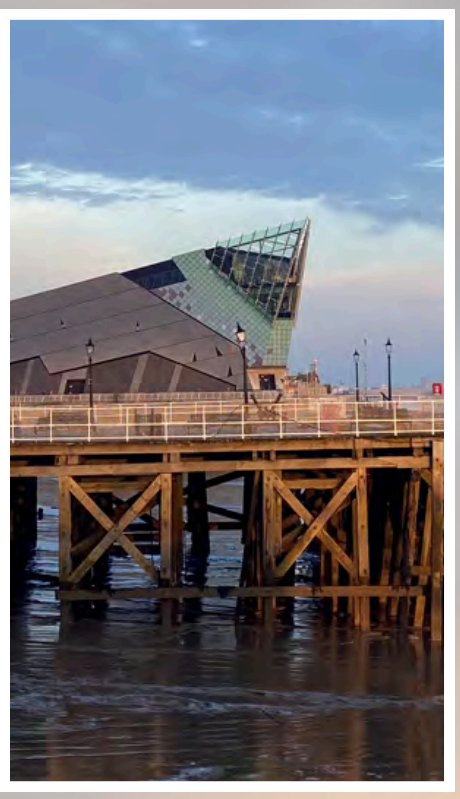
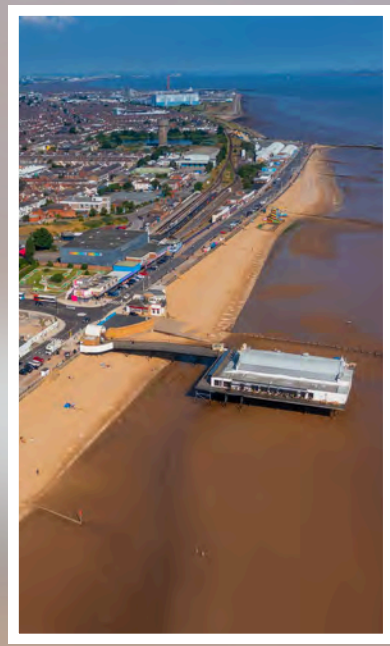
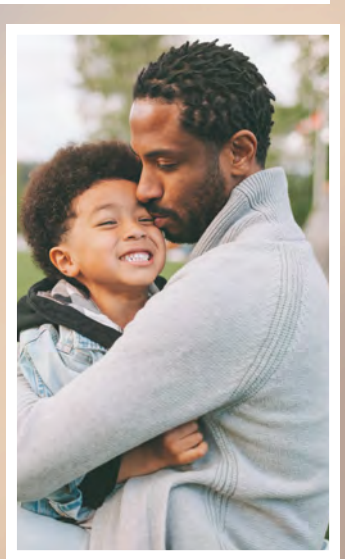
Humber and North Yorkshire
Health and Care Partnership

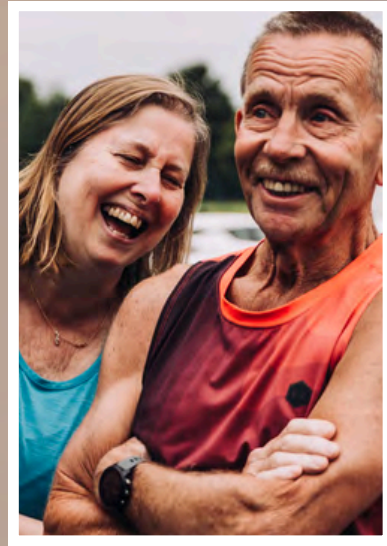
NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

Annual Report and Accounts 2024-2025



Foreword from our Chair (Deputy)

Welcome to the 2024/25 Annual Report and Accounts for the Humber and North Yorkshire Integrated Care Board (ICB). This year has been one of significant progress and challenges for our health and care system.

We began the year with the launch of our refreshed and simplified Integrated Care Partnership Strategy, setting out our renewed commitment to our partnership ambitions to narrow the gap in healthy life expectancy by 2030 and increase healthy life expectancy by five years by 2035. The Humber and North Yorkshire Integrated Strategy for Wellbeing, Health and Care provides a guiding light for the Humber and North Yorkshire Health and Care Partnership so that we remain focused on supporting our people to: Start Well, Live Well, Age Well, and Die Well.Delivering on this Strategy means that we need to create a culture that cares deeply about our people and their lives. It means building closer connections with each other, our colleagues and partners. And it means innovating to find new solutions and ways of working that will help us make a bigger difference to people, faster. So, this year also saw us launch our values, We Care, We Connect, We Innovate.

We Care We Connect We Innovate

Every day, in the decisions we make and the actions we take we are committed to living our values.

Our board has worked diligently to strengthen governance structures, ensuring accountability and transparency in all our activities. We have fostered strong partnerships with local authorities, healthcare providers, and community organisations, which have been instrumental in driving forward our strategic aims. Working collaboratively with our partners we have made strides in these areas, and you will find some examples of the excellent work being delivered across our Partnership throughout this report.

As we reflect on the past year, we are proud of the progress we have made, and the resilience shown by our teams. We know that we have similar challenges ahead but with the groundwork laid this year, through collaborative efforts and strategic initiatives, we are confident that our teams and partners will continue our journey towards a healthier, more equitable future for all residents of Humber and North Yorkshire.

Mark Chamberlain

Deputy Chair

Mark Chamberlain
Deputy Chair

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Teresa Fenech

Accountable Office (Acting Chief Executive)

June 2025

Performance Overview

Chief Executive statement

Welcome to the third annual report for Humber and North Yorkshire Integrated Care Board. I am proud to reflect on the achievements and challenges of the past year. Our focus has been on delivering core NHS and care services, enhancing productivity, and supporting our workforce to deliver high-quality care. The ambitious targets set by NHS England have guided our efforts, and we have made remarkable progress in improving service delivery and patient outcomes.

But this year has not been without its difficulties, with industrial action and workforce pressures, but our teams have risen to these challenges. Financial sustainability has been a key priority, and we have worked hard to manage resources effectively while maintaining high standards of care.

The ICB achieved measurable progress across NHS priorities in 2024/25, improving urgent care, reducing elective and community care waits, and expanding cancer and diagnostic services. Primary care access positively exceeded targets, and mental health services advanced dementia diagnosis and youth access planning. Across all domains, increased service provision and strategic initiatives laid the groundwork for continued improvement in 2025/26.

The use of data and technology has been pivotal in supporting decision-making and streamlining processes. This year, we have further evolved our approach around population health management, focusing on creating a culture that cares deeply about our people and their lives.

Given the financial challenges we face we know we need to make even bolder changes to continue providing high-quality universal health services that address the needs of our population and utilise digital, scientific, and technological advancements. Our Design for the Future aims to establish conditions for local integrated, accessible health and care services that identify needs early and target them appropriately, with emergency care provided at acute sites. Supported by our Organisational Development and Transformation plan it also seeks to create an agile, flexible Integrated Care Board (ICB) capable of adapting to the evolving health and care landscape.

The Government has announced **NHS reforms** that will have an impact on the forthcoming financial year. NHS England is to be abolished with its functions to be integrated into the Department of Health and Social Care. The focus of the ICB will be strategic commissioning, to help realise the ambitions to be set out in the 10 Year Health Plan.

I am grateful for the resilience, dedication, and hard work of our teams and partners. Despite the continued challenges we face, their unwavering commitment inspires me, and I am confident that together we will continue striving for excellence and innovation.

Key highlights 2024/25

Catterick Integrated Care Centre

In April 2024 we announced the construction of the flagship NHS and Ministry of Defence health complex at Catterick Garrison. Due to open in 2026, the joint project is the first of its kind and will deliver transformative integrated health and care services to the military and civilian communities of Catterick and wider Richmondshire areas.

Community Diagnostic Centres

In May 2024, York followed Ripon, East Riding, and Selby in opening a Community Diagnostic Centre (CDC). The next stage in the programme concluded with the opening of CDCs in Grimsby and Scunthorpe in March 2025 and Hull and Scarborough to follow from April 2025 onwards. The CDCs provide local residents with faster access to essential diagnostic services for illnesses such as cancer and heart disease and reduce waiting times for patients by offering a range of diagnostic tests, checks, and scans, including MRIs, CTs, and ultrasounds. Further details can be found within the annual report.

Armed Forces Covenant

Our commitment to our Armed Forces community was acknowledged on the eve of Armed Forces Day in June 2024. Being awarded the prestigious Silver Award in the Defence Employer Recognition Scheme (ERS) recognises our pledge to provide significant support to the armed forces community and their families through our policies and practices.

Centre of Excellence for Frailty

In July 2024 we announced the launch of a Centre of Excellence for Frailty to support older residents across Humber and North Yorkshire.

Building on the pioneering work of the Jean Bishop Integrated Care Centre in Hull, this will encourage a standardised approach to the prevention, identification, and management of frailty, and ensure older people in the region receive consistent, high-quality care and treatment regardless of their location.

The Centre of Excellence for Frailty has been a priority for the Humber and North Yorkshire Health and Care Partnership which recognises that the ageing population will continue to grow as people live longer.

Changing the narrative on suicide

We recognised World Suicide Prevention Day in September 2024, by working with our partners to launch a new action plan to change the narrative on suicide.

The action plan is aligned with strategic priorities, initially focusing on targeted support for vulnerable groups, addressing common risk factors and enhancing crisis support.

It seeks to shift the public's understanding of suicide – encouraging individuals, communities, and organisations to engage in meaningful, honest, and empathetic conversations about suicide.

We Need to Talk

In October and November 2024, we undertook "We Need to Talk" an engagement exercise starting conversations with the public on what is important to them and how they may want the NHS to change to meet the demands for the future.

Over 3,000 people provided feedback during a four-week period, and their input will feed into future proposals on how NHS services are delivered. For a full breakdown of the report, and videos please follow the link below: https://humberandnorthyorkshire.org.uk/we-need-to-talk/

Tobacco Control

The Centre for Excellence partnered with 15 local authorities across Humber and North Yorkshire, West Yorkshire, and South Yorkshire to launch the 'What Will You Miss' mass media stop smoking campaign in March 2025, spanning TV, radio, buses, social media, and online channels. This campaign is one of the largest and most extensive in the region

Connected HNY

The ICB advanced the ICP Futures Group proposal for 'Connected Humber and North Yorkshire (HNY)' this year. The initial phase prioritises the use of data for children and young people, ensuring practitioners can access secure, real-time information to improve care coordination and reduce duplication.

The Connected HNY Database and HNY Insights will support integration across health and care services by providing data-driven insights for better decision-making, efficiency, and patient outcomes, leveraging data and innovation for a more connected, person-centred system.

Proof-of-concept pilots in North East Lincolnshire and York will test integrated care models.

Teresa Fenech

Accountable Office (Acting Chief Executive)

20 June 2025

Purpose of overview section

The overview section sets out the purpose and objectives of the organisation, describing the activities, model, and structure of the ICB. It demonstrates how the ICB has led the NHS and wider system and become an anchor institution. It sets out how the ICB discharges its duty to have regard to the effect of its decisions (the 'triple aim') and how it operates as an Integrated Care System. The progress the ICB has made in 2024/25 in establishing its operating model and ways of working to meet key statutory duties are also described.

This section includes a performance appraisal which sets out a fair assessment as to how the ICB has addressed key NHS operational objectives and delivered performance. It also provides a summary and assessment of the current progress and position of the ICB as a maturing organisation.

Statement of purpose

The Humber and North Yorkshire Integrated Care Board (ICB) is a statutory organisation responsible for overseeing £4.2 billion of NHS spending and performance for approximately 1.7 million people in the region.

Its primary role is to ensure that health services are effective, high-quality, and integrated to improve the health and wellbeing of local residents while reducing health inequalities.

The ICB is a core member of the Humber and North Yorkshire Health and Care Partnership, which is one of 42 Integrated Care Systems (ICSs) across England. Our ICS which is a partnership that brings together four acute trusts, three mental health trusts, six local authorities, two ambulance trusts and four community interest or not for profit organisations. There are also around 230 GP practices, 550 residential care homes, 10 hospices, 180 home care companies and thousands of voluntary and community sector organisations all helping to keep our local people well. It deploys 50,000 colleagues with a shared passion and commitment to provide a seamless and high-quality health and social care system that meets the needs of all our population.

The Humber and North Yorkshire Health and Care Board focuses on creating a cohesive system that supports people to live healthy, independent lives and to achieve the triple aim of:

a) better health and wellbeing for everyone,

b) better care for all people, and

c) the sustainable use of resources.

The ICB plays a crucial role in the system by planning to meet population health needs, allocating resources, ensuring service delivery, facilitating transformation, and overseeing improved outcomes for the population.

It operates within a framework that emphasises collaborative and place-based arrangements to enhance health and care services across the region and over the last few years has taken decisions which further strengthens these arrangements:

Collaborative Arrangements: This involves five sector collaboratives that bring together providers to deliver specific objectives aligned with the system's strategic priorities. These collaboratives include **mental health, learning disabilities and/ or Autism**, **primary care**; **collaborative of acute providers**; **community health and care**; and the **Voluntary Community and Social Enterprise sector**. Each provider within these collaboratives works together to achieve agreed-upon goals, contributing to the overall health and wellbeing of the population. The VCSE Collaborative, for example, represents the wider VCSE sector and includes place leads from VCSE infrastructure organisations, the NHS, and the VCSE Collaborative staff team.

Place-Based Arrangements: Place-based arrangements are central to the Humber and North Yorkshire operating framework, which identifies delegation to our six Places as key to the sustainability of health and care systems (Hull, East Riding of Yorkshire, North Lincolnshire, North East Lincolnshire, City of York, North Yorkshire). These arrangements enable the development and delivery of services with local system partners, focusing on the needs of local populations. The ICB plays a pivotal role in supporting these place-based efforts by integrating services and facilitating collaboration among local authorities, NHS providers, and other stakeholders.

You can find details of our full governance arrangements in the Accountability Report.

Our Integrated Strategy for Wellbeing, Health and Care

In 2024 Humber and North Yorkshire Integrated Care Partnership published our refreshed Integrated Strategy for Wellbeing, Health and Care, which builds on existing strengths, such as the person-centred and strengths-based approach, while identifying areas for targeted investment.

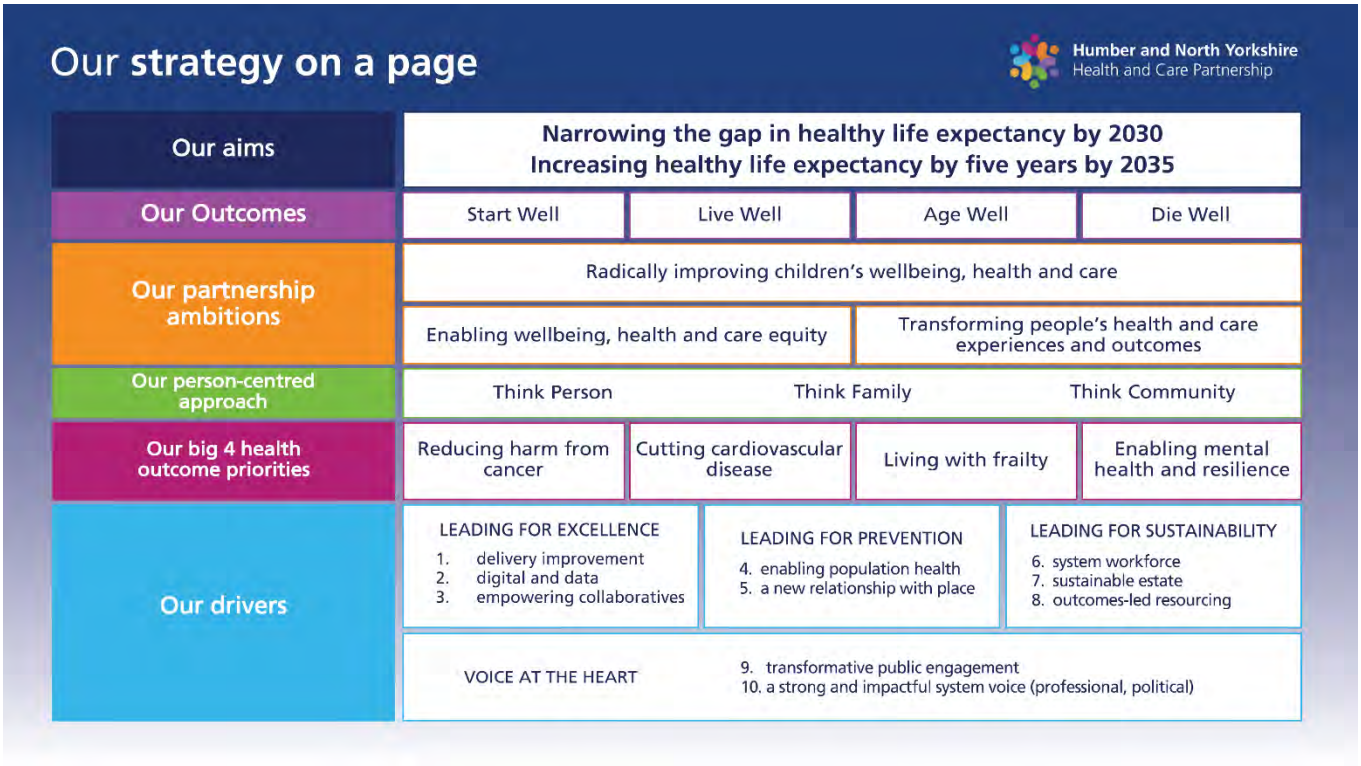
In order to narrow the gap in healthy life expectancy by 2030 and increase healthy life expectancy by five years by 2035, our Strategy introduces three overarching ambitions:

- Radically improving children's wellbeing, health, and care
- Enabling wellbeing, health, and care equity
- Transforming people's health and care experiences and outcomes

Each of our three partnership ambitions holds significant importance. We understand that individuals with health and care needs today expect access to safe and high-quality services. However, we also recognise that without a substantial shift towards the prevention of ill health, the future health and care systems will neither be excellent nor sustainable. Our 'golden ambition' is to prioritise children and young people, viewing them as our hope for the future. It is acknowledged that only by effecting generational change in health and social care outcomes for today’s children can we achieve our long-term goals.

With a clear focus on four 'big' health outcome priorities; reducing harm from cancer, cutting cardiovascular disease, supporting people living with frailty, and enabling mental health and resilience, the Strategy ensures that resources are directed toward priorities that will enhance quality of life, reduce leading causes of death.

Our four ‘drivers’; leading for excellence, leading for prevention, leading for sustainability and voice at the heart, also support strong public engagement, economic growth and aim to lower costs across Humber and North Yorkshire by creating a more sustainable health and care system.



Our Golden Ambition: Children's plan to radically improve children’s wellbeing, health, and care

The Start Well Board was created to advance the ICP's 'golden ambition' by developing the Children's Plan. It strengthens partnerships across children's health, social care, public health, and education, promoting transformation, cultural change, and focusing resources on prevention and early intervention. Embracing the concept of 'Think person, think family, think community,' we have adopted a child-centered approach that prioritises the unique needs, strengths, rights, and voices of children, young people, and their caregivers in all decisions and actions. This includes equipping teams to focus on the holistic development of children and ensuring their experiences and realities are reflected in plans and policies.

Following a series of workshops and discussions with key stakeholders the framework is built around 3 key outcomes, reflecting the local outcomes in each Place:

- Children are Safe: Ensuring children are safe from harm and supported in their families and communities.
- Children are Healthy: Promoting healthier lifestyles and better physical and mental health for children and young people.
- Children are Thriving: Creating environments that support children's growth and development, encouraging them to reach their full potential.

By developing a population health management focus for children and young people, we will identify and provide effective support to those at risk of poor outcomes, preventing issues from arising or addressing them early before they escalate. The Children's Plan supports a Core20PLUS5 approach for children and young people. This approach aims to drive action within our integrated care system to improve health outcomes for children and young people, particularly around asthma, diabetes, epilepsy, oral health, and mental health, by ensuring better access to care, enhancing service delivery, and promoting health equity across these critical areas.

Unified Prescribing Formulary for Asthma

Collaborative efforts in the Children and Young People asthma programme have led to the creation of an all-age unified prescribing formulary, aimed at reducing SABA medication use and improving asthma management. Educational events have been organised to promote better asthma care and prevent future asthma-related deaths in children and young people.

Epilepsy

The Epilepsy Mental Health screening pilot was successfully implemented in the York Trust. This initiative has recruited young individuals for support groups in collaboration with the psychology team. The project utilises mental health screening questionnaires to identify concerns and provide appropriate interventions.

Diabetes

Poverty proofing training in Hull has increased Continuous Glucose Monitoring in low-income households from 12% to 40%, improving diabetes control and reducing long-term complications. This aligns Hull with the national average. A new initiative to provide repurposed mobile phones with free data is planned to further boost uptake.

Leading for Excellence

Our refreshed Joint Forward Plan in 2024/25 reflects the ICB's commitment to improving population health, tackling health inequalities, and delivering more integrated care across the region and sets out our approach for delivering the Integrated Strategy for Wellbeing, Health and Care, focusing on the four high impact interventions for the prevention of disease and the 'golden ambition'. The System Leaders Forum, which has oversight, has approved the principle of differential investment.

Empowering Collaboratives

We are strengthening collaboration across our system empowering providers to transform models of care to meet people's needs. Our five provider collaboratives have gone from strength to strength, each harnessing their collective expertise to address system challenges, develop peer support and resilience, and promote ideas exchange.

This year, the ICB and Mental Health Provider Boards approved the work to develop a contractual joint venture for Mental Health, Learning Disabilities, and Autism with a host organisation. The goal is to enhance service integration and delivery by pooling resources, expertise, and capabilities. This decision enables providers to innovate and transform service delivery, use resources more efficiently, reduce duplication, access more funding opportunities, and offer flexible, tailored services to better meet the population's needs.

Driving Improvement through Innovation and Research

Through the Innovation and Research and Improvement System (IRIS), we aim to establish a comprehensive support structure and culture that integrates research, innovation, and improvement as core elements of our business. This approach is designed to directly support and deliver on our ICP Strategy and Joint Forward Plan (JFP).

By supporting, enabling, and connecting our integrated care system and working with leading external partners, we are securing data driven and evidence-based solutions for our health and care grand challenges. Our unique approach brings people together to encourage and promote innovation, research, and improvement in health and care, increase access to research opportunities and scale up evidence-based practice. The IRIS hub for all activity with the following achievements in 2024/25:

- Communities of Practice: The communities of practice for innovation, research and improvement were established in 2023 to form strong peer support networks across the system and to facilitate the exchange of best practices and shared learning. This year we held 21 community of practice meetings and there was a 72% increase in membership taking the total number of members across all three communities to 389 people.

- IRIS and National Institute for Health and Care Research Applied Research Collaboration Yorkshire and Humber (NIHR ARC YH) Knowledge Mobilisation Networking Event: Held at the MKM Stadium in Hull, this co-hosted event was attended by 106 people and featured presentations from external partners who enable innovation, research, and improvement across the Yorkshire and Humber region. There were also workshops focused on ICS strategy priority areas (cancer, frailty, cardiovascular disease, and mental health in children and young people).

- R&D Support Services for Primary Care: we continue to facilitate and promote research initiatives in primary care and this year awarded competitive NIHR Research Capability Funding to four GP practices.

- Research Engagement Network (REN): IRIS and the VCSE Collaborative in partnership with York and Scarborough Teaching Hospitals and York St John University, secured additional funding from NHSE. This year 14 VCSE leads participated in “train the trainer” events, 83 research champions were recruited and a programme evaluation report was published.

Case Study 1 - Enabling Evidence-Based Adoption and Spread Through Evaluation

Evaluation of Digital Personalised Videos

A collaboration between Harrogate District Foundation Trust, Health Innovation Yorkshire and Humber, and IRIS has demonstrated that digital personalised videos delivered to patients after orthopaedic surgery could lead to a **67% reduction in follow-up appointments**. IRIS continues to assist in the adoption and spread of the innovation across HNY in collaboration with the Collaborative of Acute Providers.

Case Study 2 - Championing a System-Wide Culture of Continuous Improvement

NHS Improving Patient Care Together (NHS IMPACT)

IRIS conducted a continuous improvement cultural readiness assessment in the ICB and in response produced a continuous improvement proposal. The proposal provided a detailed review of the work to date, ideas on how to proceed with becoming a continuously improving ICB, and recommendations on how to proceed.

Case Study 3: Advancing Access to Data for Research and Data-Driven Decision Making

Born and Bred in Humber and North Yorkshire (BaBi HNY)

BaBi is a collective of local electronic birth cohorts. BaBi sites invite expectant mothers to participate in the project, allowing health researchers to access routinely collected data about them and their infants. In Humber and North Yorkshire (HNY), our goal is to utilise this routine data, both locally and system-wide, to enhance the health and wellbeing of families in our area and improve the overall health of our broader population.

IRIS brings together and connects BaBi Harrogate, BaBi York, BaBi Scarborough, BaBi Hull and East Riding, and BaBi Northern Lincolnshire to foster and promote collaboration across the system and to create opportunities for shared learning. In 2024/25, IRIS successfully led a bid to secure funding from the Yorkshire and Humber Secure Data Environment programme to enable data linkage and access to BaBi HNY data for research and innovation.

Cutting edge approaches to digital and data

Humber and North Yorkshire ICB are amongst the leading ICBs for record sharing across Care Provider Partners. By using the **Yorkshire and Humber Care Record** (YHCR) we can provide a holistic view of patient's records, for the purposes of direct patient care, to many of our care provider partners. Thirteen different clinical systems are securely connected to the YHCR

providing increased empowerment to care providers including GP, Local Authority, Hospital, Mental Health, and community providers, supporting improved decision making and outcomes.

In a report published in summer 2024 we identified that approximately 150 thousand records were being shared every month, resulting in an efficiency value of over 12 thousand days effort saved, with an associated value of £2.1million.

We are especially proud of the end-of-life pathway work carried out in North Lincolnshire, which used the shared record facilities to provide a voice for the patient for decision making around their care during the entire pathway. This resulted in:

- Only 14% of patients who were on an end-of-life pathway died in hospital, in accordance with their personal choices, compared to a national average of 42%.
- Ambulance crews being empowered for better decision making supporting a reduction of over 1,000 ambulance conveyances.

Improved patient access through a digital front door: Humber and North Yorkshire ICB are committed to ensuring equitable access to services for our population, no matter which access route is chosen by the patient. A priority commitment by the ICB is to better support those patients who choose to access services via a digital route, aligning to the NHS strategy of using the NHS APP as a single digital front door. This will allow additional capacity to be dedicated to those patients who are not digitally enabled or who choose traditional routes.

Currently 57% of our population who are over 13 years old and registered with a GP have registered for access to the NHS APP. Between 01/01/2024 and 31/12/2024:

- Our Population logged onto the App over 17 million times.
- Our Population managed over 107 thousand appointments via the APP.
- Our Population used the app to access Hospital digital services over 2 million times.

This equates to:

- Over 700 thousand hours saved for our population.
- Over 119 thousand hours saved for our primary care professionals.

Increased ICB Digital Maturity: Humber and North Yorkshire ICB recognise the importance of our staff being digitally enabled to allow them to work in the most efficient and supported way possible. Over the last year we have progressed significantly to adopt new technologies to improve and streamline processes, including:

- Adoption of cloud-based collaboration tools, allowing cross geography and partner working, reducing duplication.

- Adoption of AI tools to support administration processes, including minuting meetings, ensuring that staff time is used in the most efficient way possible.

- Consolidation of IT partners into a single partnership arrangement to allow us to adopt new ways of working in a more rapid fashion.

North Lincolnshire Case Study: Supporting more effective direct care interventions
In North Lincolnshire, there has been a strong emphasis on creating access to a unified dataset, or a series of interconnected datasets. This approach aims to support more effective direct care interventions, enable preventative and proactive support for individuals, and gain a deeper understanding of the health and social care needs of the population. This understanding spans across the entire area, by locality, by cohort, and most importantly, at a personalised level. This initiative aligns with the recently published Neighbourhood Health guidance, and the ICB is developing a suite of tools to facilitate this within North Lincolnshire.

Connected Humber and North Yorkshire (HNY)

During the year the ICB also progressed the ICP's Futures Group proposal to develop 'Connected Humber and North Yorkshire (HNY).' A key focus of the initial phase is the application of data to support our 'golden ambition' for children and young people, ensuring that practitioners have access to real-time, secure, and high-quality information. By enabling seamless information sharing, these tools will support a more coordinated approach to care, reduce duplication, and ensure that services are tailored to the specific needs of children and young people. A series of proof-of-concept pilots in North East Lincolnshire and York Places will test innovative approaches to service delivery, ensuring that the needs of children and young people are met through more integrated and responsive care models.

The development of the Connected HNY Database and HNY Insights will play a critical role in supporting integration efforts across health and care services. These platforms will provide data-driven insights to enhance decision-making, drive efficiencies, and improve patient outcomes and represent a significant step forward in leveraging data and innovation to enhance integration, improve service delivery, and create a more connected and person-centred health and care system.

Leading for Prevention: Our operating model

Organisational Development and Transformation

We are transforming our organisation to become an agile ICB able to flex, adapt and respond to new opportunities and challenges so that our organisation remains relevant and impactful within a rapidly changing system for wellbeing, health and care.

As we transform our organisation we will be guided by our shared values, and the behaviours we have agreed demonstrate them. Our values and behaviours will help us create a high-trust environment where transformation and innovation can thrive.

We are evolving our operating model by delegating more responsibility, resources and decision making to our providers, our five collaboratives and six places. We will transfer, in a managed way, those functions that can be better undertaken by other organisations. We will consolidate other functions so that they are done once for the system.

By embracing delegation and integration, we can focus on excelling at our system functions - functions that only an ICB can and must do. These are functions that enable Strategy, Assurance, and Governance and Leadership.

This means that alongside our responsibilities for clinical effectiveness, performance and quality, we will be consolidating and enhancing our capability in population health management and business intelligence, digital transformation, innovation, research and improvement, system workforce and public engagement.

In 2024 engagement started on our strategic vision for the future delivery of health and care services in Humber and North Yorkshire detailed in the Design for the Future (Blueprint).Emphasising the continued need to develop a more integrated care system that works seamlessly across different services and sectors it has a strong focus on preventing health issues, intervening early to improve outcomes and encouraging community involvement in health and well-being initiatives. The design of our services is leading to changes in the form of our organisations and aligning with the ICB's values and ambition to become a more agile organisation.

