

Item: 12

REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official	✓	Proposes specific action	✓
Official: Sensitive Commercial		Provides assurance	
Official: Sensitive Personal		For information only	

BOARD

31 MARCH 2026

Report Title:

North East and North Cumbria Medium Term Planning Submissions

Purpose of report

This paper presents the ICB Medium Term Planning submission for 2026/27 to 2028/29 and the Five-Year Strategic Commissioning Plan.

Key points

NHS Planning Architecture

The Ten-Year Health Plan (10YHP) sets out the need for a significant change to the way we organise, deliver and fund services. To support this, a new model of planning is required to meet the challenges and changing needs of England's population and, crucially, build the foundation for the transformation of our services.

Delivering this change needs a different approach to planning across the NHS and with its partner organisations. Annual funding settlements and planning cycles have made it difficult to focus on thoughtful, long-term strategic planning of services. To break this cycle, a national medium-term planning framework has been released which shifts the focus towards a rolling five-year planning horizon. Planning across the NHS needs to become a continuous, iterative process that supports transformational change, delivering the three shifts set out in the 10YHP and taking full advantage of breakthroughs in science and technology.

ICBs and NHS Foundation Trusts are required to produce separate credible, integrated five-year plans to demonstrate how financial sustainability will be secured over the medium term. These will need to be refreshed annually as part of the annual planning cycle.

First (draft) plan submissions for finance, performance, workforce (primary care and non-Foundation Trust mental health workforce) and a set of board assurance statements were submitted on Wednesday 17 December 2025. For the first time in several years ICBs and Trusts submitted separate plans with the ICB no longer required to coordinate and submit a consolidated ICS set of plans. Two-year plans were submitted in December 2025 and full plan submissions were approved by the Board and were submitted on Thursday 12 February 2026. This included year three (2028/29) and four-year capital plans.

Full plan submissions also included the ICB Strategic Commissioning Plan and a final set of board assurance statements. Board accountability remains a crucial part of the plan submission process with board assurance statements now moving from the assurance of/engagement in the development plans to assuring the plans themselves.

The ICB, through established ICB and ICS governance, began developing its plans in September 2025 and via the ICB Planning MDT, we are engaging with key ICB teams, programmes, Foundation Trusts and partners to develop the various components of this medium-term planning process.

Early in the planning round, because of the changing NHS landscape, NHS England identified four Trusts who were deemed to require additional support in developing plans. An initial set of NHS England led MDT planning meetings were carried out to identify the key challenges facing those four trusts and identify any support needs. The four Trusts were:

- The Newcastle Upon Tyne Hospitals NHS Foundation Trust (NUTH)
- County Durham and Darlington NHS Foundation Trust (CDDFT)
- South Tees Hospitals NHS Foundation Trust (STHFT)
- North Cumbria Integrated Care NHS Foundation Trust (NCIC)

As the ICB had stepped up its planning process and governance, we agreed with NHS England that the ICB would continue to facilitate the planning processes across NENC and assure NHS England through other routes and as such, joint meetings were stood down

All Trusts submitted plans on 12 February 2026 but four organisations were required to submit a headline re-submission of plans on 2 March 2026. This was on the basis that issues had been identified with either performance or finance compliance (or both).

As a result of a regional review of full plans (and the resubmission of headline plans), NHS England segmented plans into four segments:

- Segment 1 – Compliant and deliverable - subject to final approval
- Segment 2 – Near compliant – ability to stretch further
- Segment 3 – Non-compliant – Regional escalation
- Segment 4 – Non-complaint – National escalation

Three Trusts were moved into segment three with trust plan regional review sessions carried out on Friday 13 March 2026. These were NCIC, STHFT and North Tees and Hartlepool NHS Foundation Trust (NTHFT), the latter because of the impact of the hospital group working. CDDFT was moved into segment four and subject to national escalation. All four submitted an improved position for finance, performance and workforce.

NHS England provided formal feedback in relation to full plans submitted on 12 February 2026 to all Trusts and the ICB which included expectations of a further plan submission by exception on 18 March 2026. This resubmission was framed as a "plan alignment" exercise for Trusts and ICBs to factor in improvement in key trajectories and resolve identified data quality issues. Any resubmission had to be an improving position and move towards compliance.

The ICB submitted an updated workforce and performance position to reflect:

- Minor change to workforce due to a data quality issue which did not affect the workforce numbers overall
- Improved performance across cancer, RTT, 52-week and diagnostics based on Trust full plan submissions on the 12 February 2026 and notified improvements by Trusts ahead of the resubmission.
- Improved performance for talking therapies and specialist community perinatal, considering feedback from NHS England.

The full detail can be found in parts B and C.

Financial Plan:

Revenue allocations have been published for three financial years, 2026/27 to 2028/29, which are summarised in the paper. Allocations for 2027/28 and 2028/29 remain indicative however and the focus at this stage has been on the plan for 2026/27.

Published revenue allocations show the ICB is now broadly in line with target funding which has removed the need for a convergence adjustment which has been significant in previous years. Whilst this is positive, allocation growth of 2.7% is lower than anticipated following the outcome of the 2025 spending review and once inflation is taken into account, real terms growth will be minimal. As such, 2026/27 and 2027/28 are expected to continue to be particularly challenging years financially, requiring similar levels

of efficiency to the current year and leaving relatively limited funding available for investment in strategic priorities.

From 2026/27 all organisations have been set individual financial plan limits and although organisations are still expected to work collaboratively across the system, the joint requirement to manage the system financial position no longer applies and there is no system financial plan submission required. As a result, this paper focuses on the ICB financial plan, although an update is provided on the latest position across the system.

As per national guidance and planning rules, ICBs and NHS trusts that have a surplus or breakeven plan in 2025/26 will be set a breakeven plan limit. Therefore for NENC ICB the plan limit set by NHSE is breakeven for each year.

ICBs that have a surplus plan position in 2025/26 that is supporting a deficit system financial position (and the system received deficit support funding) then per new national rules those surpluses are required to be released in 2026/27 to NHS trusts in the system. For NENC ICB this means £11.8m of funding, representing the agreed surplus plan for 2025/26, needs to be provided to NHS trusts within the system (to those providers with deficit plans) even though this ICB surplus was non-recurrent in make-up.

Unlike in 2025/26, no additional deficit support funding is included in ICB allocations. For those organisations that are set a deficit plan limit for 2026/27, non-recurrent deficit support funding will be made available directly to them so that those organisations can submit a breakeven financial plan after inclusion of deficit support funding.

Part A of this paper summarises the latest financial plan figures submitted on 12 February 2026, with the main focus being on 2026/27. This was agreed at the Confidential Board on 12 February 2026 to be submitted with any required material changes to any final plan submission to be approved by the CEO and CFO and reported to the next Board meeting for ratification.

Whilst the ICB agreed a planned surplus of £11.8m for 2025/26 which is expected to be delivered, this included a number of significant arising recurrent financial pressures which have been mitigated on a non-recurring basis in-year. The underlying financial position of the ICB remains a recurring deficit in 2025/26 (latest estimate of £4.4m deficit). The requirement for the ICB to effectively transfer its planned surplus for 2025/26 to relevant provider trusts in deficit, as set out by NHSE alongside other nationally unfunded precommitments and pressures for 2026/27 adds further recurrent pressure to ICB financial plans and delivery of a breakeven position for 2026/27. As such the ICB will require similar efficiency levels and other non-recurring benefits to 2025/26.

The financial plan for the ICB shows a breakeven position is expected to be delivered in each of the three financial years, including a recurrent breakeven position.

This is predicated on the delivery of total efficiencies (including non-recurrent savings) at a similar level to 2025/26, being £121m in total for 2026/27, over 5% of relevant budgets. This presents a potential risk to delivery of the plan. Net growth of only 0.1% for prescribing and 4.7% for packages of care for 2026/27 is included in line with NHSE assumptions and funding increases, with financial risk of further growth in those areas needing to be managed by the ICB.

Despite this being a particularly challenging financial plan with significant potential financial risk, the plan for 2026/27 does include investment of 4.2% in primary and community services (on top of 2% activity growth) to support the left shift ambitions outlined in the 10 year health plan. Utilisation of that funding will be agreed across the system to support current pressures and priorities.

In addition, the ICB Financial Plan accounts for other financial pressures and investments that are outside of national assumptions such as growth in ADHD/ASD investments, elective activity growth in the Independent Sector and the need to continue to provide deficit support funding to certain foundation trusts over the next few years.

There are a number of potential financial risks associated with the ICB financial plan, including in particular risk around elective activity growth and pressure on all-age continuing healthcare and prescribing budgets. There is also a risk around delivery of expected efficiency savings given diminishing

opportunities for savings and the need for transformation of services to deliver the level of continued efficiencies required.

The 2025/26 plan submission included total unmitigated net risk of £33m for the ICB. For 2026/27, the draft financial plan submission includes unmitigated net risk of £31m at this stage, with similar levels of net risk in both 2027/28 and 2028/29. This equates to less than 0.5% of total ICB allocation and work will continue to identify appropriate mitigations to reduce potential financial risk to the plan.

NENC System Financial Planning

Although there is no longer a system financial plan position from 2026/27, plans across NENC ICS have continued to be developed collaboratively to help ensure consistency and triangulation of plans.

The agreed ICS financial plan for 2025/26 was a deficit of £33.3m excluding deficit support funding. This was a net position after taking into account planned surpluses in a number of organisations, with the total planned deficit for the three providers in deficit in 2025/26 being £62.6m (prior to deficit support funding).

For 2026/27, NHSE have confirmed deficit financial plan limits for two provider trusts within NENC amounting to a deficit of £16.9m in total. This represents a significant required improvement in deficit position across three providers. The latest consolidated position based on February 2026 submissions is a total deficit of £96.6m (including expected national deficit support funding of £3m to Gateshead Health), with three individual organisations reporting a deficit plan; County Durham and Darlington NHS Foundation Trust, North Cumbria Integrated Care NHS Foundation Trust, and South Tees Hospitals NHS Foundation Trust.

Further national deficit support funding of £13.9m would have been received by North Cumbria Integrated Care, which would reduce the overall deficit to £82.7m but this funding will only be received on submission of a balanced plan.

Provider plans include total efficiencies of almost £430m in 2026/27 (5.2% on average).

Since that date Providers with plans that are not deemed financially complaint have continued to work with colleagues in NHSE with the support of the ICB to improve those plans. At the time of writing this work continues with 2 FTs receiving regional support and one receiving national support.

A summary of the ICB financial plan, a 'plan on a page' is attached as Annex 1 as a simple overview of the position (note this is split in to 4 sections on different pages purely for formatting and ease of reading in the meeting pack).

Activity and Performance:

The performance aspirations set out are included within PART B and show all metrics that the ICB is required to submit a trajectory. Some of these metrics have no target or set baseline. Where a metric has a prescribed ambition from a baseline, this is included in the table with an indicator to flag if this is a compliant submission for each of the three years (where relevant). Given the complexity of separate submissions for the ICB and Trusts and the requirement to align each section details the process which has been followed to develop trajectories to assure the board that the process has been inclusive and takes into account key assumptions around resource implications and any risks.

For key planned care metrics (including cancer), the Trusts were required to make a local submission to the ICB on Friday 6 February 2026. This was used to facilitate the development of key ICB trajectories. Using planning infrastructure across NENC, we have worked closely with Trusts across NENC to develop trajectories that are underpinned by productivity requirements and alignment to ERF allocations. Further revisions to key trajectories for planned care have been made as part of the resubmission exercise which took place on 18 March 2026. This showed an improved position from those agreed by the ICB Board for the full submission on 12 February 2026.

The ICB's performance submission for Referral to Treatment (RTT), cancer and diagnostics remain broadly not compliant against the national ambitions over the three-year period.

Urgent and Emergency Care, Primary and Community Care

Compliance across all metrics with a national ambition/target for the three-year period. The main risks remain around the quality of community datasets, particularly for intermediate care bed provision and the community waiting list. The ICB Board received a detailed update in September'25 regarding community waiting times and although the overall position is compliant, performance for CYP remains significantly lower than adults due to ongoing pressures in CYP therapy services and community paediatrics, linked to neurodiversity. Adult pressures are for podiatry at one Trust, and several Trusts have growing waiting times for community musculoskeletal services (no 52-week waits in this area). Two trusts continue to have pressures in 52-week waiters (adults and CYP) and the ICB submission is based on improvements being made across the next three years. At this point, there will still be 1,030 over 52-week waiters in March'29 which is a 50% reduction on March'26. Cora Health (previously Connect Health) remains in the NENC community waiting list figures.

Intermediate care beds is a concern due to the lack of a consistent and accurate reported position across NENC. It is recommended that work is taking forward via the Neighbourhood Health agenda to identify commissioned intermediate care beds and ensure that these are reported accurately ahead of the annual refresh for 2027/28.

Mental Health, Learning Disabilities and Autism

All metrics will be compliant over the three-year period with the exception of Individual Placement Support (IPS) which will be compliant at the end of year three. Reliance on mental health inpatient care for U18s with a learning disability and autism remains a risk as does the national expectations around talking therapies and mental health support teams. For the former, the ICB have worked with providers to ensure that the trajectories reflect the services commissioned including the workforce and resources that we have available. Risks identified in the report itself for each metric. Talking therapies and perinatal mental health were resubmitted on the back of feedback from NHS England.

