

Board Meeting

MEETING
16 June 2026 14:00 BST

PUBLISHED
12 June 2026



Agenda

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Microsoft Teams	16 Jun 2026	14:00 BST

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3	Declarations of Interest	Chair		-
	<i>A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship. In some circumstances, it could reasonably be considered that a conflict exists even when there is no actual conflict. In these cases it is important to still manage these perceived conflicts in order to maintain public trust</i>			-
4	Quoracy	Chair		-
5	Minutes of the previous Board meetings held on:	Chair		-
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7	Notification of items of any other business	Chair		-
	GOVERNANCE AND ASSURANCE			-
8	Board Assurance Framework and Risk Management Report - quarter four 2025/26	Chief Corporate Officer	14:10	27
9	Committee Escalation and Assurance Reports and Annual Effectiveness	Committee Chair	14:20	-
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10.1	Final Draft 2025/26 Annual Report and Accounts	Chief Corporate Services Officer / Chief Finance Officer	14:40	180
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10.4	Internal Audit Annual Report and Head of Internal Audit Opinion	Chief Corporate Services Officer	15:05	396
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11	Any Other Business from Members	Chair		-
	Date of next meeting - Tuesday 28 July 2026			-
	Close		15:30	-

North East and North Cumbria Integrated Care Board

**Minutes of the Board meeting in public held
on 31 March 2026, 10:30am at Durham Centre, DH1 1TN**

Present: Professor Sir Liam Donaldson, Chair
Samantha Allen, Chief Executive
Levi Buckley, Chief Delivery Officer
David Chandler, Chief Finance Officer
David Gallagher, Chief Contracting and Procurement Officer
Tom Hall, Local Authority Partner Member
Professor Sir Pali Hungin, Independent Non-Executive Member
Dr Saira Malik, Primary Medical Services Partner Member
Jacqueline Myers, Chief Strategy Officer
Dr Rajesh Nadkarni, Foundation Trust Partner Member
Dr Neil O'Brien, Chief Medical Officer
Claire Riley, Chief Corporate Services Officer
Dr Mike Smith, Primary Medical Services Partner Member
David Stout, Independent Non-Executive Member

In Attendance: Deborah Cornell, Director of Corporate Governance and Board Secretary
Christopher Akers-Belcher, Healthwatch Representative.
Michelle Evans, Director of Workforce
Lisa Taylor, Voluntary Community and Social Enterprise Representative
Toni Taylor, Board and Legal Services Officer (minutes)
Dame Lesley Regan, England's Womens Health Ambassador (agenda item 15)

B/2025/130 Welcome and Introductions (agenda item 1)

The Chair welcomed colleagues and members of the public to the Board meeting of North East and North Cumbria (NENC) Integrated Care Board (ICB).

The Chair formally announced the forthcoming departure of David Gallagher Chief Contracting and Procurement Officer and Kelly Angus Chief People Officer. On behalf of the Board, the Chair expressed gratitude for their significant contributions and extended best wishes for their future endeavours

B/2025/131 Apologies for Absence (agenda item 2)

Apologies were received from Kelly Angus Chief People Officer, Ken Bremner Foundation Trust Partner Member and Dr Hilary Lloyd Chief Nurse and AHP Officer.

B/2025/132 Declarations of Interest (agenda item 3)

Members had submitted their declarations prior to the meeting which had been made available in the public domain.

B/2025/133 Quoracy (agenda item 4)

The Chair confirmed the meeting was quorate.

B/2025/134 Minutes of the previous meetings held on 27 January and 12 February 2026 (agenda item 5)

RESOLVED:

The Board **AGREED** the minutes of the Board meeting held on 27 January 2026 were a true and accurate record.

RESOLVED:

The Board **AGREED** the minutes of the extraordinary Board meeting held on 12 February 2026 were a true and accurate record.

B/2025/135 Action log and matters arising from the minutes (agenda item 6)

There were no updates to the action log or matters arising.

B/2025/136 Notification of items of any other business (agenda item 7)

None.

B/2025/137 Chief Executive's Report (agenda item 8)

The report provided an overview of recent activities carried out by the ICB team, as well as some key national policy updates.

ICB Strategic Commissioning Transition Programme

The Chief Executive acknowledged that over 100 employees were leaving the organisation, mostly through voluntary redundancy, as part of efforts to cut running costs by 30%. Beginning 4 May 2025, the ICB's main goal will be to serve as a strategic commissioner, using a structured process to assess population needs and allocate resources for maximum impact. Achieving this will involve challenging and difficult decisions guided by the most reliable data available. We appreciate the patience of our partners including local authorities, foundation trusts, and organisations in the voluntary, community, and social enterprise sector during this period of transition.

Plans are beginning to take shape for new neighbourhood health services led by our local partners. We are collaborating with them to agree on contracting outcomes. Our key priorities during this transition include adopting a less hands-on approach and implementing an organisational development plan. We have established a strong foundation during the change process through the appointment of a Director of Population Health.

Financial Position

This has remained a busy period operationally. We are confident in achieving

our financial plan for 2025/26.