A new relationship with Place and Collaboratives:

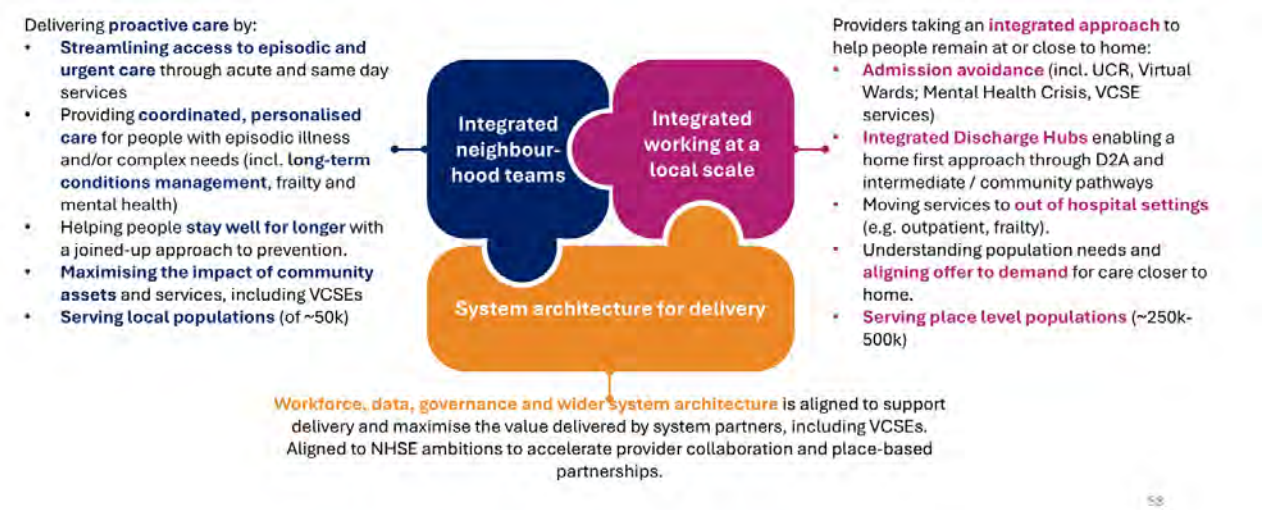
The ICB created legal and governance mechanisms to form Joint Committees and section 75 agreements across all six Places. This will support the upcoming 10-year Health plan, focusing on system transformation and integration. Examples of delivery for 2024/25 are in the Health and Wellbeing Strategy section of this report.

Integrated Neighbourhood Working

Setting out its approach to integrated neighbourhood working as described below, the ICB aims to provide proactive care for people with complex needs, including long-term conditions, frailty, and mental health issues. This involves a multidisciplinary team of professionals working together

to meet the needs of the individual. Our approach to integrated neighbourhood working is described in the following diagram:

HNY approach to integrated neighbourhood working:



The Neighbourhood Health programme for Humber and North Yorkshire (HNY) focuses on three key areas: delivering integrated neighbourhood working, integrated working at scale, and developing system architecture to support delivery. This is achieved through a collaborative approach involving the VCSE (Voluntary, Community, and Social Enterprise) and Provider Collaboratives, and Place.

In 2025, an overarching programme map was agreed, with the first phase delivered in 2024/25. This phase aimed to define our integrated neighbourhood footprints and guiding principles, establish baselines for our community and core offers, confirm population health management practices, and align our planning with digital, workforce, and estates requirements.

Neighbourhood team footprints have been identified in each Place, with Place leadership designated to support neighbourhood working. Local workshops have been conducted to understand neighbourhood working, leading to the development of local and system-level delivery plans. A maturity assessment tool has been created to support development, and an Integrated Neighbourhood Team (INT) training offer is now available across the ICB. The workforce transformation programme, Breakthrough, has identified INT working as one of its key priorities for the coming year.

Leading for Sustainability

Breakthrough HNY Workforce Transformation

In May 2024, the ICB launched year three of our Breakthrough HNY Workforce Transformation programme. Together we have developed a collaborative vision for how we will transform our shared workforce across all parts of the system, whilst meeting our current workforce challenges. Over 200 volunteers from all parts of the system have come together to work collectively on our ten workstreams, and all have made considerable progress in terms of both outcomes and

agreeing new ways of working between all organisations across our system. This has demonstrated what can be achieved through our partnership commitment to workforce transformation. The Breakthrough Storybook 24/25 - 1, Joining the Dots provides an overview of the work we have undertaken in 2023/24.

Supported by the survey findings, our fourth Workforce Summit in March 2025 identified key issues shared by every part of the system and there was a firm commitment that these could only be addressed by working together as a strong partnership with a shared 'One Workforce' vision. The Summit was a valuable opportunity to listen to and learn from all parts of our system. Our 2025/26 Breakthrough HNY programme has been informed by the Summit.

Sustainable Estate

As part of our Organisational Development and Transformation plan, this year we agreed and started to implement the ICB Corporate Estates Strategy, which aims to support agile working by reducing reliance on traditional offices and investing in fewer, higher-quality spaces for improved connection, efficiency, and wellbeing.

The preliminary evaluation of the ten corporate sites examined ways to identify and address underused estate, leading to a phased programme aimed at maximising use of sites, encouraging integration and reducing estate costs across the ICS.

Further information about our wider approach to sustainability can be found in the Performance Analysis section.

Outcomes led approaches: prioritising the causes

This year, we have developed the Shining a Light Methodology, which establishes a structured and data-driven approach to improving population health outcomes. This methodology leverages comprehensive intelligence packs, system mapping, benchmarking, and evidence-based interventions.

The intelligence packs offer a detailed analysis of population health trends, identifying key risk factors, disparities, and areas needing targeted intervention. System mapping provides a clearer understanding of how health and care services interact, highlighting gaps, inefficiencies, and opportunities for greater integration. Benchmarking measures local performance against regional and national standards, helping to identify best practices and areas for improvement. Finally, evidence-based interventions are designed and implemented to effectively address identified health challenges, ensuring that resources are used in the most impactful way.

By utilising this robust data intelligence, a sharper focus can be placed on the four major health priorities: reducing harm from **cancer**, cutting c**ardiovascular disease,** supporting individuals living with **frailty**, and enabling **mental health and resilience**. This targeted approach allows for more strategic investment, ensuring that interventions are tailored to the specific needs of the population.

Additionally, the methodology incorporates initiatives that enhance the **health and wellbeing of children and young people.** Through integrated strategies that align health, education, and

social care services, these initiatives aim to provide early support, improve health literacy, and create environments that foster long-term wellbeing. This holistic approach ensures that children and young people receive the necessary support at every stage of their development, helping to lay the foundation for healthier future generations.

By embedding data-driven decision-making and system-wide collaboration, this methodology strengthens the ICP's ability to drive meaningful and sustainable improvements in population health.

Clinical and Professional Leadership

The Clinical & Professional Group, chaired by the Executive Director of Clinical & Professional, has continued to meet during the year. This group brings together a wide range of clinical and professional colleagues to discuss topics and agree on actions for the clinical leadership community.

- In October 2024, the inaugural Clinical Summit for the ICS was held, focusing on clinical leadership development and supporting clinical colleagues in balancing organisational leadership roles with system-wide roles and ethical decision-making.

- The Clinical Network programme has linked different models of clinical networks within Humber and North Yorkshire to support clinical transformation against key strategic priorities. Two events were held to foster understanding and alignment with strategic priorities.

- The Pharmacy and Medicines Optimisation team has provided clinical leadership through initiatives like establishing a system-wide area prescribing committee, introducing a shared care enhanced service for GP practices, launching an independent prescribing pathfinder, and implementing quality initiatives to reduce harm from inappropriate prescribing.

- Primary-secondary interface groups were established across Humber and North Yorkshire to tackle issues causing delays and administrative challenges, leading to significant improvements in collaboration.
- A system-wide approach to neighbourhood health was rolled out, with training and development for health and care leaders to support integrated neighbourhood teams and better care for residents with complex health and social challenges.

- Four primary Care Networks (PCNs) were nominated for a national PCN pilot to deliver improved access, continuity of care, digitally enabled primary care, and holistic, integrated models of care.

- The ICB Cardiovascular Disease Prevention programme has brought together partners to develop a coherent approach to identifying and tackling risk factors associated with cardiovascular and cerebrovascular disease, leading to increased diagnoses and access to support and treatment.

- In the cancer agenda, the Clinical Lead has led educational events to improve patient care, developed and analysed an audit of skin cancer referrals, and focused on early cancer diagnosis initiatives.

- The ICB has developed a gap analysis, position statement, and options appraisal to ensure it can discharge its statutory responsibilities and provide appropriate support for Health Protection Incidents.

The ICB has a Clinical Effectiveness Unit (CEU) which acts as the single point in the system for coordination of all clinical policy and pathway development. The ICB inherited >140 clinical commissioning policies from across the ICB footprint and has completed a full review and harmonisation exercise, in liaison with colleagues from Places and providers across the system resulting in a single set of policies to be used from April 2025. The team has also gathered details of pathways and developed a harmonisation plan, which will commence in 2025/26.

Performance appraisal

NHS objectives and performance against the NHS plan

The performance appraisal will highlight the performance priorities established in HNY ICBs Annual Operating Plan 2024/25. While the overall performance framework covers a wide range of themes such as quality of care, patient experience, public health statistics the monthly performance report focuses on targets linked to the national operating planning guidance. The ICBs framework tracks the progress on 28 metrics from the 2024/25 NHS Operational Plan with particular emphasis on 10 key priorities that align with the ICB's long term goals or national focus.

This appraisal will summarise annual performance of these priority indicators, highlight delivery against plan, improvements and any risks. It will also summarise key actions delivered that supported performance improvement.

The 10 priority indicators are:

- Urgent Emergency Care (A&E 4 hour waiting time)
- Elective Care (RTT 65+ week wait patients)
- Diagnostics (proportion of patients waiting 6+ weeks)
- Cancer (patients treated under 62 days all routes of referral)
- Primary Care (proportion of people seen within 14 days)
- Prevention (percentage of patients with hypertension treated to NICE guidelines)
- Community (number of patients waiting over 52 days)
- Mental Health (Dementia Diagnosis Rate)
- Mental Health (inappropriate out of area placements for acute patients)
- Mental Health (access to children and young people's services)

Urgent and Emergency Care (UEC)

By March 2025, 70.8% of patients arriving at emergency departments were seen, treated, and either admitted or discharged within four hours, an improvement on the previous year, though just short of the 78% target. Emergency departments handled over 648,000 patients, a 5% rise from 2023/24. Ambulance response times for serious cases also improved significantly, dropping from nearly 40 minutes to just over 29 minutes, thanks to better handover processes between ambulance crews and hospitals.

Key actions to support improvements included:

- Trusts across the ICB implemented a programme to improve ambulance handover processes to a ceiling of no more than 45 minutes. This reduced delays, improved patient flow and allowed ambulances to respond to other calls more quickly, enhancing patient safety. This initiative will continue into 2025/26, building on early successes.
- Significant capital investment was directed modernising facilities, expanding capacity and improving patient flow in various Emergency Departments across the ICB.
- Work has been undertaken to assess the ICB Urgent Treatment Centres (UTCs) against national standards aiming to ensure consistency, identify areas for improvement and increase UTC utilisation. This work will continue into 2025/26.
- The No Criteria to Reside (NCTR) initiative resulted in a reduction of patients in beds who did not need to be there, improving cross sector collaboration between community and secondary care providers. Notable improvements were seen in Hull, York and Scarborough Places.

Planned Care

The number of patients waiting over 65 weeks for planned care dropped from 336 to 165, a big step forward, even though the goal of zero long waits was not achieved. Over the year, planned care teams delivered more than 2.1 million appointments, showing clear growth from the previous year. These improvements were made possible through strong collaboration between the ICB and hospital providers, with clinical networks playing a key role in sharing best practice and driving progress together.

Key actions to support improvements included:

- Development of clinical networks (see section on Clinical and Professional Leadership).
- Efforts throughout the year in perioperative care have been concentrated on enhancing productivity by minimising same-day cancellations and standardising pre-assessment pathways and policies.
- The outpatient network with representation from members across both primary and secondary care has reduced missed appointments from over 6% to 5.4% by sharing best practice. They have reviewed digital software for standardising services and examined Advice First Models, leading to high diversion rates through systems like Advice & Guidance.

- Our speciality networks have been working on efficiency gains to drive productivity, with a key area of focus being to improve day case rates. All networks have made great progress throughout the year.

Cancer Services

Cancer services aimed to treat 70% of patients within 62 days, and while the final figure of 65.7% fell slightly short, there were still important gains. Compared to 2023/24, an additional 1,780 patients received treatment, with more of those starting within the 62-day window, showing real progress in expanding access and speeding up care.

Key actions to support improvements included:

- Launch of the inaugural Cancer Innovation Grants scheme, which attracted 47 applications and awarded funding to 11 projects, totalling £400,000.
- Delivery of 13,463 initial lung health check assessments resulted in the detection of 107 cancers, two-thirds being early stage.
- Training for more than 1,550 Cancer Champions and collaborated with local organisations to develop Cancer Champions Community Trainers. The Cancer Alliance has trained 7,362 Cancer Champions since the programme's launch in 2018.
- Support for the introduction of artificial intelligence in the form of auto-contouring software in radiotherapy on a pilot basis to improve treatment quality.
- All areas of Humber and North Yorkshire are now served by a breast pain clinic with the launch of a breast pain clinic for Hull and East Yorkshire .
- Establishment of a hepatobiliary pancreatic cancer network across the North East and Yorkshire region, as part of work to bring healthcare professionals together to improve services for patients with rare tumours.
- Supporting local trusts (which provide cancer services) in Humber and North Yorkshire to participate in national cancer vaccine trials.

Diagnostic Services

Diagnostic services made good progress in 2024/25, with fewer patients waiting over six weeks for key tests, 25.1% compared to higher levels the year before. While the target of 17% wasn’t quite reached, teams carried out over 788,000 diagnostic tests, an increase of more than 41,000 from the previous year, helping more people get the checks they need, faster.

Key actions to support improvement included:

- Six Community Diagnostic Centre sites are now operational including new centres in Scunthorpe and Grimsby. These sites will provide up to 300,000 additional tests annually.
- Acceleration of Radiographer training resulting in 18 trainees inducted in January 2025, reducing the time to professional registration by 30% and enhancing the local workforce pipeline by 30% from January 2027.

- Introduction of New MRI software increasing activity at Northern Lincolnshire and Goole hospitals by an average of 20%, across 12 months for examinations.
- Strengthening the Endoscopy Network by meeting regularly and developing relationships with Operational, Clinical, Nursing Teams and Cancer Delivery Groups across the system.

Primary Care Services

By March 2025, 86.7% of people were seen in primary care within 14 days, meeting the 85% target, though slightly down from the previous year. Overall, primary care remained incredibly busy, with over 11.7 million appointments delivered, more than half a million more than in 2023/24, showing just how much demand has grown and how services have stepped up to meet it.

Key actions to support improvements included:

- Additional Primary Care capacity agreed across Medical and Pharmacy services through the winter to support the wider urgent care system.
- Pharmacy First mobilisation, further expanding access to healthcare in an appropriate setting.
- Additional urgent Dental capacity delivered to support improved timely access to Urgent Dental Care for our population.

In addition, there was a mobilisation of three new Dental Practice Providers securing access to Dental service for those populations.

Community Care Services

Community care services had reduced the number of patients waiting over 52 days to 939—comfortably meeting the target of 1,109 and showing clear improvement from the previous year. Capacity grew by over 16% during the year, helping more people get the care they need. However, some services are still under pressure, and work continues to tackle longer waits in those areas.

Key actions implemented to support these improvements included:

- Software has now been deployed across all acute Trusts starting with Hull University Teaching Hospitals (HUTH). HUTH reported a 30% increase the number of complex discharges managed per day along with an 8% reduction in their number of patients with No Criteria to Reside.
- Rates of referrals are above plan into structured education programmes for Diabetes Prevention Programme and Type 2 Diabetes Path to Remission (formerly low-calorie diet).
- Some of the specific impacts seen in the stroke programme include reducing the onset to arrival time at Scunthorpe hospital, increasing the thrombolysis rate at Scunthorpe hospital and faster door to scan times facilitated by the uptake of pre-hospital video triage (PVT) in Hull.

Mental Health, Learning Disabilities and Autism (MHLDA)

While not all targets were met, there was clear progress across metrics for Mental Health, Learning Disabilities and Autism: Dementia Diagnosis Rate (DDR), inappropriate out of area placements for acute patients and access to children and young people's (CYP) mental health services.

Dementia diagnosis rates showed steady improvement over the year. The target was to achieve a diagnosis rate of 62.54% with performance of 61.7% falling slightly short but marking a significant improvement from 58.6% in March 2024. This progress was underpinned by an 8% increase in the number of patients diagnosed compared to the previous year.

Key actions implemented to support these improvements included:

- A co-produced five-year dementia strategy was launched across Humber and North Yorkshire.
- A pilot programme for primary care-led dementia diagnosis was introduced in areas with the lowest DDR.
- The Dementia Steering Group led a review of Mild Cognitive Impairment (MCI) pathways to enhance early identification and support.

Inappropriate out of area placements for acute mental health patients remained a challenge. Performance stood at 22 in March 2025 against a target to reduce placements to five. Throughout the year, placement numbers fluctuated significantly with a pattern of variability consistent over the past two years.

Key actions implemented to support these improvements included:

- The ICB and the collaborative of MHLDA providers began mapping current service capacity and conducting a gap analysis. This work aims to identify unwarranted variation and inform future service planning to reduce reliance on out of area placements.

Access target for children and young people mental health services also fell short of the target of 21,300 new contacts per month. In March 2025 performance reached 20,765. Despite this, overall provision increased due to the opening of new services. However, due to the growing complexity of cases requiring more appointments this indicator, which only counts new unique patients and not total contacts, has been impacted.

Key actions delivered to support these improvements included:

- Development began on the HNY CYP Mental Health Strategic Transformation Plan (2025–2030), which focuses on early intervention, reducing waiting times, improving support while waiting, and addressing inequalities in access.
- A deep dive into data related to Children and Young People (CYP) services included the development of the HNY CYP Mental Health data dashboard to ensure regular reporting on access, waiting times and outcomes. Work is underway with CYP place leads to undertake a review in a number of areas where there are concerns about accuracy of the data.

March Performance

The charts below show the year-end performance against the expected target. They also display the nature of performance and whether it is showing overall improvement compared to previous years as well as the performance in the context of the volume of care being provided across the different sectors. The final series of charts shows performance for the year against the full list of metrics in the operating plan with the SPC icon demonstrating where there is improvement, worsening or variable progress.

This chart shows only two of the priority indicators delivered their year-end target.

Provision compared to previous years

This chart shows that provision of care has increased in the majority of cases compared to 2023/24:

Metric	22/23 Outturn	23/24 Outturn	24/25 Outturn	23/24 to 24/25 Difference	
Primary Care Appointments	10,372,012	11,193,278	11,716,158	522,880	4.7%
Emergency Department Attendances (All sites)	559,545	616,627	648,690	32,063	5.2%
Emergency Department Attendances (All sites) >4hrs	348,409	395,359	430,886	35,527	9.0%
Cancer 62 day Pathways Completed (Total all sources)	7,008	7,521	9,277	1,756	23.3%
Total Outpatient Attendances (Spec Acute) (First & Follow Up)	1,749,066	1,784,034	1,926,213	142,179	8.0%
Total Elective Admissions (Spec Acute)	225,380	254,102	261,615	7,513	3.0%
RTT numbers 52+ weeks	9,316	5,190	4,468	-722	-13.9%
Diagnostic Tests (9 priority tests)	686,602	747,055	788,775	41,720	5.6%
Community Care Contacts	21,255	28,885	33,658	4,773	16.5%
Number of patients treated with Hypertension as per NICE Guidance	209,615	212,192	228,869	16,677	7.9%
Patients were Diagnosed with Dementia	14,329	15,033	16,235	1,202	8.0%
Community Mental Health contacts	15,040	14,490	17,680	3,190	22.0%
Learning disability Health checks	7,602	7,740	7,999	259	3.3%
Talking Therapies contacts	33,515	33,610	32,820	-790	-2.4%
CYP Contacts	17,765	21,595	20,765	-830	-3.8%
Perinatal care contacts	992	1,139	1,290	151	13.3%
Learning Disability and/or Autism Inpatients (adult)	65	60	70	10	16.7%
Learning Disability and/or Autism Inpatients (children)	7	7	15	8	114.3%

The full list of metrics with performance against plan:

Area	Metric	National Objective	Detail	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	VAR.	ASS.
Urgent and Emergency Care	Ambulance Response Times CAT2 - Mean - HNY ICB		Plan	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00		
			Actual	00:38:43	00:36:48	00:34:48	00:31:22	00:41:20	00:47:44	00:44:36	00:52:07	00:34:39	00:30:10	00:29:21		
Urgent and Emergency Care	A&E 4 hour waiting times - HNY Provider Total	78% by March 2025	Plan	66.8%	67.6%	68.2%	68.2%	68.3%	69.2%	68.2%	69.0%	69.2%	69.9%	73.2%		
			Actual	67.4%	67.2%	67.3%	68.6%	67.0%	65.5%	65.5%	62.3%	65.1%	66.3%	66.9%		
Elective care	18 Week Referral to Treatment Waiting Times - Waiting List - HNY Provider Total		Plan	185245	185309	185502	185569	185936	186049	186174	186488	185713	185449	185187		
			Actual	191516	192496	191663	191008	190579	192543	189591	188835	186679	188805	188837		
Elective care	18 Week Referral to Treatment Waiting Times - 65+ Week Waits - HNY Provider Total	0 by Sept 2024	Plan	244	165	95	33	0	0	0	0	0	0	0		
			Actual	242	214	147	119	44	44	59	132	177	225	165		
Elective care	18 Week Referral to Treatment Waiting Times - 52+ Week Waits - HNY Provider Total		Plan	6341	6349	5923	5385	4819	4322	3910	3523	3280	3218	3269		
			Actual	4717	4593	4527	4911	4531	4675	5071	4914	5077	5094	4468		
Elective care	Proportion of Outpatients Attendances that are 1st Appointments or Procedures - HNY Provider Total		Plan	43.2%	43.4%	43.5%	43.4%	43.3%	43.1%	42.9%	43.3%	42.8%	43.6%	43.2%		
			Actual	45.8%	46.7%	45.8%	46.6%	45.3%	45.9%	45.7%	46.4%	46.7%	47.1%	47.5%		
Diagnostics	Diagnostics Test Waiting Times: Proportion of Patients Waiting 6+ Weeks for the 9 Targeted Tests - HNY Provider Total		Plan	25.0%	23.9%	23.7%	23.0%	20.7%	19.9%	18.7%	17.6%	17.2%	17.2%	17.9%		
			Actual	25.1%	24.2%	21.4%	24.3%	21.9%	19.4%	19.9%	22.6%	25.6%	20.2%	25.1%		
Cancer	28 Day Faster Diagnosis Standard - HNY Provider Total		Plan	74.1%	74.4%	74.9%	74.7%	74.7%	74.6%	74.9%	74.8%	75.1%	76.1%	77.0%		
			Actual	73.8%	75.2%	74.4%	73.8%	73.7%	76.4%	76.3%	75.2%	68.5%	73.7%	72.9%		
Cancer	Cancer 62 Day Waits - All referral routes - HNY Provider Total	70% by March 2025	Plan	61.5%	62.0%	64.3%	63.7%	64.4%	65.7%	66.0%	66.0%	66.3%	67.8%	70.3%		
			Actual	64.5%	65.5%	64.2%	69.0%	62.5%	64.8%	66.3%	66.6%	62.6%	63.8%	65.7%		
Cancer	Unadjusted percentage diagnosed at cancer stage 1 & 2 - HNY Provider Total		Plan													
			Actual	59.3%	58.2%	57.2%	59.7%	62.2%	62.7%	58.5%	57.3%	56.9%	57.9%			

Area	Metric	National Objective	Detail	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	VAR.	ASS.
Primary Care	Appointments in General Practice - HNY ICB		Plan	927735	856632	971766	863422	1013124	1163072	957563	872289	926171	814148	1047724		
			Actual	959179	901100	1006489	882305	950680	1240000	990246	857559	1030847	923041	974758		
Primary Care	Proportion of Appointments in General Practice Booked and Seen the Same Day - HNY ICB		Plan													
			Actual	42.3%	41.3%	41.8%	42.1%	40.5%	34.7%	39.8%	43.1%	41.8%	41.1%	40.8%		
Primary Care	Proportion of Appointments in General Practice Booked and Seen Within 14 Days - HNY ICB		Plan	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%		
			Actual	87.5%	87.5%	88.1%	88.1%	87.7%	87.5%	87.5%	88.1%	87.6%	87.9%	86.7%		
Primary Care	Units of Dental Activity Contracted - HNY ICB		Plan		100.%			100.%			100.%					
			Actual		84.%			80.%			80.%					
Prevention & Health Inequalities	Percentage of patients with hypertension treated to NICE guidance - HNY ICB		Plan	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%		
			Actual	77.1%	78.0%	73.1%	73.5%	73.3%	74.2%	74.6%	75.3%	76.2%	76.7%	79.4%		
Prevention & Health Inequalities	Percentage of patients (25-84 years) with CVD risk score greater than 20% on lipid-lowering therapies - HNY ICB		Plan	65.0%	65.0%	65.0%	65.0%	65.0%	65.0%	65.0%	65.0%	65.0%	65.0%	65.0%		
			Actual	73.4%	74.7%	75.5%	76.0%	76.5%	76.6%	76.8%	77.0%	77.2%	77.6%	78.1%		
Community	Total Number on Community services waiting list - HNY Provider Total		Plan	19097	19097	18713	18713	18713	18417	18417	18417	18200	18200	18200		
			Actual	20722	21974	21885	22445	22006	20422	20146	18775	19947	19167	20981		
Community	Total Number on Community Services waiting list over 52+ weeks - HNY Provider Total		Plan	1138	1138	1174	1174	1174	1148	1148	1149	1109	1109	1109		
			Actual	1096	1206	1085	1000	1014	1044	1015	888	980	902	939		

Area	Metric	National Objective	Detail	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	VAR.	ASS.
Learning disability & autistic people	S029a: Inpatients with a learning disability and/or autism per million head of population - HNY ICB		Plan	33.1	33.1	33.1	33.1	33.1	33.1	33.1	33.1	33.1	33.1	33.1		
			Actual	37.5	36.0	50.0	47.1	47.1	50.0	47.1	49.3	51.5	52.9	51.5		
Learning disability & autistic people	Learning disability registers and annual health checks delivered by GPs - HNY ICB		Plan	3.7%	3.7%	5.3%	5.4%	5.4%	6.0%	6.1%	6.1%	9.9%	9.9%			
			Actual	5.3%	4.6%	5.9%	5.0%	5.5%	6.8%	7.0%	6.6%	10.1%	10.%			
Learning disability & autistic people	Reliance on inpatient care for people with a learning disability and/or autism - Care for children - HNY ICB		Plan	9.0	9.0	9.0	9.0	9.0	9.0	9.0	9.0	9.0	9.0	9.0		
			Actual	30.0	27.0	24.0	24.0	33.0	30.0	30.0	36.0	36.0	39.0	45.1		
Mental Health	Estimated diagnosis rate for people with dementia - HNY ICB		Plan	60.0%	60.2%	60.4%	60.6%	60.9%	61.1%	61.3%	61.6%	61.8%	62.1%	62.5%		
			Actual	58.6%	59.2%	59.6%	59.8%	59.8%	60.1%	60.5%	60.2%	60.3%	60.3%	61.7%		
Mental Health	Inappropriate adult acute mental health Out of Area Placement (OAP) Patients - HNY ICB		Plan	19	16	14	13	11	9	9	7	6	5	5		
			Actual	30	20	13	12	29	18	16	13	29	34	22		
Mental Health	E.H.13: Percentage People with severe mental illness receiving a full annual physical health check and follow up interventions - HNY ICB		Plan		55.2%			60.3%			64.9%					
			Actual		59.2%			56.8%			58.3%					
Mental Health	E.H.31 Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses - HNY ICB		Plan	14765	14765	14765	14765	16360	16360	16360	16360	16360	16360			
			Actual	16555	16605	16770	16895	17160	17430	17570	17655	17665	17870			
Mental Health	Women Accessing Specialist Community Perinatal Mental Health Services - HNY ICB		Plan	1284	1284	1309	1309	1309	1335	1335	1335	1389	1389	1389		
			Actual	850	910	975	1030	1095	1170	1215	1255	1295	1290	1290		
Mental Health	Access to Children and Young People's Mental Health Services - HNY ICB		Plan	21690	21690	21690	21690	21690	21690	21690	21690	21690	21690	21690		
			Actual	21445	21260	20965	20750	20600	20515	20345	20060	20075	20270	20765		
Mental Health	Access to NHS Talking Therapies - HNY ICB		Plan	2998	3298	3012	3156	3012	3270	3270	2824	3386	3078	3078		
			Actual	2770	2375	2815	2570	2880	3205	2720	2465	2895	2460	2460		

Key - blue represents delivery and the blue VAR. icon represents improving. Orange is not achieving or worsening, and grey is variable.

Areas requiring further improvement.

- Urgent and emergency care remains under pressure. This continues to affect patient experience and outcomes, particularly in more vulnerable communities. To tackle this, system wide plan and responsibilities have been agreed for 2025/26 to drive improvement and reduce variations in outcomes.

- In elective care, long waits have reduced but the overall waiting list has not. Reducing this backlog is a priority for improving Referral to Treatment (RTT) performance, with coordinated action planned across the system.
- Diagnostic activity has increased but waiting lists remain high. A review of demand and capacity is planned in 2025/26 to support RTT and cancer performance.
- Cancer performance has improved overall but performance varies by provider. Backlogs and rising demand remain challenges. Providers have initiated a considerable increase in the treatment provision to address this and to reduce harm from cancer.
- Community services continue to face long waits, particularly around access to children's speech and language therapies. Broader improvements across community care are planned for the year ahead.
- Improving access to mental health services, especially for children and young people is a key priority for the ICB. Therefore, improving access to mental health services is essential for performance improvement. Plans for 2025/26 focus on expanding access and improving autism diagnostics, supporting long-term wellbeing goals.

Key issues and Risks

The approach taken by the ICB around the management of risk is set out in the Annual Governance Statement. The section on The annual governance statement (provides more detail.

There were two explicit risks, namely A1 and A2, that focus on the important areas of patient safety and quality and the delivery of the 2024/25 Operational Plan, with mitigating actions put in place throughout the year to ensure that focused effort was directed towards the delivery of the actions to achieve the agreed trajectories.

In addition to managing the risks identified as a threat to the delivery of the strategic objectives, during 2024/25, the ICB Board receives a receives a monthly report at each Board meeting where Board Members are asked to review and approve the changes to the BAF. During this time, the Board also agree any actions and consider any further areas of risk that may impact on the delivery of the ICB strategic objectives.

Strengthening the Right to Choose: Implementing Patient Choice and Provider Selection

The ICB has fully implemented the Health Care Services (Provider Selection Regime) Regulations 2023 which came into force in January 2024. We have put in place an accreditation process to enable providers to express an interest and be awarded a contract to offer patient choice for providers under Right to Choose.