Workforce:

ICB Workforce planning submission applies only to primary care (general practice) and non-NHS mental health providers; Foundation Trusts submit their own plans.

Primary Care

Data sourced from national PCN workforce figures (Sept 2025) and local ARRS claims (up to Mar 2026). Validated by Strategic Heads of Primary Care and Dr. Matthew Kurian (HEE), with minor growth projected for GPs in training.

As the ICB's neighbourhood health programme is still developing (and the absence of the Integrated Neighbourhood Health Framework), the potential impact on primary care staff is not yet fully considered at this time. This will be developed as part of the neighbourhood health programme and any impact will be taken into account as part of the annual plan refresh process.

Mental Health

Non-NHS mental health providers submitted three-year workforce plans with coordination across ICB Teams. This was requested on the basis that providers were not guaranteed contracts.

Growth anticipated only for:

- Mental Health Support Teams (MHSTs).
- Talking Therapies, linked to Autumn Statement funding (details pending).
- Individual Placement Support (IPS) (details pending)

Recruitment challenges for trainee posts remain a key dependency. Recent Talking Therapies Workforce Census will guide trainee allocation. For IPS, expansion is required to meet the fidelity model of the service and posts are to be determined based on providers' service delivery expectations.

Overall: Minimal workforce growth expected across both areas, except for targeted expansions in MHSTs, Talking Therapies and Individual Placement Support.

Board Assurance:

Board assurance is a key component of this year's planning process and submission. An assessment against each of the board assurance statements is included in the report and shows an increased level of maturity from the first submission.

NENC ICB Strategic Commissioning Plan:

The ICB has developed a [five-year strategic commissioning plan](#) which is a key component of the medium-term planning requirements for the NHS. This sets out our approach as a strategic commissioning organisation and our strategic priorities over the next five years, building on the commissioning intentions for 2026/27 which the ICB Board approved in November'25.

The strategic commissioning plan is congruent to the ICS Strategy: Better health and wellbeing for all with our key goals still our focus. Over the summer of 2026, the ICB will need to work with partners to refresh the ICS Strategy.

Risks and issues

The performance ambitions set out in the planning framework remain extremely ambitious based on current performance delivery at local and national levels. Several providers have submitted plans to meet the national ambitions for RTT which will be difficult to deliver without delivery of significant productivity and transformation.

There is still a risk that Trust plans and the ICB plans for key metrics are not aligned. The separate submissions made by the ICB and Trusts mean there is a small risk that they are not aligned when further resubmissions are made. The P&P team have maintained a close working relationship with Trusts throughout the planning round to ensure good alignment.

There is a risk that the impact of the elective/outpatient and cancer sprints do not see the level of improvement expected during February'26 and March'26. If the level of improvement required is not delivered, there will be an immediate gap which will require further delivery in 2026/27 by Trusts.

NHS England have calculated ICB targets for waiting lists and RTT over the three-year period. These have been used to calculate the ERF recurrent and non-recurrent allocations. NHS England are clear that with ERF and transformation, ICBs and Trusts will be able to deliver the required improvements. There is some risk to the non-recurrent ERF allocation if ICBs do not deliver the waiting list improvements. The targets for ICBs have been published and the current assessment of the total waiting list at March'29 is 60,000 patients higher than the NHS England expectation. As such, there is a risk that some of the non-recurrent ERF (£6m in 2026/278) is at risk.

Although the ICB is showing compliance of the national community waiting list 18-week expectation at an overall level (adults and children and young people (CYP), there variation between adults and CYP with CYP performance expected to remain below the 78% national expectation. The ICB will also still have a number of over 52-week waiters in community services at the end of 2028/29. This will need to be addressed as part of the ICB's strategic priorities over the coming years. There is also a concern over the quality of community data underpinning several of the ICB metrics. This will be picked up as part of contract discussions for 2026/278.

Assurances and supporting documentation

The ICB Executive Committee agreed to implement the ICB Planning Framework in October 2024. The framework sets out an inclusive planning process which has facilitated the development of plans with engagement from ICB teams. In response to learning from last year's planning round and the requirement to integrated key planning activities into a single process, several changes were made to better align planning activities across the ICB and ICS.

To support the planning process, a planning infrastructure was implemented which included internal ICB and external ICS governance. This includes a weekly Executive ICS reference group, established Chief Executive Officer forums and ICS wide weekly planning update call. Support from the wider ICS was

also in place via established groups and individual Trust and ICB planning meetings. Weekly planning touch points via the NEY System Coordination Group remain in place.

Regular updates have been provided to the Finance, Performance and Investment Committee (FPIC), Executive Committee and ICB Board. Due to a number of identified risks for this year's planning round, two dedicated FPIC sessions were carried out to help facilitate the development of plans ahead of the full submission on 12 February 2026.

The development of trajectories has been an inclusive process which considers the transformation agenda. Where appropriate, ICB teams including Local Delivery Teams have been engaged in the development and agreement of trajectories to ensure trajectories align to NENC priorities and plans.

The ICB Planning and Performance (P&P), workforce and finance teams carried out a review of Trust plans after the first submission in December 2025 which identified key areas that required further discussion and development as we moved from first to full submission. Our review of plans covered most of the NHS England KLOEs so we could assure NHS England that we had considered their feedback as we further developed plans for full submission.

Recommendation/action required

The Board is asked to:

- Approve the updated ICB revenue budgets for 2026/27 (as per Part A table 4).
- Ratify the full ICB three-year finance, workforce activity and performance submissions for 2026/27 to 2028/29.
- Note the requirement for robust EQIAs to be carried out for efficiency schemes in-line with the approved ICB policy.

Acronyms and abbreviations explained

ERF – Elective Recovery Fund
 FPIC – Finance, Performance and Investment Committee
 EQIA – Equality and Quality Impact Assessment
 NEY- North East and Yorkshire NHS England regional team
 FT – NHS Provider Foundation Trust
 MTP – Medium Term Plan
 NENC – North East and North Cumbria
 NHSE – NHS England
 MHLDA – Mental Health, Learning Disabilities & Autism
 ARRS – Additional Roles Reimbursement Scheme
 LoS – Length of Stay
 IPS – Individual Placement support
 OAPs – Out of Area Placements
 MHST – Mental Health Support Teams
 CYPS – Children and Young People's Services
 CDC – Community Diagnostic Centres
 RTT – Referral to Treatment
 P&P – ICB Planning and Performance Team
 NUTH – The Newcastle Upon Tyne Hospitals NHS Foundation Trust
 NCIC – North Cumbria Integrated Care NHS Foundation Trust
 STHFT – South Tees Hospitals NHS Foundation Trust
 CDDFT – County Durham and Darlington NHS Foundation Trust
 ICS- Integrated Care System

Sponsor/Approving Executive Director	Jacqueline Myers, Chief Strategy Officer David Chandler, Chief Finance Officer
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Date approved by Executive Director	18 March 2026
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Link to ICP strategy priorities

Longer and Healthier Lives						✓
Fairer Outcomes for All						✓
Better Health and Care Services						✓
Giving Children and Young People the Best Start in Life						✓
Relevant legal/statutory issues						
Medium Term Planning Framework – delivering change together 2026/27 to 2028/29 NHS Planning Framework v2.0 Planning framework for the NHS in England						
Any potential/actual conflicts of interest associated with the paper?	Yes		No	✓	N/A	
Equality analysis completed	Yes		No		N/A	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken?	Yes	✓	No		N/A	
Essential considerations						
Financial implications and considerations	Financial plan developed by finance team and reviewed by Director of Finance (Corporate) and Chief Finance Officer					
Contracting and Procurement	The contracting and procurement directorate have been involved throughout the planning process. Formal contracting processes are now in place to meet national expectations for agreeing contracts. The ICB has developed and issues formal contract intentions to NHS Trusts and Independent Sector providers, setting out expectations of providers for 2026/27.					
Local Delivery Team	Local Delivery Teams have been involved in various aspects of the planning process including the development of trajectories for key performance metrics and workforce returns.					
Digital implications	N/A					
Clinical involvement	The Chief Medical Officer has led the financial efficiency plan process and clinical engagement has been sought throughout the planning process. This includes the development of ICB performance trajectories and development of the five-year strategic commissioning plan. Quality impact assessment to be concluded on identified efficiency schemes. Further clinical engagement required on plans across the system, as part of development and delivery of final plans.					
Health inequalities	Health inequalities remain a key strategic priority of the ICB and is articulated in the five-year strategic commissioning plan.					
Patient and public involvement	Not at this stage.					
Partner and/or other stakeholder engagement	Through established internal and external governance, all relevant stakeholders have been engaged in the planning process through providers and SROs of key ICS workstreams.					
Other resources	N/A					

NHS North East and North Cumbria Integrated Care Board

Medium Term Plans for 2026/27 to 2028/29 and Five-Year Strategic Commissioning Plan

1. Purpose of paper

This paper presents the ICB Medium Term Planning submission for 2026/27 to 2028/29 and the Five-Year Strategic Commissioning Plan.

2. Introduction

The ICB is required to submit three-year finance, workforce, activity and performance plans for 2026/27 to 2028/29 (four-year capital plans to 2029/30) which are part of the national requirements set out in the Medium-Term Planning Framework – delivering change together 2026/27 to 2028/29¹. Included within the submission requirements is for the ICB to produce a five-year Strategic Commissioning Plan.

For the first time in several years, ICBs and Trusts are required to make separate submissions as the ICB is no longer for the coordination and submission of ICS plans.

Initial first submissions of two-year plans were made on 17th December'25 by the ICB which has been followed by a series of plan review meetings between the ICB and each Trust and between the NHS England regional Team (North East and Yorkshire (NEY)) and the ICB and each Trust.

The ICB Board approved submission on 12th February'26 of the full plans which were broadly non-compliant for planned care metrics. NHS England asked Trusts and ICBs to consider some specific feedback on full plans which led to a re-submission of plans (by exception) on 18th March'26. Although most Trusts re-submitted an improving position for key planned care and cancer metrics, the ICB position remains broadly non-compliant. Only CNTW, TEWV and Northumbria did not submit any revised performance information.

The structure of the paper is as follows:

- PART A – Financial Plans
- PART B – Activity and Performance
- PART C – Workforce (primary care and non-FT mental health only)
- PART D – Board assurance framework
- PART E – NENC ICB Five-Year Strategic Commissioning Plan

3. Medium term planning submissions

The medium-term planning round sees a different approach to previous years with the introduction of multi-year planning submissions and ICBs and Trusts required to make separate financial and numerical submissions for 2026/27 to 2028/29. ICBs and Trusts are also required to develop five-year strategic commissioning/integrated delivery plans.

¹ <https://www.england.nhs.uk/wp-content/uploads/2025/10/medium-term-planning-framework-delivering-change-together-2026-27-to-2028-29.pdf>

PART A – FINANCIAL PLANS

1) Introduction and context

The official NHS medium term planning framework was published in October 2025, however detailed financial and contracting guidance along with financial allocations were not published until 17 November 2025, some weeks later than expected. As such this allowed the ICB and local FTs around 4 weeks to submit initial board approved plans.

Work undertaken on the ICS Medium Term Financial Plan (MTFP) and underlying recurrent financial position provided the starting point for the 2026/27 financial plan, refreshed as required to reflect the planning guidance.

Revenue allocations have now been published for three financial years, 2026/27 to 2028/29, and the financial plan is required to cover all three years. Allocations for 2027/28 and 2028/29 remain indicative however and the focus at this stage has been on the plan for 2026/27.

From 2026/27 NHSE have signalled a different approach to financial management across the NHS with the following changes for how NHS commissioners and Foundation Trusts interact and work within the NHS.

- Organisational rather than system accountability for financial performance.
- Move towards rules-based approaches including finance (e.g. payment by activity rather than block payments).
- Transition from block contracts values to activity based contracts values.
- Fair Share Allocations and fast paced removal of all Deficit Support Funding for systems or organisations currently in receipt of.

All organisations have been set individual financial plan limits and although organisations are still expected to work collaboratively across the system, the joint requirement to manage the system financial position no longer applies and there is no system financial plan submission required. As a result this paper focuses on the ICB financial plan, although an update is provided on the latest position across the system.

The underlying financial position of the ICB has been updated on a monthly basis during the current year with the latest estimated position being an underlying deficit of £4.4m which is the starting point for the 2026/27 financial plan.

Work on financial plans has progressed alongside and aligned as far as possible to work on supporting performance trajectories and workforce plans.

2) Finance Business Rules

Both ICBs and NHS Foundation Trusts will be required to deliver financial breakeven as individual bodies from 2026/27, which reflects a change from the current business rules where ICBs and NHS trusts are required to support the delivery of financial breakeven in aggregate across the system.

As a result, the joint financial objective for ICBs and NHS trusts to act with a view to ensuring system financial balance (the 'system breakeven duty') is removed from 1 April 2026.

ICBs and NHS trusts are still expected to collaborate to support delivery of locally agreed priorities and agree plans that address the healthcare needs of the populations they serve. NHS England will hold NHS trusts accountable for the effective delivery of services and hold ICBs accountable

for the effective commissioning of services for the local population, including delivery of these locally agreed plans.