2025 NHS Staff Survey

The results of the 2025 NHS Staff Survey were published on 12 March 2026. Staff survey results will inform organisational development, and strong engagement reflects successful transition efforts. The survey shows good teamwork and appraisal rates, though appraisals could be more effective. A stable period will support transition plan implementation.

NHS Intensive Recovery Programme

Five NHS Trusts are entering the NHS intensive recovery programme, of which one is North Cumbria Integrated Care NHS Foundation Trust.

It was announced that five NHS Trusts, including North Cumbria Integrated Care NHS Foundation Trust (NCIC), will participate in the NHS Intensive Recovery Programme. The initiative aims to offer targeted insights and support to trusts facing significant challenges, with a focus on addressing priority outcomes. NCIC has experienced persistent structural issues related to healthcare delivery in rural communities over the past two decades and has engaged in several similar improvement programmes. The trust is recognised for its robust leadership, and the current Chief Executive, who joined from Gateshead, is dedicated to building a strong leadership team and investing the necessary time, with a projected commitment of three to five years. A visit with the new CEO, Dr Stephen Singleton, was scheduled to further assess the specific support requirements of the trust.

Royal College of Radiologists' Review

As part of the ongoing review and evaluation of the County Durham and Darlington NHS Foundation Trust (CDDFT) breast cancer services, the Trust and the ICB commissioned a Royal College of Radiologists' review of the symptomatic breast imaging service, which took place December 2025.

The review team made 30 recommendations to help CDDFT improve symptomatic breast imaging services. Two recommendations focused on future service configuration. These are being reviewed as part of ongoing discussions with Provider organisations and the ICB about the preferred service model.

The review process is ongoing, and mutual aid continues to support the trust.

The Board discussed high-priority actions related to medical imaging and radiation exposure, confirming these concern the PACTS system for managing and transferring images. The new system being installed this week should resolve issues like clinicians' difficulty accessing previous images, reliance on manual processes, and repeat procedures due to errors. Progress will be monitored by the oversight group. The report also noted ongoing clinical governance and culture concerns, which will be addressed in broader improvement efforts.

General Practice – Castlegate and Derwent Surgery

The Board will be aware of ongoing regulatory concerns relating to Castlegate and Derwent Surgery in Cockermouth, a practice serving approximately 18,000 patients.

The practice is currently subject to enhanced regulatory scrutiny by the Care Quality Commission (CQC). Following a recent inspection process, the CQC issued a further letter to the practice outlining areas where improvement was required and set an expectation that demonstrable progress was made within a 28 day period. The ICB continues to monitor this position closely alongside system partners.

Further Board discussion confirmed the implementation of several measures and increased capacity to promote stability within the practice. Engagement with the CQC continued as their report underwent internal quality assurance prior to submission to the practice. Contract alternatives were under evaluation, with the GP contracting team working collaboratively alongside the patient safety team, the practice, NHSE, and CQC to consider the available options.

Community Pharmacy

There are severe financial challenges for community pharmacy nationally and locally. Community pharmacies are a significant element of local primary care services and are increasingly playing a key role in neighbourhood health, as exemplified by Pharmacy First. Local Pharmacy Committees are feeding these challenges into national discussions with NHS England and Government.

Since January 2025 there have been seven community pharmacy closures and eight new pharmacies open, of which seven were distance selling pharmacies.

The ICB works closely with the Health and Wellbeing Boards to develop Pharmaceutical Needs Assessments. It was acknowledged that more work was needed as a strategic commissioner on the medium to long term plan with a specific focus on cost pressures.

Locally Commissioned Services Review

The Integrated Care Board has initiated a locally commissioned services review focused on the range of local enhanced services and other locally commissioned programs arrangements delivered through general practice across North East and North Cumbria.

The first phase targeted services already commissioned across most areas of the system, presenting a clear opportunity to adopt a single specifications and consistent commissioning model. Engagement with general practices and Local Medical Committees was positive with 96% (321 out of 335 practices) confirming their participation; discussions are ongoing with the remaining practices.

Any Qualified Provider Pathway – Adult Hearing Services

A complaint and subsequent question to the Board was received regarding the commissioning of adult hearing services in Whitehaven and the absence of Any Qualified Provider (AQP) pathway in West Cumbria.

Questions to the Board

1. Why is there a disparity in "Patient Choice" (AQP) between the North East and West Cumbria?
2. What specific steps is the ICB taking to commission AQP services for Whitehaven residents in the 2026/27 contract cycle?

3. When will the minutes and the written response to this specific query be made available to the public?

Response

We are aware of the pressures currently affecting elective pathways at North Cumbria Integrated Care NHS Foundation Trust and recognise the potential impact of excessive waiting times for routine audiology services on patients' quality of life. We are working closely with the hospital trusts in our area to minimise waiting times and meet our constitutional obligations.

However, there is variation in access to adult hearing services between different parts of the region, largely as a result of the ICB inheriting a range of contracts from predecessor commissioning organisations, clinical commissioning groups, where clinical pathways and services were commissioned individually for each locality. Acknowledging these disparities, the ICB has begun a full review of adult audiology services to recommend service redesign to address these variations in access in a sustainable and legally compliant way, and to commission a regional adult hearing service that provides value for money and ensures patients are seen in the right place, at the right time.