The ICB's accreditation process, under Direct Award Process B was created to assess the suitability of a provider to deliver the relevant financial, legal, and regulatory requirements to assure the ICB that the provider could offer patient choice services. Following feedback from providers and the NHSE Choice Team, the process was reviewed and amended in May 2024 to include quality, clinical effectiveness, and governance in the accreditation process. The ICB's

process is available for providers on the website and a panel including representatives from clinical, nursing and quality supports the accreditation process. Communications through ICB usual stakeholder bulletins have been used to support understanding and use of patient choice across the system.

Performance analysis

This section sets out an analysis of the mandatory requirements for performance analysis for ICBs. It explains how the ICB has discharged its general duties as set out in the National Health Service Act 2006 (as amended).

How does ICB measure its performance?

During 2024/25 the ICB reviewed the performance reporting framework to support the board in having a clearer understanding of delivery against the plan, whether it is improving or not and what actions are being taken. Although **all** indicators set out in the annual operating plan are reviewed and included in the Board update, for purposes of clarity, ten key priority indicators were agreed. Performance was also provided at both a provider and Place level where appropriate. Performance assurance is a critical element of good governance, accountability and supports decision making.

The performance framework in 2024/25 is aligned to the operating model and governance arrangements (six Places, five collaboratives, the ICB and its committee structure).

The work is underpinned by several principles to ensure:

- we reduce duplication and we develop one version of the truth, that can be used by multiple elements of the system.
- that the information and assessment is as timely as possible.
- that we balance quantitative assessment (e.g. delivery against plan targets and trajectories) with qualitative / narrative assessment regarding actions that are being taken, or that give context to performance delivery.
- that our reporting is automated insofar as possible – allowing time for analysis and a focus on narrative that describes the story.
- That performance delivery is understood not just in percentage terms, but also with an understanding of the changing volumes in the numerator and denominator.
- There is an understanding of cross sector narratives e.g. an increase in delivery of a performance in one sector may adversely affect delivery in another.

To enable the ICB to perform its responsibility HNY has developed an Integrated Board Report in line with recommendations made by NHS Making Data Count.

Where possible, performance is described in narrative terms, tables, and SPC charts and at the ICB Board level is based on validated data. Whether an indicator is improving or worsening is managed through statistical process control (SPC) to remove any bias in describing improvement.

The report places performance charts alongside objective analysis and key actions being

taken and includes a summary cover sheet that covers discussions at the meetings and committees below the Board that may give greater context to the monthly performance.

The report to the ICB Board is just one aspect of the overall performance framework that includes information being shared and expanded on in the relevant committees that sit below the Board as well as the System Oversight and Assurance Group (SOAG); the framework brings together programme and Place leads from across the system. There are also SOAG meetings with individual providers that go into further detail as well as Tiering meetings that are led by NHSE but supported by ICB representation.

There are agreed data sources and reports that are available at a programme level that support key initiatives and actions, and these same sources are accessed and included in the SOAG performance report that in turn forms the basis of the ICB Board report.
https://humberandnorthyorkshire.icb.nhs.uk/meetings-and-papers/

Maternity and Neonatal Transformation

Maternity and neonatal services have seen significant improvement over the last year, particularly in terms of better service user involvement, more robust governance processes that meet Perinatal Surveillance standards and more obvious shared learning between maternity and neonatal services and between sites and Trusts.

During 2024/25, the Local Maternity Neonatal Systems (LMNS) network has implemented work around better and more consistent birth education that is accessible to all our populations and communities and has put in place a triage service for 'birth reflections' provision to help those who have had a difficult perinatal journey get support more quickly. In addition, daily monitoring systems are in place that identify where the pressures are in the system and where families are waiting too long for these interventions enabling better coordination of support and waiting times are showing a downward trend from the start of 2024 onwards.

We have maintained a focus on contributory factors for pre-term birth such as smoking cessation across the system and embedding weight management services in pregnancy in targeted areas. We have increased the information available around how to have a healthy pregnancy, provided more guidance around issues such as Foetal Alcohol Syndrome support for those impacted, and increased the numbers of women and birthing people with gestational diabetes who are referred into the National Diabetes Prevention Programme from 0.2% to 42% over the duration of the year.

Case Study: Perinatal Pelvic Health Service

Trusts received funding for new physiotherapy and midwifery roles to support an ambition to improve pelvic health resources. New roles are in place, training and new equipment has been provided to ensure high quality services, and a communications package has been developed.

Case Study: Single Maternity IT System

During 2024/25 we also supported the implementation of a single Maternity IT System in each of the maternity providers, linking it to the Yorkshire & Humber Care Record. This provides digital record keeping and access for service users to information via an app. This means that when women and birthing people move around the area, their records can travel with them – supporting them in choosing care, but also our safeguarding teams, health visitors and primary care. We have also engaged with partners to ensure our users are not digitally excluded because of this change and can still access what they need in other formats and languages.

Case Study: Midwifery Workforce

A new role focuses on supporting recruitment and retention in our workforce. This includes looking at the diversity of our workforce, examining how it mirrors our community, supporting succession planning in key clinical and geographical areas, and working with local education providers to put on relevant courses for those who want to grow in their career. We are also working with universities to commence the provision of midwifery apprenticeship courses from September 2026.

Mental Health

The Mental Health, Learning Disabilities and Autism Collaborative has continued to work towrds its priority areas to better support the health and wellbeing of our population and deliver safe and quality mental health, learning disabilities and autism services. The ICB is planning to enter a Joint Venture with the Collaborative in 2025. This will enable greater partnership working to reduce unwarranted variation, bringing consistency both in terms of access to services and our pathways, yet flexing where appropriate to meet the differing needs across our footprint. It will also support best practice, mobilising what is proven to work well across the area, enhancing the prevention and early intervention offer and the level of quality of care and treatment and improving the experience of our patients.

The table below shows that the ICB met the required Mental Health Investment Standard for 2024/25 with an overall increase in funding of £20.467m.

Financial Years	2023/24 £ 000's	2024/25 £ 000's
Mental Health Spend	303,724	324,191
ICB Programme Allocation	3,915,197	4,229,017
Mental Health Spend as a proportion of ICB Programme Allocation	**7.76%**	**7.67%**

However, the Mental Health Spend as a proportion of the overall ICB programme allocation has marginally reduced. This is due to the significant increases in overall ICB programme allocation received for other specific areas of spend such as the Pay Award and the Elective Recovery Fund.

Children and Young People (CYP) safeguarding

The ICB is a strong system leader supporting the needs of children and young people.

Humber and North Yorkshire Integrated Care Board (ICB) must ensure strong safeguarding arrangements for both the ICB, and the health services it commissions. Safeguarding practices evolve with feedback from lived experiences, large-scale enquires, and legislative reforms. The ICB's safeguarding arrangements are designed to adapt to these changes, consistently applying principles and duties to protect children and adults, with their wellbeing at the heart of what we do.

As part of the multi-agency safeguarding arrangements for children the ICB Chief Executive is the Lead Safeguarding Partner (LSP) with senior leadership and accountability for safeguarding across the ICB sits with the Executive Director of Nursing also appointed as the Delegated Safeguarding Partner (DSP). Operational leadership is provided by the Deputy Director of Safeguarding. Safeguarding teams based in each Place support the delivery and oversight of statutory duties working closely with NHS providers, our Local Authority and Police statutory partners, and wider system partners.

The published multi-agency safeguarding arrangements for each Place are available below:

Place	Published MASA arrangements
North Yorkshire	NYSCP
York	https://www.saferchildrenyork.org.uk/downloads/file/17/cyscp-local-safeguarding-arrangements
Hull	https://www.hullcollaborativepartnership.org.uk/downloads/file/79/hscp-multi-agency-safeguarding-arrangements-2024-2025
East Riding	https://downloads.eastriding.org.uk/erscp/docs/about-erscp/East%20Riding%20Safeguarding%20Children%20Partnership%20MASA%202024.pdf
North Lincolnshire	https://www.northlincscmars.co.uk/wp-content/uploads/2023/09/CMARS-Local-Arrangements-24-25.pdf
North East Lincolnshire	https://safernel.co.uk/wp-content/uploads/2024/12/NEL-SCP-Local-Arrangement-2024-2025-updated-December-2024.docx

Robust governance arrangements are now embedded, and the establishment of the ICB Safeguarding Committee which facilitates the monitoring of areas of risk, oversees the adoption and spread of learning and best practice, and receives Place-based oversight and assurance. Formation of a virtual safeguarding hub brings together the safeguarding resources across the ICB, formalising existing collaborative ways of working and allowing for consistent approaches to policy and process development and broader dissemination of learning across the health economy.

Statutory Reviews

Multi-agency statutory reviews are processes for learning and improvement following a significant safeguarding event, and all NHS agencies and organisations must participate in a statutory review if requested to do so. There has been an increase in the number of statutory reviews undertaken and contributed to throughout 2024/25 which are at various stages of completion and are set out in the table below.

Rapid Reviews (RR)	Safeguarding Children Practice Review (SCPR)	Safeguarding Adults Review (SAR)	Domestic Homicide Review (DHR)	Mental Health Homicide Review (MHR)	Independent Investigation (II)
10	6	30	33	3	0

Themes and trends arising from these reviews have included, but are not limited to, a lack of professional curiosity and professional challenge, the need for improved information sharing, the identification and responding to domestic abuse, injuries to non-mobile infants, and the identification of and working with, neglect.

Examples of Applying Learning into Practice

North East Lincolnshire: North East Lincolnshire has identified child neglect as a priority area of focus for the Safeguarding Children Partnership (SCP). The Deputy Designated Nurse is leading the revision of the neglect strategy and developing a neglect toolkit on behalf of the SCP.

North Yorkshire: Following a thematic review into three cases of non-accidental injury in non-mobile babies, the North Yorkshire Safeguarding Children Partnership (NYSCP) has agreed to undertake a campaign aimed at developing professionals' safeguarding skills when working with parents of new infants. The campaign will focus on parental mental health, coping with crying (ICON), and SUDI risk minimisation.

Hull: Following a Safeguarding Adults Review (SAR) in Hull, which identified exploitation and cuckooing, the Yorkshire and Humber Probation Service has introduced Multi-Agency "Cuckooing" Management Meetings (MACAP). These meetings provide front-line professionals with a multi-agency framework to facilitate effective working with adults or children who are at risk due to cuckooing.

Sadly, across some areas of the ICB there continues to be a high number of suspected suicides during the last year, with more cases identifying a potential correlation with domestic abuse. Suicide prevention has been identified as a priority theme and has gathered a multi-agency response to raise awareness of this issue and begin to understand and identify associated themes and trends. The ICS is taking a strategic approach to address this issue, working collaboratively across all areas to implement learning and new initiatives and share good practice.

Compliance with Safeguarding Accountability and Assurance Framework (SAAF)

ICB confirmatory statement that statutory assurance processes set out in the Safeguarding Accountability and Assurance Framework (SAAF) have been followed.

The purpose of the Safeguarding Accountability and Assurance Framework is to set out clearly the safeguarding roles and responsibilities of individuals working in NHS funded care settings and NHS commissioning organisations. The Executive Director of Nursing for Humber and North Yorkshire ICB ensures adherence to the Safeguarding Accountability and Assurance Framework through the development of effective local safeguarding arrangements, which seek to prevent and protect individuals from harm or abuse regardless of their circumstances. Safeguarding

governance arrangements have been developed and embedded to ensure all elements of the statutory assurance processes set out in the Safeguarding Accountability and Assurance Framework are acted upon and reported in line with national guidance. In accordance with the statutory functions of the ICB and underlying legal duties, Humber and North Yorkshire ICB undertakes statutory commissioning assurance functions of NHS safeguarding arrangements to ensure services commissioned are safe and effective, and that organisations work together to seek solutions to the changing context of safeguarding and to deliver the NHS long-term plan.

Regular audits of safeguarding arrangements are undertaken at the request of NHS England to demonstrate compliance with SAAF requirements, these are collectively responded to across the ICB, using the identified single point of contact for each area of focus. Examples of recent audits undertaken include ensuring multi-agency safeguarding arrangements are in place, Child Death Review arrangements, and compliance in publishing a modern slavery statement. Outputs from the audits are utilised for local assurance and to drive improvements in practice across the ICB. Quarterly submissions to NHS England have demonstrated consistent confidence in ICB safeguarding arrangements, throughout 2024/25.

A programme of safeguarding assurance and improvement work has continued through 2024/25, examples include:

- Hosting a face-to-face safeguarding conference with nationally acclaimed guest speakers including Dez Holmes and Professor Jane Monkton-Smith.

- Arranging and facilitating four lunch and learn sessions has been delivered by the GLAA to raise awareness of labour exploitation within the care sector in response to a modern slavery case within our ICB region. The sessions have been attended by more than 170 staff members across the ICB from health, Local Authority for fire service and others. This work has been shared by NHS England at Regional and National Level as good practice.

- Hosting an online conference with guest speakers including Jim Gamble and Zoe Lodrick

- Arranging an all-staff Domestic Abuse in the workplace online learning event – facilitated by Safelives.

- Renewal of safeguarding policies including the HNY ICB Safeguarding Policy, HNY ISB Safeguarding Supervision Policy.

- Arranging and facilitating safeguarding supervision training.

- Further developing the evidence base for a Forensic Service in Safeguarding Adults, securing the funding for a second academic evaluation by Hull University.

Looking to 2025-26, plans are in place to focus on:

- Improving the health offer to care leavers

- Developing programmes to address and respond to domestic abuse and sexual safety.

- Embed the revised safeguarding internal operating model.

- Support to the safeguarding professional's workforce to ensure the retention of staff and pathways for succession planning.

Links to local safeguarding arrangements.

Place	Adult Safeguarding	Children's sa e uardin
North Yorkshire	Safeguarding Adults Board: https://safeguardingadults.co.uk	Safeguarding Children's Partnership: https://www.safeguardingchildren.co.uk/
York	Safeguarding Adult Board: www.safeguardingadultsyork.org.uk/us	Safeguarding Children's Partnership: www.saferchildrenyork.org.uk
Hull	Safeguarding Adults Board: https://www.hullcollaborativepartnership.org.uk/hull-safeguarding-adults-partnership-board	Safeguarding Children's Partnership: https://www.hullcollaborativepartnership.org.uk/hull-safeguarding-children-partnership
East Riding	Safeguarding Adults Board: www.ersab.org.uk	Safeguarding Children's Partnership: www.erscp.co.uk
North Lincolnshire	Safeguarding Adults Board: www.northlincssab.co.uk	Safeguarding Children's Partnership: www.northlincscmars.co.uk
North East Lincolnshire	Safeguarding Adults Board: www.safernel.co.uk/safeguarding-adults-board/	Safeguarding Children's Partnership: www.safernel.co.uk/safeguarding-children-partnership/

Links to safeguarding partnership annual reports.

Place	Adult Safeguarding	Children's sa e uardin
North Yorkshire	Annual report: https://safeguardingadults.co.uk/resource-library/	Annual reports https://safeguardingchildren.co.uk/resource-library/?search=annual+report
York	Annual report: https://www.safeguardingadultsyork.org.uk/us/annual-reports-1	Annual report: https://www.saferchildrenyork.org.uk/cyscp-1
Hull	Annual report: https://www.hullcollaborativepartnership.org.uk/downloads/download/29/hull-safeguarding-adults-partnership-board---annual-report	Annual report: https://www.hullcollaborativepartnership.org.uk/hull-safeguarding-children-partnership
East Riding	Annual report: https://www.ersab.org.uk/about-us/about-ersab/	Annual report: https://www.erscp.co.uk/procedures-guidance/documents/
North Lincolnshire	Annual report: North Lincs SAB | About us - North Lincs SAB	Annual report: https://www.northlincscmars.co.uk/childrens-mars-arrangements/
North East Lincolnshire	Annual report: SaferNEL | Safeguarding adults board - SaferNEL	Annual report: https://www.nelincs.gov.uk/scp/about-scp/

Special Educational Needs and Disability (SEND)

HNY ICB SEND programme focuses on improving the timeliness and quality of health advice for Education, Health, and Care Plans (EHCPs), enhancing engagement with children, young

people, families, and partners, and ensuring compliance with statutory requirements and inspection readiness. Additionally, HNY ICB prioritises the development of guidance and training for requesting health advice for annual reviews, SENCo training, and digital health questionnaires.

Long-term developments include the implementation of the SEND Plan, which aims to integrate services effectively, promote mainstream inclusion, and address the medical needs of children and young people with complex health needs in educational settings. Furthermore, HNY ICB is dedicated to workforce development, including mandatory training for Designated Clinical Officers (DCOs) and Associate Designated Clinical Officers (ADCOs). The creation of a new SEND structure across the ICB, focuses on reducing variation, embedding a holistic approach to reduce duplication, and improving efficiency of systems working together across the areas. These strategic initiatives are designed to ensure high-quality, cost-effective service provision that meets the needs of children and young people with SEND in a timely and effective manner.

Domestic violence and supporting victims of abuse

The ICB has delivered all the requirements as a Specified Authority in relation to the Serious Violence duty set out in the plan including completion of a needs assessment, response strategy and a mutually agreed definition of serious violence.

The ICB has actively supported the introduction of A&E Navigators in ED departments and to develop meaningful data collection process to develop a better system wide understanding of serious violence across the Place areas.

The ICB has a suite of approved safeguarding policies in place, with additional staff experiencing domestic abuse and sexual safety policies introduced and developed, following the introduction of the NHS E sexual safety charter which the ICB has signed up to.

These policies have been supported by a range of learning opportunities commissioned by the ICB to raise awareness and provide a better understanding of domestic abuse, both for internal staff and external partners.

The ICB has developed a Domestic Abuse and Sexual Violence forum which brings together health partners across the ICB geography providing an opportunity to share good practice, avoid duplication of effort, and collaboratively consider practice challenges.

Domestic abuse and sexual safety continue to be a priority workstream as we move into 2025-26.

Environmental matters

Taskforce on Climate-related Financial Disclosures (TCFD)

NHS Humber and North Yorkshire ICB has reported on climate-related financial disclosures consistent with HM Treasury's TCFD-aligned disclosure application guidance, which interprets and adapts the framework for the UK public sector. NHS Humber and North Yorkshire ICB does not consider climate to be a principal risk and has therefore complied with the TCFD recommendations and recommendations disclosures. The ICB plans to provide

recommended disclosures for Strategy and Metrics and Targets in future reporting periods in line with the central government implementation timetable.

Whilst the ICB has not identified climate change as a principal risk in its Board Assurance Framework, we recognise the importance of addressing climate-related challenges and enhancing our resilience and have a robust risk management process outlined in the Accountability Report. The Executive Director of Strategy and Partnerships has oversight of the relevant climate-related policies and strategies working closely with system partners and reporting into the ICB Executive Committee, ICB Board and Audit Committee. Our efforts include:

Adverse Weather Preparedness: We have effective arrangements in place to manage adverse weather events, informed by climate change risk assessments. These arrangements ensure we are prepared for extreme events such as heatwaves, storms, and floods working through the Local Health Resilience Partnership/ Local Resilience Forums.

Local Authority Collaboration: Several local authorities within our area have declared a climate change emergency. We collaborate with all authorities to align our strategies and support regional climate action initiatives.

Net Zero Targets: We are committed to supporting the NHS's broader goal of achieving Net Zero carbon emissions. This includes addressing estate-related gaps in control, recently reported to the ICB Board, and developing a standard set of metrics to monitor and report on our progress. We have also continued to minimise our transport emissions through promoting our flexible working policy, remote working, encouraging non-car alternatives to travel and investing in digital ways of working.

Sustainability Initiatives: We are actively implementing various sustainability initiatives aimed at reducing our carbon footprint and promoting environmental stewardship and through our Digital Strategy we continue to support the digital transformation of our services and activities.

Estates and facilities: We have reviewed our ten sites developing a corporate estates strategy that will optimise future estate and will work closely with our landlords to improve the energy efficiency of those sites we retain.

Waste and recycling: Equipment re-use, reducing waste and reducing reliance on single use plastics are key elements of our Green Plan.

Green Plan

We recognise as a system that the objectives of the Green Plan directly support our core mission by enhancing healthcare, delivering cost efficiencies, easing workload pressures, and reducing waste. Demonstrating our ongoing commitment to sustainability, the ICB has been embedding our Health and Care Partnership Green Plan 2023-2025, across our system operations and governance recognising that shared ownership is crucial for successful delivery.

Collaborating with system partners in the Humber and North Yorkshire Climate Change and Sustainability Group this year, we have also focused on a comprehensive refreshing of the plan

to ensure it continues to be relevant and impactful. The refreshed plan will ensure full alignment with the latest green plan guidance and the guiding principles of Delivering a Net Zero NHS.

Drawing on the work of the Yorkshire and Humber Climate Commission, and to make certain the system works together with other partners in the region, the Humber and North Yorkshire system is dedicated to tackling the challenges of a changing climate according to the following four clear guiding principles; To support rapid progress towards net zero carbon emissions, to foster climate resilience and adaptation to climate risks and impacts, to promote climate actions that also protect and restore nature and biodiversity and to encourage a just and inclusive transition that helps reduce inequalities and that leaves no-one and nowhere behind.

Better and Greener Asthma Care

Humber and North Yorkshire ICB recognise that reducing inhaler carbon footprint is intrinsically connected to improving asthma care and have been leading this work in the region. Approximately half of our asthma patients have poorly controlled asthma, and well controlled asthma has 1/3 of the carbon footprint of poorly controlled asthma. In 2024/25 the HNY ICB Respiratory Clinical Network has developed an all-age strategy for preventing asthma deaths. In 2024/25 HNY ICB offered a prescribing quality scheme to practices supporting better asthma control creating a Local Enhanced Service to improve respiratory diagnosis which will be implemented in 2025/26. In the coming year we will focus on patient-facing communications and support a newly created network of primary care respiratory champions.

Reduced emissions from inhalers

Emissions from inhalers contribute to 13% of the emissions that the NHS directly control. HNY ICB has reduced its carbon footprint by 32%, compared to 2019-20 levels and we are on course to meet the NHSE target of 50% reduction by 2028. Using an online carbon calculator (carbonfootprint.com) the reduction in inhaler CO2e emissions is equivalent to over 10,000 flights (10,476) from Manchester to New York.

Across the system, our trusts are collectively making very good progress with outstanding examples of good practice and projects including transport projects, switches to electric vehicles, waste reduction, renewable energy projects, embedding social value and sustainable procurement and investment to the NHS Forest to increase our green spaces. Here's some examples of the work within our Trusts:

York and Scarborough NHS Foundation Trust

In the 2024/25 financial year, York and Scarborough NHS Foundation Trust reinforced its commitment to sustainability by appointing a dedicated Head of Sustainability. This role, along with an effective team, led the implementation of key strategic documents, including a revised Green Plan introduced in June and a new staff travel plan in January 2025. These initiatives were supported by extensive staff engagement and behavioural change programmes, such as the relaunch of a Green Champions network.

The Trust also advanced its infrastructure and energy projects by securing multiple grants. They increased LED lighting coverage to over 80% of sites and installed a heat pump at Bridlington Hospital, complementing its solar farm. A notable achievement was receiving the BREEAM Excellence award for the new Scarborough Hospital Urgent and Emergency Care Centre, which incorporates substantial photovoltaic (PV) and other energy-reducing measures.

Humber Teaching Hospitals NHS Foundation Trust

Aligned with their Green Plan and commitment to achieving Net Zero by 2035, Humber Teaching Hospitals NHS Foundation Trust made significant progress in its decarbonisation journey over the past 12-18 months. Key initiatives included:

- **Tree Planting:** Over 300 trees were planted across three sites with the help of staff, patients, and the local community, enhancing carbon absorption, air quality, local wildlife, and community spirit.
- **Resource Optimisation:** At East Riding Community Hospital, an old biomass boiler was upgraded to sustainably provide heating using responsibly sourced wood pellets.
- **Energy Efficiency:** At four sites (Alfred Bean Hospital, Hornsea Cottage Hospital, St Andrews Place, and Westend), a "fabric-first" approach was adopted, involving upgrades like better insulation and new windows to reduce energy needs before installing new heating systems like air source heat pumps. Solar panels are also planned.
- **Fleet Transition:** The vehicle fleet is rapidly transitioning to electric, with three electric SUVs and fourteen electric vans currently in use and plans to replace remaining diesel vehicles with electric options as leases expire.

Humber Health Partnership

The Humber Health Partnership secured significant funding in 2024/25 to upgrade all lighting to LED, improving efficiency, cutting energy use, and reducing running costs.

- **Major Upgrades**: £20.6 million from the Public Sector Decarbonisation Scheme is funding major upgrades at Scunthorpe Hospital, including electric boilers, solar PV, and insulation, expected to save over 3,600 tonnes of CO2e annually.

- **Greener Transport**: Hull University Teaching Hospitals (HUTH) portering team portering team went electric, trialling an e-cargo bike for deliveries, aiming for a greener transport option.

  North Lincolnshire and Goole Trust's fleet continues to become more carbon efficient, with 10 electric Vans, electric cars, and 84 self-charging (SC) hybrids equating to 39% of the fleet.

- **Solar Power**: An additional 0.5MW of solar power was installed at Hull Royal Infirmary (HRI) using the NHS Energy Efficiency Fund. Heat network efficiency was improved with partial funding from the Heat Network Efficiency Scheme (HNES).

- **Nitrous Oxide Reduction**: The Partnership completely decommissioned piped nitrous oxide in 2024/25, switching to mobile cylinders and achieving over a 60% reduction, saving over 1,000 tonnes of CO2.

Emergency Preparedness

As a "Category 1 Responder" under the Civil Contingencies Act 2004, the ICB is required to plan for and respond to emergencies and incidents. The NHS England EPRR Framework further outlines the roles and responsibilities of health organisations in England, including the need to complete training, exercises, and submit the NHS Core Standards for EPRR annually.

The annual submission assesses the preparedness of an organisation to respond to incidents and emergencies. Standards rated as partially or non-compliant should result in actions to improve compliance.

In 2023/24, the ICB reported 32% compliance, resulting in a non-compliant rating due to a more rigorous baseline reset. In 2024/25, compliance increased to 60%, showing substantial improvement despite challenges. However, the ICB did not meet the 76% threshold for full compliance. Improvements were noted in governance, planning, co-operation, and business continuity and actions will continue through 2025/26 due to the NHS EPRR Core Standards process.

The ICB has not declared any organisational incidents in 2024/25, however it has undertaken significant amounts of work on the leadership and response to various incidents including some industrial action, adverse weather, outbreaks of avian influenza, IT incidents including the Crowdstrike IT outage, the Summer Civil Unrest, utilities outages, and a hospital evacuation.

The ICB has also participated in a range of exercises to test existing plans, with scenarios including mass casualties, power outages, infectious diseases, cyber-attacks, port health, evacuations, business continuity incidents and communications cascades.

Learning being carried forward from these incidents and exercises includes:

- Development of Action Cards on Digital Incidents and strengthening of availability of physical plans.
- Finalised Vulnerable Persons Process resulting from a large-scale power outage exercise and plans to improve resilience in the event of the loss of digital capabilities.
- Strengthened links between the ICB's EPRR and Infection Prevention and Control Teams.
- The System Coordination Centre to be incorporated into all planning arrangements.
- Business Continuity Planning should account for staff absences due to isolation after being identified as contacts of an infectious disease.

Improve quality

Humber and North Yorkshire ICB have accountability with associated duties in ensuring that the services and pathways of care provided to the population are of high quality, personalised and equitable to all. With a commitment to fostering a culture of continuous learning and improvement we work in partnership; focused on outcomes for people and the population using our services and in ensuring that we strive to provide high quality and safe care. It is important to us that the experiences and voices of those who use our services are reflected in our improvement ambitions.

The Nursing and Quality Directorate is dedicated to aligning its work with the National Quality Board (NQB) definition of quality. This commitment ensures robust quality oversight, assurance, and a continuous focus on improvement.

Quality Governance

The ICB has a robust framework for quality governance, overseen by the Quality Committee (QC), a sub-committee of the ICB Board with delegated authority for quality oversight and assurance.

The Quality Committee (QC) ensures scrutiny and challenge, fulfilling statutory duties, and maintaining quality governance across the system. It mitigates risks and ensures the delivery of sustainable, high-quality care and is supported by the System Quality Group (SQG), a strategic, multi-stakeholder meeting that strengthens oversight through quality insights, intelligence, and structured reviews. The SQG focuses on emerging risks, escalations, and identifies opportunities for improvement.

A clear reporting framework highlights ‘assurance,’ ‘alert,’ ‘advise,’ and ‘applaud’ to identify improvement opportunities and risks to quality. Promotes a culture of learning and ongoing improvement while reducing inequalities. In support of Quality Risk Response and Escalation in ICSs, escalation reports are routinely submitted to the Regional Quality Group to support NHSE oversight and assurance.

Core membership of both the QC and SQG includes ICB Executive leadership, ICS partners, regional NHS England teams, CQC, , Public Health, and Healthwatch. Outputs and conclusions are reported to the ICB Board.

Sub-Groups support the delivery of statutory duties, including the ICB Patient Safety Group, ICB Safeguarding Assurance Group, and ICB Experience of Care Group.

This structure ensures comprehensive oversight and continuous improvement in quality governance across the ICS.

The Quality Assurance Improvement Framework (QAIF) shared with key stakeholders in February 2024 continues to support the work of the ICB in delivering continuous improvement.

Quality improvement

The ICB continues to collaborate with partners across the ICS in delivering our statutory duties in respect of securing continuous improvement in the quality of services. Our priority is to being to create a constant quality and improvement culture, and to ensure quality is everyone's responsibility and business.

Humber and North Yorkshire ICS remain dedicated to improvement and were pleased to receive recommendations this year from work supported by the Advancing Quality Alliance (Aqua). This involved co-developing and co-delivering Action Learning Collaboratives focused on Maternal Safety and Deconditioning for acute providers across the ICS. By applying continuous improvement techniques and methodologies, this initiative aimed to address specific harms. In partnership with service users, a series of dedicated workshops, peer engagement sessions, and problem-solving events were held, fostering a collaborative environment for sharing insights, challenges, and innovations in safety improvement.

The ICB continues to seek opportunities for both local and scalable improvement across the ICS. Currently improvement work is focused upon areas including,

- PIER project for patients with a Learning Disability and at risk of physical deterioration. This work promotes better prevention, identification, escalation, and response (PIER) and is supported by the involvement of patients, their families, and carers. Identifying what is working well and where improvement is most needed, with problems addressed in an evidence-informed manner.

- A review of support for families and carers when a child dies (Hull and East Riding of Yorkshire). Meetings were held with families which have brought about meaningful improvements which will impact on the experiences of families at what is the most difficult time. These improvements include further developing the `dedicated bereavement space` for families in their early stages of loss, changes to memory boxes and enhancing the support to parents when a child dies.