As in previous years, there is a key requirement for the ICB to deliver at least a breakeven position. The ICB is also required not to exceed the running cost allowance limit.

The ICB financial duties and requirements are summarised in the table below:

Duty or requirement	Summary	Further information
ICB breakeven duty	Statutory duty to act with a view to ensuring expenditure does not exceed funding received.	Not applicable.
ICB revenue resource use limit	Statutory duty to comply with the limit set by NHS England.	Set by NHS England in financial directions with reference to closing ICB allocations.
ICB administration limit	Statutory duty to comply with the limit set by NHS England (referred to as ICB running cost allowance).	Set by NHS England in financial directions with reference to closing ICB running cost allowance.
Better Care Fund (BCF)	Requirement to comply with the ICB funding conditions set by DHSC.	Set by DHSC in the BCF policy framework.
Mental Health Investment Standard (MHIS)	Requirement to comply with the ICB MHIS values set by NHS England.	Set by NHS England as part of planning information shared with ICBs.
Dental services ringfence	Requirement to comply with the ICB dental services ringfence values set by NHS England.	Set by NHS England as part of planning information shared with ICBs.

The cumulative system position in the current business rules will be carried forward by ICBs. Where systems have a cumulative system surplus at the end of 2025/26 this will be carried forward as a surplus in the ICB cumulative position and may be accessed in accordance with the ICB drawdown policy.

To support the transition to the new NHS operating model, ICB repayments of any cumulative system deficits will be paused in 2026/27 and 2027/28. Where the ICB delivers a breakeven revenue position in both 2026/27 and 2027/28, NHSE will consider wiping the historical system cumulative deficit where the ICB is considered to have demonstrated sound financial management.

Where the ICB does not deliver a breakeven revenue position in both 2026/27 and 2027/28 or is not assessed as having demonstrated sound financial management over recent years, NHSE reserves the right to carry-forward the system cumulative deficit to the new ICB cumulative position, adjusted to include 2026/27 and 2027/28 ICB positions.

Similar to the current position, any subsequent repayment of prior year deficit positions would commence in the second year after the year in which the deficit first arose, with repayments being made over a 3-year period, subject to an annual cap set at 0.5% of the recurrent ICB core programme allocation.

Clarity continues to be sought from NHSE on the current cumulative system position for the ICS following the system deficit delivered in 2023/24 (c£27m excluding deficit support funding). The ICB view is the overall cumulative position remains a surplus due to the surplus delivered across the system in 2022/23, however the ICB is waiting for this to be formally confirmed,

As noted above, NHSE will set every ICB and NHS trust a revenue financial plan limit. Where ICBs and NHS trusts have a surplus or breakeven plan in 2025/26 they will be set a breakeven plan limit, therefore for NENC ICB the plan limit is breakeven.

Where organisations have a deficit plan limit, non-recurring deficit support funding will be made available to allow a breakeven financial plan. The deficit support funding will reduce over the period, with all organisations expected to move to breakeven without deficit support funding. The expected improvement in deficit positions will be up to a maximum of 2% of provider income.

Where ICBs have a surplus plan position in 2025/26 that is supporting a deficit system financial position (and the system has received deficit support funding in 2025/26) this will need to be released in 2026/27 to NHS trusts in the system. For NENC ICB this means £11.8m of funding, representing the agreed surplus plan for 2025/26, needs to be provided to NHS trusts within the system (to those providers with deficit plans). These sums will be added to Trust block contracts but these contract values are expected to be replaced by corrected contract values based on cost per case payment values as part of the block deconstruction work that is on-going.

Where an ICB or NHS trust with a breakeven plan limit does not deliver the plan position and records a year-end deficit position, the organisation will then become subject to the financial override in the NHS Oversight Framework. The organisation will be expected to recover its financial position in future years without deficit support funding. Furthermore, any ICB deficit will be applied against the ICB cumulative position and subject to repayment in future years in line with the updated NHS finance business rules.

3) ICB Revenue Allocations

Published revenue allocations have been recalculated by NHSE and show the ICB is now broadly in line with target funding which has removed the need for a convergence adjustment which has been significant in previous years. Whilst this is positive, allocation growth of 2.7% is lower than anticipated following the outcome of the 2025 spending review and once inflation is taken into account, real terms growth will be minimal. As such, 2026/27 and 2027/28 are expected to continue to be particularly challenging years financially, requiring similar levels of efficiency to the current year and leaving little funding available for investment in strategic priorities.

Revenue allocations for the two financial years 2026/27 and 2027/28 (indicative) were published in November 2025 with indicative allocations for 2028/29 following.

As set out in the 10 Year Health Plan, ICB allocations will move towards their target distribution ('fair share') over the period to 2028/29 with deficit support funding also being removed.

Whilst there are a number of complexities within the funding allocations, the intent in this paper is to summarise the main points so that Board members are sufficiently briefed.

Table 1 below summarises total confirmed ICB revenue allocations for 2026/27 and indicative published allocations for 2027/28 and 2028/29.

Table 1:

	2026/27	2027/28 (indicative)	2028/29 (indicative)
Recurrent allocations	£m	£m	£m
Core Programme	7,355.0	7,568.0	7,801.7
Primary Medical Care	721.6	730.8	739.8
Delegated Primary Care (POD)	411.4	419.0	426.8
Specialised Commissioning	828.4	853.9	879.8
Running Costs	50.0	51.1	52.1
Recurrent allocation	9,366.4	9,622.9	9,900.3

Non-recurrent allocations	£m	£m	£m
Additional non-recurrent elective / diagnostic funding	5.9	6.7	7.2
Service Development Fund (SDF)	28.2	24.5	29.3
Charge exempt overseas visitor and UK cross border adjustment	(3.3)	(3.3)	(3.3)
Depreciation/amortisation - additional ringfenced funding	13.7	13.8	16.1
Central technology licence arrangement adjustment	(1.9)	(1.9)	(1.9)
Activity growth funding for emergency ambulance services	6.7	6.8	6.7
SR21 CDC funding	37.1	37.1	37.1
Other allocation	10.2	5.1	0.0
Other POD allocations	7.4	7.6	7.7
ICB Cost of Commissioning Adjustment	(25.1)	(25.6)	(26.1)
Management of obesity drugs	3.9	9.4	9.4
Specialised commissioning	35.6	36.6	37.6
Secondary dental elective funding transfer to POD	(6.4)	(6.5)	(6.6)
Total Non Recurrent allocation	112.0	110.3	113.1

Deficit support funding	0.0	0.0	0.0
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Total NENC ICB Allocation	9,478.4	9,733.2	10,013.4
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Key points to note:**Growth**

- Base allocation growth has been set at 2.70% for 2026/27 (amounting to almost £194m for NENC) and 2.90% for 2027/28.
- This is lower than expected given the Spending Review 2025 indicated an increase for the NHS of 3% above inflation each year
- Base growth includes a cost uplift factor (CUF) of 2.03% and general efficiency factor set at 2%, giving a net CUF uplift of only 0.03%. This reduces to 0% net uplift in 2027/28 and 2028/29 (2% gross uplift offset by 2% efficiency).

Convergence

- A convergence adjustment (funding added or removed) continues to be applied to ICBs based on distance from target allocation. For NENC, the recurrent baseline is now only 0.01% away from target hence no convergence adjustment is applied.

Baseline adjustments

- Adjustments have been made to 2025/26 baselines to reflect recurrent funding made available in-year, including for example 2025/26 in-year pay award funding, covid-19 testing funding, discharge funding, 2025/26 transfers from Service Development Fund (SDF) and including elective recovery funding in recurrent baselines.

Delegated Primary Care and Specialised Commissioning Allocations

- Separate funding allocations are received for delegated primary medical care and other primary care (pharmacy, ophthalmic and dental services, or 'POD'), together with delegated specialised commissioning.
- The utilisation of Primary Care allocations remains subject to the additional rule that dental budgets are ringfenced.

ICB Running Cost Allocations

- ICBs continue to be set running cost allowances which are broadly unchanged from total 2025/26 funding, uplifted for expected pay inflation.
- A separate allocation defund has been applied to ICB core programme funding to reflect the expected savings from reducing overall ICB 'cost of commissioning' down to £19 per head of population. The £19 per head baseline figure includes ICB running costs, programme pay and commissioning support unit costs. This reduction is £25.1m in 26/27 – roughly a third of current spend.

Service Development Funding (SDF)

- Most SDF bundles were transferred to ICB core programme allocations in 2025/26 and now form part of the recurrent ICB baseline.
- Where funding has been transferred into ICB core programme allocations this is no longer ringfenced.
- The main areas of funding remaining in SDF for 2026/27 are Cancer, Mental Health relating to Individual Placement Support (IPS), Talking Therapies and Mental Health Support Teams in schools, and Diabetes funding for Hybrid Closed Loop devices. Total value of SDF funding in 2026/27 is £28.2m.

Elective Activity and Elective Recovery Fund (ERF)

- Elective Recovery Funding used to support patients being seen at levels more in line with constitutional standards post Covid - was previously provided on a non-recurrent basis. For 2026/27, a total of £5.5bn of elective funding has been added to recurrent ICB core programme allocations on a fair share distribution.
- For NENC this amounts to £313m, which includes an increase of over £40m from the previous year as funding is now distributed on a fair share basis. For context the £40m equates to roughly an extra 4% FT activity compared to last year's funding which is on top of regular ICB growth funding for more elective activity (2%).
- Additional non-recurrent funding has also been provided to support delivery of the 6-week diagnostic and 18-week RTT access standards by 2028/29. This non-recurrent allocation (£5.9m for NENC in 2026/27) will be subject to clawback where the required improvements in performance are not planned for and delivered.

- NHSE requirement is to improve RTT (Referral to Treatment) performance by a minimum of 7% compared to March 2026 plan levels.

National Deficit Support Funding (DSF)

- In 2025/26 (and previous years) additional non-recurrent deficit support funding was received to allow a balanced ICS financial plan to be submitted. For NENC this equated to £33.3m in 2025/26 (reduced from £50m in 2024/25).
- In 2026/27 no deficit support funding is included in ICB allocations. All ICBs and NHS trusts have been set a revenue financial plan limit for 2026/27. For those with a deficit plan limit, non-recurrent deficit support funding will be made available so that those organisations can submit a breakeven financial plan after inclusion of deficit support funding.

4) Planning Approach and Key Assumptions

Efficiency Requirement

The national efficiency 'ask' for 2026/27 (and future years) built into the national tariff calculation is 2.0%, the same as 2025/26.

This, combined with the significant underlying financial pressures facing the ICS, and expected improvements in deficit plan limits for relevant organisations, results in a true efficiency ask which is far in excess of the 2% included in tariff.

Total efficiencies of around 6% are expected to be delivered in 2025/26 across the ICS, although a significant element of this is currently non-recurrent in nature. A similar level is expected to be required in 2026/27.

Key Planning Assumptions

The following key planning assumptions have been applied in the draft financial plan:

- NHS provider contract values are based on:
 - Rolled forward 2025/26 values adjusted for non-recurring funding and any agreed in-year recurrent changes including impact of 2025/26 pay award,
 - 2026/27 inflationary uplift of 2.03% net of efficiencies of 2.0% (see above),
 - Activity growth applied in line with NHSE assumptions built in to ICB funding allocations, including elective, non-elective, A&E, maternity, community growth / left shift, mental health growth, drugs and devices. These are shown in Table 2 below,
 - ICB surplus plan in 2025/26 allocated to provider trusts in line with NHSE schedule.
- Spend on mental health is planned to increase in line with the Mental Health Investment Standard (MHIS), which has a requirement to grow at the minimum of the overall ICB core allocation increase.
- Better Care Fund growth of 3.0% for 2026/27 has been included in line with planning guidance, with the full amount of growth expected to be used to increase the minimum contribution to adult social care of 4.4%.
- Remaining Service Development Funding included within the financial allocations (not transferred to core programme allocations) has been protected and is planned to be spent.