This review will take place in 2026/27 and will feed into any future procurement process.

A written response to the questions will be made available through the meeting minutes at the next Board meeting in public.

RESOLVED:

The Board **RECEIVED** the Chief Executive report for information.

B/2025/138 Highlight Report and Minutes from the Executive Committee (agenda item 9.1)

The Board received a summary of the Executive Committee's 10 March 2026 meeting, along with confirmed minutes and decision logs for January and February 2026.

Service Reform Workstream 2025/26 Closedown Report

The Committee noted the programme met its goals for 2025/26 and delivered £37.8 million in savings. Some longer-term service changes, such as work on eyecare and hearing services, would continue through normal commissioning processes.

National Special Educational Needs and Disabilities (SEND) Reforms

The Committee discussed new national plans to improve support for children and young people with special educational needs and disabilities.

Manchester Arena Inquiry Recommendations

The Committee received an update on national expectations following the Manchester Arena Inquiry. The discussion highlighted the good resilience in our system, with the ICB continuing in the role as a category one responder and where content actions were being addressed locally.

RESOLVED:

The Board **NOTED** the key highlights from the Executive Committee meeting held on 10 March 2026 and **RECIEVED** the decision log and confirmed minutes for the meetings held on 13 January and 10 February 2026 for assurance.

B/2025/139 Highlight Report and Minutes from the Quality and Safety Committee (agenda item 9.2)

The Board received a summary of the Quality and Safety Committee's 12 March 2026 meeting, along with confirmed minutes for 15 January 2026.

Patient Story

The Committee listened to a patient's experience that highlighted challenges in obtaining clinical recognition, management, and an effective treatment plan for a child experiencing uncontrollable physical and speech tics. Personal stories like this continue to significantly influence our approach, and the ICB is now working on developing more suitable pathways.

Complaints

The Committee were assured the complaints handling process was now better established but noted that the backlog remained.

Patient Care in Temporary Environments

The Committee observed that the national report from the Health Services Safety Investigations Body (HSSIB) did not contain specific data for North East and North Cumbria. The report indicated there were no seasonal fluctuations, with patient flow pressures remaining constant throughout the year. Currently, there is no national standard for measuring corridor care, but efforts are being made to develop a more consistent method at the national level.

RESOLVED

The Board **NOTED** the key highlights from the Quality and Safety Committee meeting held on 12 March 2026 and **RECEIVED** confirmed minutes for 15 January 2026 for assurance.

B/2025/140 Highlight Report and Minutes from the Audit Committee (agenda item 9.3)

The Board received a summary of the Audit Committee's 5 February 2026 meeting, along with confirmed minutes for 9 October 2025.

Information Governance

The Committee were satisfied with the interim assessment undertaken with internal audit.

Internal Audit

The Committee reviewed progress reports and observed that the ICB is in a good position, with no outstanding management actions required. Some risks remain as staff turnover occurs and new systems are implemented to facilitate operational changes. Conducting internal audits may prove challenging with reduced personnel; therefore, it is essential to remain attentive throughout the year to ensure audits are conducted effectively.

Annual Review of Effectiveness

An annual assessment of internal audit effectiveness was conducted. Managers provided positive feedback regarding the service, with just one area identified for improvement.

Freedom to Speak up (FTSU)

The new ICB FTSU guardian attended the Committee's meeting and presented a report covering quarter three. The Committee expressed satisfaction that the role was being managed well, with contributions made to primary care to help support their own arrangements. The FTSU position was established several years ago due to concerns about whistleblowers not being heard. It was noted that the responsibilities of the role vary across the system, especially now that the national requirement has been withdrawn. Despite this, the ICB has pledged ongoing investment in the role, acknowledging its significance for the organisation.

RESOLVED

The Board **NOTED** the key highlights from the Audit Committee meeting held on 5 February 2026 and **RECEIVED** confirmed minutes from 9 October 2025 for assurance.

B/2025/141 Integrated Delivery Report (agenda item 10)

The report provided an overview of quality, performance and finance and aligns to the new NHS Oversight Framework for 2025/26. The report used published performance and quality data covering December 2025 and January 2026. Finance data was for January 2026 (Month 10).

The Chief Strategy Officer presented the report to the Board and highlighted some key performance indicators;

- NENC performance in January 2026 for A&E 4 hour waits was reported as 74.9%, this was below plan of 78.5% but above the national average of 71.4%.
- North East Ambulance Service maintains a strong position and the best performing ambulance trust across England.
- Referral to treatment performance dropped -2.2% below plan for 18 week waits, however remains above the national ask. Additional funding has been made available for extra elective work.
- 52+ week waits have improved reducing the waiting list.
- A strong improvement in cancer 62-day performance was reported in December but worsened slightly in January to 66.7%.
- Urgent dental appointments delivered continue to be below plan but is on track to deliver national ask.
- Performance regarding inpatient beds for individuals with learning disabilities and autism is still below target, with 40 more patients than the improved trajectory allows. There is significant ongoing work focused on individual case management, in collaboration with local authority partners and community support services.
- Community waiting list growth continues, driven by counting changes and data quality issues. Data quality issues emerged at North Cumbria Integrated Care NHS Foundation Trust with a potential over-reporting of 694 patients under investigation.