Patient Safety

The NHS Patient Safety Strategy sets out how the NHS will support staff and providers to share safety insight and empower people, patients and staff with the skills, confidence, and mechanisms to improve safety.

Following publication of the Patient Safety Incident Response Framework (PSIRF), the ICB has successfully executed its role in supporting providers in the development of their patient safety incident response plans and policies.

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between 'patient safety incidents' and 'Serious Incidents'. As such it removes the 'Serious Incidents' classification and the threshold for

it. Instead, PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

In progressing the new arrangements, an ICB implementation group was developed and a robust sign-off process established; that demonstrated readiness for providers to transition to the new framework. This group has now evolved to an oversight function and reports to the ICB Patient Safety Committee.

Ensuring patient safety remains a top priority across Humber and North Yorkshire with all work aligning to the national strategy's foundations of 'patient safety culture' and 'patient safety systems,' and the three strategic aims 'insight', involvement' and 'improvement.'

Implementing the NHS Patient Safety Strategy encompasses work by many teams and the partnerships, in acknowledging the ICBs oversight function, quality and safety representatives are now embedded within provider patient safety and PSIRF groups. This supportive oversight ensures that systems and processes in response to patient safety events are effective, learning responses are proportionate, there is compassionate engagement with those affected by patient safety events and evidence of continuous and sustained improvement.

As per the national requirements and in readiness to undertake, support and coordinate system wide learning responses, a cohort of ICB staff have successfully undertaken all relevant training by an NHS England approved PSIRF training provider.

In further enhancing a safety culture of continuous learning and improvement, a new safety improvement through learning outcomes group (SILOG) has been established led by the ICB. This provides a forum for providers across the ICB to come together to not only share but proactively act on learning from other organisations to create a system safety culture of proactive harm reduction that is evidence based.

The ICB is now supporting PCNs and General Practices who are taking part in the primary care PSIRF pilot. An implementation group has been established, and training has been delivered by an NHS England approved provider in Systems approach to Patient Safety Incident Investigations, creating a Just and Learning Culture and Patient, family, and staff involvement in learning from Patient Safety Incidents.

The ICB continually reviews its assurance levels relating to its role aligned to PSIRF, within an internal audit scheduled for reporting in Q1 of 2025/26. Assurance that the ICB is executing its roles and responsibilities in respect of PSIRF, this audit will identify and recommend any further areas for improvement.

Learning from Lives and Deaths (LeDeR)

Humber and North Yorkshire ICB have now published the third LeDeR annual report. Written as an Integrated Care System (ICS), this report informs and promotes a greater thematic understanding from partners, as to the contributing factors which may be associated with the sad

death of a person with a learning disability and autism. The review and panel process considers the needs and risks of the person who died and in seeking to further opportunities for improvement and learning from the death of a person.

LeDeR arrangements are in place across the ICB, with a single panel meeting across Humber of North Yorkshire and one steering group which continues to be well attended by partner organisations, key stakeholders and has good representation by people using our services.

All LeDeR partners and local area contacts (LACs) continue to link with regional and national leads, ensuring that local learning is both shared and informs the national priorities and the delivery of improvement objectives.

With a focus on learning and seeking to address health inequalities, the team continues to inform the strategic direction for services for people with a learning disability and autism nationally, regionally, and locally.

Final statement

As we continuously evolve, we are already looking to the challenges we expect to see in the coming year, addressing the quality, finance and delivery challenges whilst achieving ambitious transformation in the health and care sector.

By working collaboratively and swiftly across our system partnerships, we are committed to delivering high-quality and safe services for the people of Humber and North Yorkshire. Our strong relationships and ongoing collaborative efforts enable us to effectively address challenges and emerging risks as a unified partnership.

Voice at the Heart: Engaging people and communities

Involving people and communities is built into the fabric of Humber and North Yorkshire ICB because we know that it leads to improved health outcomes. Our overarching ambition is to foster meaningful relationships with communities and patients, ensuring diverse voices are heard and involved in shaping services.

Our aim is to enhance co-production to improve patient outcomes, promote health equity, and build trust through transparency and inclusion and improve people's understanding of both physical and mental wellbeing. In addition to being a statutory duty we believe that meaningful patient and public participation can help us to develop and deliver services that are safe, effective, and efficient. We take the voice of the public seriously as an organisation with engagement reports, voices of lived experience and patient stories reporting into Board meetings every month.

Examples of the work undertaken in 2024/25 include:

Engagement Approach

Our new engagement approach was developed in collaboration with partners that make up the Humber and North Yorkshire Integrated Care System, including engagement and patient

experience professionals, people from voluntary and community groups, Healthwatch, as well as patients and members of the public.

The Humber and North Yorkshire Integrated Care Board approved the refreshed plan in October 2024, and it will be reviewed in 2028, in alignment with the Joint Forward Plan.

Insight Bank

We have developed an online platform to help our colleagues in the ICB and across the ICS; to make best use of the data and insight we hold about our local communities and their experiences of accessing health and care services.

The aim of the insight bank, which every partner in the system can access, is to get all insight quickly about any health service subject, avoid duplication of public engagement across partners and thus focusing on engaging on subjects, or with cohorts, that really matter. In its first few months, our insight bank already hosts 120 pieces of public intelligence, with almost 150 colleagues signed up and growing.

Using data from our Insight Bank and our diverse public membership, we will facilitate service change and development and target our social marketing work where it can have the biggest impact.

We Need to Talk

In 2024, the ICB undertook the 'We Need to Talk' campaign/engagement exercise to help us frame the next chapter of our NHS. 3,429 survey responses were submitted over a 4-week period; fifty-four engagement events took place, and this resulted in 1,121 face-to-face conversations with people. We targeted underrepresented communities as much as possible and sought views and ideas on how we can:

- Use technology better.
- Improve the way we plan and organise our workforce.
- Focus on preventing illness.
- Listen to people's needs and involve everyone.
- Move more care into the community.
- Ensure patient safety and consistent high-quality care everywhere.
- Focus on what matters most.

From our engagement, 97% of people agreed that the NHS needs to change and 70% think some services should be stopped or delivered differently. Without further investment in the NHS, people want us to prioritise Primary Care, Emergency Care and Mental Health Care. The campaign has provided valuable insights into public opinion and priorities as we start to build the NHS of the future. For a full breakdown of the report, and videos please follow the link below: https://humberandnorthyorkshire.org.uk/we-need-to-talk/

The Nothing About Us Without Us

Children and Young People's Mental Health Advisory group works with over 200 young people aged 10-25 from across our ICB to coproduce improvements to access, waiting times, outcomes and experience to mental health services and support. The young people involved who all have lived experience of mental health issues and services are representative of our diverse communities including LGBT+, looked after children and care leavers, young carers, neurodivergent young people and young people of colour as well as young people from all 6 Places in our ICB.

The group has produced 50 recommendations from recent consultations and are working with senior leaders across the system to coproduce solutions to address them. They have also coproduced an ICB wide CYP Engagement and Coproduction strategy with partners including health, local authority, and voluntary sector, based on the national Lundy model which is just being finalised. They have also delivered campaigns on improving support from Trusted adults and the impact of everyday racism on young people's mental health which include short films which can be used to embed lived experience of CYP into staff training to improve support and experience.

Catterick Integrated Care Centre (CICC)

Throughout the spring and autumn of 2024, the ICB, in partnership with colleagues from North Yorkshire Council working on the Catterick Town Centre Regeneration Project, hosted a series of public roadshow events across Catterick, Richmond and Colburn to promote a united message of regeneration in the area.

Case study: health and care services in Bridlington:
NHS Humber and North Yorkshire Integrated Care Board, Bridlington Health Forum, The Hinge Centre, Smile Foundation and representatives from NHS trusts came together to coproduce a survey to understand the public's views better. The collaborative survey will ultimately shape the strategy for the Humber and North Yorkshire Health and Care Partnership. Bridlington residents were encouraged to participate in the survey to share their views on improving local health and care services and the town's general wellbeing. Feedback Report available here

These events were designed to inform, engage, and involve the local community, providing updates, answering questions, and gathering valuable feedback. More than 530 people took part, including veterans, serving military personnel, staff, and members of the Nepalese and Gurkha communities.

In response to this engagement, we have developed a dedicated CICC webpage, https://humberandnorthyorkshire.org.uk/locations/north-yorkshire/our-work/catterick-integrated-care-centre-cicc/, a comprehensive FAQ hub, and a mailing list of over 140 local residents and stakeholders to support ongoing communication.

We are also working closely with Tilbury Douglas, the project's lead contractor, to support their social value commitments. This includes hosting regular public drop-ins at the site, offering

residents the chance to view the development up close and speak directly with the builders and architects, engagement with local primary schools and finally volunteering at a welcome box packing event to support incoming military families.

We remain committed to continuing this engagement throughout 2025 and through to the completion of the Integrated Care Centre in spring 2026**.**

Non-Emergency Patient Transport Services

We worked with Yorkshire Ambulance Service to review eligibility for Non-Emergency Patient Transport Services, in line with updated national criteria from NHS England. To assess the local impact in Humber and North Yorkshire, we gathered patient feedback via a survey in October and November 2024.

The survey, sent by Yorkshire Ambulance Service on our behalf, went to 1,020 patients likely to be affected—including those receiving chemotherapy or radiotherapy, patients in rural/coastal areas, and a random sample of other service users. We had a 28% response rate.

The Clinical and Professional Committee reviewed the survey results and other evidence, endorsing the implementation of the national criteria. However, based on feedback, it is recommended that eligibility continues for patients undergoing chemotherapy or radiotherapy, as well as for children under 17 with medical needs. A summary of feedback is below, and the full report is available at www.humberandnorthyorkshire.icb.nhs.uk/get-involved.

NHS111 patient experience and insight exercise

More than 1,200 participants engaged in this exercise to gather feedback from users on the NHS 111 service. People were able to visit our roadshow stands, complete a questionnaire, or attend a targeted focus group.

Our aims were to:

- Raise awareness of the national NHS111 communications campaign by visiting popular, high footfall community locations across the ICB geography.

- Test the effectiveness, success, and reach of the national communications campaign by understanding where people see/hear key messages, and what methods of communication/promotion they prefer.

- Gather insight as to where people are on their journey of fully understanding what NHS111 is and when/how it can be used.

- Understand what people's default behaviours are should they require urgent but non-threatening medical care.

- Identify potential case studies where people have had a particularly positive/negative.

The full report is available to read at www.humberandnorthyorkshire.org.uk/getinvolved.

Healthier Together Website

The HNY Healthier Together website (https://www.hnyhealthiertogether.nhs.uk/) is a vital resource offering information and advice for children, young people, their families, and professionals. It is supported by local and national specialists, providing safe clinical advice and decision-making tools for managing childhood conditions.

The Young Connectors Programme and WRAP Project

The Young Connectors programme delivered through six Health Watches, empowers young people to voice their opinions on health services, leading to the establishment of a long-term condition's forum. Additionally, the WRAP project launched in collaboration with Barnardo's aims to enhance resilience, emotional well-being, and mental health across Hull & East Riding.

Reducing Health Inequalities - enabling wellbeing, health, and care equity

Wide inequalities persist across Humber and North Yorkshire (HNY). In 2023, Hull had one of the lowest life expectancies in England, while North Yorkshire and York had the highest in the region. Males in Hull live 4.6 years less than those in North Yorkshire, and females in Hull live 3.2 years less than those in York.

Effective action to address health inequalities in HNY requires a coordinated and whole system approach, with targeted prevention work using Population Health Management (PHM) as an enabler. PHM data helps the system to identify areas of focus and individuals or communities for targeted interventions. Linked datasets provide insight into current and future population needs, allow targeted action to prevent ill health and reduce health inequalities, and enable the delivery of better coordinated care and better use of scarce resources. It will enable us to move from data to action and have much greater impact than could be achieved previously. The development of the ICS Population Health Outcomes Framework will incorporate insights from public and community engagement work via the ICB Insight Bank, with a particular focus on Core20Plus5 populations, inclusion groups, and those with protected characteristics.

The ICB acts as an anchor organisation by strategically managing its resources and operations to address local social, economic, and environmental priorities. The ICBs Population Health and Prevention (PH&P) Committee provides leadership in tackling health inequalities. Jointly chaired local authority Directors of Public Health it is built on a system-wide approach focused on prevention, population health and health inequalities. This committee brings together partners across local authorities, VCSE, provider collaboratives and the ICB to share intelligence and improve analytical insights, guiding collaborative work that responds to observed inequalities. Embedding a health inequalities lens across all ICS work programmes is a key component.

Targeting activity

A major focus is on the harm caused by tobacco, the leading preventable cause of death in England, which disproportionately affects deprived populations. Adult smoking rates in Humber

and North Yorkshire are 12.7%, down from 13.0% last year but still above the national average of 11.6%. This equates to around 176,000 adults who smoke, costing the health system an estimated £1.39 billion annually. Stop Smoking support is now offered by all HNY local authorities and by all five NHS trusts. 4,078 smokers set a quit date with HNY Stop Smoking Services last year, achieving a 66% successful quit rate, significantly better than the national average (54%). The Centre for Excellence (CfE) in Tobacco Control leads a number of initiatives to support efforts to reduce the burden from smoking:

- Working with local partners, the ICB has identified 6 priority topics around tackling smoking this year. The CfE co-ordinates efforts to address these topics which include increasing footfall into local Stop Smoking Services and increasing Trading Standards capacity and capability to tackle the illicit tobacco trade.
- In March 2025, the CfE launched its first region-wide stop smoking mass media campaign. The "What will you miss?" campaign will utilise television, radio, digital, outdoor and PR channels to encourage smokers to access a region-wide website from which they can access local support and choose the quitting option best suited to them.

- Stop smoking support has now been rolled out as part of routine Lung Health Checks across parts of Hull, East Riding, North-East Lincolnshire, and North Lincolnshire. Over the last 18 months 412 smokers have set a quit data as a result of this intervention, with 304 (74%) successfully quitting. This innovative approach is to be rolled out across other parts of East Riding and North Yorkshire in 2025/26.

- NHS Long Term Plan tobacco dependence treatment in maternity and acute settings is now in place across all 5 of our trusts. Up until the end of Quarter 3, 2024/25, 4,535 were seen by an advisor, 1,866 smokers accepted support, with 586 quitting successfully.

- The CfE has commissioned the National Centre for Smoking Cessation and Training to work together on a Workforce Strategy. This will adapt current Stop Smoking Service models and help services tailor their interventions to the individual needs of smokers.

The Cancer Alliance has undertaken targeted campaigns in areas with poor screening uptake, such as Goole, Scarborough, Hull, and Scunthorpe, focusing on young women for cervical cancer screening and men in areas with high rates of late-stage prostate cancer diagnosis and higher Black, African, and Caribbean populations. They also provided specialised Cancer Champion training for beauty and hairdressing salons to facilitate informed discussions about cervical cancer screening. The Cancer Alliance also commissioned a region-wide Cancer Awareness Measure survey in conjunction with Healthwatch to gain further insight into the understanding and beliefs about cancer within the general population, focusing on areas of deprivation and inclusion health groups. The insight from patient and public views is integral to the work of the Cancer Alliance, with public representatives on the delivery board of each work programme.

Women's Health Hubs

In 2024/25 twenty-four Women's Health Hubs have been launched in Humber and North Yorkshire, serving 485,000 women. This far exceeds the national ambition for each ICB to have

one and is a testament to the model advocated by HNY and the appetite from primary care, for women's health to be embedded into health care. Investment has been made in developing the skills of clinicians and improving services for women. A committed and enthusiastic community has been created, consisting of GPs, practice nurses, clinical pharmacists, social prescribers, and support staff undertaking innovative improvement projects to improve patient access and quality of care. The network of Hubs provides access to high quality care close to women's homes.

A Focus on Inclusion Health

In 2024-2025 we co-developed our ICS Inclusion Health Strategic Approach and System-wide Action Plan 2025-2028 aimed at improving access, experiences, and outcomes for Core20PLUS5 population. This comprehensive all-ages framework was created in collaboration with key stakeholders across the health, care and community system, building upon
NHS England » A national framework for NHS – action on inclusion health

Our Inclusion Health Approach focuses on socially excluded groups experiencing the most extreme health inequalities. These groups are represented in the PLUS5 element of the NHS Core20Plus5 approach to reducing health inequalities and includes:

- People who experience homelessness
- People with drug and alcohol dependence
- Migrants in vulnerable circumstances and refugees
- Gypsy, Roma, and Traveller communities
- People in contact with the justice system
- Victims of modern slavery
- Sex workers
- Other groups experiencing multiple unmet needs

Inclusion health groups are often underrepresented in existing datasets, making it difficult to accurately plan and commission services that meet their needs. To address this, we have resourced and developed a pilot to use a standardised primary care coding system in York, with the aim to be tested, refined and replicated across Humber and North Yorkshire. This initiative aims to improve the identification and recording of inclusion health status in GP practices, ensuring that groups—such as people experiencing homelessness, Gypsy, Roma and Traveller communities, and migrants in vulnerable circumstances among other groups experiencing severe disadvantage and worse health outcomes—are more accurately represented in healthcare data.

In only three months, the Inclusion Health Register Pilot has shown significant early benefits, with a 14.23% increase in the number of patients formally coded under inclusion health categories. This means an additional 1,179 individuals are now recognised within the system, allowing for better tracking of health outcomes and more tailored care interventions. The pilot successfully engaged 10 out of 11 general practices in York, demonstrating strong participation. Key learnings have been captured to support a successful rollout, ensuring the approach is adapted to varying levels of engagement and capacity across HNY practices.

For a comprehensive review on health inequalities, view our annual health inequalities reports published on the ICB website. Publications - Humber and North Yorkshire Integrated Care Board (ICB)

Inclusion Health Needs Assessment

The PLUS population includes those with multiple unmet needs, poorer healthcare access, worse outcomes, and negative patient experiences. Inclusion health groups often account for a disproportionate demand on emergency and acute services, as they face significant health inequalities, limited access to routine care, and multiple disadvantages, which drive greater reliance on crisis-driven healthcare. This year, we conducted a comprehensive Health Needs Assessment (HNA) focusing on inclusion health populations. The HNA aimed to enhance understanding of these groups' health and social care needs using available data; however, we recognise that this presents limitations in fully capturing their experiences and healthcare needs.

The HNA revealed that inclusion health groups in Humber and North Yorkshire face significant health and social challenges. Approximately 5,000 households are homeless, 212 people are sleeping rough, 9,900 people are affected by drug dependence (6,750 in treatment), and 19,000 people have alcohol dependence (3,500 in treatment). Additionally, there are around 5,400 vulnerable migrants, over 3,000 Gypsy, Roma, and Traveller community members, and about 2,400 individuals released from custody annually. Health data on these and other inclusion health groups is scarce and insufficient, and the true numbers are likely to be higher due to outdated data sources and the invisibility of these populations in health records.

To address this, we have initiated actions to improve data collection and insights, using Population Health Management approaches to enhance our understanding of population changes and ensure that commissioning decisions are better informed to meet the needs of inclusion health groups effectively.

Addressing Interpretation and Translation Needs

Effective communication is the key for delivering high quality healthcare. For the estimated 23,919 residents in Humber and North Yorkshire (HNY) who cannot speak English well or at all, comprehensive interpretation and translation services are essential for accessing both treatment and preventive care. Appropriate communication significantly improves patient outcomes, increases satisfaction, reduces potential harm, and ensures timely access to appropriate healthcare services.

In 2024/25, we made substantial progress by commissioning and procuring comprehensive interpretation and translation services across all primary care settings—including pharmacy, optometry, and dentistry effectively addressing previous variations and undersupply throughout HNY.

Our comprehensive service model now includes:

- Face-to-face interpretation
- British Sign Language (BSL) interpretation and translation
- Telephone interpreting
- Document translation and transcription.
- Video interpretation.

This integrated approach ensures that language barriers no longer prevent residents from receiving the healthcare they need, while optimising resources across our system.

Coastal Ageing Well

Throughout the year we have worked through the ICP to raise the profile of the issues faced by people who live on our coasts with a view to enhancing the quality of life for older populations by addressing key areas essential for healthy and active ageing. This has included promoting the concept of Age-Friendly Cities and Communities, which has been explored by all our local authorities.

Addressing transport challenges

The Voluntary, Community, and Social Enterprise (VCSE) Collaborative has undertaken a comprehensive mapping of patient transport services across the region. This analysis highlights variations in spending and funding structures, providing valuable insight into the current landscape, which our local authority partners have agreed to address.

Delivering health and wellbeing strategy

Health and wellbeing boards are responsible for commissioning a Joint Strategic Needs Assessment (JSNA) for the local population and setting the Joint Health and Wellbeing Strategy. Our six Place Health and Wellbeing Boards play a vital role in delivering the Integrated Strategy for Wellbeing, Health and Care and with shared aims, ambition, and priorities the local Joint Health and Wellbeing Strategies create the culture and conditions for health and wellbeing to flourish at a local level.

In addition, the developments of the Health and Care partnership arrangements through our operating model have enabled us to further progress the Strategy.

York

York Health and Care Partnership has made notable progress in enhancing health and care services. The Frailty Crisis Response and Health Integration service, which has been operational since 2023, has continued to expand to deliver 7300 crisis cases in 2023/24 and our approach has developed further by streamlining hospital discharge processes and a ‘home first’ care approach.

The first Mental Health hub was launched in May 2024 to provide flexible, community-connected mental health support aimed at early intervention and prevention. A range of initiatives have focused on supporting vulnerable populations and reducing health inequalities in York, including social and wellbeing activities for asylum seekers and GP outreach services for women with

urgent healthcare needs who face barriers to accessing conventional care and enhanced support for children with autism and anxiety.

A second Brain Health Cafe was also launched to aid individuals with mild cognitive impairment.

East Riding

The East Riding Health and Care Partnership strives to enhance community health and wellbeing through collaboration among the NHS, local government, and other partners. Six outcome themes have been established to align with the strategic ambitions: social value, maximising independence, access to services, co-production, the voice of those seldom heard, and system integration. This has been informed by our 'Vibrant and Healthy Communities' programme, a suite of population focussed programmes, projects and enabling programmes. A highlight of this approach has been the Inclusion Groups Programme. This addresses the needs of socially excluded individuals by improving service providers' understanding, increasing confidence in services, and involving representatives in decision-making.

Support for specific populations has also been developed with the Bridlington Rough Sleepers Mental Health and Wellbeing Service which has supported 128 individuals through 4066 attendances in 2024/25 by providing essential services, resulting in improved health outcomes and increased access to necessary support. Since using the hub 95% of users felt safer, 100% reported feeling physically better, 82% reported improved mental health and 89% accessed services they would not have otherwise.

Hull

The Hull Health and Care Partnership (HCP) has sponsored the Integrated Neighbourhood Teams (INT) initiative to address the priorities outlined in the Hull Health and Wellbeing Strategy and create a significant change programme. In 2024/25 the integrated care at home project pilot, an integrated approach between primary and adult social care, has utilised shared data across health and social care to holistically review people's needs at home. Feedback has shown the quality of care and experience is positive and the project will be expanded to Primary Care Networks across the City alongside other emerging projects including Children's initiatives.

In 2024 the partnership agreed that COPD (Chronic Obstructive Pulmonary Disease) is the priority inequality for the city of Hull with the 2nd highest smoking prevalence in the UK. COPD exacerbations can lead to irreversible loss of lung function. With the ambition of aligning to neighbourhood health the Respiratory project will focus on 4 key areas as part of the logic model. Diagnosis, annual reviews, smoking cessation, and pulmonary rehabilitation aligned to NICE best practice. we have a wide range of evidence-based treatments that can improve outcomes for people living with COPD. Smoking cessation and Pulmonary rehabilitation are two main areas. To optimise treatment for people living with COPD, these patients need to be diagnosed and recorded as diagnosed. Late diagnosis can result in faster respiratory deterioration and a higher number of exacerbations. The project aims to improve equitable access and reach patients in need of support that may not otherwise present in primary care. During 2025 the project will embed education and learn about issues to be able to develop further, and improve patient experience reducing the need of hospital intervention.

North Lincolnshire

North Lincolnshire Health & Wellbeing approach remained aligned to its Community First Strategy. We have made good progress over the last year with strong and committed system leadership and governance setting the frame. Our ambition is to ensure that North Lincolnshire is the best place for all our residents to be safe, well, prosperous and connected, experiencing better health and wellbeing. There has been a continued focus on integrated commissioning, with a transformational Care at Home model which aims to provide an outcomes-based focus, giving people more control of their care and supporting innovative approaches to supporting their care.

Working across five neighbourhoods in North Lincolnshire and across all age populations we have emerging Integrated Neighbourhood teams across health, social care, housing, and voluntary sector partners. Knowing our people and all their needs and nuances is helping us improve outcomes and be person centred which we support by utilising a Population Health Management approach focussed on address the CORE20Plus5 Health Inequalities.

North Lincolnshire's Population Health and Prevention Partnership is emerging as the overarching Neighbourhood Health Partnership, and this is beginning to yield benefits by linking to other Place, Neighbourhood, Community, Family and Person-centred priority activity. Integrated Neighbourhood Teams are being developed within the frame of a Neighbourhood Health model. An Organisation Development supported approach is underpinning a 6-month programme that is creating the culture, infrastructure, and processes to meet need on a proactive, reactive and crisis basis. This is enabling people with, or at risk of developing, long term conditions and or disabilities, and those who have existing conditions, with high-quality, person-centred care. As a result, people can remain in their own homes, communities, families, schools, and employment.

We continue to adopt a single system approach to integrated urgent care, to enable people to remain and return to their normal place of residence centred around our Home First approach. The supports people to live independently, by supporting timely and safe hospital discharge, providing rehabilitation and reablement to improve their daily living and mobility skills and ultimately stay in their own homes.

North Yorkshire

The North Yorkshire Health and Wellbeing Board (NYHWB) is a collaboration of leaders from across the NHS, local government, and other partners which endeavours to promote integration and partnership in health and wellbeing provision across North Yorkshire.

The board's strategic priorities, prevention, place and people, focus on areas where there are opportunities for partners to work together to have a real impact on health and wellbeing outcomes for people of all ages, to provide children with the best start in life and to reduce health inequalities. A detailed agenda of population focussed programmes sits beneath each of the strategic priorities and good progress is being made against each of them. Key achievements in 24/25 include:

Prevention – on-going implementation of the new national Modern General Practice model to support recovery of access to primary care in communities. This supports the continuing growth in the number of appointments available in GP Practices.

Place – a renewed focus on improving food infrastructure and the local food environment, taking a whole system approach that looks to provide accessible, sustainable, and nutrient dense food, from food production to distribution, nutrition, consumption and food waste disposal and development of the first North Yorkshire Food Strategy; and

People - supporting the most vulnerable families with the cost of living by ensuring they are enrolled in schemes for which they are eligible including free school meals; the Healthy Start Scheme and government-funded childcare.

We look forward to continuing to work together in 25/26 to deliver the intentions of our Joint Health and Wellbeing Strategy 2023-2030 through which we aim to make real, generational change to the health and wellbeing of people across North Yorkshire now, and for generations to come.

North East Lincolnshire

The Health and Care Partnership in North East Lincolnshire is working actively to support the local Health and Wellbeing agenda as well as contributing to the ICB's Health and Wellbeing approach. We have been working across organisations in order to provide a holistic response and proactive interventions aimed at optimising health and wellbeing for our local residents and developed areas of focus around which our teams can coalesce. This integrated approach makes best use and builds on the long history of integrated working and commissioning services in North East Lincolnshire. Achievements over the last year include:

Frailty Sector Network - we have developed the Frailty Sector Network which has brought together individuals from primary and secondary care as well as voluntary sector, fire service and carers to identify and remove gaps and duplication and align with the ICB's Frailty Centre of Excellence programme.

A Population Health approach - we have worked with over 270 people from the local community in East Marsh to develop the East Marsh Community Plan. We have also used the engagement sessions to undertake opportunistic health interventions such as BP checks. We have now started the same approach in West Marsh. As part of the population health programme, we have also funded a voluntary sector grant programme that has reached over 1200 adults and children with an aim to improve health and wellbeing.

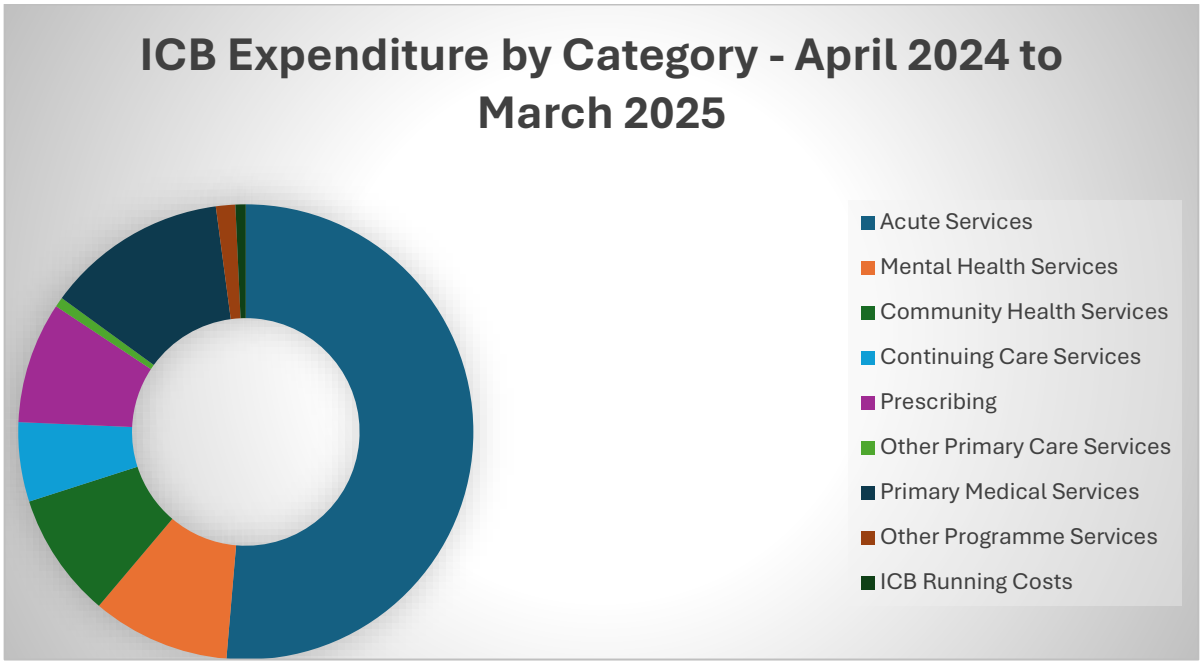
Social Prescribing/Green Social Prescribing - Over the last year we have strengthened and built upon our unique approach to Social Prescribing – Thrive NEL- helping 685 more people with long term conditions to manage their conditions effectively and improve their health and wellbeing and consequent quality of life This has included an additional element of Green Social Prescribing aimed at people experiencing low level mental health difficulties such as stress, anxiety and depression. A further 75 people have enjoyed outside activities such as guided walks and derived all the wellbeing benefits of experiencing nature and making friends.