- Place fair share funding - £2.7m per annum to be allocated as an uplift to Middlesbrough place (to be split across relevant acute, mental health and other place budgets) as part of a 3-year pace of change towards fair share funding agreed in 2024/25, following analysis produced for the ICB Resource Allocation Group.
- Community Growth - a total of 6.2% growth has been incorporated to cover community and primary care activity growth and left shift funding, based on NHSE assumptions. From this, 2% has been allocated as activity growth consistent with other activity growth assumptions. The remaining 4.2% is indicatively allocated to support left shift with plans to utilise that funding to be agreed, subject to affordability. For year 1 of the plan this is expected to cover existing pressures in community services in the main.
- Prescribing – A net 0.1% increase in prescribing costs has been assumed in 2026/27 in line with national planning assumptions. This is lower than usual, and increases to 3.5% in 2027/28, due to expected nationally led opportunities and savings on SGLT2 (mostly used to treat diabetes) drugs.
- Packages of Care - A total of 4.7% growth has been included in respect of individual packages of care (continuing healthcare and s117 packages) in line with NHSE assumptions. This represents a potential risk given growth seen in previous years and the impact of the increase in national living wage from 1 April 2026.
- Total ICB efficiencies of £121m are included in the plan for 2026/27. Total planned efficiencies across provider trusts within the ICS are expected to be between 5-7% of provider turnover overall, similar to 2025/26.
- Table 2 below summarises the programme growth assumptions made over the three year period, showing relevant % growth uplifts and financial cost

Table 2:

PROGRAMME GROWTH ASSUMPTIONS	2026-27		2027-28		2028-29	
	%	£m's	%	£m's	%	£m's
Tariff Uplift	2.03%		2.0%		2.0%	
Tariff Efficiency	-2.0%		-2.0%		-2.0%	
Net Tariff Impact	0.03%	1.6	0.0%	0.0	0.0%	0.0
Elective	2.0%	23.5	2.0%	23.2	2.0%	23.7
Non Elective	2.4%	23.6	1.6%	16.1	3.1%	31.7
A&E	1.8%	5.5	1.7%	5.3	1.8%	5.7
Maternity	2.0%	4.0	2.0%	4.1	2.0%	4.2
Community	2.0%	18.3	2.0%	19.1	2.0%	19.9
Community left shift	4.2%	28.0	5.1%	37.3	5.5%	42.8
BCF	3.0%	10.4	3.2%	11.3	3.3%	11.9
Mental Health & Learning Disabilities	2.0%	15.7	2.0%	16.3	2.0%	16.5
Other commissioned services	2.0%	0.9	2.0%	1.0	2.0%	0.9
CHC	4.7%	31.1	4.7%	28.1	4.7%	29.3
S117	4.7%	9.9	4.7%	9.2	4.7%	9.9
Prescribing	0.1%	0.7	3.5%	23.0	3.3%	22.4
Excluded Drugs and Devices Growth	5.6%	11.2	5.5%	11.6	5.3%	11.8
CNST	8.0%	6.9	5.9%	6.9	5.5%	6.9
RAG Distance from target	0.0%	2.7	0.0%	2.7	0.0%	0.0
Total Programme growth		193.9		215.3		237.7

Contracts

The ICB commissions services from NHS Foundation Trusts, NHS Trusts and other providers such as the independent and voluntary sector. As noted, NHSE has announced that ICB and NHS FT contract relationships are changing. Within NENC it has recognised that 2026/27 is very much a transition year and it has been agreed within the NENC system that NHS Provider Trust contract baselines have been rolled forward from 2025/26 adjusted for non-recurring funding and the impact of any in-year recurrent changes agreed in 2025/26 to produce a recurrent 2026/27 opening contract baseline. These have then been adjusted for 2026/27 additions, including for example net inflation uplifts, ERF and activity growth assumptions as set out in planning guidance.

Contracts will continue to include a fixed, block amount, but with a variable element for activity within the scope of elective recovery funding and urgent & emergency care (UEC). Per national rules the variable element will be transacted in-year with activity paid for at 100% of the NHS unit price for elective activity and 20% marginal rate for urgent and emergency activity unless contracts stipulate otherwise.

Contract Rebasing

Initial FT contract rebasing work requested by NHSE was conducted in 2025/26 with the output being heavily caveated due to limitations and uncertainty in the underlying data used, with further validation work required. The planning guidance sets out an expectation that the outcome of work to deconstruct blocks and review fixed payments should be used to inform contract discussions and adjustments in setting fixed contract payment values.

To avoid destabilising providers or commissioners, any adjustments as a result of the work to deconstruct blocks should be set at a reasonable and affordable level which is considered to be no more than 2.5% of total contract values.

The Contract Rebasing working group, whose membership includes representation from the ICB and all eight Acute trusts, articulated the issues inherent in the original exercise and proposed the following:

1. An interim approach for 26/27 to allow the time for a refresh of the outcomes of the original exercise to be completed

The agreed approach for 2026/27 is to fund the two trusts deemed underfunded in the original exercise up to their maximum in-year movement, calculated as 2.5% of ICB Acute Contract income, adjusted for any material movements agreed during the 26/27 planning round.

This impacts on two trusts, The Newcastle upon Tyne Hospitals NHSFT and Northumbria Healthcare NHSFT:

	RTD	ROB	RXP	RTF	RTR	RNN	RWW	RR7	
	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	GATESHEAD HEALTH NHS FOUNDATION TRUST	
MAX movement in 26/27	16,681 -	9,101 -	12,647	11,979	1,246 -	404 -	8,282 -	824 -	1,352
Updated Max Movement (incl in year additions)	5,972 -	19,259 -	11,457	5,474	89 -	6,417 -	11,061 -	3,417 -	40,076
Proposed Movement 26/27	5,972	-	-	5,474	-	-	-	-	11,446

2. A full, principles-led refresh of the Contract Rebasing exercise during 26/27, including a full review of local tariffs, business rules and coding and counting.

The outputs from this exercise would then be applied up to the maximum annual movement of 2.5% of Acute Contract value, taking account of any other qualifying in-year movements, national deficit reduction requirements and pending affordability.

Contract Uplifts

The cost uplift factor (CUF) for 2026/27 is 2.03%, with a general efficiency requirement of 2.0%, leaving a net uplift of 0.03%.

The breakdown of the CUF is shown below, this is predominantly driven by pay growth with an estimate of 2% included for pay award.

Cost	Estimate	Cost weight	Weighted estimate
Pay	2.10%	71.31%	1.49%
Drugs	0.58%	2.37%	0.01%
Capital	1.66%	4.44%	0.07%
Other	2.20%	19.66%	0.43%
Unallocated CNST	0.52%	2.22%	0.01%
Total			2.03%

5) ICB financial plan and budgets

The Financial Plan for the ICB for each year shows a breakeven position, in line with the revenue financial plan limit set by NHSE.

2026/27 Budget

Table 3 below shows a high-level overview of the source and application of funding for 2026/27, starting with the latest forecast 2025/26 underlying deficit position for the ICB.

Table 3:

	£m	£m	£m
	Resource	Application	Total
2025/26 Underlying position (surplus) / deficit			4.4
Programme growth	-193.7	193.8	0.1
Ringfenced growth (GP, POD, specialised commissioning, running costs)	-43.0	43.0	0.0
ERF baseline increase	-43.9	43.9	0.0
ICB unfunded pressures (Elective IS, CHC, s117, MO, ADHD, ICB surplus to FTs, NR support to system FTs)		151.7	151.7
Efficiency programme	-121.1		-121.1
Release of reserves	-15.2		-15.2
Unidentified management of position	-20.0		-20.0
2026/27 planned position (surplus) / deficit			0.0

The ICB allocation growth funding is fully utilised in applying relevant NHSE planning assumptions that we agreed to use as part of budget and contract setting.

This leaves ICB unfunded pressures of almost £155m including expected financial pressures from independent sector elective activity growth, packages of care and AHD/ASD assessments in excess of NHSE assumptions as well as a significant local deficit support pressure of £47m. This relates to funding allocated to provider trusts within the system in 2025/26 on a non-recurrent basis, for which there appears to be an expectation from NHSE that this is continued, in a similar way to the requirement for the ICB to allocate its £11.8m planned surplus in 2025/26 to providers in deficit.

This is largely offset by the ICB planned efficiency programme and release of any remaining reserves, leaving a pressure of £20m for which mitigations still need to be identified at this stage.

Three Year Financial Plan

A summary balanced ICB financial plan and proposed budgets for 2026/27, together with the indicative position for 2027/28 - 2028/29 is shown in Table 4 below:

Table 4:

ICB Financial Plan and Budgets 2025/26	Annual Plan 2026/27 £'000	Annual Plan 2027/28 £'000	Annual Plan 2028/29 £'000
ICB Allocation	9,478,406	9,733,204	10,013,414
ICB Expenditure:			
Acute Service Expenditure	-4,215,364	-4,293,569	-4,390,985
Mental Health Service Expenditure	-1,027,619	-1,070,773	-1,105,346
Community Health Service Expenditure	-803,502	-818,459	-863,968
All-age Continuing Care Service Expenditure	-582,122	-611,805	-641,684
Primary Care Service Expenditure	-759,074	-795,891	-822,487
Other Programme Service Expenditure	-15,836	-22,051	-22,250
Other Commissioned Service Expenditure	-14,597	-12,540	-10,468
Primary Medical Services Expenditure	-721,556	-730,845	-739,791
Delegated Primary Care Expenditure	-418,878	-426,596	-434,512
Delegated Specialised Commissioning Expenditure	-864,009	-890,503	-917,387
Total ICB Commissioning Service Expenditure	-9,422,557	-9,673,032	-9,948,878
Running Costs	-50,022	-51,062	-52,124
Reserves/Contingencies	-5,827	-9,110	-12,412
Total ICB Expenditure	-9,478,406	-9,733,204	-10,013,414
Total ICB Net Position Surplus / (Deficit)	0	0	0
Total ICB Underlying Recurrent Position	0	0	0

The ICB agreed a planned surplus of £11.8m for 2025/26 which has been managed throughout the year and is expected to be delivered. However a number of in-year recurrent pressures have been mitigated on a non-recurring basis in-year.

The underlying financial position of the ICB is a recurring deficit from 2025/26 (latest estimate £4.4m) and the NHSE requirement for the ICB to effectively transfer its planned non-recurrent surplus for 2025/26 to relevant provider trusts in deficit adds a further recurrent pressure. Hence delivery of a breakeven position for 2026/27 will require similar efficiency levels and other non-recurring benefits to 2025/26.

The financial plan submission position shown above delivers an underlying recurrent breakeven position in all three years.

Delivery of a breakeven position for 2026/27 includes the following assumptions:

- Delivery of efficiencies totalling £121m, being over 5% of relevant in scope budgets,
- Net growth of only 0.1% for prescribing and 4.7% for packages of care in line with NHSE assumptions, with financial risk of further growth in those areas needing to be managed,
- Remaining financial pressure of £20m (0.2% of allocation) to be managed in-year.

ICB Efficiency Requirements

The level of total efficiencies (including non-recurrent benefits) required each year is similar to 2025/26 and presents a potential risk to delivery of the plan given the diminishing potential opportunity for non-recurrent benefits year on year. Efficiencies included in the ICB plan are shown in Table 5 below:

Table 5:

	£m	£m	£m
Efficiency Schemes	2026/27	2027/28	2028/29
All-age continuing care (AACC)	18.5	19.3	20.2
Prescribing	19.5	20.1	21.7
Service reform	30.0	30.0	30.0
Estates	1.0	1.0	-
£19 per head reductions	25.1	-	-
Total Recurrent	94.1	70.4	71.8
Non-recurrent efficiency programme in-year savings	27.0	42.1	32.1
Total Efficiency	121.1	112.5	103.9

Efficiency expectations for Packages of Care and Prescribing have been set at 3% in line with previous years. Members will note that in 2025/26 the packages of care budget area was subject to higher levels of efficiency given NHSE benchmarks that showed the ICB as being an outlier on spending. Whilst progress has been made in this area more reform work is necessary to ensure best value from ICB budgets in relation to need.

Service Reform savings are a catch all area that include savings from Local Delivery Team Budgets, unused SDF budgets and ICB service or pathway changes such as changes to Long Covid commissioning.

The £19 per head savings are in relation to the expected savings by NHSE for ICBs to become smaller and more strategic organisations.

The non-recurrent savings are those that the ICB will need to find in year in order to balance the financial position (assuming no other pressures in year). The ICB has always had an in year target and this represents around 0.2%-0.4% of total allocation each year.

For 2026/27 most efficiency plans are well worked up ahead of the start of the financial year. Work is now commencing to further identify savings plans for future years in order to plan ahead and to take account of the fact that notice periods are always required where services are being decommissioned for example.

Pressures and Investments

Despite this being a particularly challenging financial plan with significant potential financial risk, the plan does include funding for investment of 4.2% in primary and community services (on top of 2% activity growth) to support the left shift ambitions outlined in the 10 year health plan. This funding equates to a total of £28m in 2026/27 and a further £80m across the following two years. Utilisation of that funding will be agreed across the system to support current pressures and priorities.

For 2026/27 it is expected this funding will largely be used to address existing commitments and funding pressures. This includes required growth in Better Care Fund, agreed investment arising from local primary care commissioned services review and existing pressures in activity based community contracts. Plans will be agreed for the investment of funding in future years.

In addition, as shown in Table 3 above, there are a range of other pressures funded within the plan in 2026/27 totalling £151.7m which are set out in the table below.

As noted in section 2, there is a requirement for the ICB planned surplus in 2025/26 (£11.8m) to be provided to those system providers will deficit positions. A further £70.6m has been included in the plan for non-recurrent support to system providers. This incorporates 'local deficit support funding' of £47.8m which is explained further below, along with the impact of contract rebasing and other non-recurrent support.

A range of other pressures are also set out in Table 6 below, including the full year impact of pressures seen in 2025/26 relating to acute independent sector activity and ADHD/ASD assessments, along with expected growth in AACC, section 117 packages of care and prescribing costs. These are partially offset by expected efficiency savings in 2026/27.

