned to closure of escalation areas and service reconfigurations. The mitigations are for robust cost control and financial management in all organisations alongside national support for significant costs in excess of national assumptions (e.g. pay award, NICE TAs).
- **Efficiency delivery risk** – the delivery of the plan relies on significant productivity and efficiency savings over and above the levels planned in previous years. The C&P system has a strong track record of achieving their plans. However, the NHS reorganisation and national emphasis on operational performance targets will require a strong delivery focus to meet the ambitions set out in the plan. Additional mitigations will require new efficiency schemes to be developed and / or enhanced in-year cost control measures.
- **Cash risk** – recognising the financially challenging environment and some use of non-recurrent resources may present cash flow risks in year. This can be mitigated via management of working capital and PDC draw down for capital schemes alongside system alignment on commissioner payment dates.

Risks	£m	Additional information
Other commissioner income risk	16.3	Plans are reliant on contract offers aligning to national planning guidance for approprirate uplifts and growth.
Income reduction risk	10.1	Linked to NHSE Genomic contract and HWE pathology contract
Inflation risk	7.5	Inflation (CHC, CPI, PFI, Electricity and Rates) is above the levels set in national planning assumptions.
Pay cost risk	15.0	Nationally determined pay award allocation does not fully cover the local implementation. Additional risk linked to workforce re-banding initiatives (bands 2-3, bands 5-6).
Prescribing risk	11.6	NICE recommendations, growth due to Right to Choose (ADHD and obesity), price concessions and impact of medication shortages.
Efficiency risk	43.1	Due to operational performance targets and the NHS re-organisation, identification/delivery of efficiency plans may slip.
Service re-design	10.7	Re-design of CDC and Genomics services to accommodate lower funding expectations.
Risk total	**114.3**	

Mitigations	£m	Additional information
Contract negotiation support	15.0	Support from ICB and NHSE in support of contract discussions with other commissioners.
Enhanced cost control & non-recurrent mitigations	39.1	Assessment and removal of costs where there is no identified funding source. Enhanced cost controls over discretionary/uncommitted funds. Use of non-recurrent resources.
Prescribing efficiencies and control	11.6	Increased control, waste reduction and increased efficienty opportunities (switches, over-prescribing).
Efficiency plan focus	43.1	Increased delivery focus on efficiency plans in particular emphasis on key milestones for achieving cost reductions. Support and engagement across all disciplines particularly for workforce changes. ICB and providers have track record of delivering over 95% of efficiency targets.
Elective recovery funding	5.5	Redistribution of elective recovery funding from ISPs into the system.
Mitigations total	**114.3**	

Capital

The table below sets out the capital allocations to C&P. There is £88m of operational capital available across the system which includes core allocations plus a further £12.25m linked to delivery of the 2024/25 breakeven revenue plan for the system and an additional £10.7m conditional on submitting a breakeven revenue plan for 2025/26.

There is an indicative £49.3m of additional capital available to the system subject to NHSE approval of the specific schemes. Plans are being developed ahead of submitting to NHSE for approval. This covers:

- RAAC remedial works
- High priority secondary care estates safety
- Investment towards reducing out of area placements and rehabilitation for mental health patients
- Improvements in primary care estates
- Return to constitutional standards across diagnostics, elective and UEC

Any further capital allocations will be subject to a separate bidding / application process.

£'k	2025/26 Capital Allocation
Operational Capital Allocation	63,246
2024/25 Revenue Fair Shares Allocation Adjustment	12.250
2025/26 Revenue Fair Shares Allocation Adjustment	10,707
Primary Care BAU	1,788
Operational Capital Total	87,991
Indicative items and subject to scheme approval:	
RAAC	4,920
Estates Safety	11,654
Mental Health - Reducing Out of Area Placements	1,741
Primary Care Utilisation Fund	1,495
Return to Constitutional Standards - Diagnostics	13,500
Return to Constitutional Standards - Elective	1,500
Return to Constitutional Standards - UEC	14,500
Indicative items and subject to scheme approval:	49,310
Total Capital	137,301

At the time of plan submission, UEC capital bids have been reviewed and the ICB notified of the outcome. £10.6m of UEC capital has been supported, with support in principle for a further £3m, subject to further information and system assurance on deliverability of schemes.

Diagnostic and Elective capital bid processes have not yet concluded, and no capital bids were submitted against the Mental health – reducing out of area placements allocation, as no local plans met the strict criteria.

Workforce

Retention, Recruitment and Optimising our workforce are key strategic priorities for C&P ICS. Our ICS wide People Board has worked with system providers to mitigate the risk, to the extent that vacancy rates are below plan, turnover is down, and sickness absence is below plan, at a time when temporary staffing levels are being significantly reduced. In 2025/26, we will be focused on delivering the following priority work programmes.

Anti-racism central, Inclusion strategy

In Cambridgeshire and Peterborough 30% of our workforce belong to the global majority (PGMs). The 2024 NHS staff survey once again indicates that ethnicity is the most common basis (58%) on which discrimination is experienced in the workforce. Driving down discrimination, bullying and harassment are key to building teams that are productive and deliver quality service to all C&P patients.

The profile of that 30% in health and care reveals that the majority of people of the global majority (PGMs) are at the base of our structures, thinning out as we go higher up, forming the shape of a triangle. This is what Roger Kline once called the 'Snowy White Peaks.' With this in mind, the ICS is taking a priority approach to change the shape of that representation so that people of all backgrounds have the opportunity to develop and excel at every level in our organisations. This more proportionate representation would be a huge step in reducing health inequalities. It would engender the inclusive culture that would allow us to realise our vision for the new models of care, delivering to our communities from cohesive, inclusive teams that support each other to deliver with excellence. That is our overarching goal as an ICS.