Financial review

The financial position covers the period 1st April 2024 to 31st March 2025.

The annual accounts demonstrate the ICB has achieved delivery within the statutory financial performance duty, in the form of a surplus of £74k (£97k exc. IFRS 16 finance costs) against a total resource limit of approximately £4.2bn.

The chart below provides the split of ICB resources utilisation across the service lines during the financial period:



As a statutory public body there is a responsibility to contain administrative costs within the "running cost" allocation for the organisation.

The ICB has spent £31.2m on the administration of the organisation in 2024/25 which is significantly below the running cost allocation available of £32.5m.

The accounts have been prepared under a direction issued by the NHS Commissioning Board (NHS England) under the National Health Service Act 2006 (as amended).

Over recent years, there have been significant levels of non-recurrent funding made available. Whilst welcome and has supported delivery of the statutory financial performance duties, the underlying financial pressure within organisations and budgets continues to be a significant challenge.

The ICB has on focused delivering value for money and ensuring robust financial control is in place, all whilst dealing with changing and unpredictable circumstances. Humber and North Yorkshire Integrated Care Board Annual Report and Accounts have been prepared on a Going Concern basis.

The Joint Capital Resource Use Plan (prepared by ICB's and partner trusts) is intended to ensure there is transparency for local residents, patients, NHS health workers and other NHS stakeholders to demonstrate how the capital funding provided to ICBs is being prioritised and

spent to achieve the ICB's strategic aims. This aligns with ICBs' financial duty to ensure allocated capital is not overspent and the obligation to report annually on the use of resources.

A copy of the published plan is available on our website

The table below highlights the movement from the opening 2024/25 plan to the actual 2024/25 spend.

Capital Departmental Expenditure Limit (Capital Spending Limit) 2024/25		Total Full Year Plan £'000	Total Full Year Actual £'000	Total Full Year Variance £'000	Narrative relating to the main categories of expenditure
Provider	Operational Capital	97,547	97,308	(239)	Capital to Revenue Expenditure
ICB	Operational Capital	15,036	15,035	(1)	
Total Operational Capital		**112,583**	**112,343**	**(240)**	
Provider	Impact of IFRS 16	20,090	20,090	0	
ICB	Impact of IFRS 16	410	141	(269)	Estate leases not agreed
Provider	Upgrades & NHP Programmes	0	0	0	
Provider	National Programmes (Diagnostics, Front Line Digitisation, Mental Health, TIF)	86,370	86,369	(1)	
Provider	Other (Technical Accounting)	1,496	1,496	0	Private Finance Initiative (PFI) payments
Total System CDEL		**220,949**	**220,439**	**(510)**	

Mana in our r esources in 2025/26 and beyond

The annual NHS finance and operational planning round requires the Integrated Care Board (ICB) to build and produce a robust financial plan.

Demonstrating affordability and delivery within the published allocations set by NHSE England and provide balanced plans for the financial year 2025/26 both for the ICB and the wider Integrated Care System (ICS). This includes providers within the geographical boundary.

Balanced plans for the ICB and the system were submitted on 30th April 2025.

The planning round for 2025/26 has been particularly challenging as the system faces the removal of large non recurrent sources of income; excess inflation across all areas of expenditure; significant workforce challenges (including the expectation of a 50% reduction across corporate functions), as well as issues of quality.

The plans contain a level of risk recognised by all system partners with a pragmatic agreement, sharing risk across the system on the basis to work together collaboratively, to successfully mitigate these risks.

There has never been a greater need for organisations to work together to ensure maximum value is achieved from every pound spent. The following guiding principles remain a key focus for the ICB:

- decisions taken closer to the communities they affect are likely to lead to better outcomes.

- collaboration between partners in a place across health, care services, public health, and voluntary sector can overcome competing objectives and separate funding flows to help address health inequalities, improve outcomes, and deliver joined-up, efficient services for people; and

- collaboration between providers (ambulance, hospital, and mental health) across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity.

To respond to the significant financial and quality challenges facing the NHS, Humber and North Yorkshire continues to develop and enhance the system wide approach to quality, efficiency, and productivity.

The key focus for 2025/26 is the financial sustainability and delivery of the financial plan for Humber and North Yorkshire, delivering the transformation needed to live within the financial means available to the Integrated Care System.

Access to Information (Freedom of Information)

During the period from 1 April 2024 to 31 March 2025, the ICB processed the following requests for information under the Freedom of Information Act 2000 (FOIA):

Freedom of Information (FOI)	2024/25
Number of FOI requests processed	563
Percentage of requests responded to within 20 working days	98.8%
Average time taken to respond to an FOI request (in days)	13 days

The ICB provided the full information requested in 183 cases and for 151 requests an exemption was applied either to part of, or to the whole request. The exemptions applied during this period were:

- The cost of providing the information exceeded the limits set by the FOIA.
- The request was vexatious or repeated.
- The information was accessible by other means.
- Information requested related to personal data and compliance would breach the principles in Data Protection Legislation.
- The information was intended for future publication.
- The information was exempt as compliance would prejudice law enforcement.
- Disclosure of information would or would be likely to prejudice to the conduct of public affairs.
- The request fell within the scope of the Environmental Information Regulations 2004.
- The information was provided to the ICB in confidence.
- The information was covered by legal professional privilege.

- Disclosure of information would, or would be likely to, prejudice the commercial interests of any legal person.

In 354 cases, the ICB was unable to provide all the information requested, as it was either not held in full, or only partially held. Where information was not held, the applicant was redirected, where possible, to other organisation(s) that may hold the information.

The ICB conducted six internal reviews, and in each case, upheld the original decision either partially or fully. In one instance, additional information was supplied, and in another, Section 12 of the FOI Act was invoked to refuse a request due to excessive cost. Additionally, in one review, the ICB cited Section 36 of the FOIA for exempting requested information.

As a matter of best practice the ICB publishes FOIA reports on a quarterly basis at the link below: https://humberandnorthyorkshire.icb.nhs.uk/foi/3-what-our-priorities-are-and-how-we-are-doing/

Our publication scheme contains documents that are routinely published, this is available on our website: https://humberandnorthyorkshire.icb.nhs.uk/foi/

Accountability Report

Teresa Fenech

Accountable Office (Acting Chief Executive)

June 2025

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 2023 to 31 March 2024 including the membership and organisation of our governance structures and how they support the achievement of our objectives.

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

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

Corporate Governance Report

Members Report

The Members' Report contains details of our Board membership and where people can find Board member profiles and the register of interests.

Member profiles

Board Member profiles can be found on the ICB website.
(https://humberandnorthyorkshire.icb.nhs.uk/board-members/)

Details of Board member roles, attendance, quorum, and effectiveness can be found ICB Board Annual Review of Effectiveness 2024/25 report available on our website https://humberandnorthyorkshire.icb.nhs.uk/meetings-and-papers/9-april-2025/

Composition of the Board

(Memberships run from 1 April 2023 – 31 March 2024 inclusive unless stated otherwise)

ICB BOARD MEMBERS (ORDINARY MEMBERS - VOTING)
Sue Symington, Independent Chair Left post March 2025
Stephen Eames, Chief Executive
Amanda Bloor, Acting Chief Executive Acting up from 1 December 2024
Amanda Bloor, Deputy Chief Executive / Chief Operating Officer In substantive post until 1 December 2024
Jane Hazelgrave, Acting Deputy Chief Executive / Chief Operating Officer Acting up from 9 June 2024 – 5 March 2025
Jane Hazelgrave, Executive Director of Finance & Investment In substantive post until 9 June 2024
Emma Sayner, Acting Executive Director of Finance & Investment 10 June 2024 – 30 November 2024
Mark Brearley, Interim Executive Director of Finance & Investment Interim from 1 December – 31 March 2025
Teresa Fenech, Executive Director of Nursing & Quality
Dr Nigel Wells, Executive Director of Clinical & Professional Services
Jayne Adamson, HNY ICB Executive Director of People
Mark Chamberlain, Non-Executive Director
Stuart Watson, Non-Executive Director
Richard Gladman, Non-Executive Director
Dr Bushra Ali, Primary Care Partner Member
Jonathan Lofthouse, Provider Partner Member
Councillor Jonathan Owen, LA Partner Member / ICP Vice-Chair

ICB BOARD MEMBERS (PARTICIPANTS – NON-VOTING)
Karina Ellis, HNY ICB Executive Director of Corporate Affairs
Anja Hazebroek, HNY ICB Executive Director of Comms, Marketing and Media Relations
Peter Thorpe, HNY ICB Executive Director of Strategy & Partnerships
Max Jones, HNY ICB Chief Digital Information Officer
Andrew Burnell, Participant Community Interest Companies
Michele Moran, Participant Mental Health Left Post April 2024
Brent Kilmurray, Participant Mental Health Joined April 2024
Jason Stamp, Participant Voluntary & Community Sector
Louise Wallace, Participant Public Health
Helen Grimwood, Participant Healthwatch
Councillor Michael Harrison, Participant Local Authority North Yorkshire
Councillor Stanley Shreeve, Participant Local Authority North East Lincolnshire
Professor Charlie Jeffery, Participant Further Education
Simon Stockill, Participant Primary Care Collaborative Lead
Mike Napier, Board Secretary Until December 2024

* From 1 April 2025, Teresa Fenech was appointed by NHS England as the Accountable Officer and Acting Chief Executive of NHS Humber and North Yorkshire Integrated Care Board. In this capacity, Teresa Fenech will serve as the signatory of the Annual Report and Accounts for the financial year 2024/25.

Committee(s), including Audit Committee

The ICB has established several committees to support in the discharge of its functions. These include:

- Audit Committee
- Remuneration Committee
- Quality Committee
- Executive Committee
- Population Health & Prevention Committee
- Clinical & Professional Committee
- Digital Committee (merged November 2024)
- Innovation Research Improvement System (IRIS) Committee (merged November 2024)
- Workforce Committee (aka Workforce Board)
- Finance, Performance & Delivery Committee
- Pharmaceutical Services Regulations Committee (Committees in Common)
- North East Lincolnshire Joint Committee
- Digital, Data, and Innovation Committee (DDIC) – newly formed committee merged from Digital Committee and Innovation Research Improvement System (IRIS) Committee.

The Integrated Care Partnership is a statutory committee jointly convened by six Local Authorities and the NHS Humber & North Yorkshire Integrated Care Board and comprises of a broad alliance of organisations and other representatives as equal partners concerned with improving the health, public health and social care services provided to their population.

Each committee operates under terms of reference agreed by the Board. All terms of reference are published in the ICB's Governance Handbook.
https://humberandnorthyorkshire.icb.nhs.uk/governance-publications/

Further detail around the membership and work of the other Committees is included later in this report as part of the Annual Governance Statement.

The 2024/25, committees Annual Reports and Effectiveness Reviews, which include details of membership, attendance, quoracy, outcomes from agenda items discussed, how conflicts of interest (where applicable) have been managed and the results of an assessment of effectiveness can be found in the published Board papers. https://humberandnorthyorkshire.icb.nhs.uk/meetings-and-papers/9-april-2025/

Register of Interests

The declared interests of our Board and Committee members are recorded in the ICB's Register of Interests, which can be viewed on the ICB's website at https://humberandnorthyorkshire.icb.nhs.uk/governance/conflicts-of-interest/

Personal data related incidents

The ICB recognises the importance of maintaining data in a safe and secure environment and we place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information.

The ICB currently utilises a desktop incident reporting portal to report and assess any matters involving potential data loss to the organisation.

As reported in our Annual Governance Statement to this Annual Report, the ICB has reported one data security incident to the Information Commissioners Office (ICO) in 2024/25, which was in relation to an incident at a GP Practice. As the ICB is not the data controller for this incident the ICO advised it must be reported via the Practice.

Modern Slavery Act

NHS Humber & North Yorkshire Integrated Care Board fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the period ending 31 March 2025 is published on our website

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 NHS Humber and North Yorkshire Integrated Care Board and of its income and expenditure, Statement of Financial Position, and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- 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 Teresa Fenech to be the Accountable Officer of NHS Humber and North Yorkshire Integrated Care Board. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the NHS Humber and North Yorkshire Integrated Care Board'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 Humber and North Yorkshire Integrated Care Board'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.

Annual Governance Statement

Introduction and context

NHS Humber and North Yorkshire Integrated Care Board is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

The NHS Humber and North Yorkshire Integrated Care Board's statutory functions are set out under the National Health Service Act 2006 (as amended).

The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

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

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Humber & North Yorkshire Integrated Care Board's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in the NHS Humber & North Yorkshire Integrated Care Board's Accountable Officer Appointment Letter.

I am responsible for ensuring that the NHS Humber & North Yorkshire Integrated Care Board is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the ICB as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the ICB Board is to ensure that the group 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.

Good governance is important for NHS Humber and North Yorkshire ICB. It helps meet legislative responsibilities and ensures efficient and effective operation. Governance processes include accountability, transparency, ethics, and strong leadership, which contribute to trust in the ICB among staff, the public, system partners, NHS England, and the Government.

The ICB Constitution and Standing Orders approved by the Board is compliant with NHS England requirements. The Scheme of Reservation and Delegation (SoRD) and Operational Scheme of

Delegation (OSD) outline decisions reserved for the ICB, its committees, officers, and employees.

The Constitution includes:

- Core purpose of the Integrated Care System (ICS)
- Composition of the Board of the ICB
- Appointments process for the Board
- Arrangements for the exercise of our functions
- Procedures for making decisions.
- Arrangements for conflicts of interest management and code of conduct and behaviours
- Arrangements for ensuring accountability and transparency.
- Arrangements for determining terms and conditions of employees.
- Arrangements for public involvement
- Appendices include definitions and the Standing Orders.

The ICB, mandated by NHS England, must maintain and publish its Constitution and Standing Orders. Amendments require Board approval before submission to NHS England.

Amendments of the Constitution and Standing Orders went to the Board in February 2025. Those changes included:

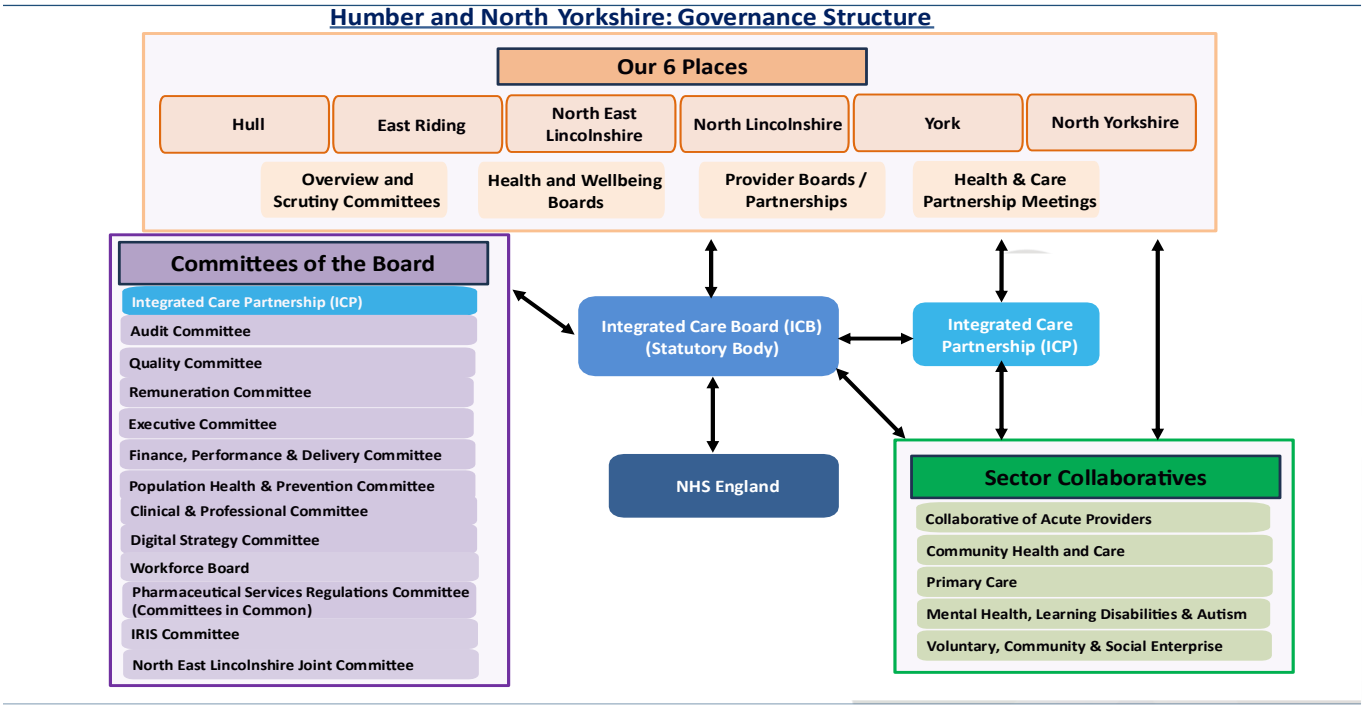
- Amendments requested by NHS England following changes to the model constitution.
- Minor changes to Member roles to enhance commitments and capacity for the ICB Board.

These changes were submitted to NHS England in April 2025 and subsequently approved. The revised Constitution and Standing Orders is published on our website https://humberandnorthyorkshire.icb.nhs.uk/governance/

ICB Board and Committee Structure

The ICB Board includes Executive, Clinical, Non-Executive Directors, and key stakeholders from the Integrated Care System. Responsibilities are clearly divided, preventing any single individual from having unregulated decision-making power.

The Board leads performance and finance development and has several committees to help deliver statutory functions and strategic objectives. The Board regularly reviews reports from these committees and various updates to assess performance and direct necessary actions. The following structure outlines the governance of the ICB Board and its Committees.



An annual report has been created for each Committee of the Board. These reports include key responsibilities, membership, attendance, quorum, conflicts of interest, and highlights of their work over the year. The ICB Committees Annual Reports are available on our website https://humberandnorthyorkshire.icb.nhs.uk/meetings-and-papers/9-april-2025/

ICB Board Effectiveness

The ICB Constitution outlines the Board's composition and key roles. A formal competency-based assessment process governs Board Member appointments and aligns with the Fit and Proper Person Test (FPPT).

All ICB Board members possess the leadership skills required for their roles and have established credibility with stakeholders and partners. To maintain and develop their knowledge and skills they undergo statutory training, with additional learning provided through Board workshops and individual appraisals.

The ICB Board receives strategic information on the delivery of finance, performance, strategy, policy, risk, and quality assurance at every meeting. The Board regularly reviews its own performance, using HFMA Audit Committee Handbook guidance. In March 2025, the Board assessed its effectiveness for 2024/25, confirming it has met its duties.

Each Committee of the Board has also reviewed their effectiveness for 2024/25, reporting findings to the ICB Board alongside the Committee Annual Reports in April 2025. These reports are available on our website.
https://humberandnorthyorkshire.icb.nhs.uk/meetings-and-papers/9-april-2025/

In 2024/25, the ICB Board maintained quorum and high attendance at all meetings.

Committees and sub-committees

In line with its Constitution, the ICB Board has the authority to establish committees and delegate its functions to them. Each committee can further appoint sub-committees and delegate functions to these sub-committees. The terms of reference for each committee, detailing these arrangements, are available on the website:
https://humberandnorthyorkshire.icb.nhs.uk/governance/

Other Important ICS features are:

***Place-based partnerships**:* between the NHS, local councils, voluntary organisations, residents, service users, carers, and families will design and deliver integrated services locally.

***Provider collaboratives**:* NHS providers working together across one or more ICBs with clinical networks, alliances, and partners to benefit from scale.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance.

However, we have reported on our corporate governance arrangements by incorporating best practices, including relevant aspects of the UK Corporate Governance Code applicable to the ICB Board. For the financial year ending 31 March 2025, and up to the date of signing this statement, the ICB Board has aligned with the provisions outlined in the UK Corporate Governance Code as shown below:

Leadership

The strategic and operational management of the ICB is overseen by the ICB Board. This Board comprises a diverse range of skills from Executive, Clinical, and Non-Executive Directors, as well as key stakeholders across the ICS, with other attendees participating as appropriate. The ICB Board has clearly defined responsibilities delegated to its formal Committees and Officers, along with a transparent decision-making process. The individual members of the Board contribute varied perspectives based on their professions, roles, backgrounds, and experiences. These differing insights into the challenges and opportunities faced by the ICB ensure a balanced approach across all aspects of its operations.

Accountability

Good governance is crucial for Humber and North Yorkshire ICB, ensuring compliance with laws and efficient operations. Our processes foster accountability, transparency, ethics, and strong leadership. This builds confidence and trust among staff, the public, NHS England, and the Government in our decisions.

The ICB regularly reviews its governance arrangements throughout the financial year, with particular focus at year-end for assurance purposes, as detailed within this statement.

In 2024/25, the ICB Board appointed one of its Non-Executive Directors as a Senior Independent Director (SID). The SID supports the Chair, oversees the Chair's appraisal and succession

planning, intervenes during Board conflicts, and ensures effective governance to meet statutory duties and improve care quality.

The ICB Audit Committee is overseen by the Non-Executive Director for Audit. The Audit Chair has served as the Conflicts of Interest Guardian throughout 2024/25, supported by the Executive Director of Corporate Affairs and their team.

The ICB has established several controls to ensure lines of accountability are clear, including the Scheme of Reservation and Delegation (SoRD), the Operational Scheme of Delegation (OSD), a Governance Handbook, and a Functions and Decisions Map. These controls will be strengthened further in 2025/26.

The ICB Board utilises a Board Assurance Framework (BAF) to manage risks that could affect the achievement of its strategic objectives and takes this in public at its monthly meetings. Further detail on this is included in Risk Assessment section of this report. Internal Audit completed an audit of the ICB Board's Board Assurance Framework for 2024/25, providing an opinion of **High Assurance**.

The ICB's internal audit services are provided by Audit Yorkshire, while external audit services are provided by Forvis Mazars LLP on behalf of the ICB. Both Internal Audit and External Auditors report to the Audit Committee.

Remuneration

The Remuneration Committee is established to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. In summary, this is to confirm the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including board members) and Non-Executive Directors excluding the Chair.

The Remuneration Committee has delegated authority from the ICB Board on the oversight of executive board member performance. The Remuneration Committee does not include Members that are fulltime employees. Conflicts of Interest are managed so that no individual is involved in deciding their own remuneration.

Relationships with Stakeholders

ICB Board meetings are held publicly, with papers published on the ICB website five working days before the meetings. Minutes of public meetings are also available for accountability and transparency. The ICB Constitution outlines the decision-making process and voting rights.

The ICB's Annual General Meeting (AGM) communicates with stakeholders and the public, encouraging their participation. At the AGM, the Chair, Chief Executive, and other ICB members, including committee chairs, will answer questions.

Discharge of Statutory Functions

NHS Humber and North Yorkshire Integrated Care Board has reviewed all of 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 lead Executive Director. 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

The ICB has a statutory and regulatory obligation to ensure that systems of control are in place to minimise the impact of all types of risk. The Board Assurance Framework (BAF) and Committee, Collaborative and Place Risk Registers are essential elements of a robust and comprehensive internal control framework for the ICB.

The ICB Executive Team oversees the development of the wider risk management strategy and framework of which the BAF and ICB risk register are important elements. The ICB committees and collaboratives have oversight of the risks aligned to them with relation to the BAF and maintain their own risk registers. The Place Health, and Care meetings of the ICB have oversight of the shared risks within the Place based risk registers.

In 2024/25, HNY ICB risk management maintained a strong relationship between managed risks at different levels. High-risk key themes were escalated to the Executive Committee for validation before being considered by the Board as potential principal risks.

The training programme in 2024/25 included development sessions, Bitesize chunk sessions, and Demo oversight for individual staff, the Place committee, and collaborative meetings as requested.

Capacity to Handle Risk

The Board Assurance Framework (BAF) provides the organisation with a clear and comprehensive method for managing key risks that may either impede or facilitate the Integrated Care Board (ICB) in achieving its strategic objectives and statutory duties. The BAF also serves as an essential source of evidence, demonstrating how the ICB is meeting its internal control obligations.

The BAF is crucial for ensuring that risk management is embedded within the organisation. A primary function of the Board Assurance Framework is to identify gaps in control or assurance related to these principal risks. Furthermore, it offers a structure for the evidence supporting the Annual Governance Statement. This approach streamlines Board reporting and prioritises action plans, resulting in more effective performance management.

In 2024/25, Board members reviewed and ratified the ICB's strategic objectives, aligning these objectives with the principal risks identified within the BAF. The BAF delineates the controls implemented to manage these risks and provides assurances to support evaluations of whether these controls are yielding the intended outcomes. Additionally, it outlines actions to further mitigate each risk.

The BAF has been designed to ensure clear connections between the governance responsibilities of the Board, the accountability lines across the Executive Directors, and the assurance activities of the Board's Governance Committees. The Audit Committee oversees the

development of the broader risk management strategy and framework, of which the BAF is a component. The Audit Committee also maintains oversight of the BAF's development.

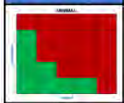
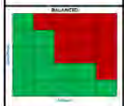
The ICB's Board Assurance Framework was submitted to the Board for consideration and approval at every monthly meeting throughout 2024/25 and is available on our website https://humberandnorthyorkshire.icb.nhs.uk/meetings-and-papers/

All BAF risks, including scores, assurances, control gaps, and mitigating actions, are regularly updated and signed off by Executive Director Leads and/or the aligned Committee. The Executive Committee reviews these updates before ICB Board approval.

The ICB's risk register is linked to the agreed risk appetite by risk type to support the effective management of risks across the organisation. Risk appetite is aligned to the 10 risk domains (agreed drivers) included in the table below. The resultant heat maps allow the ICB Board, committees, collaboratives, and staff to focus resources and attention more effectively on key risks that are 'out of appetite.'

Strategic Objective	Domain (10 agreed drivers)	Risk Appetite	Descriptors
A: Leading for Excellence	Delivery Improvement	Balanced (8)	• Quality Improvement • Patient Safety • Innovation & Research • Upscaling Digital Solutions / Cyber-Security • Data Quality / BI and real time decision making • Resource shift across sectors • Embed accountabilities and delegated authority
	Data and Digital	Open (12)	
	Empowering Collaboratives	Open (12)	
B: Leading for Prevention	Population Health	Open (12)	• Outcomes through transformation and service improvement • Pop health & inequalities, targeting most deprived communities • Focus on cancer, CVD, MH and elderly/frail and H&WB of children • HNY centre for excellence for tobacco control
	Relationship with Place	Open (12)	
C: Leading for Sustainability	System workforce	Open (12)	• Workforce breakthrough programme • Leadership development • Productivity, including use of technology • Service provision blueprint (productivity and efficiency plans, incl estate)
	Sustainable Estate	Open (12)	
	Outcomes Led Resourcing	Balanced (8)	
D: Voice at the Heart	Transformative public engagement	Open (12)	• Meaningful engagement and co-production • Engagement for prevention, focussed on health inequalities • Stakeholder management
	System Voice and Relationships	Open (12)	

The ICB's Board has defined a clear approach to risk taking, tolerances, and control. In April 2024 the Board revisited the risk appetite to ensure appropriate tolerances and controls are in place. Reconfirming our risk appetite fosters confidence, competence, and resilience incrementally. While risk is inevitable, the ICB's risk appetite, outlined below, is informed by experience and knowledge.

Heat Map	Tolerance Level	Risk Appetite	Description
	**Very low**	**Minimal (4)**	Avoidance of any risk or uncertainty. Every decision will be to terminate the risk.
	**Low**	**Cautious (6)**	Preference for the safe option but is able to tolerate low level risk and uncertainty. Every decision will be to mitigate the level of risk.
	**Medium**	**Balanced (8)**	Will seek to mitigate all risks and take actions to minimise harm or adverse clinical outcomes, while considering all options and tolerating a modest amount of risk if the benefit is clearly demonstrated. There is an acceptance that some impact may occur in pursuit of the outcome.
	**High**	**Open (12)**	Open to consider all options and take a greater amount of risk and uncertainty to achieve a bigger reward. Likely to choose an option that has a greater reward and accepts some impact.
	**Very high**	**Hungry (16)**	Eager to take on risk to achieve objectives. Will choose the option with greater reward and will accept any impact for the price of reward.

Risk Assessment

As of 31 March 2025, the ICB's BAF identifies 12 principal risks that pose a threat to the achievement of organisational strategic objectives. Among these risks, 7 are managed 'out of appetite' and 5 are managed ‘in appetite’. Additionally, six risks were closed in the 2024/25 period.