Table 6:

	2026-27		
	£m's	£m's	£m's
	Rec	NR	Total
Precommitments			
Non Recurrent support to system providers		70.6	70.6
ICB 25-26 planned surplus to system providers	11.8		11.8
Unfunded Pressures			
Acute Independent sector activity	15.0		15.0
AACC (Inflation and package growth)	17.1		17.1
Section 117 (Inflation and package growth)	5.4		5.4
Prescribing (Price and Item growth)	19.7		19.7
ADHD ASD Assessments (Activity growth)	7.0		7.0

Other Pressures	5.0		5.0
Total pressures funded in plan	81.1	70.6	151.7

Deficit Support Funding - Local

Table 7 below summarises the position in respect of ICB surplus funding and local ICB support funding from 2025/26.

As noted above, under the finance business rules for 2026/27, the ICB planned surplus for 2025/26 of £11.8m must be provided to relevant NHS providers within the system with deficit plans. The split by provider shown in the table below has been mandated by NHSE and forms part of agreed financial plan limits for those providers.

In addition, during 2025/26 the ICB agreed a total of £65.6m of additional non-recurrent support funding to five provider trusts as shown in the table below. £16.6m of this was effectively a 'top-up' to national deficit support funding – in 2024/25 national deficit support funding from NHSE was £49.9m, in 2025/26 this reduced to £33.3m and it was agreed that growth funding would be used to effectively maintain deficit support funding at the same level as 2024/25. £49m related to an agreed reduction to the initial planned ICB surplus which was offset by improvements in relevant provider positions as shown below.

As this local support funding was helping to offset provider deficits across the system, the expectation is that this should follow a similar approach to the national deficit support funding with a maximum reduction of 2% of provider income per year.

As a result, it is currently assumed that non-recurrent funding will continue to be provided but at reducing levels each year; a total of £47.8m in 2026/27, reducing to £29.2m in 2027/28 and £16.7m in 2028/29. Reductions have been calculated at a maximum of 2% of income for relevant providers, after taking into account any expected movements in national deficit support funding.

Table 7:

	Gateshead Health NHSFT	North Cumbria Integrated Care NHSFT	County Durham & Darlington NHSFT	South Tees Hospitals NHSFT	Cumbria, North'land, Tyne & Wear NHSFT	Total
	£m	£m	£m	£m	£m	£m
National transfer of ICB 25/26 Surplus:						
ICB 25/26 surplus transfer to be transacted in 2026/27 as per NHSE	2.3	5.7	0	3.9	0	11.9
'Local' Non-recurrent Support Funding 2025/26:						
Deficit Support Funding 'top-up'	1.7	8.2		5.4	1.3	16.6
ICB surplus reduction	9.0	22.0	2.0	14.0	2.0	49.0
Total 'local' non-recurrent support funding 2025/26	10.7	30.2	2	19.4	3.3	65.6
Total 'local' non-recurrent support funding assumed in 2026/27	9.1	27.7	0	11.0	0	47.8
Total 'local' non-recurrent support funding assumed in 2027/28	4.0	25.2	0	0.0	0	29.2
Total 'local' non-recurrent support funding assumed in 2028/29	0	16.7	0	0	0	16.7

6) Key ICB Financial Risks

There are a number of potential financial risks associated with the ICB financial plan. The main risk areas for the ICB are:

- Risk around elective activity growth, particularly in the independent sector. Significant growth has been seen in 2025/26 which will cause a pressure going in to 2026/27 if activity plans cannot be agreed and appropriately managed,
- Risk of pressure on all-age continuing healthcare and prescribing budgets given the relatively low net growth figures applied in NHSE planning assumptions in comparison to growth seen in previous years
- Risk around delivery of expected efficiency savings given diminishing opportunities for savings and the need for transformation of services to deliver the level of continued efficiencies required. This risk increases in years two and three of the plan where efficiency plans are not currently as developed as in 2026/27.

There is also a risk of continued pressure relating to ADHD and ASD assessments at non-NHS providers given the growth seen over the last 12 months, along with a potential risk relating to the urgent and emergency care marginal rate introduced for 2026/27.

The 2025/26 plan submission included total unmitigated net risk of £33m for the ICB. For 2026/27, the draft financial plan submission includes unmitigated net risk of £31m at this stage, with similar levels of net risk in both 2027/28 and 2028/29. This equates to less than 0.5% of total ICB allocation and work will continue to identify appropriate mitigations to reduce potential financial risk to the plan.

Management of the potential risk around elective activity will be important to ensure delivery of the ICB financial plan for 2026/27 given pressures seen in the current year and expected improvements to waiting time performance. As described above, significant additional elective recovery funding is included in the plan for 2026/27 which helps to mitigate some of this risk. A renewed focus on demand management will be critical to mitigating activity pressures, along with agreement and management of Indicative Activity Plans (IAPs). The development of neighbourhood health plans and Integrated Health Organisations (IHOs) is expected to support service reform plans and contribute to a shift in activity away from secondary care.

7) ICS Financial Plan Position

As referenced above, from 2026/27 all organisations have individual financial plan limits which they are expected to deliver. Unlike in previous years there is no overall system financial plan submission, although all organisations are still expected to work collaboratively and ensure plans are triangulated.

As in previous years, plans across NENC ICS have been developed collaboratively using common planning assumptions and following similar processes to the development of system plans previously. This should help to ensure consistency and triangulation of plans.

The agreed ICS financial plan for 2025/26 was a deficit of £33.3m excluding deficit support funding. This was a net position after taking into account planned surpluses in a number of organisations, including the ICB. The total planned deficit for the three providers in deficit in 2025/26 was £62.6m (prior to deficit support funding).

For 2026/27, NHSE have confirmed deficit financial plan limits for two provider trusts within NENC amounting to a deficit of £16.9m in total. This represents a significant required improvement in deficit position across three providers. All other organisations within NENC are expected to deliver at least breakeven plan positions for 2026/27.

For 2027/28 the position is expected to improve further to a deficit of only £4m in total in one provider trust, with a further improvement expected in 2028/29 to leave no deficit remaining.

Although a system financial plan is no longer required, the latest consolidated position based on February 2026 submissions is a total deficit of £96.6 m with three individual organisations reporting a deficit plan; County Durham and Darlington NHS Foundation Trust, North Cumbria Integrated Care NHS Foundation Trust, and South Tees Hospitals NHS Foundation Trust.

National deficit support funding of £13.9m would have been received by North Cumbria Integrated Care, which would reduce the overall deficit to £82.7m but this funding will only be received on submission of a balanced plan.

The total deficit across the system reduces to £54.1m in 2027/28 and £20.4m in 2028/29.

Provider plans include total efficiencies of over £430m in 2026/27 (5.2% on average).

At the point in writing this report, work has continued by those Providers not having a financially compliant plan. Those Providers have continued to work to improve their plans and are being supported by the ICB and national and regional colleagues within NHSE.

8) NENC Capital Plan

In previous financial years the ICB was responsible for overview of the whole system capital and approving a trust level breakdown of Capital Departmental Expenditure Limit (CDEL) allocations. From 2026/27 provider CDEL capital allocations are communicated directly by NHS England at organisation level.

Therefore, total confirmed capital allocations for 2026/27 – 2029/30 for the ICB are as follows:

- Core ICB capital allocation for Primary Care digital and Estates,
- ICB Strategic Capital – an ICB specific allocation top sliced from provider operational capital allocations to support the shift from hospital to community.

Table 8:

Capital Allocations	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/30 £'000
ICB capital allocation	6,570	6,567	6,564	6,564
Strategic Capital	10,500	10,957	11,162	11,372
Total ICB capital allocation	17,570	17,524	17,726	17,936

As in previous years systems have an allowable over-programming tolerance of 5% of operational capital allocations at plan stage, however this has not been factored into ICB plans at this stage.

In addition to the Provider specific CDEL allocations that are now communicated direct to trusts by NHS England, Estates Safety Funding is now also handled directly between NHS England and individual trusts. In addition, from 2026/27 NHS England are also holding a number of strategic capital schemes at regional level with allocations to systems controlled through a bidding process.

This includes the Return to Constitutional Standards funding for Diagnostics, Urgent Care (UEC), Mental Health and Learning Disabilities (MHLDA), Community and Elective workstreams. Trusts bid individually against the regionally held funding, with regional oversight of scheme approval and delivery. The North-East and Yorkshire Region funding available is as follows:

Table 9:

Allocation	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/30 £'000	Total £'000
Diagnostics	93,000	29,000	29,250	15,250	166,500
UEC	100,000	77,750	67,250	49,750	294,750
MHLDA	18,000	18,250	24,500	7,750	68,500
Community	16,750	9,500	8,750	8,750	43,750
Elective	18,705	11,740	-	-	30,445
Total Constitutional Standards and Left Shift	246,455	146,240	129,750	81,500	603,945

In prior financial years the ICB also had access to ICB specific allocation for better utilisation of Primary Care Estate across NHS systems. From 2026/27 the Primary Care Utilisation Fund will also be managed through a regional bidding process, however the NENC ICB indicative share of that funding allocation, included in plan submissions, is as follows:

Primary Care UMF	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/30 £'000
NENC Indicative allocation	2,750	3,000	3,000	3,250

PART B – ACTIVITY AND PERFORMANCE

Introduction

This section provides an overview of the 2026/27 to 2028/29 medium-term plan submission to NHS England in relation to activity and performance on 12th February'26 (adjusted for the resubmission on 18th March'26). The tables below set out all ICB metrics across each of the key domains for the three-year period and highlights whether the proposed submission meets the national requirement (where applicable) and any risks. Due to the nature of each of the metrics, each section also sets out the approach taken to develop the proposed trajectories to provide assurance around the process.

Elective, Cancer, Referral to Treatment and Diagnostics

Approach to developing trajectories

Activity, referral to treatment and cancer trajectories are heavily dependent on Trust specific plans. Historically the ICB has used Trust submissions to inform its own plans but as the submissions are now separate, the ICB asked trusts to submit a draft submission on 6th February'26. This was to understand what the Trusts were planning to submit at a point of time but also to help inform the ICB submissions for key metrics. The ICB was required to re-submit plans on the 18th March'26 which took into account Trust submissions on the 12th February'26 and improvements made for resubmission by CDDFT, NTHFT, STHFT, STSFT and NCIC.

Elective, Cancer and Diagnostics									
Ref	Metric	NENC Plan 26/27	NENC Plan 27/28	NENC Plan 28/29	Baseline / Target	Meets National Ambition 26/27	Meets National Ambition 27/28	Meets National Ambition 28/29	Risks

E.M.8	Consultant-led first outpatient attendances (Spec acute) - System Total Activity	+1.7%	+2.6%	+0.7%	No specific target	NA	NA	NA	<p>Full submissions from Trusts on 12th February'26 with improvements from key Trusts for their resubmission on 18th March'26. ISP activity is based on current forecasts and reductions based on current IAP assessments</p> <p>Activity assumptions at this point include a forecast for one Trust due to gaps in the draft submission.</p> <p>RTT 18-week position is not compliant at ICB level across each of the three years</p> <p>National waiting list modelling released by NHS England predicts a waiting list that is 60,000 patients lower by March'29.</p>
E.M.9	Consultant-led follow-up outpatient attendances (Spec acute) - System Total Activity	-0.2%	+1.2%	-0.5%	No specific target	NA	NA	NA	
E.M.9b	Consultant-led follow-up outpatient attendances - of which Outpatient Procedures - System Total Activity	+5.0%	+2.6%	+1.0%	No specific target	NA	NA	NA	
E.M.10a	Total number of specific acute elective day case spells in the period - System Total Activity	+1.0%	+2.5%	+0.5%	No specific target	NA	NA	NA	
E.M.10b	Total number of specific acute elective ordinary spells in the period - System Total Activity	+1.3%	+2.4%	+0.6%	No specific target	NA	NA	NA	
E.M.42	Percentage waiting for a first appointment at the snapshot date that have been waiting less than 18 weeks	79.3%	N/A		No specific target however expectation likely to be >80.6% (NENC Mar26 plan)		N/A	NA	
E.B.18	Number of 52+ week RTT waits	1,251 0.4%	534 0.2%	90 0.1%	<1% of total RTT waiting list				
E.B.3a	RTT waiting list – total	321,465	302,292	287,984	Organisation specific targets expected – reduction on baseline				
	RTT % within 18 weeks	80.1%	85.6%	90.9%	26/27: 7% improvement on Mar26 plan which is 81.0% for NENC				

					27/28: Bridge ask between 26/27 and 92% target in 28/29 which is 86.5% for NENC				
E.B.27	Percentage of people waiting no more than 28 days from urgent referral to receiving a communication of diagnosis for cancer or a ruling out of cancer	79.9%	80.3%	80.6%	Maintain 80% threshold average across year (26/27, 27/28 and 28/29)				Full submissions from Trusts on 12 th February'26 with improvements from key Trusts for their resubmission on 18 th March'26. ISP activity is based on current forecasts and reductions based on current IAP assessments
E.B.35	Percentage of patients receiving a first definitive treatment for cancer within 62 days of receipt of an urgent GP (or other referrer) referral for urgent suspected cancer/breast symptomatic referral/an urgent screening referral/consultant upgrade	79.2%	82.0%	84.7%	26/27: 80% by Mar27 27/28: 82.5% by Mar28 28/29: 85% by Mar29				28 Day Faster diagnosis not compliant year 1 62 day not compliant each of the three years. 31 Day not compliant year 1
E.B.38	Percentage of people treated beginning first or subsequent treatment of cancer within 31 days of receiving a decision to treat/earliest clinically appropriate date	93.8%	96.0%	96.1%	26/27: 94% by Mar27 27/28: 96% by Mar28 28/29: 96% across 28/29				
E.B.28x	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over	8.6%	4.9%	1.9%	26/27: NENC system level target of 2.7% by Mar27 27/28: NENC system level target of 2.0% by Mar28				Full submissions from Trusts on 12 th February'26 with improvements from key Trusts for their resubmission on 18 th March'26

					28/29: NENC system level target of 1% by Mar29				
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Urgent and Emergency Care, Primary Care and Community Care

Approach to developing trajectories

The P&P Team have worked with ICB Teams and FT colleagues to develop trajectories for key primary and community care metrics. Underpinned by historical and future analysis developed by the BI and Insight Team, models were used to review with ICB leads for key metrics which were then adjusted for local or national intelligence. The UEC 4hr and 12hr standard, and Average Ambulance Handover metrics are not included as part of the ICB submission and are for individual FTs to submit.