- Talking Therapies remains a challenge with a range of actions underway to support the pathways including development of a standardised service specification and an aim to expand the workforce capacity.

The impact of employee illness on service delivery is widely acknowledged. Chief People Officers throughout the organisation are continuing efforts to address this issue.

RESOLVED

The Board **RECEIVED** the report for information and assurance.

B/2025/142 Finance Report (agenda item 11)

The Board received an update the Board on the financial performance of the NENC ICB and NENC Integrated Care System in the financial year 2025/26 for the ten months to 31 January 2026. The Chief Finance Officer also provided the Board with an update on the year end position

ICS Revenue Position

As at 31st January 2026, the ICS reported a year-to-date deficit of £11.9m compared to a planned deficit of £19.5m. As previously highlighted and following the application of the NHS England forecast change protocol at Month 10, approval was given for one provider organisation (CDDFT) to deteriorate its forecast position by £24m. This deterioration has been fully offset by improvements in other organisations across the system and as a result, there has been no adverse impact on the overall system forecast, which remains in line with plan.

There has been a significant deterioration in recurrent efficiencies, with the current position at £84m shortfall. Whilst this is partially offset by non-recurrent efficiencies in the current year, the recurrent shortfall will impact on underlying positions moving into 2026/27 financial plans and organisations are being asked to take appropriate action where required to recover that position.

The level of risk across the ICS continues to reduced with the reported position being £22m at month ten. At month 11 this reduced further to £11m.

In summary from an ICS perspective, the system is on track to achieve the overall plan, with the recurrent efficiencies specifically in relation to workforce haven't always been delivered which will make next year challenging especially for those providers where workforce reduction is not included in their plan.

ICB Revenue Position

As at 31st January 2026 the ICB reported a year-to-date surplus of £23.0m compared to a plan of £9.9m.

There continue to be four main areas of pressure and potential risk to highlight within the ICB position:

- Risk around growth in elective activity
- Significant growth in Right to Choose ADHD/ASD assessments with non-NHS providers
- Pressure on all-age continuing care budgets particularly relating to the challenging efficiency targets

- Growth in prescribing costs over budget

The financial risk associated with ICB is considered minimal and well-managed, and there is confidence in ICB's ability to meet its objectives. At the beginning of the year, the Board acknowledged ICB's reported financial risk of £244 million. Being among the systems positioned to achieve plan this year represents a positive outcome from a financial standpoint.

ICB Running Costs

The ICB remains on track to deliver plan.

ICS Capital

The ICS remains on track to deliver plan.

The Chair expressed gratitude to the Chief Finance Officer for his leadership throughout this complex process during a period of considerable financial constraints and challenges. Appreciation was echoed by the Board and also extended to the broader team.

In response to a question around working collaboratively to identify efficiency opportunities and improve productivity, the Chief Finance Officer advised it was anticipated that the Provider Collaborative would take the lead on some areas for example workforce or elective activity. The work will continue but it will feel different in terms of the ICB's role, with new year being a transition year.

A question was raised about how cost reductions might affect the voluntary sector. The Chief Finance Officer explained that one of the main responsibilities of an ICB is to ensure value for money by prioritising services that matter most to patients and have the greatest impact. For 2026/27, there have been some reductions, but no major changes; instead of cutting existing services, the decision was made not to invest in new services that might have been desired.

RESOLVED

The Board **NOTED** the latest year to date and forecast financial position for 2025/26, the latest underlying position and the financial risks across the system still to be managed.

B/2025/119 NHS Medium Term Planning Submission (agenda item 12)

The Board were provided with ICB Medium Term Planning Submission for 2026/27 to 2028/29 and the Five Year Strategic Commissioning Plan.

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 17 December 2025. Full plan submissions were approved by the Board and were submitted on 12 February 2026, this included year three (2028/29) and four-year capital plans, the ICB Strategic Commissioning Plan and a final set of board assurance statements.

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. Whilst the ICB are no longer responsible for ICS financial plans we will still have a role working with region.

NENC ICB Financial Planning

The newly published national guidance describes a shift from block contracts for acute care to an activity-based approach. The ICB has decided to implement this change with providers over the next three years.

North East and North Cumbria Integrated Care Board has a budget to commission healthcare services of £9.5bn for 2026/27 which will rise to £10b in 2028/29. That growth in funding is approximately 2.7% per annum, an assumed inflation of 1.7% means real time growth for ICBs is 1%. The ICB plan itself allocates the growth that we've had at 2.7% to services and providers. Using the national application workings that were issued and are detailed in page 8 of the report, increase is around 2% for areas such as extra elective care or planned care in hospitals.

The Chief Finance Officer drew the Board's attention to the extra 4.2% uplift rising to £5.5% for additional community services spend as part of the NHS ten year plan ambition to shift more services of care into the community rather than hospital, how this money is spent over the next ten years will be crucial to success.

The Board was informed of a local national uplift of 0.1% for pharmaceuticals, with the expectation that prices may decrease as certain drugs transition from branded to generic. However, there remain risks associated with potential inflation in drug pricing.

The Chief Finance Officer reported the ICB is now deemed to be no longer over funded which means we're not losing convergence funding.