The tables below provide the full details of the risks including those in and out of appetite and those that have closed:

Out of Appetite

Strategic Objective A: Leading for Excellence

REF	Domain	Principal Risk	Risk Owner	Assurance Committee	Current Risk (After Mitigation) I	L	Rating I x L	Risk Appetite	Status (In / Out of Appetite)
A1	Delivery Improvement	**1:** Failure to effectively recognise, monitor and have mitigating actions to improve standards of local care will impact on patient safety and positive health outcomes for local people and communities.	ED Nursing & Quality	Quality Committee	5	5	25	8 BALANCED	OUT
A2	Delivery Improvement	**2:** Failure to deliver the ICB Operating plan for 2024/25, and the associated 32 national objectives, may result in patients not being treated in a timely and appropriate manner.	Deputy Chief Executive / COO	Finance, Performance & Delivery Committee	4	4	16	8 BALANCED	OUT

Strategic Objective C: Leading for Sustainability

REF	Domain	Principal Risk	Risk Owner	Assurance Committee	Current Risk (After Mitigation) I	L	Rating I x L	Risk Appetite	Status (In / Out of Appetite)
C3a	Outcomes Led Resourcing	**3:** Failure to operate within the ICBs available resources for 2024/25 will cause financial instability leading to poorer outcomes for the population; threaten individual organisation sustainability; undermine confidence in the ICB leadership; risks the system being subject to escalated oversight from regional and national processes that detract from getting on with the required responsibilities and priorities.	ED Finance & Investment	Finance, Performance & Delivery Committee	3	3	9	8 BALANCED	OUT
C3b	Outcomes Led Resourcing	**3:** Failure to operate within the ICSs available resources for 2024/25 will cause financial instability leading to poorer outcomes for the population; threaten individual organisation sustainability; undermine confidence in the leadership; risks the system being subject to escalated oversight from regional and national processes that detract from getting on with the required responsibilities and priorities.	ED Finance & Investment	Finance, Performance & Delivery Committee	4	5	20	8 BALANCED	OUT
C5a	Outcomes Led Resourcing	**5:** Failure to deliver a medium-term financial plan for the ICB, that achieves financial sustainability and recovery, leading to poorer outcomes for the population; threatens ICB sustainability; undermines confidence in the ICB and ICS leadership, as part of the system.	ED Finance & Investment	Finance, Performance & Delivery Committee	4	3	12	8 BALANCED	OUT
C5b	Outcomes Led Resourcing	**5:** Failure to deliver a medium-term financial plan for the system, that achieves financial sustainability and recovery, leading to poorer outcomes for the population; threatens individual organisations sustainability; undermines confidence in the ICB, ICS leadership and System leaders.	ED Finance & Investment	Finance, Performance & Delivery Committee	4	4	16	8 BALANCED	OUT
C7	System Workforce	**7:** Failure to recruit and retain staff of the right calibre and with the right values will prevent the ICB organisation delivering its core purposes. Lack of effective succession planning will reduce the leadership capability of the ICB and limit the impact and effectiveness of the organisation in leading the improvement and transformation of the HNY health and care system.	ED People	Workforce Board (Workforce Committee)	4	4	16	12 OPEN	OUT

In Appetite

Strategic Objective A: Leading for Excellence										
BAF REF	Domain	Principal Risk	Risk Owner	Assurance Committee	Current Risk (After Mitigation) I	L	Rating I x L	Risk Appetite	Status (In / Out of Appetite)
A3	Data and Digital	**3:** Failure to develop data and digital maturity (including Cyber Security) will prevent the ICS from delivering against its core purposes.	Chief Digital Information Officer	Digital Data and Innovation Committee	4	3	12	12 OPEN	IN
Strategic Objective B: Leading for Prevention										
BAF REF	Domain	Principal Risk	Risk Owner	Assurance Committee	Current Risk (After Mitigation) I	L	Rating I x L	Risk Appetite	Status (In / Out of Appetite)
B1	Empowering Collaboratives	**1:** Failure of the ICB to align with the wider partnership vision and priorities and therefore not transforming services to achieve enduring improvement to the health & wellbeing of our population & local communities.	Deputy Chief Executive / COO	Population Health & Prevention Committee	4	3	12	12 OPEN	IN
Strategic Objective C: Leading for Sustainability										
REF	Domain	Principal Risk	Risk Owner	Assurance Committee	Current Risk (After Mitigation) I	L	Rating I x L	Risk Appetite	Status (In / Out of Appetite)
C2	Sustainable Estates	**2:** The estates infrastructure of the ICS hinders our ability as an ICB to deliver consistently high-quality care.	ED Finance & Investment	Finance, Performance & Delivery Committee	4	3	12	12 OPEN	IN
C6	System Workforce	**6:** Failure to recruit and retain staff of the right calibre and with the right values will prevent the ICB organisation delivering its core purposes. Lack of effective succession planning will reduce the leadership capability of the ICB and limit the impact and effectiveness of the organisation in leading the improvement and transformation of the HNY health and care system.	ED People	Workforce Board (Workforce Committee)	4	2	8	12 OPEN	IN
Strategic Objective D: Voice at the Heart										
BAF REF	Domain	Principal Risk	Risk Owner	Assurance Committee	Current Risk (After Mitigation) I	L	Rating I x L	Risk Appetite	Status (In / Out of Appetite)
D1	Transformative Public Engagement	**1:** Failure to effectively engage and deliver our legal duty to involve patients and the public in decision making and service development will prevent the ICS from providing integrated, coordinated and quality care.	ED Communications, Marketing & MR	Quality Committee	4	3	12	12 OPEN	IN

BAF Risks Closed in 2024/25

CLOSED RISKS 2024/25 (old reference system)	
BAF Ref: B2 (old reference system)	**STRATEGIC OBJECTIVE B: Managing Tomorrow**
Principal Risk: Failure to connect and build relationships with all partners and stakeholders around meeting the wider needs to the population will lead to fragmentation and reduce the impact on wider determinants that affects the population.	
Reason for Closure: Risk score met risk appetite and became part of business as usual	
Date Approved for Closure by the ICB Board: 10 April 2024	
BAF Ref: C2 (old reference system)	**STRATEGIC OBJECTIVE B: Enabling the effective operation of the organisation**
Principal Risk: Failure to ensure the ICB maintains robust governance processes and effective control mechanisms will prevent the ICB meeting regulatory and compliance standards and threaten organisational sustainability and undermining confidence in the ICS leadership	
Reason for Closure: Risk score met risk appetite and became part of business as usual	
Date Approved for Closure by the ICB Board: 10 April 2024	
BAF Ref: A6 (old reference system)	**STRATEGIC OBJECTIVE B: Managing Today**
Principal Risk: Failure to deliver the ICB Operating plan for 2023/24, and the associated 31 national objectives, may result in patients not being treated in a timely and appropriate manner.	
Reason for Closure: Risk specific to 2023/24 – New risk opened for 2024/25	
Date Approved for Closure by the ICB Board: 8 May 2024	
BAF Ref: A3 (old reference system)	**STRATEGIC OBJECTIVE B: Managing Today**
Principal Risk: Failure to operate within the ICB's available resources for 2023/24 will cause financial instability leading to poorer outcomes for the population and threaten organisational sustainability undermining confidence in the ICS leadership.	
Reason for Closure: Risk specific to 2023/24 – New risk opened for 2024/25	
Date Approved for Closure by the ICB Board: 8 May 2024	

CLOSED RISKS 2024/25 (new reference system)	
BAF Ref: C1	**STRATEGIC OBJECTIVE C: Leading for Sustainability**
Principal Risk: Immediate term financial pressure, employment relations challenges and increasing workload lead to reductions in the availability of workforce across the system and in the numbers of people who choose to start training this year for future health and care careers, negatively affecting service user experience and individual outcomes.	
Reason for Closure: Previously, risks C1 and C4 were identified within the "today" and "tomorrow" risk domains on the Balanced Assessment Framework (BAF). Subsequent to the revision of risk domains to incorporate "leading for sustainability," the Workforce Board/Committee determined that a single consolidated risk, C7, adequately encompasses the elements of the original risks C1 and C4.	
Date Approved for Closure by the ICB Board: 14 August 2024	
BAF Ref: C4	**STRATEGIC OBJECTIVE C: Leading for Sustainability**
Principal Risk: Failure to deliver or capitalise on priority workforce transformation initiatives lead to static or worsening workforce recruitment and retention challenges system-wide over coming years, which in turn negatively affect population health outcomes and limit impact on health inequalities	
Reason for Closure: Previously, risks C1 and C4 were identified within the "today" and "tomorrow" risk domains on the Balanced Assessment Framework (BAF). Subsequent to the revision of risk domains to incorporate "leading for sustainability," the Workforce Board/Committee determined that a single consolidated risk, C7, adequately encompasses the elements of the original risks C1 and C4.	
Date Approved for Closure by the ICB Board: 14 August 2024	

ICB Committee, Collaborative and Place Risk Registers

The ICB committees and collaboratives maintain their own risk registers and web-based dashboards. Our established processes ensure clear links between the Board's governance responsibilities, the lines of accountability across the Executive Directors, and the assurance activities of the Board's Committees and collaboratives, particularly the Audit Committee, which oversees the development of the wider risk management strategy and framework.

Individual system risk assessments are crucial for consistently identifying, quantifying, mitigating, or eliminating key threats to the Integrated Care Board's (ICB) objectives, as well as those shared with its Integrated Care System (ICS) partners. In 2024, significant progress was made with the implementation of a unified ICB-wide risk management approach, including the alignment of new strategic objectives and domains for all ICB risks in May 2024.

Key facets include:

- To maintain a bottom-up approach to risk, with the primary building block for the ICB risk management process being the risks managed at the appropriate level within the system be it Place, collaboratives, committees, and all other aspects of the ICB.
- The designing of the ICB risk management framework around the principle of variable risk appetite, which balances the ICB's tolerance to risk against the delivery of its vision and ambitions.
- The management and oversight of risks should be carried out as close to the source of the risk as possible, with onward reporting and assurance being undertaken in accordance with the Board defined out of appetite risk thresholds.
- The adoption of a single ICB methodology to enable the consistent recording and appraisal of risk, irrespective of its source.
- The ability to recognise the continued move to a shared responsibility model within the ICS and therefore distinguish in future between those risks that are directly within the control of the ICB and those that are shared and therefore to be managed between system partners.
- Further development of ICB risk management software that enables real-time addition and analysis of risk across the ICB at the level of granularity required – including Place, committee, and collaborative level.

The ICB's risk identification involves examining all sources of risk, both internally and externally and through a variety of sources.

During 2024/25, the ICB has maintained sound risk management and internal control systems of its significant risks detailed within the Board Assurance Framework.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the NHS Humber and North Yorkshire Integrated Care Board 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 ICB has several internal control measures monitored by the ICB Board and Audit Committee. These measures include risk management, a scheme of reservation and delegation, an operational scheme of delegation, physical controls, management controls, security controls, accounting controls, policies, and mandatory training. Additionally, the Board Assurance Framework is the main document that provides an overview of the controls and assurances in place to help the ICB achieve its strategic objectives and manage the principal risks identified.

The governance structure within the ICB establishes a control mechanism and the ICB receives regular minutes and reports from its committees to provide internal assurances on financial, organisational and quality performance.

The Audit Committee specifically advised the ICB on the effectiveness of the system of internal control by the review of the internal audit report, external audit report and the Risk Assurance Framework. Any significant control issues would be reported to the ICB by the Audit Committee.

Management of Conflicts of Interest

NHS Humber and North Yorkshire ICB strives to always achieve the highest standards of business conduct and is committed to conducting its business with honesty and impartiality. One of the overriding objectives of the ICB is to ensure that decisions made by the ICB are both taken, and taken to be seen, without any possibility of the influence of external or private interest.

The ICB's Conflicts of Interest (COI) policy reviewed in accordance with guidance issued by NHS England was approved by the Board. The Conflicts of Interest policy is available on the ICB website. https://humberandnorthyorkshire.icb.nhs.uk/governance-publications/

The procedures outlined in our policy aim to ensure that decisions made by the ICB are carried out with integrity and are perceived as unbiased by external or private interests. The ICB Constitution states that registers of interest should be maintained for members of the ICB Board, members of the board's committees and sub-committees, and its employees. The ICB maintains a Conflicts of Interest Register and, in accordance with guidance, has published all declarations of interest for individuals deemed as 'decision makers' on our website.

In 2024, NHS England rolled out a new 'Managing Conflicts of Interest' e-learning module, which is now available to all ICB staff on the ESR platform. This training package has been specially designed for integrated care boards (ICBs) and should be completed by all ICB staff, board members and sub-/committee members. The new training module explains how NHS Conflict of Interest rules should be applied within ICBs and guides and supports staff in identifying and managing real and perceived conflicts of interest.

Further details of the ICB's control mechanisms are set out throughout the governance statement.

Data Quality

The ICB acknowledges that data and evidence are essential for decision-making at every level within the health and care system, whether it pertains to productivity and efficiency, commissioning, or population health.

Our approach to managing and processing data, understanding its quality and limitations, and utilising it to support decision-making is crucial. All data is processed and stored within our secure data environment, with our data teams dedicated to ensuring timely reporting, consistent messaging through single processing, and addressing issues within our data quality frameworks.

The Board, its sub-committees, and programme leads receive high-quality performance reports based on recognised best practices, such as Plot the Dots, which emphasise the importance of performance improvement. The Board report also served as the foundation for The Insightful ICB Board example performance report published in November 2024.

The report undergoes a six-monthly review to ensure the use of appropriate measures and metrics and to maintain high-quality information flow.

Additionally, the ICB is undertaking an ambitious project, Connected HNY, to integrate further patient data into its secure data environment. This includes broader public sector data, such as educational and social care information from Local Authorities. This integration will ensure that decisions made on behalf of our population consider not only their current health needs but also other factors contributing to their overall happiness and well-being.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently, and effectively.

The ICB’s information governance arrangements, as well as demonstrating compliance with data protection legislation and NHSE guidance, are a key enabler to delivery of its strategic objectives with Information Governance an integral part of the Integrated Impact Assessment completed to support decisions for any changes to ICB policy or services.

Compliance with the ICB’s suite of information governance policies and processes is overseen by an Integrated Governance Steering Group (IGSG) supported by an Operational Information Governance Group. The IGSG also has accountable for the Data Security and Protection Toolkit (DSPT) submission and is the ICB primary policy making body for Information Governance.

During 2024/25, the ICB has been carrying out its annual assurance activities to support the DSPT submission, now aligned with the Cyber Assurance Framework. This included a review of Information Governance Policies and plans to review IG/ IT policies following the migration IT contract in April 2025. Staff responsible for various aspects of Information Governance regularly

meet to discuss progress and address any issues before the submission deadline on 30 June 2025. An audit of the evidence commenced in March 2024.

The ICB published the Privacy or Fair Processing Notice on its website: https://humberandnorthyorkshire.icb.nhs.uk/privacy-policy/

All staff must complete annual information governance training, which is regularly monitored. A staff information governance handbook has been published to clarify roles and responsibilities. Key roles such as Senior Information Risk Owner (SIRO), Caldicott Guardian (CG), and Data Protection Officer (DPO) have been assigned and trained. Information Asset Owners and Administrators must sign the Information Asset Owners Handbook and complete eLearning. Regular training sessions and updates are provided through staff meetings and briefings.

There are processes in place for incident reporting and investigation of serious incidents. The ICB has reported one data security incident to the Information Commissioners Office (ICO) in 2024/25, however this was in relation to an incident at a GP Practice therefore the ICB are not the data controller for this incident and the ICO advised it must be reported via the Practice.

Business Critical Models

The ICB has an appropriate framework and environment in place to provide quality assurance of business-critical models, in line with the recommendations in the Macpherson report, providing a structured approach to managing resources, assessing performance, mitigating risks, and ensuring high-quality service delivery. These include:

- Stakeholder experience including patient complaints and serious untoward incident management arrangements.
- Comprehensive risk management frameworks to identify, assess, and mitigate risks associated with business-critical models.
- Internal Audit Programme and External Audit review to ensure adherence to legal and regulatory requirements.
- Robust governance structures with clear portfolios for Executive Leads.
- Policy control and review processes.
- Public and Patient Engagement, and
- Third Party Assurance mechanisms.

Third party assurances

During 2024/25 the ICB has contracted with a number of external organisations for the provision of back-office services and functions. Assurances on the effectiveness of the controls in place for these are received in part from an annual Service Auditor Report from the relevant service, for 2024/25 these included:

Capita Business Services Ltd Primary Care Support England (PCSE)

Opinion: Qualified

This ISAE 3402 Type II Report provided by Forvis Mazars for the period 1 April 2024 to 31 March 2025 offered a qualified opinion. Capita provide a range of payment and pensions administration services under the Primary Care Support England (PCSE) contract. Within the scope of their work, External Audit have identified a qualification relating to one out of 15 control objectives during the period. The exception resulted in the non-achievement of the control objective: ‘Controls provide reasonable assurance that logical access by internal Capita staff and GPs to NHAIS system, Demographic Spine Application and PCSE Online is restricted to authorised individuals.' In their opinion, in all material respects, except for the matters outlined in their report, Forvis Mazars concluded that the controls tested, which were those necessary to provide reasonable assurance that the control objectives stated in the description were achieved, operated effectively throughout the period from 1 April 2024 to 31 March 2025.

CSU Collaborative, led by South Central West CSU (SCW) to manage the national Calculating Quality Reporting Service (CQRS National) Report on Internal Controls (Type II)

Opinion: Unqualified

This report, covering the period 1 April 2024 to 31 March 2025, has been prepared by Deloitte in accordance with the International Standards on Assurance Engagements 3000 (revised) and 3402 (“ISAE 3000 and 3402”) and the Institute of Chartered Accountants in England and Wales Technical Release AAF 01/20 (“AAF 01/20”). CQRS National is an approval, reporting and payments calculation system for General Practitioner (GP) practices. It helps practices to track, monitor and declare achievement for the Quality and Outcomes Framework (QOF), Direct Enhanced Services (DES) and Vaccination and Immunisation (V&I) programme. In addition, the data collected by CQRS National is used to help track GP workload, feeds into the National Diabetes Audit and forms part of the GP Collections service. The report offers an unqualified opinion, confirming that the controls tested were operating with sufficient effectiveness to provide reasonable assurance that the related control objectives stated in the report were achieved throughout the period from 1 April 2024 to 31 March 2025 if the commissioner user entities effectively operated the complementary user entity controls referred to within the report and the subservice organisations effectively operated the complementary subservice organisation controls referred to within the report. The scope of their engagement encompassed all control objectives and control activities, excluding Control Objective 1.4. They were unable to perform any procedures on the control activity related to this objective due to the absence of relevant events during the period. Consequently, they did not express an opinion on it.

NHS Business Services Authority (NHSBSA) provision and maintenance of the Electronic Staff Record system

Opinion: Unqualified

The ISAE 3000 Type II Controls Report prepared by Grant Thornton UK LLP provided an unqualified opinion. The ESR solution is a single payroll and Human Resources (HR) Management system that has been fully implemented across the whole of the NHS in England and Wales. Grant Thornton UK LLP concluded that controls tested, which together with

complementary subservice organisations and user entity controls assumed in the design of NHS Business Services Authority and IBM United Kingdom Limited's controls, if operating effectively, where those necessary to provide reasonable assurance that controls operated effectively during the period 1 April 2024 to 31 March 2025.

NHS Shared Business Services Limited's Control System or Finance and Accountin Services and on the Suitability of Design and Operating Effectiveness of its Controls

Opinion: Qualified

This ISAE 3402 report by Ernst & Young LLP for the period 1 April 2024 to 31 March 2025 provided a qualified opinion, confirming that, with the exception of three control measures relating to validation checks. The control weakness highlighted above relates to bank account change requests received by SBS from Suppliers. This weakness could have a potential impact on the ICB, particularly regarding non-NHS suppliers. Whilst geographically local suppliers/providers tend to send their requests to the ICB (where we have our own verification process in place) requests, particularly for nation-wide companies, can go directly to SBS. Unverified changes to pose to two risks to the ICB:

- A legitimate request is applied to the wrong supplier. The impact, should this occur, is low risk as it is highly likely the incorrectly paid supplier will refund the payment.
- An Illegitimate request is applied to any supplier. The impact, should this occur, is high risk as no refund would be forthcoming.

However, whilst one of these risks has been classed as high, we believe that the change of it occurring remains low. Appropriate authorisation and segregation of duties, the controls tested, which, together with the complementary user entity controls referred to in the assurance report, if operating effectively, were those necessary to provide reasonable assurance that the control objectives stated in the description were achieved, operated effectively throughout the period 1 April 2024 to 31 March 2025.

NHS Business Services Authority: Prescription Payments Process

Opinion: Unqualified

This Type II ISAE 3402 Report for the period 1 April 2024 to 31 March 2025 by Grant Thornton UK LLP provided an unqualified opinion, confirming that controls operated effectively to provide reasonable assurance that control objectives were achieved for the period 1 April 2023 to 31 March 2024 if complementary subservice organisations controls and complementary user entity controls assumed in the design of NHS Business Services Authority controls operated effectively throughout the period 1 April 2024 to 31 March 2025.

NHS Business Services Authority: Dental Payments Process

Opinion: Unqualified

This Type II ISAE 3402 Report for the period 1 April 2024 to 31 March 2025 by Grant Thornton UK LLP provided an unqualified opinion, confirming that controls operated effectively to provide reasonable assurance that control objectives were achieved for the period 1 April 2024 to 31 March 2025 if complementary subservice organisations controls and complementary user entity

controls assumed in the design of NHS Business Services Authority controls operated effectively throughout the period 1 April 2024 to 31 March 2025.

Report on NHS En l and's description o its Control System or Extraction and Processin of General Practitioner Data Services in England

Opinion: Qualified

The Type II ISAE 3000 Report for General Practitioners Payment Services and Extraction and Processing of General Practitioner Data services for the period 1 April 2024 to 31 March 2025 prepared by PricewaterhouseCoopers LLP provided a qualified opinion. For 2024/25, the auditors noted exceptions on two control objectives. The controls related to approval of new user access, the revocation of access for leavers and the quarterly review of access to the GP Data Collector (GPDC) application and appropriate segregation of duties between the production and the development environments of GPDC. In their opinion, in all material respects, except for the matters outlined in their report, PricewaterhouseCoopers LLP conclude that the controls tested, which, together with the complementary user entity controls referred to in the scope paragraph of their assurance report, if operating effectively, were those necessary to provide reasonable assurance that the control objectives stated in the description were achieved, operated effectively throughout the period 1 April 2024 to 31 March 2025.

Control Issues

As described throughout this Governance Statement, the ICB has identified a number of 'out of appetite' risks that could impact the achievement of specific strategic objectives. These risks are being actively managed through established governance and risk management systems.

During 2024/25, no significant internal control issues have been identified. Although a small number of internal audit reviews resulted in limited or low assurance ratings, these have been addressed through targeted action plans, senior management oversight, and regular monitoring.

With the exception of these known risk areas, the ICB continues to operate within a sound internal control framework, supported by established systems and processes that underpin the delivery of its statutory duties, policies, and strategic objectives.

Review of economy, efficiency & effectiveness of the use of Resources

As described earlier in this Governance Statement, the ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act. The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. One of these duties includes exercising its functions effectively, efficiently, and economically (section 14Z33 of the 2006 Act).

The Board has overarching responsibility for ensuring that the ICB has appropriate arrangements in place to exercise its functions effectively, efficiently, and economically and in accordance with the organisation's principles of good governance.

The ICB closely monitors budgetary control and expenditure. The annual budget setting process for 2024/25 was approved by the board and was communicated to all budget holders within the ICB. The Board receives a Finance update from the Executive Director of Finance and Investment at every Governing Body meeting which presents the financial position for the ICB and the ICS.

The Audit Committee has the responsibility to scrutinise in detail the ICB's financial statements, together with the report from external audit, before these are presented to Board.

The Audit Committee, which is accountable to the Board, provides the Board with an independent and objective view of the ICB's financial systems, financial information and compliance with the laws, regulations and directions governing NHS bodies. The ICB develops its control framework based on the opinion and recommendation of Internal Audit and External Audit during the year and ensures that controls operate effectively and continuously identify areas for improvement. Audit action plans are monitored, and implementation is reviewed by the Directors and reported to the Audit Committee. Internal Audit plans, approved by the Audit Committee at the outset of the year, are linked to the ICB's assurance framework with a particular focus on financial and corporate governance.

The Board receives regular reports from the Audit Committee and Finance, Performance and Delivery Committee and its other Committees. The Board forward plan and agenda provides an opportunity for the Chair of each Committee to report at each meeting and raise any matters of concern.

NHS England has a legal duty (Section 14Z16 of the National Health Service Act 2006 as amended by the Health and Care Act 2022) to annually assess the performance of each ICB in respect of each financial year and publish a summary of its findings.

Delegation of ICB functions

NHS Humber and North Yorkshire Integrated Care Board's decision reservation and delegation arrangements are outlined in this scheme of reservation and delegation (SoRD). Nonetheless, the ICB is accountable for all its functions, even those it has delegated.

The SoRD should be read with the Operational Scheme of Delegation (OSD), which outlines financial limits and operational delegations to ICB staff. The Board monitors this via regular reports from ICB's Officers and committees on resource use and risk responses.

As described earlier, processes are established that include risk assessment, management, and monitoring related to collaborative commissioning. This falls within the overall risk management framework of the ICB. Additionally, where delegated arrangements exist, they are supported by:

- Board Assurance Framework
- Risk Registers
- Consistent and regular reporting through Committees of the Board
- Consistent and regular reporting through management board arrangements.

In the context of commissioning support services, these are guided by detailed service specifications and formal contract management arrangements, with no indications of control failures.

Counter fraud arrangements.

The ICB's Audit Committee reviews and approves an annual counter fraud work plan identifying the actions to be undertaken to create an anti-fraud culture, deter, prevent, detect and, where not prevented, investigate suspicions of fraud. The counter fraud team also produces an annual report and regular progress reports for the review and consideration of the Executive Director of Finance and Investment and the Audit Committee.

All NHS services are required to provide assurance against the Government Functional Standard GovS 013: Counter Fraud (Functional Standard). The work plan for 2024/25 followed the requirements of the standard and described the tasks and outcomes that informed anti-fraud activity. There are 12 components within the Functional Standard which are sub divided as:

- Governance which outlines how the organisation supports and directs counter fraud, bribery and corruption work undertaken to create a strategic organisation-wide response when combatting fraud, bribery, and corruption.
- Counter Fraud Bribery and Corruption Practices, which outline the organisations operational counter fraud activities undertaken during the year when detecting and combatting fraud.

The ICB's counter fraud arrangements are underpinned by several key elements: the appointment of accredited Local Counter Fraud Specialists (LCFS), the implementation of an ICB-wide counter fraud and corruption policy, the designation of the Executive Director of Finance and Investment as the executive lead for counter fraud, and the establishment of a Counter Fraud Champion at a strategic level. These measures ensure access to relevant staff groups and actively encourage staff participation in fraud awareness initiatives.

The ICB completed an online Counter Fraud Functional Standard Return (CFFSR) to assess the work completed around anti-fraud, bribery and corruption work and assessed itself as a 'Green' rating for 2024/25. This self-assessment (CFFSR) detailing our scoring was approved by the Executive Director of Finance and Investment and Audit Committee Chair prior to submission.

The ICB has a team of accredited Local Counter Fraud Specialists (LCFSs) that are contracted to undertake counter fraud work proportionate to identified risks.

Head of Internal Audit Opinion (HoIA)

Following completion of the planned audit work for the period 1 April 2024 to 31 March 2025 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance, and internal control.

The provision of the HoIA opinion is a requirement of Public Sector Internal Audit Standards (PSIAS). The HoIA opinion is the rating, conclusion and/or other description of results provided

by the HoIA addressing, at a broad level, governance, risk management and/or control processes of the organisation and, for 2024/25.

NB: The new Global Internal Audit Standards in the UK Public Sector will apply from 1 April 2025.The Head of Internal Audit concluded that:

Significant Assurance

The overall opinion for the 2024/25 reporting period provides **Significant Assurance**, that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

The **basis** for forming the opinion is as follows:

- An assessment of the design and operation of the underpinning Board Assurance Framework and supporting processes.
- An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses; and
- An assessment of the organisation's response to Internal Audit recommendations, and the extent to which they have been implemented.

Unless explicitly detailed within reports, third party assurances have not been relied upon.

The 2024/25 audit plan (approved by the ICB Audit Committee on 20 June 2024) is based on consideration of the whole internal control system and the magnitude and incidence of the risks that the control system is designed to mitigate. This risk assessment approach is built around discussions and assessments with ICB Executives and Committees of the ICB Board and linked to the Assurance Framework. Internal Audit's professional judgement is also used in allocating necessary resources to each auditable area, making use, where available, of opportunities.

During this reporting period, Internal Audit issued the following audit reports:

Audit Area	Audit Assurance
Governance & Risk Management	
Board Assurance Framework	**High Assurance**
Risk Management	**High Assurance**
Freedom to Speak Up	**Limited Assurance**

Information Governance & Technology	
Data Security and Protection Toolkit (DSPT)	**High Assurance**
Cyber – Identity and Access Controls **[DRAFT]**	**Low Assurance**
Financial Management	
Financial Management of Delegated Funds for Pharmaceutical, Ophthalmic and Dental services	**High Assurance**
Stakeholders and Partnership	
Health Inequalities Funding at Place	**Significant Assurance**
North East Lincolnshire Place S75 Agreement	**Limited Assurance**
Contracting and Commissioning	
Tobacco Control Centre for Executive Health Programme	**Significant Assurance**
Dental Services	**Significant Assurance**
Individual Funding Requests	**Limited Assurance**
Quality & Safety	
Risk Management Arrangements within Nursing & Quality [**DRAFT]**	**Significant Assurance**
Safeguarding Children	**Significant Assurance**
Patient Safety Incident Response Framework **[DRAFT]**	**Significant Assurance**
Benchmarking Audits	
Patch Management	**Not Applicable (advisory)**
Board Assurance Framework and Risk Management Arrangements	
Children and Young People Health Inequalities Funding Bids review	

Audits ongoing/ to be completed during 2025/26

Report Title	Outline Scope
Procurement	Assurance that the correct tendering procedure was followed for existing contracts held by the ICB. Audit to include a review of the implementation of the new Provider Selection Regime that came into force from 1st January 2024.
Personal Health Budgets (PHB) – draft report with management for review	Assurance on the arrangements in place to support personalisation of care and to comply with national standards including the recoupment of public money where required. Audit will include the capturing of system notes for all 6 Places to identify where processes differ and the reasons why

Better Care Fund	Assurance on the pooled budget arrangements between the NHS and Local Government to deliver an agreed integrated spending plan.

While the overall Head of Internal Audit Opinion for 2024/25 provides significant assurance, reflecting that the ICB's internal control framework is generally robust and effective. We acknowledge that a small number of audits received limited or low assurance ratings. These reports were subject to detailed scrutiny at the Audit Committee, including a comprehensive review. Each report included targeted recommendations to address identified weaknesses and enhance governance and operational efficiency.

ICB Senior Managers have provided formal management responses and agreed remedial actions at the conclusion of each audit. The ICB has embedded a structured and transparent process for tracking and managing audit recommendations. Internal Audit provides regular implementation updates to the Audit Committee, ensuring that progress is monitored, and overdue actions are escalated appropriately. This approach demonstrates the ICB's commitment to continuous improvement and effective risk management.

The following potential opinion levels are available when determining the overall HoIA opinion. These levels link closely with Audit Yorkshire's standard definitions for report opinions:

Opinion Level	HoIA Opinion Definition
 **High Assurance**	High assurance can be given that there is a strong system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are being applied consistently in all areas reviewed.
 **Significant Assurance**	Significant assurance can be given that there is a good system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are generally being applied consistently.
 **Limited Assurance**	Limited assurance can be given as there are weaknesses in the design and/or inconsistent application of the framework of governance, risk management and internal control that could result in failure to achieve the organisation's objectives.
 **Low Assurance**	Low assurance can be given as there is a weak system of internal control and/or significant weaknesses in the application of controls that will result in failure to achieve the organisation's objectives.

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

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers, and clinical leads within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principles objectives have been reviewed.