Urgent And Emergency Care and Community Care									
Ref	Metric	NENC Plan 26/27	NENC Plan 27/28	NENC Plan 28/29	Baseline / Target	Meets National Ambition 26/27	Meets National Ambition 27/28	Meets National Ambition 27/28	Risks
E.T.5	Virtual ward occupancy	Mar-27 80.0%	Mar-28 80.0%	Mar-29 80.0%	Virtual ward utilisation should be consistently above 80%	Yes	Yes	Yes	No change to metric from draft submission. Whilst the trajectory assumes achievement of the 80.0% during Nov-Mar in each year (to support winter pressures) we have not reduced capacity during Apr-Oct and activity is lower during these months, therefore occupancy falls below the 80.0%.
E.T.8	Urgent Community Response (UCR) referrals	132,443	136,416	140,508	No specific target	N/A	N/A	N/A	No change to metric from draft submission.

									Assumes 3% year on year growth from 25/26 forecast outturn.
E.T.13	Attended Community Care Contacts	7,207,686	7,423,916	7,646,634	No specific target	NA	NA	N/A	No change to metric from draft submission. Assumed 3% year on year growth on 25/26 forecast outturn.
E.M.43	Percentage of commissioned intermediate care beds within the service which are occupied by people with no criteria to reside	Jan-Mar-27 15.2%	Jan-Mar-28 14.7%	Jan-Mar-29 13.8%	No specific target	NA	NA	N/A	Work has been undertaken with LDTs to understand the commissioned bed position for full submission. This has resulted in some minor adjustments to both the numerator and denominator for the trajectory. Further work is required in 2026/27 as part of the Integrated Neighbourhood Health agenda to ensure that reporting of intermediate care beds is accurate and consistent with national guidance. Any impact of this will need to be taken into account as part of the annual refresh.
E.T.9a	Number of people on waiting lists for CYP services who are waiting over 52 weeks	Mar-27 941	Mar-28 800	Mar-29 630	Reduction in long waits	Yes	Yes	Yes	Since draft submission we have liaised with each of the 8 Acute Trusts to ensure system level plans are built up from individual Trust plans. This has resulted in a slight improvement from draft, in

									each of the 3 years, with each year showing a reduction on the last. 3 Trusts are currently reporting CYP >52 weeks, NTHFT, NuTH and NCIC. NTHFT have robust plan to remove all by end of 26/27. NuTH and NCIC have plans to reduce their numbers in each of the 3 years. On-going work is required with these 3 Trusts to ensure plans are met.
E.T.9b	Number of people on waiting lists for adult services who are waiting over 52 weeks	Mar-27 560	Mar-28 480	Mar-29 400	Reduction in long waits	Yes	Yes	Yes	Since draft submission we have liaised with each of the 8 Acute Trusts to ensure system level plans are built up from individual Trust plans. This has resulted in a slight improvement from draft, in each of the 3 years, with each year showing a reduction on the last. 2 Trusts make up the majority of current >52 weeks, NuTH and NCIC with both submitting plans to reduce their numbers in each of the 3 years. On-going work is required with these 2 Trusts to ensure plans are met.
E.T.12a	Percentage of people on waiting lists for Adult Community Services per system who are waiting 18 weeks or less as proportion of entire Adult waiting list	Mar-27 87.9%	Mar-28 88.0%	Mar-29 88.1%	No specific target	N/A – Ambition is on total community waiting list	N/A – Ambition is on total community waiting list	N/A – Ambition is on total community waiting list	Since draft submission we have liaised with each of the 8 Acute Trusts to ensure system level plans are built up from individual Trust plans. This has resulted in a slight deterioration from draft in each of the 3 years but warranted with increased

									focus on CYP (see below). Planned final submissions are still significantly above the national ambition for each of the 3 years and showing an improvement on the previous year.
E.T.12b	Percentage of people on waiting lists for CYP Community Services per system who are waiting 18 weeks or less as proportion of entire CYP waiting list	Mar-27 63.5%	Mar-28 65.7%	Mar-29 66.5%	No specific target	N/A – Ambition is on total community waiting list	N/A – Ambition is on total community waiting list	N/A – Ambition is on total community waiting list	Since draft submission we have liaised with each of the 8 Acute Trusts to ensure system level plans are built up from individual Trust plans. This has resulted in a significant improvement from draft in each of the 3 years. Planned final submissions are still below the national ambition for each of the 3 years but showing an improvement on the previous year.
E.T.12	Percentage of people on waiting list for Community Services per system who are waiting 18 weeks or less as a proportion of the entire waiting list	Mar-27 84.9%	Mar-28 85.2%	Mar-29 85.3%	78.0% by Mar-27 79.0% by Mar-29	Yes	Yes	Yes	Combination of ET.12a and ET.12b

Primary Care									
Ref	Metric	NENC Plan 26/27	NENC Plan 27/28	NENC Plan 28/29	Baseline / Target	Meets National Ambition 26/27	Meets National Ambition 27/28	Meets National Ambition 28/29	Risks
E.D.19	Appointments in General Practice	21,305,249	21,710,049	22,122,540	No specific target	NA	NA	NA	No change from draft submission.

									<p>Assumes 1.9% year on year growth from 25/26 forecast outturn.</p> <p>Practices have already made significant changes as part of PCARP/MGPA already, there is uncertainty as to how much more can be done, so growth in appointments might not be as big as we have previously seen.</p> <p>ARRS funding has also been available for the past few years and used - therefore not much further growth to be realised.</p> <p>It is likely there is going to be further challenges with the contract and collective action which may impact in 26/27</p> <p>As we progress with neighbourhood health models, there may also be a change in access arrangements, with potentially patients accessing neighbourhood services as a first point of contact which could also impact on GP appointment (e.g. be stable or see a reduction)</p>
E.D.26	Count of Pharmacy First Consultations	363,627	376,281	389,375	No specific target	NA	NA	NA	<p>No change from draft submission.</p> <p>We have used 25/26 FOT as baseline (351,398) and added</p>

									in year-on-year growth of 3.48% (this is consolidated growth but varies across the 3 service lines within)
E.D.27	Percentage of clinically urgent appointments seen on the same day	NOT REQUIRED FOR FULL SUBMISSION							
E.D.28	Urgent dental appointments	293,723	293,725	293,725	Baseline plus share of 700K (57,559 for NENC)	Yes	Yes	Yes	<p>No change from draft submission.</p> <p>NHSE intends to write to ICBs and provide activity information on urgent dental care to inform the planning process. The figures detailed in this planning submission are therefore subject to change once national data-pack has been received and analysed.</p> <p>Assumptions made are that the contract reforms that will be forthcoming in April 2026 will include a requirement for all NHS dental practices to provide a mandated level of urgent care and that this is based on national delivery positions plus the expected 700k (NENC share is 57,559).</p>
E.D.22	Percentage of resident population seen by an NHS dentist - adult	40.0%	40.0%	40.0%	No specific target	NA	NA	NA	<p>No change from draft submission.</p> <p>Trajectory set to maintain expected 2025-26 out-turn position of 40% due to the uncertainty around the impact of the national dental contract</p>

									<p>reforms expected to come into effect in April 2026.</p> <p>Assumes no contract hand-backs or significant re-basing of contracts.</p>
E.D.23	Percentage of resident population seen by an NHS dentist - child	62.6%	62.6%	62.6%	No specific target	NA	NA	NA	<p>No change from draft submission.</p> <p>Trajectory set to maintain expected 2025-26 out-turn position of 62.6% due to the uncertainty around the impact of the national dental contract reforms expected to come into effect in April 2026.</p> <p>Assumes no contract hand-backs or significant re-basing of contracts.</p>
E.D.24	Units of dental activity delivered	80.6%	80.6%	80.6%	No specific target	NA	NA	NA	<p>No change from draft submission.</p> <p>Trajectory set based on maintaining 2025-26 delivery profile due to the uncertainty around the impact on the national dental contract reforms, i.e. 3,770,677 UDAs delivered against an annual UDA contracted number of 4,679,721 which equates to a year end outturn of 80.6% delivery.</p>

									<p>The quarterly profiling reflects the seasonal delivery trend based on 2025-26 rather than linear split based on number of working days in each quarter.</p> <p>Assumes no contract hand-backs or significant re-basing of contracts.</p>
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Mental Health, Learning Disabilities and Neurodiversity

Approach to Developing Trajectories

A coordinated approach has been taken between the ICB Planning and Performance team, Mental Health Learning Disabilities and Autism (MHLDA) Transformation team, Local Delivery teams and Mental Health providers in the development of the MHLDA 26/27 planning trajectories.

Provider level plans were not required for all ICB level metrics (Mental Health Trust submission covers Length of Stay (LoS), Children and Young People (CYPS) 104week waits and out of area placements (OAPS)). Where the Trusts are key partners in delivery of particular service lines, e.g. Individual Placement Support (IPS) they have been fully engaged in ICB metric trajectory development. This approach has been welcomed by both organisations. Similarly, where appropriate we have liaised with our Local Delivery Team leads, specifically on Children and Young Peoples (CYPS) access, ensuring that our trajectories account for any locally planned changes to commissioning arrangements which may impact upon delivery.

Ambitions for indicators relating to inpatient care have been co-developed with the All Age Continuing Care team, to understand any drivers that may impact on performance going forward and what is deemed to be achievable in terms of reducing admission rates, given the external influencing factors associated with these.

Throughout the process, planning updates and our approach to trajectory setting and metric development have been shared with the MHLDA Performance Overview Group and the weekly MHLDA Team briefing sessions as well as the MHLDA Sub-committee.

Feedback from both regional and national colleagues in relation to the 12th February'26 submission has been reflected upon and where appropriate, revised plans have been submitted to show an improved position, particularly against metrics for TT and perinatal mental health. For TT, the following caveats apply to our resubmission:

- NENC were not provided the year 1 Autumn Statement trainee cohort allocation and do require this to be re-allocated over the remaining years to be able to improve performance. We also require flexibility between high and low intensity trainee numbers to recalibrate our providers workforce ratios.
- Funding is being utilised to support expansion and growth in talking therapies, with key investments planned for an improved infrastructure in 2026/27.
- The requirements of the Autumn Statement funding are to demonstrate 'reasonable growth' which we are showing. It is markedly more complex to achieve reliable recovery and reliable improvement in populations with significant deprivation. This is not factored into funding allocations.