Nationally, elective recovery funding is being reallocated, giving the ICB an extra £40m for 2026/27. This represents a 4% increase in elective activity, to be reflected in provider contracts.

The ICB has submitted a compliant financial plan that achieves a breakeven position. However, this plan relies on achieving annual efficiencies of £110m to fund areas that NHSE growth funding may not fully cover, such as increased pressures in packages of care, prescribing needs, and more ADHD assessments. Additionally, we are required to provide some non-recurrent financial support to certain providers until they reach a more sustainable position.

The ICB faces an estimated unmitigated risk of approximately £30 million, a figure comparable to last year's and expected to be equally challenging. This estimate does not yet factor in potential risks emerging from strike action or inflation.

Members were informed of a substantial increase in capital funding provided by the Treasury and NHS England. The amount allocated to our ICB is three times higher than what we typically manage, and there have also been notable allocation increases throughout the region, primarily aimed at meeting constitutional standards.

NENC Integrated Care System Financial Plan

Several providers initially faced challenges in submitting balanced plans. However, we believe that they have now presented more acceptable and, hopefully, more compliant plans, which will be confirmed in due course.

Performance

The ICB's performance submission against the national ambitions over the three-year period:

- Referral To Treatment (RTT), cancer and diagnostics: broadly not compliant.
- Urgent and emergency care, primary care and community care: Compliant across all metrics.
- Mental health, learning disabilities and autism: Compliant for all metrics except Individual Placement Support (IPS). The ambition is to be compliant for this in year three.

A major focus is the planned care RTT target, which originally required that at least 92% of patients wait less than 18 weeks. As part of this three-year plan, all providers are expected to achieve the 92% standard again by March 2029. Although this goal is challenging, it is considered achievable with the additional funding and opportunity to improve productivity.

If we agree to more ambitious plans with providers, the Board is asked to delegate authority to add them to the overall plans.

Although the plan is not fully compliant, work continues to get a fully compliant plan within the allocations now agreed for each of our providers.

Workforce

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

The number of primary care workers is expected to stay consistent over the forecasted period, although this is contingent on how the neighbourhood health programme progresses after the Integrated Neighbourhood Health Framework is published. Once the framework is released, a review will be carried out.

Work continues on commissioning and procurement for non NHS mental health providers, it is anticipated that workforce will be expanded to meet national ambitions.

The Chief Executive noted that over 20% of the NHS workforce are represented across more than 200 countries globally, reflecting a highly diverse team. Many colleagues have been personally affected by the ongoing conflict in the Middle East. The Board should consider including additional risks on the risk register, specifically regarding increased inflation and rising fuel costs. Scenario modelling of various inflation cases and potential contingencies was proposed to facilitate a comprehensive assessment by the Board, ensuring appropriate actions are taken throughout the year as necessary from a financial perspective but also emergency preparedness resilience and response.

ACTION:

The Chief Finance Officer to initiate scenario modelling exercises to assess potential inflation and related risks.

Questions from members of the Board

A question about contingency planning for a major medication disruption was addressed by the Chief Executive, who stated that a coordinated national response would be needed.

The Quality and Safety Committee Chair asked the Chief Finance Officer about managing budgets and reallocating funds between trusts to improve efficiency and equity of access. The Chief Finance Officer explained that a resource allocation group annually reviews whether resources are fairly distributed. The new ICB structure will grant more autonomy, helping improve service equality across regions; the recent local enhanced services review is an example of this progress.

The Audit Committee Chair asked about the efficiency initiatives and whether there could be some delays in achieving them during the first year. The Chief Finance Officer responded that, when developing the plans, they are confident that nearly all of the £30 million target is already secured, with the possibility of exceeding this amount—though any overachievement has not been included in the current plans. The following years are expected to be more challenging.

The Audit Committee Chair inquired about resource allocation, noting that we are no longer considered overfunded. The question was raised as to whether the outcome is satisfactory or if additional work is needed over the next three years to ensure fair allocation. National efforts to revise the fair share formula, which were supported by the ICB, have identified any areas of concern that were communicated to NHS England. We have been assured these issues will be addressed through their standard processes. The Chief Executive formally corresponded with the Chair of the Advisory Committee on Resource Allocation (ACRA) panel, which oversees allocations, to advocate for further necessary work.

RESOLVED:

The Board **APPROVED** the updated ICB revenue budgets for 2026/27.

The Board **RATIFIED** the full ICB three-year finance, workforce activity and performance submissions for 2026/27 to 2028/29 and **DELEGATED** authority to the executive team to accept any further improvements to performance trajectories.

The Board **NOTED** the requirement for robust Equality Quality Impact Assessments to be carried out for efficiency schemes in-line with the approved ICB policy.

B/2025/144 Oral Health Strategy and Primary Care Dental Access Recovery Programme update (agenda item 13)

The Board were updated on the implementation on the Oral Health and Dental Strategy and primary care dental access recovery programme.

The report summarised the key actions;

Improving access to routine dental care and specialist services

Re-commissioned over 98,000 Units of Dental Activity (UDAs) in 2025-26 rising to over 327,000 in 2026-27 including 3 new contracts yet to commence.