The formal process for maintaining and reviewing the effectiveness of the system of internal control is:

- Since the development of the Board Assurance Framework, the ICB Board has reviewed the BAF at all of its meeting both in public and private. The ICB Board has also reviewed the BAF and its risk appetite at development sessions. Executive Directors have consistently updated BAF risks and the ICB Board has noted its assurance that risks on the BAF are being managed effectively. For 2024/25, Internal Audit gave an opinion of **High Assurance** on the BAF and the continued development of the BAF will continue to be a key focus in 2025/26. The Board keeps under review the systems of internal control not only through reports on risk management and the assurance framework but also via performance, contracting, finance and quality reports.
- At a committee level the Finance, Performance and Delivery, Clinical & Professional Executive and Quality Committees take responsibility for keeping under review the governance arrangements relating to finance, contracting, performance and clinical governance.
- The Audit Committee has oversight of the ICB's financial systems, financial information, risk management, audit, and information governance processes.
- Auditors provide further assurance through the delivery of their annual work plans and providing assurance as well as recommendations on different aspects within the system of internal control.
- Self-assessment of the risk management system and committee governance arrangements undertaken on an annual basis.
- Third party assurance. Alongside the Head of Internal Audit opinion and the annual report, the ICB considers the assurance statements received from other service providers.

Conclusion

I am assured, based on the evidence presented in this Annual Governance Statement, the Head of Internal Audit Opinion, and the control issues identified during 2024/25, that the NHS Humber and North Yorkshire Integrated Care Board has operated within a robust and effective system of internal control. This includes established governance and risk management systems that support the achievement of its statutory duties, policies, aims, and objectives.

Mitigating actions are in place to address the risks identified, and no other significant internal control issues have been identified during the reporting period.

Remuneration and Staff Report

REMUNERATION AND STAFF REPORT

Remuneration Report

Remuneration Committee

Membership of the NHS Humber and North Yorkshire ICB Remuneration Committee is comprised of the following (All memberships run from 1 April 2024 to 31 March 2025 unless stated otherwise)

Name	Title
Mark Chamberlain	Independent Non-Executive Director, Chair Remuneration Committee
Sue Symington *(left post March 2025)	Chair, Humber and North Yorkshire ICB
Dr Bushra Ali	Primary Care Partner Member
Angela Schofield	Independent Member
Charles Parker	Independent Member

Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:

- Executive Director of People or their nominated deputy
- Executive Director of Finance and Investment or their nominated deputy
- Executive Director of Corporate Affairs or their nominated deputy
- Chief Executive or the Deputy Chief Executive

The ICB Committees Annual Reports (including that of the Remuneration Committee) are published on our website. https://humberandnorthyorkshire.icb.nhs.uk/meetings-and-papers/9-april-2025/

Policy on the remuneration of senior managers (not subject to Audit)

The ICB has set pay rates for its Very Senior Managers' taking into account guidance received from NHS England.

The ICB follows appropriate guidance on setting remuneration levels for Very Senior Managers and takes into account the prevailing financial position of the wider NHS and the need for pay restraint. Performance of Very Senior Managers will be monitored in line with the organisation's objective setting and appraisals processes.

Very Senior Managers are employed on substantive and permanent contracts. They are required to give and are entitled to receive three months' notice. Any termination payments will be made in line with the individual's contract of employment and terms and conditions of service.

Very Senior Managers Performance Related Pay (not subject to audit)

No performance related pay was paid to any senior manager of the ICB in the period 1st April 2024 to 31st March 2025.

Very Senior Managers Service Contracts (not subject to audit)

Mr Max Jones, Strategic Digital Transformation Lead/Chief Digital Information Officer, and a participant member of the ICB's Board, was employed through a company called Agilisys Limited. His commitment to the ICB started on the 1 November 2023, through a provision of services contract. This was initially for 2 days per week, rising to 3 days per week from 1 June 2024 before ending on the 31 March 2025. For further information please refer to the ICB's statutory accounts, note 16, related party transactions.

Percentage change in remuneration of highest paid director

	Salary & Allowances	**Performance Pay & Bonuses**
The percentage change from the previous financial year in respect of the highest paid director	5% (5% in 2023/24)	nil% (nil% in 2023/24)
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	9.16% (5.2% in 2023/24)	nil% (nil% in 2023/24)

The NHS Agenda for Change pay award for 2024/25 was 5.5% (was a 5% consolidated pay award in 2023/24). This was applied to all non-medical posts within the ICB. The average percentage change of 9.16%, reported in the table above, is greater than this pay award figure and arises from the additional pay resulting from incremental increases from continuous service/experience. In 2023/24 this was compounded by the introduction of incremental step pay rates for higher banded posts (Agenda for Change bands 8&9).

Prior to this, staff on these bandings had to gain 5 years of continuous service before being considered for an incremental increase. Under the new rules, staff would be considered for a smaller incremental increase after 2 years, then again after 5 years. This has resulted in staff with between 2- and 5-years' service all receiving this increase.

Fair Pay Disclosure (subject to audit)

Pay ratio information.

As at the 31 March 2025, remuneration ranged from £297,500 (mid-point in the £5,000 banding) (was £282,500 as at 31st March 2024) to £23,615 (was £20,270 as at 31 March 2024) based on

annualised, full-time equivalent remuneration of all staff (including temporary and agency staff). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer national insurance or employer pension contributions and the cash equivalent transfer value of pensions.

Remuneration breakdown is shown in the table below:

Year	25th percentile	Median	75th percentile
2024/25	£72,293	£48,526	£37,338
2023/24	£68,525	£45,996	£34,581

The ratios of staff remuneration against the mid-point of the banded remuneration of the highest paid director, is illustrated in the table below:

Year	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
2024/25	4.12:1	6.13:1	7.96:1
2023/24	4.12:1	6.14:1	8.17:1

In 2024/25 all NHS staff on Agenda for Change terms and conditions received a 5.5% pay award (was a 5% consolidated pay award in 2023/24). The ICB made the decision to apply similar percentage uplifts for its 2024/25 pay award to its senior management, which includes the highest paid director.

Reporting bodies are required to disclose the relationship between the 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 is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded remuneration of the highest paid director/member of the Governing Body of the ICB in the accounting period to 31 March 2025 was £295,000-£300,000 (was £280,000-£285,000 in the accounting period to 31 March 2024). The relationship to the remuneration of the organisation's workforce is disclosed in the below table:

2024/25	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration Ratio (£)	4.12:1	6.13:1	7.96:1
Salary Ratio (£)	4.12:1	6.13:1	7.96:1
2023/24	25th percentile	Median pay ratio	75th percentile pay ratio
Remuneration Ratio (£)	4.12:1	6.14:1	8.17:1
Salary Ration (£)	4.12:1	6.14:1	8.17:1

No employees received remuneration in excess of the highest-paid director/member.

1 April 2024 to 31 March 2025 Very Senior Manager Remuneration (subject to audit)

Salaries and Allowances						
Name and Title	**(a) Salary (bands of £5,000) £000**	**(b) Expense payments (taxable) to nearest £100 £00**	**(c) Performance pay and bonuses (bands of £5,000) £000**	**(d) Long-term performance pay and bonuses (bands of £5,000) £000**	**(e) All pension related benefits (bands of £2,500) £000**	**(f) Total (bands of £5,000) £000**
Mrs S Symington Chair	75-80	-	-	-	-	75-80
Mr S Eames Chief Executive	295-300	3	-	-	-	295-300
Mrs A Bloor Acting Chief Executive/ Deputy Chief Executive/ Chief Operating Officer	190-195	-	-	-	110.0-112.5	300-305
Mrs J Hazelgrave Acting Deputy Chief Executive/ Chief Operating Officer/ Executive Director of Finance & Investment	185-190	-	-	-	50.0-52.5	240-245
Mrs E Sayner Executive Director of Finance & Investment	75-80	-	-	-	47.5-50.0	125-130
Mr M Brearley Interim Executive Director of Finance & Investment	70-75	-	-	-	-	70-75
Mrs T Fenech Executive Director of Nursing & Quality	145-150	-	-	-	40.0-42.5	185-190
Dr N Wells Executive Director of Clinical & Professional	205-210	-	-	-	75.0-77.5	280-285
Mrs J Adamson Executive Director of People	170-175	-	-	-	90.0-92.5	265-270
Mrs K Ellis Executive Director of Corporate Affairs	125-130	-	-	-	55.0-57.5	180-185
Mrs A Hazebroek Executive Director of Communications, Marketing and Media Relations	130-135	-	-	-	35.0-37.5	165-170

Salaries and Allowances						
Name and Title	**(a) Salary (bands of £5,000) £000**	**(b) Expense payments (taxable) to nearest £100 £00**	**(c) Performance pay and bonuses (bands of £5,000) £000**	**(d) Long-term performance pay and bonuses (bands of £5,000) £000**	**(e) All pension related benefits (bands of £2,500) £000**	**(f) Total (bands of £5,000) £000**
Mr P Thorpe Executive Director of Strategy & Partnerships	170-175	-	-	-	40.0-42.5	210-215
Mr M Chamberlain Non-executive Director/Deputy Chair	15-20	-	-	-	-	15-20
Mr S Watson Non-executive Director/Senior Independent Director (SID)	15-20	-	-	-	-	15-20
Mr R Gladman Non-executive Director	15-20	-	-	-	-	15-20
Dr B Ali Primary Care Partner Member	35-40	-	-	-	-	35-40

Further Salaries & Allowances Declaration Notes

a) Mrs A Bloor was acting Chief Executive from 1 December 2024 to 31 March 2025. During the period as Acting Chief Executive, her salary was adjusted to reflect the responsibilities of the role.

b) Mrs J Hazelgrave was Executive Director of Finance & Investment until 9 June 2024. She then acted as Deputy Chief Executive / Chief Operating Officer until 5 March. During her period as acting Deputy Chief Executive/Chief Operating Officer she moved from full time to part time before retiring on 5 March 2025.

c) Mrs E Sayner was acting Executive Director of Finance & Investment from 10 June 2024 to 30 November 2024.

d) Mr M Brearley was Interim Executive Director of Finance & Investment from 1 December 2024 to 31 March 2025. Mr Brearley was employed by Hull University Teaching Hospitals NHS Trust and seconded to the ICB.

e) Mrs T Fenech had a period of unpaid leave during 2024/25.

f) Dr B Ali's salary also includes her GP Lead for Prescribing for Hull Health & Care Partnership role.

1 April 2023 to 31 March 2024 Very Senior Manager Remuneration (subject to audit)

Salaries and Allowances						
Name and Title	**(a) Salary (bands of £5,000) £000**	**(b) Expense payments (taxable) to nearest £100 £00**	**(c) Performance pay and bonuses (bands of £5,000) £000**	**(d) Long-term performance pay and bonuses (bands of £5,000) £000**	**(e) All pension related benefits (bands of £2,500) £000**	**(f) Total (bands of £5,000) £000**
Mrs S Symington Chair	75-80	-	-	-	-	75-80
Mr S Eames Chief Executive	280-285	2	-	-	-	280-285
Mrs A Bloor Deputy Chief Executive/Chief Operating Officer	180-185	-	-	-	-	180-185
Mrs J Hazelgrave Executive Director of Finance & Investment	190-195	-	-	-	42.5-45.0	235-240
Mrs T Fenech Executive Director of Nursing & Quality	150-155	-	-	-	-	150-155
Dr N Wells Executive Director of Clinical & Professional	195-200	-	-	-	157.5-60.0	355-360
Mrs J Adamson Executive Director of People	165-170	-	-	-	57.5-60.0	225-230
Mrs K Ellis Executive Director of Corporate Affairs	115-120	-	-	-	57.5-60.0	175-180
Mrs A Hazebroek Executive Director of Communication Marketing and Media Relations	120-125	-	-	-	30.0-32.5	115-160
Mr P Thorpe Interim Executive Director of Strategy and Partnership	65-70	-	-	-	15.0-17.5	85-90
Mr M Chamberlain Non-executive Director	5-10	-	-	-	-	5-10
Mr S Watson Non-executive Director	15-20	-	-	-	-	15-20

Salaries and Allowances						
Name and Title	**(a) Salary (bands of £5,000) £000**	**(b) Expense payments (taxable) to nearest £100 £00**	**(c) Performance pay and bonuses (bands of £5,000) £000**	**(d) Long-term performance pay and bonuses (bands of £5,000) £000**	**(e) All pension related benefits (bands of £2,500) £000**	**(f) Total (bands of £5,000) £000**
Mr R Gladman Non-executive Director	0-5	-	-	-	-	0-5
Dr B Ali Primary Care Partner Member	15-20	-	-	-	-	15-20

Further Salaries & Allowances Declaration Notes

a) Mr P Thorpe joined the ICB on the 1 November 2023.

b) Mr M Chamberlain was on a secondment between June 2023 and October 2023. During this period, he did not receive any payment from the ICB.

c) Mr R Gladman joined the ICB on the 1 January 2024.

1 April 2024 to 31 March 2025 Pension benefits (subject to Audit)

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2025 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2024	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2025	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Mrs A Bloor Acting Chief Executive/ Deputy Chief Executive/Chief Operating Officer	-	55.0-57.5	80-85	225-230	1,536	344	2,003	-
Mrs J Hazelgrave Acting Deputy Chief Executive/ Chief Operating Officer/ Executive Director of Finance & Investment	2.5-5.0	-	5-10	-	59	38	124	-
Mrs E Sayner Executive Director of Finance & Investment	0.0-2.5	0.0-2.5	40-45	100-105	762	23	877	-
Mrs T Fenech Executive Director of Nursing & Quality	2.5-5.0	-	2.5-5.0	-	-	35	55	-
Dr N Wells Executive Director of Clinical & Professional	2.5-5.0	-	25-30	40-45	469	31	557	-
Mrs J Adamson Executive Director of People	2.5-5.0	-	45-50	-	791	38	904	-
Mrs K Ellis Executive Director of Corporate Affairs	0.0-2.5	-	20-25	-	279	22	334	-
Mrs A Hazebroek Executive Director of Communications, Marketing and Media Relations	0.0-2.5	-	5-10	-	57	19	95	-
Mr P Thorpe Executive Director of Strategy & Partnerships	2.5-5.0	-	0-5		18	25	65	-

Further Pension Declaration Notes

a) Mrs A Bloor opted back into the pension scheme on the 1 April 2024.

b) Mrs J Hazelgrave retired from the ICB on the 5 March 2025.

c) Mrs E Sayner was the ICB's Interim Executive Director of Finance & Investment from 10th June 2024 to 30th November 2024.

d) Mrs T Fenech opted back into the pension scheme on the 1 April 2024.

e) Certain staff members of the ICB do not receive pensionable remuneration therefore there are no entries in respect of pensions noted above. For our ICB this applies to the posts of Chair, Non-Executive Directors and Primary Care Partner Member.

f) Certain members of the ICB board have opted out of the pension scheme. In 2024/25 this related to Mr S Eames (Chief Executive) and Mr M Brearley (Interim Exec Director of Finance & Investment).

1 April 2023 to 31 March 2024 Pensions Benefits (subject to audit)

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2024 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 20224 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2023	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2024	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Mrs J Hazelgrave Executive Director of Finance & Investment	2.5-5.0	-	0-5	-	-	34	59	-
Dr N Wells Executive Director of Clinical & Professional	5.0-7.5	7.5-10.0	20-25	40-45	274	149	469	-
Mrs J Adamson Executive Director of People	0.0-2.5	-	40-45	-	630	75	791	-
Mrs K Ellis Executive Director of Corporate Affairs	0.0-2.5	-	15-20	-	191	54	279	-
Mrs A Hazebroek Executive Director of Communications, Marketing and Media Relations	0.0-2.5	-	0-5	-	20	19	57	-
Mr P Thorpe Interim Executive Director of Strategy & Partnerships	0.0-2.5	-	0-5	-	-	9	18	-

Further Pension Declaration Notes

a) Mrs J Hazelgrave is in receipt of her earlier pension scheme and is now contributing to the current pension scheme.

b) Certain staff members of the ICB do not receive pensionable remuneration therefore there are no entries in respect of pensions noted above. For our ICB this applies to the posts of Chair, Non-Executive Directors, and Primary Care Partner Member.

c) Certain members of the ICB have opted out of the pension scheme. In 2023/24 this related to Mr S Eames (Chief Executive), Mrs A Bloor (Deputy Chief Executive / Chief Operating Officer), and Mrs T Fenech (Exec Director of Nursing & Quality).

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 (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement or for loss of office (subject to audit)

No payments have been made to any senior managers of the ICB for loss of office during 1 April 2024 to 31 March 2025.

Payments to past directors (subject to audit)

No payments have been made to any past Directors of the ICB during 1 April 2024 to 31 March 2025.

Staff Report

Number of senior managers

Please see table below for information on the head count of Senior Managers by band and analysed by ‘permanently employed’ and ‘other’ staff for NHS Humber and North Yorkshire Integrated Care Board as of 31 March 2025.

Pay band	Total
Band 8a	108
Band 8b	64
Band 8c	47
Band 8d	33
Band 9	18
VSM (which includes x5 Executive Directors of the Board)	14
Any other spot salary (which includes Chief Executive & Chair)	51

Staff composition

Pay band	Female	Male
Band 8a	79	29
Band 8b	48	16
Band 8c	31	16
Band 8d	21	12
Band 9	14	4
VSM	9	5
Any other spot salary	25	26
All other employees (including apprentice if applicable)	388	84

Assignment category	Total
Permanent	745
Fixed term	61
Bank	35
Honorary	14

Sickness absence data

The sickness absence data for NHS Humber and North Yorkshire ICB between 1 April 2024 and 31 March 2025 is below:

Absence	Total
Average sickness %	3.33%

Total number of FTE days lost	9,053.76

The ICB regularly reviews reasons for absence and all sickness is managed in line with the organisation's Attendance Management Policy.

Staff turnover percentages

The average staff turnover for NHS Humber and North Yorkshire ICB between 1 April 2024 and 31 March 2025 is below:

Turnover	Total
	15.91%

There has been an increase in the average turnover rate for 2024/2025 compared to previous years due to the running of a voluntary redundancy scheme.

Staff costs and staff numbers

Staff cost and staff numbers are included in note 4 of the ICB statutory accounts which can be found at the end of this report.

Workforce health and wellbeing

The ICB is fully committed to ensuring a healthier, happier, and engaged workforce and supported by the ICB Health and Safety and Colleague Wellbeing and Engagement Groups ensure safe, welcoming environments and a robust wellbeing offer (also see 'Other employee matters – Colleague Engagement'). This includes:

- Support for physical and emotional wellbeing through management and self-referral to Occupational Health services, including the ability to access counselling sessions.
- Access for staff and their immediate family members to an Employee Assistance Programme; a support network that offers expert advice and compassionate guidance 24/7 covering a wide range of issues. Services include legal information, online CBT, and bereavement support.
- Access to a number of free wellbeing sessions running throughout the year such as self-care and relaxation, menopause awareness at work, mental health in the workplace, coaching masterclasses, postural awareness and understanding suicidality and can also talk at any time to a wellbeing champion.

Support from Wellbeing champions a grassroots programme designed to embed a culture of wellbeing across the organisation. These champions support colleagues across four key pillars: mental health, physical health, financial wellbeing, and social wellbeing. Their role includes facilitating wellbeing conversations, signposting to local and national support offers, and raising awareness of wellbeing resources through meetings, newsletters, and intranet updates. The programme is supported by regular training, a dedicated resource pack, and a growing community of practice.

Staff Training

The ICB is dedicated to developing a confident and skilled workforce equipped to address current challenges and drive future success. Recognizing that our people are our most valuable asset, we invest in a comprehensive training and development programme. By nurturing the skills, knowledge, and potential of individuals and teams, we are not just supporting performance we are empowering everyone to thrive and contribute to our shared purpose.

The ICB has a Board approved Learning and Development Policy, which aims to encourage all staff to develop to their full potential, enabling them to meet their own and their organisation's objectives. The ICB also supports a wide and flexible range of qualification and continuing professional development opportunities to facilitate the recruitment, motivation, and retention of staff.

Alongside the Learning and Development Policy there is an approved Training Needs Analysis (TNA) which focuses predominantly on Statutory, Mandatory, and specific non-mandated training but includes potential wider mandated training and enhanced mandatory training (for Clinical and Non-Clinical Staff and Specialist Practitioners). The ICB has a responsibility for ensuring that there is a robust, consistent, and effective programme of statutory and mandatory training available for all employees to enable them to undertake their roles safely, effectively and in compliance with legislation. Our training requirements remain compliant the Skills for Health 'Core Skills Training Framework', a trusted benchmark for statutory and mandatory training.

Staff policies

As an employer the ICB recognises and values people as individuals and accommodates differences where possible by making adjustments. Policies in place to support this include:

- Agile Working
- Managing Attendance
- Flexible Working
- Recruitment and Selection

Policies continue to be reviewed as and when there are legislative changes or after a period of four years to ensure that they reflected up to date best practices. All policies are reviewed in partnership and consultation with employees and staff side representatives.

Trade Union Facility Time Reporting Requirements

Number of relevant union officials during 1 April 2024 to 31 March 2025	5
Full Time Equivalent employee number	5
Percentage of time spent on facility time	1-50%
Percentage of pay bill spent on facility time	
Total cost of facility time	£9,600
Total pay bill	£40,427,000
Percentage of total pay bill spent on facility time	0.0002%
Paid Trade Union Activities	
Time spent on trade union activities as a percentage of paid facility time	100%

Other employee matters

The ICB has two staff groups that play a crucial role in fostering a supportive and engaging work environment, ensuring that staff voices are heard in organisational decisions:

Colleague Wellbeing and Engagement Group

The ICB Colleague Wellbeing and Engagement Group at NHS Humber and North Yorkshire Integrated Care Board (ICB) focuses on promoting the health, wellbeing, and engagement of its staff. Regular meetings are held to discuss various topics and also serve as a platform for staff to provide feedback and influence change within the organisation. Here are some key aspects of their work:

- Promoting Wellbeing Champions: These are staff members who actively promote employee health and wellbeing within their teams. They initiate and create local wellbeing activities, promote conversations about wellbeing, and share information from the central wellbeing team.
- Developing Health and Wellbeing Support Offer: A comprehensive guide on health and wellbeing support was made available to all colleagues. This includes a range of offers including the Employee Assistance Programme (EAP), which offers 24/7 support, counselling, financial advice, and access to an online wellbeing hub.
- Engagement Activities: The group organises various activities and initiatives to engage staff, such as Christmas engagement activities, the "lunch break challenge" and the creation of a TikTok account under the 'Let's Get Better' branding to promote engagement and wellbeing.
- Influencing Policy: topics such as agile working, sexual safety, menopause awareness, organisational development.
- Staff Surveys: The group has provided guidance on responding to surveys and influenced the design of the local Pulse survey. They have used information to inform wellbeing initiatives and improve ICB offerings.

ICB Inclusion Network

The ICB Inclusion Network is a staff network for minoritised colleagues working at the ICB. The network operates as a critical friend for our organisation, providing feedback and suggesting areas of focus that influence meaningful change. The group acts as a pipeline of new insight, knowledge and talent whilst offering peer support to minoritised colleagues.

Network members influence policy change and development, make recommendations on improving inclusion and accessibility and provide guidance based on diverse lived experience to ensure we meet our organisational values of We Care, We Connect, We Innovate; ensuring every colleague can bring their whole self to work and thrive through equity, justice and opportunity.

Expenditure on Consultancy (not subject to audit)

During the year to 31 March 2025 the ICB spent £474,000 (£751,000 year to 31 March 2024) on consultancy fees. This was across 3 different consultancy companies.

Expenditure on Agency Staff (not subject to audit)

During the year to 31 March 2025 the ICB spent £1.5m (£2m year to 31 March 2024) on agency staff. This was for 37 different staff, from 13 different agencies, covering a total of 776 weeks, at an average weekly cost of £1,973 per person (£2,378 per person for the year to 31 March 2024).

Off-payroll engagements

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23rd May 2012, NHS organisations must publish information on their highly paid and/or senior off-payroll engagements.

Table 1: Off-payroll engagements longer than 6 months

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

	Number
Number of existing engagements as of 31 March 2025	12
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	7
for between 2 and 3 years at the time of reporting	2
for between 3 and 4 years at the time of reporting	-
for 4 or more years at the time of reporting	-

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

Table 2: Off-payroll workers engaged at any point during the financial year

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

	Number
No. of temporary off-payroll workers engaged between 1 April 2024 to 31 March 2025	26
Of which:	
No. not subject to off-payroll legislation (2)	-
No. subject to off-payroll legislation and determined as in-scope of IR35(2)	-
No. subject to off-payroll legislation and determined as out of scope of IR35(2)	26

the number of engagements reassessed for compliance or assurance purposes during the year	-
Of which: no. of engagements that saw a change to IR35 status following review	-

(1) The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

(2) A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: Off-payroll engagements / senior official engagements

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

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period	1
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 reporting period. This figure should include both on payroll and off-payroll engagements.	20

Exit Packages (subject to audit)

Please refer to the ICB's statutory accounts, note 4, at the end of this report for further information on exit packages

Going Concern

The ICB's accounts, which are attached at the end of this annual report, have been prepared on a going concern basis.

Parliamentary Accountability and Audit Report (subject to audit)

- The 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 where relevant. An audit certificate and report are also included in this Annual Report below.

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF NHS HUMBER AND NORTH YORKSHIRE INTEGRATED CARE BOARD

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of NHS Humber and North Yorkshire Integrated Care Board ('the ICB') for the year ended 31 March 2025, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including material accounting policy information.

The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2024/25 as contained in the Department of Health and Social Care Group Accounting Manual 2024/25, and the Accounts Direction issued by NHS England with the approval of the Secretary of State as relevant to Integrated Care Boards in England.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2025 and of its net expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2024/25; and
- have been properly prepared in accordance with the requirements of 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 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 we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

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

Based on the work we have performed, and taking into account the requirements of the Department of Health and Social Care Group Accounting Manual, 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 at least twelve 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.

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. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our 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 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 or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on regularity

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.

Responsibilities of the Accountable Officer for the financial statements

As explained more fully in the Statement of Accountable Officer's Responsibilities 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.

The Accountable Officer is required to comply with the Department of Health and Social Care Group Accounting Manual 2024/25 and prepare the financial statements on a going concern basis, unless the ICB is informed of the intention for dissolution without transfer of services or function to another public sector entity. The Accountable Officer is responsible for assessing each year whether or not it is appropriate for the ICB to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

Auditor's responsibilities 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 aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice and as required by the Local Audit and Accountability Act 2014.

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

Based on our understanding of the ICB, we identified that the principal risks of non-compliance with laws and regulations related to the National Health Service Act 2006 (as amended by the Health Care Act 2022) and we considered the extent to which non-compliance might have a material effect on the financial statements.

Auditor's responsibilities for the audit of the financial statements (continued)

To help us identify instances of non-compliance with these laws and regulations, and in identifying and assessing the risks of material misstatement in respect to non-compliance, our procedures included, but were not limited to:

- inquiring with management and the Audit Committee, as to whether the ICB is in compliance with laws and regulations, and discussing their policies and procedures regarding compliance with laws and regulations;
- inspecting correspondence from NHS England;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the ICB which were contrary to applicable laws and regulations, including fraud.

We also considered those laws and regulations that have a direct effect on the preparation of the financial statements, such as the National Health Service Act 2006 (as amended by the Health Care Act 2022).

In addition, we evaluated the Accountable Officer's incentives and opportunities for fraudulent manipulation of the financial statements (including the risks of override of controls) and determined that the principal risks related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, significant one-off or unusual transactions and the risk of fraud in financial reporting relating to expenditure recognition due to the potential to inappropriately record expenditure in the wrong period.

Our audit procedures in relation to fraud included but were not limited to:

- making enquiries of management and the Audit Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud;
- addressing the risks of fraud through management override of controls by performing journal entry testing; and
- addressing the risk of fraud in expenditure recognition in relation to year-end accruals through substantive testing.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with management and the Audit Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in November 2024.

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

Report on the ICB's arrangeme nts for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

We have nothing to report in this respect.

Responsibilities of the Accountable Officer

As explained in the Statement of Accountable Officer's responsibilities, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the ICB's resources.

Auditor's responsibilities or the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required under section 21 of the Local Audit and Accountability Act 2014 to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in November 2024.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Health and Care Act 2022; and
- the other information published together with the audited financial statements in the Annual Report for the period for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS England; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014; or
- we issue a report in the public interest under section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the ICB under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

Use of the audit report

This report is made solely to the Members of the Board of NHS Humber and North Yorkshire ICB, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Governing Body of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the ICB, as a body, for our audit work, for this report, or for the opinions we have formed.

Delay to certificate

We cannot formally conclude the audit and issue an audit certificate until we have received confirmation from the NAO that the group audit of the Department of Health and Social Care has been completed and that no further work is required to be completed by us.

Mark Kirkham, Partner
For and on behalf of Forvis Mazars LLP

Forvis Mazars
5th Floor
3 Wellington Place
Leeds
LS1 4AP

20 June 2025

Annual Accounts

Teresa Fenech

Accountable Office (Acting Chief Executive)

June 2025

NHS Humber & North Yorkshire ICB - Annual Accounts to 31st March 2025

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the Year Ended 31st March 2025

	Note	2024/25 £'000	2023/24 £'000
Income from sale of goods and services	2	(134,750)	(127,648)
Other operating revenue	2	(3,482)	(3,344)
Total Operating Revenue		**(138,232)**	(130,992)
Employee benefits	4	57,489	52,959
Purchase of goods and services	5	4,339,336	4,043,619
Depreciation and impairment charges	5	500	573
Other operating expenses	5	2,298	3,082
Total Operating Expenditure		**4,399,623**	4,100,233
Net Operating Deficit		**4,261,391**	3,969,240
Finance costs		23	19
Other gains & losses		-	14
Net Expenditure for the Financial Period		**4,261,414**	3,969,273
Comprehensive Net Expenditure for the Financial Period		**4,261,414**	3,969,273

Statement of Financial Position as at 31st March 2025

	Note	31st March 2025 £'000	31st March 2024 £'000
Non-Current Assets:			
Right-of-use assets		989	1,348
Total Non-Current Assets		**989**	1,348
Current Assets:			
Trade and other receivables	8	19,444	20,999
Cash and cash equivalents	7	147	1,551
Total Current Assets		**19,591**	22,550
Total Assets		**20,580**	23,898
Current Liabilities			
Trade and other payables	9	(275,685)	(281,645)
Lease liabilities		(450)	(477)
Provisions	10	(124)	(4,455)
Total Current Liabilities		**(276,259)**	(286,577)
Non-Current Assets less Net Current Liabilities		**(255,679)**	(262,679)
Non-Current Liabilities			
Lease liabilities		(546)	(883)
Total non-current liabilities		**(546)**	(883)
Assets less Liabilities		**(256,225)**	(263,562)
Financed by Taxpayers' Equity			
General fund		(256,225)	(263,562)
Total taxpayers' equity:		**(256,225)**	(263,562)

The notes on pages 7 to 23 form part of this statement

The financial statements on pages 2 to 6 were approved by the Board on the 19th June 2025 and signed on its behalf by:

Teresa Fenech
Acting Chief Executive
19th June 2025

Statement of Changes In Taxpayers' Equity for the Year Ended 31st March 2025

Changes in Taxpayers' Equity for the Financial Period to 31st March 2025

	General Fund £'000
Balance at 1st April 2024	(263,562)
Changes in Taxpayers' Equity for the Financial Period	
Net operating expenditure for the financial period	(4,261,414)
Net Recognised Expenditure for the Financial Period	**(4,261,414)**
Net funding	4,268,751
Balance at 31st March 2025	**(256,225)**

Changes in Taxpayers' Equity for the Financial Period to 31st March 2024

	General Fund £'000
Balance at 1st April 2023	(240,188)
Changes in Taxpayers' Equity for the Financial Period	
Net operating costs for the financial period	(3,969,273)
Net Recognised Expenditure for the Financial Period	(3,969,273)
Net funding	3,945,899
Balance at 31 March 2024	(263,562)

The notes on pages 7 to 23 form part of this statement

Statement of Cash Flows for the Year Ended 31st March 2025

	Note	**12 months to 31st March 2025 £'000**	12 months to 31st March 2024 £'000
Cash Flows from Operating Activities			
Net expenditure for the financial period		(4,261,414)	(3,969,273)
Depreciation and amortisation	5	500	573
Other gains & losses		-	14
(Increase)/decrease in trade & other receivables	8	1,554	(2,677)
Increase/(decrease) in trade & other payables	9	(5,958)	22,782
Provisions utilised	10	(4,331)	-
Increase/(decrease) in provisions		-	4,455
Net Cash Inflow (Outflow) from Operating Activities		**(4,269,649)**	(3,944,126)
Cash Flows from Investing Activities			
Interest received		23	19
Net Cash Inflow (Outflow) from Investing Activities		**23**	19
Net Cash Inflow (Outflow) before Financing		**(4,269,626)**	(3,944,107)
Cash Flows from Financing Activities			
Grant in aid funding received		4,268,751	3,945,899
Repayment of lease liabilities		(529)	(604)
Net Cash Inflow (Outflow) from Financing Activities		**4,268,222**	3,945,295
Net Increase (Decrease) in Cash & Cash Equivalents	7	**(1,404)**	1,188
Cash & Cash Equivalents at the Beginning of the Financial Year		**1,551**	363
Cash & Cash Equivalents at the End of the Financial Year		**147**	1,551

The notes on pages 7 to 23 form part of this statement

1. Notes to the Financial Statements

1.1 Accounting Policies

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

1.2 Going Concern

These accounts have been prepared on a going concern basis.
Public sector bodies are assumed to be going concerns 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.