Mental Health									
Ref	Metric	NENC Plan 26/27	NENC Plan 27/28	NENC Plan 28/29	Baseline / Target	Meets National Ambition 26/27	Meets National Ambition 27/28	Meets National Ambition 28/29	Risks
E.A.4a	Reliable recovery rate for those completing a course of treatment and meeting caseness	51%	52%	53%	48.5%	Yes	Yes	Yes	No change to metric. Revised plan submitted which confirms compliance against % but also commits to increasing the number of completed treatments.
E.A.4b	Reliable improvement rate for those completing a course of treatment	69%	70%	71%	69%	Yes	Yes	Yes	No change to metric. Revised plan submitted which confirms compliance against % but also commits to increasing the number of completed treatments.
E.A.5	Number of active inappropriate adult acute	0	0	0	0	Yes	Yes	Yes	No change to metric (26/27)

	out of areas placements (OAPs) at the end of the reporting period								<p>The scope of beds included in this metrics has now been increased. This will be shadow monitored in 26/27 but applied in 27/28. As yet, it is not clear the impact this will have on the NENC position and further analysis is required. Based on this the 27/28 plan may need to be adjusted to consider those additional beds.</p> <p>Feb26 update: No change to plan from draft submission.</p>
E.A.6	Number Accessing Mental Health Support Teams for Children and Young People	16,442	18,650	20,735	7,525	Yes	Yes	Yes	<p>New Metric.</p> <p>Requires significant recurrent financial investment, however indicative SDF have now been released to support this. Expansion of teams is also reliant upon available training (nationally allocated) in addition to recruitment into training posts. The scope of provision has been amended during the planning process and home-schooled children are now not captured, this has meant that the number of teams required to meet national directive has reduced.</p> <p>Access numbers are driven by the number of teams in place and how established they are as each team/status has a</p>

									<p>maximum number deemed to be an appropriate caseload.</p> <p>Feb26 update: Plan updated to reflect 12 month rolling position.</p>
E.A.7	Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period	0	N/A	N/A	3,675	Yes	N/A	N/A	<p>New Metric.</p> <p>This metric presents significant challenge that has been recognised locally and nationally.</p> <p>This metric relates to a specific cohort of patients captured as a referral spell wait which is related to mental health. Whilst this does exclude Neurodevelopmental referrals, if a historical spell for the patient has included neuro as some point and has not been closed off they will be captured.</p> <p>Providers are unable to resubmit historical data via MHSDS and therefore it is likely that many of these spells will remain open. Given the complexities of this, our providers are understandably anxious and feel that the national set target of zero is virtually unachievable.</p>

									Discussions remain ongoing with NHSE around this. Feb26 update: No change to plan from draft submission.
E.H.38	Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds	28.1	27.4	26.8	35.1	Yes	Yes	Yes	Amended Metric – Previously combined with E.H.39 No national ambitions have been set for this indicator, ICBs are required to demonstrate a reduction determined locally. The NENC LoS is primarily derived from CNTW and TEWV activity. TEWV have a relatively low LoS therefore any local reductions are reliant upon CNTW achieving their planned reduction targets which are stretching. Feb26 update: No change to plan from draft submission.
E.H.39	Average Length of Stay for Patients in Older Adult Acute Mental Health Beds	86.0	76.9	72.4	89.7	Yes	Yes	Yes	Amended Metric – Previously combined with E.H.38 No national ambitions have been set for this indicator, ICBs are required to demonstrate a reduction determined locally. The NENC LoS is primarily derived from CNTW and TEWV activity. TEWV have a relatively low LoS therefore any local

									<p>reductions are reliant upon CNTW achieving their planned reduction targets which are stretching.</p> <p>Feb26 update: No change to plan from draft submission.</p>
E.H.15	Number of women accessing Specialist Community Perinatal Mental Health Services - rolling 12 month	2,379	2,573	2,960	2,350	Yes	Yes	Yes	<p>No change to metric.</p> <p>No risks or issues to note. Whilst plans were able to be set at August'25 outturn, NENC have opted to set a more challenging ambition of a 1% increase against 25/26 ambition and then a further 2% increase from 26/27 to 27/28 and 28/29</p>
E.H.9	Number of Children And Young People (0-17) accessing (1+ contact) mental health services (rolling 12-month)	61,506	62,429	63,677	59,815	Yes	Yes	Yes	<p>No change to metric.</p> <p>No risks or issue to note. Plans were able to be set at August'25 outturn, therefore NENC have rolled over the 25/26 ambition into 26/27 and then applied a further 1% increase in 27/28</p> <p>Feb26 update: Revised plan submitted with a more challenging trajectory and increases access from 25/26 to 28/29 by 4.6%.</p>

E.H.34	Number of patients accessing Individual Placement Support services - rolling 12-month	3,063	3,776	4174	2,125	No	No	Yes	<p>No change to metric.</p> <p>National ambition set, however, a revised plan has been submitted to NENC. Revised plan will generate full compliance by 28/29 but takes a more graduated approach to reach it.</p> <p>In order to create additional capacity, teams will be required to expand to meet the fidelity model; this in turn requires additional investment.</p> <p>Feb26 update: Revised plan submitted which meets 85% of national ambition in 26/27 and 27/28 and 100% in 28/29.</p>
E.C.2	Mental Health Support Team coverage of total pupils/learners	80.7%	89.3%	96.1%	Not Applicable	Yes	Yes	Yes	<p>New Metric.</p> <p>Requires significant recurrent financial investment, however indicative SDF have now been released to support this. Expansion of teams is also reliant upon available training (nationally allocated) in addition to recruitment into training posts. The scope of provision has been amended during the planning process</p>

									<p>and home-schooled children are now not captured, this has meant that the number of teams required to meet national directive has reduced.</p> <p>Trajectories have been calculated using the indicated number of teams by NHSE, published methodology in the national technical guidance including the numerators and denominators. Despite following methodologies correctly, this unfortunately, does bring us under national ambition by 1.5% for 26/27 and 5% for 27/28</p> <p>Feb26 update: No change to plan from draft submission.</p>
E.C.2	Mental Health Support Team coverage of total schools/learners	61.7%	68.7%	74.3%	Not Applicable	Yes	Yes	Yes	<p>New Metric.</p> <p>Requires significant recurrent financial investment, however indicative SDF have now been released to support this. Expansion of teams is also reliant upon available training (nationally allocated) in addition to recruitment into training posts. The scope of provision has been amended during the planning process and home-schooled children are now not captured, this has</p>

									<p>meant that the number of teams required to meet national directive has reduced. Trajectories have been calculated using the published methodology in the national technical guidance</p> <p>Feb26 update: No change to plan from draft submission.</p>
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Learning Disabilities and Autism									
Ref	Metric	NENC Plan 26/27	NENC Plan 27/28	NENC Plan 28/29	Baseline / Target	Meets National Ambition 26/27	Meets National Ambition 27/28	Meets National Ambition 28/29	Risks
E.H.32	Reliance on mental health inpatient care for adults with a learning disability (who may also be autistic)	78.0	Not Required	Not Required	103	Yes	Not required	Not required	<p>No change to metric.</p> <p>Baselines and ambitions have been set via NHSE for 26/27 only – future plans are not required. There are some risks around achievement of this indicator and therefore will require close monitoring in-year.</p> <p>Feb26 update: No change to plan from draft submission.</p>
E.H.33	Reliance on mental health inpatient care for autistic adults	43	Not Required	Not Required	64	Yes	Not Required	Not required	<p>No change to metric.</p> <p>Baselines and ambitions have been set via NHSE for 26/27 only – future plans are not required. There are some risks</p>

									<p>around achievement of this indicator and therefore will require close monitoring in-year.</p> <p>Feb26 update: No change to plan from draft submission.</p>
E.K.1c	Reliance on mental health inpatient care for U18s with a learning disability and autistic U18s	8	Not Required	Not Required	10	Yes	Not Required	Not Required	<p>No change to metric.</p> <p>Baselines and ambitions have been set via NHSE for 26/27 only – future plans are not required. There are some risks around achievement of this indicator and therefore will require close monitoring in-year.</p> <p>Feb26 update: No change to plan from draft submission.</p>
E.K.4	Reduction in the longest length of stay (<18s, unrestricted adults and restricted adults)	57%	56%	55%	58%	Yes	Yes	Yes	<p>New metric.</p> <p>No national ambitions have been set, but ICBS are required to demonstrate a reduction in LoS. Calculation of this metric is complex and is dependent upon several contributing factors. A nominal reduction has been set, however further work with key partners is required and therefore the locally set ambition is subject to change</p>

									Feb26 update: No change to plan from draft submission.
E.K.5a	Adult 12-month admission rate per million population	27.3	26.5	25.6	28.2	Yes	Yes	Yes	<p>New metric.</p> <p>No national ambitions have been set, but ICBS are required to demonstrate a reduction in admission rate. Calculation of this metric is complex and is dependent upon several contributing factors. A nominal reduction has been set, however further work with key partners is required and therefore the locally set ambition is subject to change.</p> <p>Feb26 update: No change to plan from draft submission.</p>
E.K.5b	Under-18 12-month admission rate per million population	21	20	19	22	Yes	Yes	Yes	<p>New metric.</p> <p>No national ambitions have been set, but ICB requirement to demonstrate a reduction in admission rate. Calculation of this metric is complex and is dependent upon several contributing factors. A nominal reduction has been set, however further work with key partners is required and therefore the locally set ambition is subject to change.</p>

									Feb26 update: No change to plan from draft submission.
E.K.6	Percentage of Annual Health Checks delivered to patients aged 14+ on the GP Learning Disability Register	76%	76.5%	77%	Not Applicable	Yes	Yes	Yes	<p>Amended metric.</p> <p>Whilst this metric has been in place for several years, with strong performance across NENC, there is now a requirement to ensure the patient has a documented Health Action Plan. Based on this, NENC have opted to take a more conservative approach and apply the 25/26 trajectory into 26/27 and then apply a further 0.5% uplift into 27/28 - this will still leave NENC above the national ambition of 75%.</p> <p>Feb26 update: No change to plan from draft submission.</p>

PART C – WORKFORCE

The ICB workforce submission planning requirements relate only to primary care and non-NHS mental health providers. Foundation Trusts are responsible for submitting their workforce plans. As the ICB's neighbourhood health programme is still developing (and the absence of the Integrated Neighbourhood Health Framework), the potential impact on primary care staff is not yet fully considered at this time. This will be developed as part of the neighbourhood health programme and any impact will be taken into account as part of the annual plan refresh process therefore the information provided below is at a point in time.

For **Primary Care**, the Insights team have used the nationally published Primary Care Network Workforce data to extract current workforce as at September '25. To ensure an accurate position for ARRS roles, data has been extracted based on local practice state covering the period to March '26. All data has been shared with the Strategic Heads of Primary Care within the Local Delivery Teams who feel this is an accurate representation. Alongside this, a meeting was held with Dr Matthew Kurian, Primary Care Dean at Health Education England. Again, Dr Kurian supported the data provided but added in a very small element of growth against GPs in training grades.

Generally, the return does not indicate growth in any areas other than as identified above (GPs in training grade). This reflects a prudent and evidence-based assessment of the current workforce position, taking account of ongoing contractual, financial, and system changes affecting general practice. While further development and potential reconfiguration is anticipated through the Neighbourhood Health programme, it would not be appropriate at this stage to assume expansion in baseline workforce numbers. The return therefore provides an accurate representation of current capacity, alongside continued work with the Primary Care Collaborative to develop more detailed, responsive, and proactive workforce plans over time.

A summary of the collated return is as follows:

Total Staff WTE by Staff Group	Forecast Out-turn	Plan	Plan	Plan	Plan	Plan	Plan
	31/03/2026	30/06/2026	30/09/2026	31/12/2026	31/03/2027	31/03/2028	31/03/2029
	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Total Workforce	10578.56	10578.56	10578.56	10588.56	10588.56	10598.56	10608.56
Total GPs	2229.00	2229.00	2229.00	2239.00	2239.00	2249.00	2259.00
Total Nurses	1306.00	1306.00	1306.00	1306.00	1306.00	1306.00	1306.00
Total ARRS Funded Roles	1949.56	1949.56	1949.56	1949.56	1949.56	1949.56	1949.56
Total Direct Patient Care roles	618.00	618.00	618.00	618.00	618.00	618.00	618.00
Total Administrative and Non-Clinical Staff	4476.00	4476.00	4476.00	4476.00	4476.00	4476.00	4476.00

For **Mental Health**, contracting leads within NENC contacted their individual non-NHS mental health providers to submit their workforce plans. As three-year plans are required, the request was caveated to advise that despite requesting three-year plans this was not to be assumed a three-year contract offer. Each individual place's providers returns have been collated to offer a full ICB wide picture.

In addition to this, there has also been inclusion of expansion of workforces to support the growth of teams to meet the national expectation around Mental Health Support Team. Whilst this expansion has been captured under the non-NHS mental health providers return, there is the expectation that some of this workforce will move into NHS providers returns once we understand the future commissioning arrangements of this teams.

Similar, we are anticipating growth in Talking Therapies workforce in line with Autumn Statement monies. Whilst we understand the growth associated with the funding, formal contracting and commissioning arrangements are yet to be finalised and therefore it is likely that some of this workforce activity may move into other providers returns and there is also the potential that the allocation per staff discipline may be altered slightly. NENC have recently participated in the bi-annual Talking Therapies Workforce Census which will support decision-making around allocations of trainees across the system.

To meet the national ambition in relation to Individual Placement Support (IPS) access there is a requirement for teams within our two providers to expand. There is a national recommended model which clarifies the minimum caseload at which a specialist should deliver. This model is being used to calculate the team expansion at provider level to support our trajectories for access.

Like, Primary Care there is very little growth anticipated across Mental Health other than for MHSTs, IPS and Talking Therapies as described above and is reliant on the ability to recruit into trainee and established posts in those service lines.