Increasing access to urgent and unscheduled care dental appointments

Significant additional urgent care capacity put in place in 2025-24 with a sustainable network of Urgent Dental Access Centres (UDACs) established that will deliver 109k appointment per year going forward.

Sustainability and retention for NHS dental practices

Increased rate paid to dental practices above national minimum requirement.

Supporting workforce recruitment and retention

Loyalty payment made to most experience NHS dentists to incentivised staying within NHS and provided over £1m to support stabilising, upskilling and growing the dental workforce.

Improving oral health

Oral health and dental strategy developed setting out priorities to reduce health inequalities, prevent dental disease and improve access to high quality NHS dental care. £2m provided to combined/local authorities to tackle oral health needs due to poverty and support a range of oral health programmes. The Department of Health and Social Care approved the expansion of water fluoridation across the North East.

Improving patient, public and wider stakeholder information and signposting

Launched a dental web page on the ICB's website, which also includes an on-line portal to enable patients to book appointments at the network of UDACs. Also launched an urgent dental care toolkit and undertaken digital media campaigns to promote and raise awareness of urgent dental appointments.

Despite ongoing workforce recruitment and retention issues and a number of NHS dental contract hand-backs as providers move to more private dental care, the North East and North Cumbria ICB implemented initiatives which have resulted in improvements in access to NHS dental services for patients, particularly with regard to access to urgent and unscheduled dental care;

- 8th highest ICB for UDAs commissioned per head of population at 1.45 against an England average of 1.28.
- Within the top 5 ICBs for improvement in urgent and unscheduled courses of treatment above the 2024/25 baseline position.
- access rate for adults within the 24 months prior to end of November 2025 (41%) above the England average (35%).
- access rate for children within the 12 months prior to end of November 2025 (63%) above the England average (58%).

Delivery of NENC's share (+57,559) of the 700K additional urgent appointments will fall short of achievement with a projected end of year achievement of circa 84%. This is despite the ICB exceeding its obligation to commission its' share of

the additional appointments. Based on feedback received, the government has now confirmed that the 700k commitment will be broadened with immediate effect to all dental appointments measured through courses of treatment.

Dental workforce recruitment and retention remain a limiting factor to increasing access for patients. There is still an unknown around the new dental contract payment reforms set to take effect from April 2026 and the impact this will have going forward.

This example demonstrates how the dental team maintained their roles and responsibilities effectively, even amidst challenging circumstances, resulting in notable progress while acknowledging that further improvement is needed.

As colleagues may recall, a national consultation regarding fluoridation in the North East was conducted. Following its approval, Northumbria Water is now implementing measures to ensure that water is fluoridated throughout the region.

The Chief Executive drew the Board's attention to the preventative element working with the combined authority in tackling child poverty and resources allocated in schools going back to basics i.e. toothbrushing which is fundamentally important alongside water being fluoridated.

The Chair and Chief Executive commended the Chief Contracting and Procurement Officer and dental commissioning team for this really significant piece of work and progress made in challenging circumstances.

A question was raised regarding urgent dental access centres and whether they have improved access in rural and coastal areas of the region, or if challenges remain. It was confirmed that the centres are strategically located across the North East and North Cumbria and offer some solutions, though further work still needs to be done.

RESOLVED:

The Board **RECEIVED** the report for information and assurance.

Dame Lesley Regan joined the meeting.

B/2025/145 Womens Health (agenda item 14)

Dame Lesley Regan, England's Womens Health Ambassador

The Chief Corporate Services Officer updated the Board on women's health in North East and North Cumbria, beginning with thanks to Dame Lesley Regan, England's Women's Health Ambassador, and Sam Allen, NENC ICB Chief Executive, for their guidance and leadership in advancing women's health in the region.

From a North East and North Cumbria perspective:

- 51% of the population are women
- Women spend on average 21 years more than men in poor health
- Our region has the lowest healthy life expectancy in England
- Our region has 8.3 year gap in life expectancy between most and least

deprived women.

The Women's Health Strategy for England, first published in August 2022, will become a key part of the 10 Year Health Plan with its 2026 renewal. The main task is converting national goals into effective local action. Through 'The Big Conversation', we consulted women across our region, thanks to Healthwatch and the Voluntary, Community and Social Enterprise Sector, including seldom heard groups like women with learning disabilities, unpaid carers, and those with maternal mental health needs.

Since the launch of the national plan we've;

- Invested over £1 million
- Created a learning disability menopause passport
- Listened to over 5000 women through the Big Conversation
- Co-designed a violence against women and girls audit tool
- Developed a five year NENC women's health plan
- Undertook a women's health profile and needs assessment
- Started to develop a regional contraception plan
- Created an ICB Menopause policy
- Piloted three women's health hubs

What we've learnt through the women's health hub pilot;

- 37% of pathways can be changed for women
- For every £1 invested, the hub generates £8 in benefits
- Earlier detection of cervical cancer
- Quality of life improvements; reduced waiting times and improved access to care
- Reduced workplace absences, helping women stay in work
- Secondary care cost savings: providing LARC services in the community rather than hospitals
- More staff trained in the community

It is recognised that the North East records the highest rates of domestic violence and abuse in the United Kingdom, with 19 cases per 1,000 women. Violence is considered a public health concern due to its serious physical and mental health consequences; one in four women across the country are affected, and children are often impacted as well. In response, measures are being implemented, including routine enquiry in general practice, VCSE-led interventions targeted at high-risk areas, and trauma-informed training for staff.