1.3 Critical Accounting Judgements and Key Sources of Estimation Uncertainty

In the application of the ICB's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The ICB has assessed its accruals and deemed that none of them fall into this category.

1.4 Pooled Budgets

The ICB has entered into pooled budget arrangements in accordance with section 75 of the National Health Service Act 2006 and accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

If the ICB is in a "jointly controlled operation", the ICB recognises:

- The assets the ICB controls;
- The liabilities the ICB incurs;
- The expenses the ICB incurs; and,
- The ICB's share of the income from the pooled budget activities.

If the ICB is involved in a "jointly controlled assets" arrangement, in addition to the above, the ICB recognises:

- The ICB's share of the jointly controlled assets (classified according to the nature of the assets);
- The ICB's share of any liabilities incurred jointly; and,
- The ICB's share of the expenses jointly incurred.

1.4.1 Pooled Budgets - Better Care Fund

On the 1st July 2022 the ICB took over responsibility for the Section 75 contractual arrangements with the following Councils who remained the host entity for a pooled budget arrangement as part of the NHS 'Better Care Fund' national policy initiative. These arrangements were initially approved on the 1st April 2015 by the former clinical commissioning group entities. Note 14 provides further information with regards to the other parties to these arrangements.

- East Riding of Yorkshire Council
- North Yorkshire County Council

The ICB also took over responsibility for Section 75 contractual arrangements with the following local Councils, for a pooled budget arrangement as part of the NHS 'Better Care Fund' national policy initiative. For these agreements either the ICB is the overall host or the agreement states that either party is responsible for its own transactions with no overall host. These arrangements were also initially approved on the 1st April 2015 by the former clinical commissioning group entities. Note 13 provides further information with regards to the other parties to these arrangements.

- Hull City Council
- North-East Lincolnshire Council
- North Lincolnshire Council
- City of York Council

Consideration has been given as to whether IFRS 10 - Consolidated Financial Statements applies to this pooled budget arrangement, but has been deemed irrelevant as no individual organisation has sole control over the fund.

Consideration has been given as to whether IFRS 11 - Joint Arrangements applies to this pooled budget arrangement. As the ICB accounts for its own share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, it has been deemed irrelevant.

Consideration has been given as to whether IFRS 12 - Disclosure of Involvement with Other Entities applies to this pooled budget arrangement, and has been deemed relevant. The ICB has therefore applied the required disclosure in these accounts.

1.5 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. Other sources of income include:

- S75 adult social care partnership agreement with North East Lincolnshire Council.
- Prescription fees & charges
- Dental fees & charges

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.

1.6 Employee Benefits

1.6.1 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.

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.

1.6.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the scheme. Therefore, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.6.3 Local Government Pensions

Some employees are members of the Local Government Pension Scheme (LGPS), which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees was transferred to the ICB on the 1st July 2022 from NHS North-East Lincolnshire CCG but were subsequently transferred to North-East Lincolnshire Council during 2022/23. The ICB makes relevant deductions from employee salaries and applies the relevant employers contributions. Deductions are then paid over to North-East Lincolnshire Council.

1.7 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.8 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.

1.9 Cash

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash, bank and any overdraft facilities are recorded at current values.

1.10 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.

1.11 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.

1.12 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.

1.13 Contingent Liabilities

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.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.14 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 and the ICB has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;

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.

1.14.1 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.

1.14.2 Impairment

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, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.

The ICB adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the ICB does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.15 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.

1.16 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.

1.17 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).
For further information please see note 17.

1.18 Accounting Standards That Have Been Issued But Not Yet Adopted

IFRS 19 Subsidiaries without Public Accountability: Disclosures - Application required for accounting periods beginning on or after 1 January 2027. The standard has not yet been endorsed in the UK therefore has not yet adopted by the FReM. As such, the ICB has not been able to assess the impact of the standard.

IFRS 18 Presentation and Disclosure in Financial Statements - Application required for accounting periods beginning on or after 1st January 2027. The standard has not yet been endorsed in the UK and therefore has not yet been adopted by the FReM. As such, the ICB has not been able to assess the impact of the standard.

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. The Standard will be adopted by the 2025/26 FReM with limited options for early adoption. The ICB has reviewed it's contracts register and does not issue any insurance contracts. Therefore there is no impact of this standard on the ICB.

IFRS 14 Regulatory Deferral Accounts – Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.

2. Other Operating Revenue

	2024-25 £'000	2023-24 £'000
Income from Sale of Goods and Services (Contracts)		
Non-patient care services to other bodies	3,694	3,301
Prescription fees and charges	23,615	22,448
Dental fees and charges	26,542	26,034
Other contract income	80,899	75,865
Total Income from Sale of Goods and Services	**134,750**	127,648
Other Operating Income		
Charitable and other contributions to revenue expenditure: non-NHS	189	10
Other non contract revenue	3,293	3,334
Total Other Operating Income	**3,482**	3,344
Total Operating Revenue	**138,232**	130,992

3. Revenue

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

	2024-25				
	Non-patient care services to other bodies	**Prescription fees and charges**	**Dental fees and charges**	**Other Contract income**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
Source of Revenue					
NHS	184	-	-	1,753	1,937
Non NHS	3,510	23,615	26,542	79,146	132,813
Total	**3,694**	**23,615**	**26,542**	**80,899**	**134,750**

	2024-25				
	Non-patient care services to other bodies	**Prescription fees and charges**	**Dental fees and charges**	**Other Contract income**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
Timing of Revenue					
Point in time	3,694	23,615	26,542	6,518	60,369
Over time	-	-	-	74,381	74,381
Total	**3,694**	**23,615**	**26,542**	**80,899**	**134,750**

	2023-24				
	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income	Total
	£'000	£'000	£'000	£'000	£'000
Source of Revenue					
NHS	177	-	-	470	647
Non NHS	3,124	22,448	26,034	75,395	127,001
Total	3,301	22,448	26,034	75,865	127,648

	2023-24				
	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income	Total
	£'000	£'000	£'000	£'000	£'000
Timing of Revenue					
Point in time	3,301	22,448	26,034	4,382	56,165
Over time	-	-	-	71,483	71,483
Total	3,301	22,448	26,034	75,865	127,648

3.2 Fees and Charges

	2024-25		
	Income £'000	**Full Cost £'000**	**Surplus/ (deficit) £'000**
Dental	26,542	(119,736)	(93,194)
Prescription	23,615	(359,949)	(336,334)
Total fees and charges	**50,157**	**(479,685)**	**(429,528)**

	2023-24		
	Income £'000	Full Cost £'000	Surplus/ (deficit) £'000
Dental	26,034	(102,330)	(76,296)
Prescription	22,448	(350,034)	(327,586)
Total fees and charges	48,482	(452,364)	(403,882)

The financial objective of prescription and dental charges is to collect charges only from those patients that are eligible to pay.

Prescription charges are a contribution to the cost of pharmaceutical services including the supply of drugs. In 2024/25, the NHS prescription charge for each medicine or appliance dispensed was £9.90 (was £9.65 in 2023/24). However, a significant number of prescription items are dispensed free each year where patients are exempt from charges. In addition, patients who were eligible to pay charges could purchase pre-payment certificates in 2024/25 at £32.05 (was £31.25 in 2023/24) for 3 months or £114.50 (was £111.60 in 2023/24) for a year.

Dental charges are for those patients who are not eligible for exemption. They are required to pay NHS dental charges which fall into 3 bands depending on the level and complexity of care provided. In 2024/25 the charge for Band 1 treatments was £26.80 (was £25.80 in 2023/24) , for Band 2 was £73.50 (was £70.70 in 2023/24) and for Band 3 was £319.10 (was £306.80 in 2023/24).

4. Employee Benefits and Staff Numbers

4.1 Employee Benefits

	2024-25		
	Permanent £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	40,427	3,117	**43,544**
Social security costs	4,469	169	**4,638**
Employer contributions to NHS pension scheme	8,764	211	**8,975**
Other pension costs	9	-	**9**
Apprenticeship levy	192	-	**192**
Termination benefits	132	-	**132**
Gross Employee Benefits	**53,993**	**3,497**	**57,490**
Less recoveries in respect of employee benefits	-	-	**-**
Total - Net Employee Benefits	**53,993**	**3,497**	**57,490**

	2023-24		
	Permanent £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	35,197	2,460	37,657
Social security costs	3,907	12	3,919
Employer contributions to NHS pension scheme	6,517	15	6,532
Other pension costs	12	-	12
Apprenticeship levy	168	-	168
Termination benefits	4,672	-	4,672
Gross Employee Benefits	50,473	2,487	52,960
Less recoveries in respect of employee benefits	-	-	-
Total - Net Employee Benefits	50,473	2,487	52,960

4.2 Average Number of People Employed

	2024-25 Permanent Number	2024-25 Other Number	2024-25 Total Number
Total	**726**	**41**	**767**

	2023-24 Permanent Number	2023-24 Other Number	2023-24 Total Number
Total	667	32	700

4.3 Exit Packages Agreed in the Financial Period

2024-25

	Compulsory Redundancies Number	Compulsory Redundancies £	Other Agreed Departures Number	Other Agreed Departures £	Total Number	Total £
Less than £10,000	-	-	2	14,309	2	14,309
£10,001 to £25,000	-	-	9	156,572	9	156,572
£25,001 to £50,000	-	-	13	508,602	13	508,602
£50,001 to £100,000	2	132,455	13	1,057,521	15	1,189,976
£100,001 to £150,000	-	-	8	1,002,715	8	1,002,715
£150,001 to £200,000	-	-	8	1,270,643	8	1,270,643
Over £200,001	-	-	-	-	-	-
Total	**2**	**132,455**	**53**	**4,010,362**	**55**	**4,142,817**

2023-24

	Compulsory Redundancies Number	Compulsory Redundancies £	Other Agreed Departures Number	Other Agreed Departures £	Total Number	Total £
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	1	57,104	-	-	1	57,104
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	1	160,000	-	-	1	160,000
Over £200,001	-	-	-	-	-	-
Total	**2**	**217,104**	**-**	**-**	**2**	**217,104**

4.4 Analysis of Other Agreed Departures

	2024/25 Other agreed departures Number	2024/25 Other agreed departures £	2023-24 Other agreed departures Number	2023-24 Other agreed departures £
Voluntary redundancies including early retirement contractual costs	**53**	**4,010,362**	-	-
Total	**53**	**4,010,362**	-	-

These tables report the number and value of exit packages agreed in the financial periods. Agreement means that the package has been approved at the appropriate level within NHS England and the recipient of the redundancy informed. 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 standard NHS redundancy rules and regulations.

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

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

In 2023/24 NHS Humber & North Yorkshire ICB commenced a voluntary redundancy scheme open to all staff groups subject to certain criteria. The assessed cost of the scheme was £4.455m and a provision for this was included in the 2023/24 annual accounts. This provision has been utilised in year for the 53 redundancies noted above. 1 redundancy remains outstanding at the 31st March 2025 and part of the provision remains in place to cover these costs.

4.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period. The employer contribution for the next reporting period is expected to remain at 23.7% (estimated annual cost of £8,975,000 subject to delivery of national requirement with regards to staffing reductions).

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.

An outline of these follows:

4.5.1 Accounting Valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the 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 (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% (was 20.6% to 31 March 2024) 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.

4.6 Ill-Health Retirements

NHS bodies are required to disclosure the number of early retirements agreed on the grounds of ill-health during the financial period, together with the estimated resulting additional pension liabilities borne by the relevant pension scheme.

31st March 2025
Number of ill-health retirements: nil
Estimated additional pension liabilities: £nil

31st March 2024
Number of ill-health retirements: 2
Estimated additional pension liabilities: £243,357

5. Operating Expenses

	2024-25 £'000	2023-24 £'000
Purchase of goods and services		
Services from other ICBs and NHS England	7,520	9,301
Services from foundation trusts	1,778,827	1,669,549
Services from other NHS trusts	732,441	662,903
Purchase of healthcare from non-NHS bodies	680,207	635,004
Purchase of social care	90,163	82,089
General dental services and personal dental services	119,736	102,330
Prescribing costs	359,949	350,034
Pharmaceutical services	69,109	65,827
General ophthalmic services	17,887	17,744
GPMS/APMS and PCTMS	384,549	361,366
Supplies and services – clinical	7,151	2,326
Supplies and services – general	67,034	62,360
Consultancy services	474	751
Establishment	9,102	7,585
Transport	1,867	791
Premises	8,059	8,101
Audit fees*	294	302
Other non statutory audit expenditure		
· Internal audit services***	-	-
· Other services**	42	32
Other professional fees***	3,869	4,249
Legal fees	416	231
Education, training and conferences	636	742
Total Purchase of Goods and Services	**4,339,335**	4,043,619
Depreciation and Impairment Charges		
Depreciation	500	573
Total Depreciation and Impairment Charges	**500**	573
Other Operating Expenditure		
Chair and non executive members	135	115
Grants to other bodies	49	360
Research and development (excluding staff costs)	136	198
Expected credit loss on receivables	408	605
Other expenditure	1,570	1,804
Total Other Operating Expenditure	**2,298**	3,082
Total Operating Expenditure	**4,342,133**	4,047,274

* Forvis Mazars are NHS Humber & North Yorkshire ICB's external auditors. The fee includes non-recoverable VAT.

** Other non-statutory audit expenditure is in respect to the reasonable assurance audit work undertaken by Forvis Mazars with regard to NHS Humber & North Yorkshire ICB's achievement of the Mental Health Investment Standard (MHIS). This is a requirement by the regulating authority, NHS England, which stipulates that ICBs must obtain reasonable assurance from an independent reporting accountant, that their investment in mental health expenditure rises at a faster rate than their overall published programme funding. Within the 2024/25 accounts there is an accrual of £42,000 towards the 2024/25 assessment (£32,000 in the 2023/24 accounts for the 2023/24 assessment). Costs are inclusive of non-recoverable VAT.

*** Internal audit service costs, provided by Audit Yorkshire, are included within 'other professional fees' and amounted to £179,000 for 2024/25 (£229,000 for 2023/24). Audit Yorkshire is a trading name only and the actual contract is with NHS York & Scarborough NHS Foundation Trust.

6. Payment Compliance Reporting

6.1 Better Payment Practice Code

Measure of Compliance	2024-25		2023-24	
	Number	**£'000**	Number	£'000
Non-NHS Payables				
Total non-NHS trade invoices paid in the period	80,038	1,262,790	73,721	1,181,233
Total non-NHS trade invoices paid within target	78,475	1,187,002	72,062	1,126,667
Percentage of Non-NHS Trade Invoices Paid Within Target	**98.05%**	**94.00%**	97.75%	95.38%
NHS Payables				
Total NHS trade invoices paid in the period	4,274	2,548,720	2,088	2,331,835
Total NHS trade invoices paid within target	4,244	2,548,183	2,057	2,331,337
Percentage of NHS Trade Invoices Paid Within Target	**99.30%**	**99.98%**	98.52%	99.98%

The better payment practice code target is to pay invoices within 30 days.
Compliance is achieved when 95% of invoices are paid within 30 days.

7. Cash

	2024-25	2023-24
	£'000	£'000
Balance as at 1st April 2024	1,551	363
Net change in year	(1,404)	1,188
Balance as at 31st March 2025	**147**	1,551
Made up of:		
Cash with the Government Banking Service	147	1,551
Balance as at 31st March 2025	**147**	1,551

8. Trade & Other Receivables

8.1 Trade & Other Receivables

	31st March 2025 Current £'000	31st March 2024 Current £'000
NHS receivables: revenue	939	948
NHS prepayments	-	-
NHS accrued income	166	3,931
Non-NHS and Other WGA receivables: revenue	7,149	5,252
Non-NHS and Other WGA prepayments	3,979	3,492
Non-NHS and Other WGA accrued income	3,519	3,205
Non-NHS and Other WGA contract receivable not yet invoiced	29	1,246
Expected credit loss allowance-receivables	(2,845)	(2,594)
VAT	935	1,323
Other receivables and accruals	5,575	4,195
Total Trade & Other Receivables	**19,444**	20,999

8.2 Receivables Past Their Due Date But Not Impaired

	31st March 2025		31st March 2024	
	DHSC Group Bodies	Non DHSC Group Bodies	DHSC Group Bodies	Non DHSC Group Bodies
	£'000	£'000	£'000	£'000
By up to three months	96	1,145	440	667
By three to six months	1	346	105	296
By more than six months	2	671	-	451
Total	**99**	**2,162**	545	1,414

8.3 Loss Allowance on Asset Classes

	31st March 2025		31st March 2024	
	Trade and other receivables - Non DHSC Group Bodies	Total	Trade and other receivables - Non DHSC Group Bodies	Total
	£'000	£'000	£'000	£'000
Balance as at 1st April 2024	**(2,594)**	**(2,594)**	(2,211)	(2,211)
Lifetime expected credit losses on trade and other receivables-Stage 2	(408)	(408)	(605)	(605)
Amounts written off	156	156	222	222
Balance as at 31st March 2025	**(2,845)**	**(2,845)**	(2,594)	(2,594)

9. Trade & Other Payables

	31st March 2025 Current £'000	31st March 2024 Current £'000
NHS payables: revenue	1,595	671
NHS accruals	6,309	25,844
NHS deferred income	70	-
Non-NHS and Other WGA payables: revenue	45,660	49,734
Non-NHS and Other WGA accruals	215,593	198,199
Non-NHS and Other WGA deferred income	943	609
Social security costs	555	548
Tax	580	530
Other payables and accruals	4,381	5,509
Total Trade & Other Payables	**275,686**	281,645

NHS Humber & North Yorkshire ICB does not have any future years liabilities under arrangements to buy out the liability for early retirement.

Other payables include £2,955,531 outstanding pension contributions at 31 March 2025 (£2,892,525 at 31st March 2024)

10. Provisions

	31st March 2025 Current £'000	31st March 2024 Current £'000
Redundancy	124	4,455
Total	**124**	4,455

	31st March 2025		31st March 2024	
	Redundancy £'000	Total £'000	Redundancy £'000	Total £'000
Balance as at 1st April 2024	**4,455**	**4,455**	-	-
Arising during the year	-	**-**	4,455	4,455
Utilised during the year	(4,331)	**(4,331)**	-	-
Balance as at 31st March 2025	**124**	**124**	4,455	4,455
Expected timing of cash flows:				
Within one year	124	**124**	4,455	4,455
Balance as at 31st March 2025	**124**	**124**	4,455	4,455

In March 2024 NHS Humber & North Yorkshire ICB had offered all of its employees, subject to certain terms and conditions, the opportunity to apply for voluntary redundancy. As the scheme was in it's very early stages a provision of £4.455m was included in the 2023/24 accounts. The scheme has progressed throughout 202425 with 55 of the 56 agreed redundancies completed. Part of the provision remains in place to cover the costs of the remaining redundancy

11. Contingencies

During 2024 a joint procurement [the Procurement] was undertaken with 23 other ICBs for a Primary Care Clinical Waste Collection and Disposal contract, for a period of 5 years with the option to extend for a further 4 years. Each ICB procured an individual Lot. In December 2024, 9 of the ICBs, including NHS Humber and North Yorkshire ICB, published standstill letters with an intention to award a contract. During the subsequent standstill period, in December 2024 legal proceedings [the Claim] challenging the contract award decisions were commenced by one of the unsuccessful bidders [the Claimant], naming all 22 of the ICBs which remained involved in the Procurement (2 ICBs having decided not to proceed) as Defendants. At this early stage of the Claim, it is not possible to sensibly nor accurately determine the probability of success by the Claimant, nor is it possible to estimate the financial impact of a successful Claim with any level of certainty. Given this uncertainty of both of these key components, the ICB is therefore classifying this challenge as a contingent liability.

12. Financial instruments

12.1 Financial Risk Management

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

Because NHS Humber & North Yorkshire 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 NHS Humber & North Yorkshire 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 NHS Humber & North Yorkshire ICB in undertaking its activities.

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

12.1.1 Currency Risk

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

12.1.2 Interest Rate Risk

The NHS Humber & North Yorkshire 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 NHS Humber & North Yorkshire ICB therefore has low exposure to interest rate fluctuations.

12.1.3 Credit Risk

Because the majority of the NHS Humber & North Yorkshire ICB revenue comes parliamentary funding, NHS Humber & North Yorkshire ICB 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.

12.1.4 Liquidity Risk

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

12.1.5 Financial Instruments

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

12.2 Financial Assets

	31st March 2025 Financial Assets Measured at Amortised Costs £'000	31st March 2024 Financial Assets Measured at Amortised Costs £'000
Trade and other receivables with NHSE bodies	819	4,559
Trade and other receivables with other DHSC group bodies	484	341
Trade and other receivables with external bodies	16,073	13,878
Cash and cash equivalents	147	1551
Total at 31st March 2024	**17,523**	**20,329**

12.3 Financial liabilities

	31st March 2025 Financial Liabilities Measured at Amortised Costs £'000	31st March 2024 Financial Liabilities Measured at Amortised Costs £'000
Trade and other payables with NHSE bodies	173	937
Trade and other payables with other DHSC group bodies	7,730	25,578
Trade and other payables with external bodies	262,678	250,550
Private Finance Initiative and finance lease obligations	995	1,360
Total at 31st March 2024	**271,577**	**278,425**

13. Joint Arrangements

13.1 Interests in Joint Operations

Name of Arrangement, Parties to the Arrangement & Description of Principal Activities	2024-25 Income £'000	2024-25 Expenditure £'000	2023-24 Income £'000	2023-24 Expenditure £'000
Adult Social Care Partnership - North East Lincolnshire NHS Humber & North Yorkshire ICB, North-East Lincolnshire Council. A formal pooled budget arrangement for the delivery of integrated health and social care services within the North-East Lincolnshire Council footprint.	-	74,430	-	73,212
Better Care Fund - Hull NHS Humber & North Yorkshire ICB, Hull City Council. A formal pooled budget arrangement for the delivery of Better Care Fund requirements.	-	33,874	-	31,578
Better Care Fund - East Riding of Yorkshire NHS Humber & North Yorkshire ICB, East Riding of Yorkshire Council. A formal pooled budget arrangement for the delivery of Better Care Fund requirements.	-	31,635	-	29,263
Better Care Fund - North East Lincolnshire NHS Humber & North Yorkshire ICB, North-East Lincolnshire Council. A formal pooled budget arrangement for the delivery of Better Care Fund requirements.	-	17,147	-	15,863
Better Care Fund - North Lincolnshire NHS Humber & North Yorkshire ICB, North Lincolnshire Council. A formal pooled budget arrangement for the delivery of Better Care Fund requirements.	-	17,149	-	15,874
Better Care Fund - North Yorkshire NHS Humber & North Yorkshire ICB, NHS Lancashire & South Cumbria ICB, NHS West Yorkshire ICB, North Yorkshire Council. A formal pooled budget arrangement for the delivery of Better Care Fund requirements.	-	51,498	-	47,603
Better Care Fund - City of York NHS Humber & North Yorkshire ICB, City of York Council. A formal pooled budget arrangement for the delivery of Better Care Fund requirements.	-	17,157	-	15,894
Integrated Community Care - North Yorkshire NHS Humber & North Yorkshire ICB, Harrogate & District NHS Foundation Trust, North Yorkshire Council, Tees Esk Wear Valleys NHS Foundation Trust. A formal joint commissioning and service delivery of integrated health and social care community teams.	-	5,911	-	5,700
Section 75 Health Care - North East Lincolnshire NHS Humber & North Yorkshire ICB, North-East Lincolnshire Council. A formal pooled budget joint arrangement for the delivery of integrated services within the North-East Lincolnshire Council footprint. This is the first year of this joint arangement.	-	84,451		

14. Operating Segments

NHS Humber & North Yorkshire ICB only has one operating segment, namely the commissioning of national health services.

15. Related Party Transactions

The Department of Health and Social Care is regarded as the parent department. During the year, the ICB has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent. The main entities are NHS England, Harrogate & District NHS Foundation Trust, Hull University Teaching Hospitals NHS Trust, Humber Teaching NHS Foundation Trust, North of England CSU, Northern Lincolnshire & Goole NHS Foundation Trust, South Tees Hospitals NHS Foundation Trust, Tees Esk Wear Valleys NHS Foundation Trust, York & Scarborough Teaching Hospitals NHS Foundation Trust and Yorkshire Ambulance Service NHS Trust.

In addition, the ICB has had a number of transactions with other government departments and other central and local government bodies. Most of these transactions have been with City of York Council, East Riding of Yorkshire Council, Hull City Council, North-East Lincolnshire Council, North Lincolnshire Council and North Yorkshire Council.

Furthermore, related party declarations made by Ministers, senior managers and non-executive directors with the Department of Health & Social Care highlighted a link to Accurx Ltd, Alzheimer's Society & NHS Confederation. The ICB made payments within this accounting period to these organisations.

Details of related party transactions with individuals are as follows:

	2024-25			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
The following people are the NHS Humber & North Yorkshire ICB's board members				
Bushra Ali (Primary Care Lead)				
A General Practice Partner at Modality Partnership Hull group of GP Practices	9,091	-	-	-
Emma Sayner (Acting Director of Finance & Investment)				
Public sector representative at Hull Citycare Limited	81	-	4	-
Karina Ellis (Director of Corporate Affairs)				
Spouse is employed by North East Lincolnshire Council	4,449	(324)	3,166	(5)
Mark Chamberlain (Non-Executive Director)				
Associate of Capsticks LLP	309	-	209	-
The spend with Capsticks reflects the gross cost to the ICB. However, a siginificant element of this is recharged to other ICBs				
Max Jones (Chief Digital Information Officer)				
Executive Manager of Agilisys Ltd	379	-	38	-
Nigel Wells (Chief Medical Officer)				
GP Partner at Beech Tree Surgery, Selby	2,628	-	-	-
Richard Gladman (Non-Executive Director)				
Director of Verbena Digital Ltd	14	-	-	-

15. Related Party Transactions Continued

	2023-24			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
The following people are the NHS Humber & North Yorkshire ICB's board members				
Bushra Ali (Primary Care Lead)				
A General Practice Partner at Modality Partnership Hull group of GP Practices	8,701	-	-	-
Karina Ellis (Director of Corporate Affairs)				
Spouse is employed by North East Lincolnshire Council	3,240	(534)	153	(43)
Richard Gladman (Non-Executive Director)				
Director of Verbena Digital Ltd	154	-	14	-
Max Jones (Chief Digital Information Officer)				
Executive Manager of Agilisys Ltd	100	-	33	-
Nigel Wells (Chief Medical Officer)				
GP Partner at Beech Tree Surgery, Selby	2,617	-	-	-
Director of Beech Tree Eyecare Ltd	33	-	3	-

16. Events After the End of the Reporting Period

From 1st April 2025 NHS Humber & North Yorkshire ICB has delegated specialised commissioning responsibility from NHS England which is in the region of £420m. Acute hospitals that provide specialised commissioning services will receive income directly from the NHS Humber & North Yorkshire ICB rather than NHS England. Therefore, expenditure in 2025/2026 is likely to increase by £420m due to the delegation of commissioning responsibility.

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

The financial statements of these accounts were authorised for issue on the 19th June 2025, as authorised by the Teresa Fenech, Acting Chief Executive.

17. Losses

The total number of losses, and their total value, was as follows:

	2024-25		2023-24	
	Total Number of Cases Number	**Total Value of Cases £'000**	Total Number of Cases Number	Total Value of Cases £'000
Administrative write-offs	149	156	135	222
Book Keeping Losses	4	19	10	11
Total	**153**	**175**	**145**	**233**

These amounts are reported on an accruals basis but excluding provisions for future losses

18. Financial Performance Targets

NHS Humber & North Yorkshire ICB have a number of financial duties under the NHS Act 2006 (as amended). The ICB's performance against those duties was as follows:

	2024/25		
	Target £000s	**Performance £000s**	**Achieved?**
Expenditure not to exceed income	4,399,719	4,399,622	Yes
Capital resource use does not exceed the amount specified in Directions	141	141	Yes
Revenue resource use does not exceed the amount specified in Directions	4,261,487	4,261,390	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	n/a
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	n/a
Revenue administration resource use does not exceed the amount specified in Directions	32,470	31,205	Yes

	2023/24		
	Target £000s	Performance £000s	Achieved?
Expenditure not to exceed income	4,100,466	4,100,233	Yes
Capital resource use does not exceed the amount specified in Directions	-	-	n/a
Revenue resource use does not exceed the amount specified in Directions	3,969,473	3,969,240	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	n/a
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	n/a
Revenue administration resource use does not exceed the amount specified in Directions	37,748	29,710	Yes

Humber and North Yorkshire
Health and Care Partnership

NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

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