To kick-start the programme, a workshop was delivered with the aim of providing an opportunity for system partners to build on and accelerate the work that has been taking place through the EDI Sub-Group and in particular the System's Inclusive Leadership Programme delivered by Above Difference. Participants were challenged to consider how we can commit and hold each other to account for sustainable and transparent actions to address the disparity and discrimination that exists across all of the organisations in our system. The outcomes of this session are on-going with a second workshop planned for late March 2025 and the development of a strategy to achieve key objectives.

Stabilise and developing our workforce

The ICB has worked to systematically implement all elements of the People Promise to improve the working lives of all staff and increase staff retention and attendance and implement the 6 high impact actions to improve equality, diversity and inclusion. It is well recognised that engaged, motivated staff improve productivity and patient outcomes and with this in mind, the ICS has engaged in a wide range of programmes and interventions, which includes:

- Leadership programmes (e.g. Mary Seacole/ Ready Now/ Stepping Up/ Leading Beyond boundaries), developed a data led decision making approach through the development of a strategic workforce planning function which works closely with the Business Intelligence function to aid decision making and planning based on population health needs.
- Stabilisation and planning of the workforce is also stretched across Primary Care, supporting programmes such as the ICS GP Retention programme, GP Fellowship Programme/GPN development /AHP Fellowship and works closely with the Cambridgeshire & Peterborough Training Hub, which delivers a wide range of programmes across the primary care workforce.
- The development of a system wide Health and Care Academy, which works with schools, colleges and HEI's on several engagement programmes, working to highlight the health and care sector as an employer of choice, taking a widening participation approach to engagement (e.g. Breaking Barriers Innovation

Pilot Programme, aimed at care leavers and now part of a national programme). The Academy is also responsible for the delivery of the ICS Careers Expo, which is a system collaborative, working with health and care providers and attracts more than 2000 Year 10 and 12 students from schools across the geography.

- The workforce programme team and providers have also supported the People Promise Exemplar Programme locally and hosted on behalf of the region, which participation from 11 trusts. The programme is designed to retain nursing workforce and ensure that the workforce is supported to deliver the best possible care. It will end in July 2025.
- The Legacy Practitioner Programme is part of the High Impact Retention initiatives programme, run nationally but with an AHP/Nursing focus. This is a 12-24-month programme that is designed to draw on the experience of experienced clinicians who retire and return into practice and support colleagues with practice development and improve the quality and standards of care.

Make the best use of all resources

C&P ICS has made significant reductions in bank and agency during 24/25, reducing utilisation and reliance across all providers. For 25/26 planning round, providers have committed to reducing further utilisation and reliance across the system to meet the 30% agency and 10% bank reduction targets. Robust workforce plans are currently being developed across the ICS, with trusts undertaking benchmarking exercises against productivity and efficiency targets, whilst reviewing WTE and workforce numbers accordingly.

As part of the 25/26 workforce and operational planning proves, providers are exploring options to address growth over recent years, reviewing job families and where alternative mechanisms could deliver efficiency and productivity outcomes, including for example, utilisation of AI/RPA to automate practice and support functions such as HR, recruitment and finance.

In addition, system partners have developed plans to take infrastructure staffing back to pre-Covid levels, to deliver the cost reduction and productivity gains that are imperative for a break-even plan. Additional options being explored include unified payroll functions, with shared services across the ICS. Contracting arrangements for occupational health services, HR databases and health and well-being platforms are also being explored. The development of new care models will involve robust workforce planning and associated workforce transformation activity to explore new roles across all services and patient pathways, which will demand for high cost urgent and emergency care with the attendant workforce costs. A summary of key changes in workforce, aligned to the national plan expectations is shown in the table below.

KPI	CUH	CCS	CPFT	NWAFT	RPH	ICS
Bank 10% reduction in Plan Bank reduction ops plan average compared to 2024/25 PWR average	13%	21%	23%	19%	-30% (plan to move agency staff onto bank and stop 'overtime' payments to bring down overall paycosts by moving staff to bank)	14%
Agency 30% reduction Agency reduction ops plan average FTE compared to 2024/25 PWR FTE average	48%	15% Mitigation - they have reduced from 11.6 to 9.8 FTE average	40%	45%	32%	40%
Reduce Spend on support functions to April 2022 levels Close activity/WTE gap against pre-COVID levels Metric is 50% increase in SIP FTE since March 2020	312.5	14.5	83.5	67	37	514.5
FTE SIP reduction NHS infrastructure 2025/26	375	+5.21 (FTE has increased)	74 (hasn't cut 50% from March 2020 levels)	100.68	+15.5 (FTE has increased)	529
Corp % opportunities utilised	tbc	10.6%	47.2%	169%	13%	-
Temp staffing % opportunities utilised	tbc	9.97%	42%	104%	57%	-
SIP change (total staffing)	-4%	3% (service TUPE from CPFT - exact match)	-4%	-4%	0%	-934.93 FTE or -3%

Live our leadership compact

Live our leadership compact – the ICS undertook a refresh of the leadership compact, by consultation with a wide range of people from across the health and care landscape. In addition, the next iteration of ICB behaviour statements has been derived from a study of external best practice and has been distilled into 10 'I' statements, which will form the basis of leadership behaviours and commitments around system work moving forward. The statements will be used to guide objective setting, agenda setting, meeting reviews, leadership development and appraisal reviews. The development of the statements is iterative and currently in a second phase when they will be expanded for easy adoption in the activities listed opposite.

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Version 1 April 2025