All of our NHS organisations have signed up to the NHS England sexual safety in healthcare charter and as part of our efforts across the region to ensure all staff are safe at work.

The data for our region tells us:

- 241,600 women are economically inactive.
- Employment rates lag behind men.
- Unplanned hospital admissions are higher for women.
- Gynaecology waiting lists are up 46%, of which half of those are aged 18-44 and from the most deprived areas.
- Self-harm admissions are higher in women and above the national average.

- Suicide is lower in women, but premature mental illness deaths exceed England average.
- Long-acting Reversible Contraception (LARC) is rising in women 25+ but huge variation.
- Teen pregnancy is declining but still highest in Middlesbrough and Redcar.
- Smoking in pregnancy down, yet worse than England average.
- Cervical screening is falling in 25-49 age group.
- Cervical screening rates are 62% in the most deprived areas and 71% in the least deprived areas.

The North East and North Cumbria ICB Women's Health Plan 2025-2030 has a shared commitment to better, fairer women's health and was shaped by the voices of 5,000 women and will influence strategic commissioning intentions going forward. The eight priorities and ambitions include;

- Menstrual and gynaecological health
- Fertility, pregnancy and postnatal care
- Menopause
- Mental health and wellbeing
- Cancers
- Violence against women and girls
- Healthy ageing and long term conditions
- Women's Health Hubs

The immediate next steps involve creating a scalable community model to support more women's health hubs, completing the regional contraception strategy, running campaigns with partners to boost syphilis awareness and improve access to contraception services, as well as preparing an expression of interest to become a Women's Health Regional Centre of Excellence for the Group Clinics Programme.

Dame Lesley Regan, Women's Health Ambassador for England presented to the Board why every nation needs to invest in a Women's Health Strategy.

Females comprise 51% of the population, represent 49% of the workforce, account for 68% of unpaid carers, and make 80% of household health decisions.

Health challenges for the women in the UK in 2026 include;

- Contraception is difficult to access; 45% of pregnancies are unplanned, Europe's highest rate of teenage pregnancy exists here, and abortion rates among women aged 32 and over are increasing.
- Cervical cancer is now a preventable disease and cervical screening uptake is at an all time low; marginalised women are at greatest risk.
- Heavy menstrual bleeding is a prevalent condition that remains stigmatized, and it results in iron deficiency in approximately one-third of women.
- Maternal mortality is three times higher for Black women and twice as high for Asian women. NHS Resolution litigation costs surpass maternity care

spending in the UK. All maternal deaths in the latest report involved a high BMI, and suicide remains a major cause of maternal death.

- Menopause is a natural stage in every woman's life. Each year, over 400,000 women in the UK experience menopause, and symptoms can persist for as long as seven years. Around a quarter of women have severe symptoms, and menopausal women make up one fifth of the NHS workforce.
- Urinary incontinence is experienced by a third of women of 60 years, yet no one talks about it.
- Symptoms of Cardiovascular Disease (CVD) are often different for women and they tend to receive their diagnosis later than men. Women respond to interventions and drugs differently and are twice as likely to die from CVD than breast cancer.
- Osteoporosis and frailty are significant contributors to illness and death, particularly among women. Women suffer fractures more frequently, with one in three experiencing them, compared to one in six men.
- Dementia affects more women than men, and women tend to wait longer for diagnosis.

After a 2021 consultation engaging 100,000 women and drawing on 400 expert reports, England released its Women's Health Strategy in summer 2022. The strategy outlines a ten-year plan to improve health outcomes of women and girls and reduce disparities, but also to improve how the healthcare system listens to women. Notably, 84% of participants reported feeling ignored, dismissed, or disbelieved.

The first two year priorities aimed to build the foundations for long-term change and included;

- Expansion of women's health hubs
- Improving information provision on women's health
- Supporting women's health in the workplace
- Certificates to recognise pregnancy loss
- Access to fertility treatment
- Improving access to hormone replacement treatment prepaid certificates
- Healthy aging and long term conditions
- Boosting research and evidence into women's health

Nine conditions account for more than a third of the women's health gap;

- Endometriosis
- Menopause
- Migraine
- Premenstrual syndrome
- Maternal hypertensive disorders
- Cervical cancer
- Breast cancer
- Ischemic heart disease
- Post-partum haemorrhage

Closing the gap starts with addressing the health of girls and the key to progress is collaboration.

In partnership with the voluntary sector, the period symptom checker was introduced in March 2025. Over 100,000 girls and women have downloaded a summary of symptoms to share with healthcare professionals. The initiative aims to enhance understanding of menstrual health issues, support self-advocacy, and encourage more women to seek appropriate medical assistance.