A summary of the collated return is as follows:

	31/03/2026			31/03/2027			31/03/2028			31/03/2029		
	Establishment	Substantive	How many of these substantive roles are ARRS?	Establishment	Substantive	How many of these substantive roles are ARRS?	Establishment	Substantive	How many of these substantive roles are ARRS?	Establishment	Substantive	How many of these substantive roles are ARRS?
	Forecast Out-turn	Forecast Out-turn	Forecast Out-turn	Forecast Out-turn	Forecast Out-turn	Forecast Out-turn	Forecast Out-turn	Forecast Out-turn	Forecast Out-turn	Forecast Out-turn	Forecast Out-turn	Forecast Out-turn
Total Staff WTE by Service Area	Year Ending	Year Ending	Year Ending	Year Ending	Year Ending	Year Ending	Year Ending	Year Ending	Year Ending	Year Ending	Year Ending	Year Ending
	WTE	WTE	Whole Number	WTE	WTE	Whole Number	WTE	WTE	Whole Number	WTE	WTE	Whole Number
Total Workforce	1086.10	1509.26	23.80	1126.50	1125.31	118.80	1216.62	1218.87	8.80	1286.62	1286.77	8.80
Children and Young People (excluding MHST)	73.73	77.26	0.00	62.23	63.76	0.00	62.23	63.76	0.00	62.23	63.76	0.00
Mental Health Support Teams	84.30	84.30	0.00	116.30	116.30	0.00	151.30	151.30	0.00	183.30	183.30	0.00
Perinatal Mental Health	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
NHS Talking Therapies	337.61	334.80	15.00	356.06	356.06	30.00	403.40	403.40	0.00	443.40	443.40	0.00
Individual Placement and Support	0.00	0.00	0.00	16.40	16.40	0.00	37.80	37.70	0.00	49.00	49.00	0.00
A&E and Ward Liaison	3.40	3.40	0.00	3.40	3.40	0.00	3.40	3.40	0.00	3.40	3.40	0.00
Adult Community Crisis	61.05	61.05	0.00	56.25	56.25	0.00	56.25	56.25	0.00	56.25	56.25	0.00
Community Mental Health (Adult & Older Adult)	274.74	284.55	0.00	271.05	273.25	0.00	265.06	269.80	0.00	265.06	269.80	0.00
Acute Inpatient	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total other mental health workforce	251.27	663.90	8.80	244.81	239.89	88.80	237.18	233.26	8.80	223.98	217.86	8.80

PART D – BOARD ASSURANCE FRAMEWORK

Board assurance is a key component of this year's planning process and submission.

Assurance can be defined as the process by which a board gains confidence that its organisation is operating effectively, safely, and in accordance with its statutory duties, strategic objectives, and governance standards. The boards of individual ICBs and providers are ultimately accountable for

the development and delivery of their plans and have a responsibility to be assured in terms of the credibility, deliverability and affordability of the plans that have been agreed.

- Credibility means the plan's assumptions and targets are evidence-based and convincing to stakeholders (including regulators and the public).
- Deliverability means that the plan can realistically be executed with the available resources and operating environment.
- Affordability means the plan's financial assumptions are sustainable and align with available funding and budgetary limits.

To support this a set of Board Assurance Statements have been developed covering the key expectations of the board outlined in the planning framework for the NHS in England alongside some specific elements of assurance that are required.

There is a national recognition that the level of board engagement and confidence should evolve over the planning period. For first submission in December'25, NHS England acknowledged that assurance should be based on boards being engaged in the process rather than assuring the plans themselves. For full submission, this moved to assurance of the plans themselves and the outcomes from the plan.

NHS England have published a support pack for the board assurance process, and they are clear that whilst there would be an expectation of maturity to improve between first and full submission, this may not always be possible, and some statements will remain static. The level of board assurance does not necessarily need to correlate completely with numerical plan submissions, and our assessment should focus on the maturity of the ICB, indicating that despite the plan outcome you are assured that everything has been considered and put in place to get to the best possible plan position

Teams across the ICB have undertaken an assessment of each of the board assurance statements and rated them based on the current position. Using the nationally prescribed maturity assessment key below, each of the statements has been assessed which also includes a narrative.

The following table shows the final approved assessment of maturity of each of the board assurance statements for full submission compared to the 17th December'25 submission. Changes in the statements themselves between both submissions is highlighted in red.

Maturity Assessment Key	
1. Embedded [Full Assurance]	The action is fully integrated into normal operations. It is standardised, sustainable, and reinforced by policy, leadership, systems, and culture. Continuous improvement is an established norm, and outcomes are consistently positive.
2. Maturing	The action is becoming routine. There are documented processes, growing staff awareness, and increasing consistency across teams. Evaluation and improvement mechanisms may be in place but are not yet fully optimised.
3. Developing	Steps have been taken to introduce and implement this action. There may be informal processes, or isolated examples of good practice, but they lack consistency, coordination, or broad awareness.
4. Not Embedded [No Assurance]	There is little to no evidence that this action has started. If it has, it's ad hoc, inconsistent, or heavily reliant on individuals rather than being supported by systems or structures.

Updates since first submission	Category / Area For Assurance	Statement	Response at first submission (pre-populated & fixed)	Response for full submission (1-4 see key above)	Commentary (required against a response of 2-4. Limited to 500 characters - see guidance above)
No change	Foundational activities	The board has reviewed the outputs from the foundational work undertaken as part of phase one of planning.	3 - Developing	1 - Embedded [Full Assurance]	The ICB Board and Board Members, through various Committees and briefings for NEDS, has received updates throughout the planning round and approved the ICB's Strategic Commissioning Intentions for 2026/27.
Updated	Governance and leadership	The board can confirm strong clinical leadership has been involved in the development of plans.	2 - Maturing	1 - Embedded [Full Assurance]	Clinical leadership embedded within programme and planning activities. Chief Medical Officer oversight of efficiency planning and prioritisation. Plans developed with strategic alignment to ICS Strategy, NHS 10 Year Health Plan and Clinical Conditions Strategic Plan. Clinical involvement has been integral to the planning processes and will be further strengthened in the EQIA process which is fully embedded within the ICB.
Updated	Governance and leadership	The board can confirm that the plans reflect the consideration of population needs, underserved communities and inequalities.	3 - Developing	2 - Maturing	Existing tools and analytics are being used to develop the ICB's strategic commissioning plan. Director of Population Health Management working with Planning and Performance, Insight and Healthier and Fairer programme to ensure population health analytics is considered.

Updated	Governance and leadership	Robust quality and equality impact assessments (QEIA) have been undertaken and reviewed by the Board to inform the sign off of the organisation's plan.	3 - Developing	1 - Embedded [Full Assurance]	ICB EQIA policy in place. Plan development aligned to EQIA process with any decommissioning or efficiency requirements to undergo EQIA ahead of implementation, EQIAs are in development. Existing efficiency schemes which are fully developed have been subject to appropriate EQIA processes.
Updated	Governance and leadership	The board has played an active role in setting direction, reviewing drafts and constructively challenging assumptions– rather than simply endorsing the final version of the plan.	3 - Developing	2 - Maturing	The ICB Board and its members receive regular planning updates providing opportunity for constructive challenge of planning assumptions. The Board has approved the ICB Strategic Commissioning intentions. The 5-year strategic plan has been reviewed by the FPIC. Dedicated FPIC plan review sessions on key areas have taken place to inform full submission including Performance, Workforce and Finance.
No change	Governance and leadership	The board is confident that there is a data-driven and clinically-led continuous improvement approach in place. The organisation has a systematic approach to building improvement capacity and capability.	3 - Developing	2 - Maturing	We are supporting teams to use evidence and data to develop and quantify plans. Clinical involvement in ICS programmes is in place and the ICB's improvement capabilities via BOOST are in place. The ICB's strategic commissioning approach will be underpinned by the Model ICB Blueprint and focus on the core components of the commissioning cycle.
No change	Governance and leadership	The board can confirm the organisation has the appropriate structures to work constructively across the system and that system working is effective.	2 - Maturing	1 - Embedded [Full Assurance]	ICS and ICB planning governance stepped up November'25 and in place throughout planning process. ICS leadership provided by CEO Leadership Group. Weekly ICB Chief Officer planning group in place and weekly ICS Planning Group. Weekly finance infrastructure in place covering key financial activities. Workforce Board overseeing the development of Trust workforce plans. Trust and ICB meetings have taken place with each Trust throughout the planning round.
No change	Plan development	The board can confirm that the plan is evidence-based, robust and deliverable. The board is content that the phasing of the plan across three years is realistic.	3 - Developing	2 - Maturing	Integrated planning processes implemented by the ICB and the infrastructure put in place between first and full submission has led to further development of plans across the three year period.
No change	Plan development	The board can confirm that plans have been triangulated across finance, workforce and performance, ensuring each element of the plan reinforces the	3 - Developing	2 - Maturing	The ICB does not submit Trust workforce. Trusts are required to triangulate as part of their submission process. The ICB commissioned a local performance submission to aid alignment for full submission.

		others, making the plan internally consistent.			
Updated	Productivity	The Board can confirm that the organisation has fully considered and incorporated productivity opportunities into plans, and that any phasing is credible and realistic. The board can provide justification where any identified opportunities cannot be fully delivered during this planning round, especially in the context of decisions to submit non-compliant financial or performance plans or plans that do not deliver the 2% productivity improvement.	3 - Developing	2 - Maturing	Efficiency programme considers the productivity opportunities across the scope of commissioned. This has also included an enhanced focus on the AACC productivity opportunities within the NENC system.
No change	Risk	The board can confirm that the organisation has a robust approach to risk management in place including the ability to demonstrate a comprehensive understanding of financial risk and an agreed approach to managing and mitigating risks in year.	1 - Embedded [Full Assurance]	1 - Embedded [Full Assurance]	The ICB have processes and arrangements in place to monitor and manage risks throughout the year, as reported through the Finance, Performance and Investment Committee.
Updated	NHS standard contract and commissioning	The board can confirm that the organisation has commissioned sufficient activity from its providers to meet expected performance trajectories.	3 - Developing	2 - Maturing	ERF has been deployed into Trust contracts over and above the national 2.7% elective uplift. ICB and Trust meetings have taken place to underpin the expectations of performance submissions aligned to ERF.
Updated	NHS standard contract and commissioning	The board can confirm that the organisation has engaged with its providers to ensure contract values used in planning submissions are agreed across (commissioner and provider) activity and financial plans	3 - Developing	2 - Maturing	Facilitated via ICS governance and individual ICB and Trust discussions. Weekly contract mandate process and flash returns used.
No change	NHS standard contract and commissioning	The board can confirm that there is an effective process in place to manage the sign-off of contracts.	2 - Maturing	1 - Embedded [Full Assurance]	The ICB has a process for the sign off of contracts. Contract leads are meeting with Trusts to discuss and agree contract variations in-line with the national timetable. Processes for escalation are in place.
No change	NHS standard contract and commissioning	The board can confirm that there is a timetable in place to ensure that the board will be updated on the sign-off of contracts and any delays to signing	2 - Maturing	1 - Embedded [Full Assurance]	

		contracts will be reviewed by the board.			
Updated	Workforce	The board can confirm the impact of the 10 Year Health Plan on the workforce has been considered in plans. This includes the impact of productivity gains and how staff are deployed including the three shifts - from hospital to community, from analogue to digital, from sickness to prevention.	3 - Developing	3 - Developing	The ICB is involved in the national Neighbourhood Health programme with two ICB places accepted as wave 1 participants. The Living and Ageing Well partnership is overseeing the strategic development of Neighbourhood plans which includes how healthcare is delivered as part of the left shift including workforce. Our plans recognise embedding the three shifts is a journey, and will develop as we learn pilots, recognising the full workforce impact is challenging to determine at this stage
New	Plan development	The board can confirm plans have been developed in line with the ambition to move care from hospital to community and this shift is evident in plan returns and the strategic commissioning plan.	N/A	2 - Maturing	Plans are aligned to the NENC ICS Strategy and congruent to the 10 year health plan. The 5 year strategic commissioning plan sets out our ambition and priorities for the next 5 years including left shift ambitions.
New	Plan development	The board can confirm that the ICB has worked with providers to ensure that their plans are fully aligned.	N/A	2 - Maturing	ICS governance in place which has been supported by ICB CEO led planning discussions with Trusts. Individual ICB and Trust planning meetings in place and will continue throughout February and March by exception as part of Contracting and any potential plan refresh requirements in March.
New	Plan development	The board can confirm that the five year strategic commissioning plan is fully aligned with the numerical returns.	N/A	1 - Embedded [Full Assurance]	Our Strategic Commissioning Plan represents a continuation of ICS Strategy and our operational plans and trajectories remain aligned to this.

PART E – NENC ICB Five-Year Strategic Commissioning Plan

The ICB is required to develop a [five-year strategic commissioning plan](#) which is a key component of the medium term planning requirements for the NHS.

Strategic commissioning is the central purpose of the ICB, and the draft five-year strategic commissioning plan sets out our continued commitment to partnership working in the context of the changing NHS landscape set out in the NHS England 10 Year Health Plan.

Our five-year strategic commissioning plan is complimentary to the NENC Integrated Care Strategy (ICS): Better health and wellbeing for all¹ and this plan represents a commitment to shift from hospital-centric care to community based-care, delivered through collaboration at a neighbourhood level.

As the ICB transitions into a strategic commissioning organisation, our primary emphasis will be on the effective commissioning of services, with clear articulation of the intended outcomes for our communities. Additionally, we will reinforce our quality monitoring frameworks to ensure desired results are achieved and variations in outcomes are appropriately addressed.

Included as a separate attachment is the final NENC ICB strategic commissioning plan which was approved by the ICB Board on 12th February'26. It sets out our key priorities aligned to our ICS goals and takes into consideration the ICB as a strategic commissioning organisation and our response to key local challenges we face in NENC.

4. Recommendations

The Board is asked to:

- Approve the updated ICB revenue budgets for 2026/27 (as per Part A table 4).
- Ratify the full ICB three-year finance, workforce activity and performance submissions for 2026/27 to 2028/29.
- Note the requirement for robust EQIAs to be carried out for efficiency schemes in-line with the approved ICB policy.

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