It is now important to take forward the Women's Health Strategy with a focus on women's health actions supporting delivery of the government's manifesto commitments;

- Shifting care from hospital into the community
- Analogue to digital
- Moving from treatment to prevention

Further Board discussion highlighted;

- The connection between women's health strategy and broader policies like family hubs, working together can help us achieve progress more quickly.
- Addressing violence against women and girls is a significant issue, and it requires collective action and shifting the narrative.
- Curiosity around cardioversion of atrial fibrillation and the insight into why men are three times more likely than women to be cardioverted.
- Curiosity around the deterioration in access to contraception and the reasons for this.
- Interest in how the left shift funding could potentially be allocated to support women's health.
- Examples in other areas of the country of women's health initiatives.
- A gap in training for health professionals with an aim to improve access to approved training giving people the skills and confidence to make every contact count.
- 80% of NHS workforce are female, we are the largest employer in the North East and North Cumbria. How do we as a system look at this further.
- How to get widespread adoption from a national level down to a local level.

The Board expressed its appreciation for the detailed update and extended thanks to Dame Lesley Regan for joining them.

RESOLVED:

The Board **RECEIVED** the update on women's health from both a national and local level.

B/2025/146 Questions from the Public on agenda items (agenda item 15)

None.

B/2025/147 Any other business (agenda item 16)

There were no items of any other business to discuss.

The meeting closed at 14:15

DRAFT

North East and North Cumbria Integrated Care Board

**Minutes of the Extraordinary Board meeting held on
16 April 2026, 10:00am on Microsoft Teams**

Present: Professor Sir Liam Donaldson, Chair
Samantha Allen, Chief Executive
Levi Buckley, Chief Delivery Officer
Ken Bremner, Foundation Trust Partner Member
David Chandler, Chief Finance Officer
Professor Sir Pali Hungin, Independent Non-Executive Member
Dr Hilary Lloyd, Chief Nurse and AHP Officer
Jacqueline Myers, Chief Strategy Officer
Dr Neil O'Brien, Chief Medical Officer
Claire Riley, Chief Corporate Services Officer
Dr Mike Smith, Primary Medical Services Partner Member
David Stout, Independent Non-Executive Member

In Attendance: Deborah Cornell, Director of Corporate Governance and Board Secretary
Christopher Akers-Belcher, Healthwatch Representative
Michelle Evans, Director of Workforce
Lisa Taylor, Voluntary Community and Social Enterprise Representative
Toni Taylor, Board and Legal Services Officer (minutes)

B/2026/1 Welcome and Introductions (agenda item 1)

The Chair welcomed colleagues the extraordinary Board meeting of North East and North Cumbria Integrated Care Board.

The Chair formally announced changes to the Board's composition due to the transition to a strategic commissioner and noted that this would be the final Board meeting for Levi Buckley Chief Delivery Officer, Dr Mike Smith Primary Medical Services Partner Member and Lisa Taylor Voluntary Community and Social Enterprise Representative. On behalf of the Board, the Chair thanked them for their valuable contributions and wished them well in their future endeavours.

B/2026/2 Apologies for Absence (agenda item 2)

Apologies were received from Tom Hall Local Authority Partner Member, Dr Saira Malik Primary Medical Services Partner Member and Rajesh Nadkarni Foundation Trust Partner Member.

B/2026/3 Declarations of Interest (agenda item 3)

Members had submitted their declarations prior to the meeting which had been made available in the public domain.

B/2026/4 Quoracy (agenda item 4)

The Chair confirmed the meeting was quorate.

B/2026/5 Notification of items of any other business (agenda item 5)

None.

B/2026/6 Governance Handbook issue 12 (agenda item 6)

The Chief Corporate Services Officer presented the updated governance handbook to the Board for consideration and approval.

Changes were made to reflect the new operating model and governance framework and included;

- Scheme of reservation and delegation updated to realign delegations with the new committee structure
- Standing financial instructions
- Terms of reference for new Committees and Subcommittees
- Revised terms of reference for existing committees and subcommittees

The Audit Committee Chair confirmed that the updated governance handbook was reviewed in detail by the Audit Committee and recommended to the Board approval.

The representative from the Voluntary, Community and Social Enterprise (VCSE) sector expressed concern regarding the absence of VCSE representation on the Neighbourhood Health Subcommittee. The Chief Strategy Officer clarified that the decision was taken for the committee's membership to comprise exclusively of ICB members, while engagement would be maintained through partnership groups.

The governance handbook is recognised as a living document that will adapt over time as the new committee structure becomes established. The Board decided that once the transition is complete, a review of Committee functions should take place. Members expressed concerns about the accountability and scope of the Quality and Safety Committee given the system's complexity and scale. It was suggested that these concerns be added to the risk register, outlining the underlying risks to guide future reviews and actions.

The governance team were commended for their hard work in reorganising the organisation whilst going through the restructure themselves.

ACTION:

The scope and accountability of the Quality and Safety Committee to be added to the risk register.

RESOLVED:

The Board **APPROVED** the governance handbook issue 12 and publication on the NENC ICB website.

B/2026/7 Finance Performance and Investment Committee Highlight Report and Confirmed Minutes (agenda item 7)

The Board were provided with an overview of the key points and confirmed minutes from the Finance Performance and Investment Committee meetings.

The Committee met an additional three times in January 2026 to conduct a comprehensive review of the draft submission for the NHS Medium Term Plan.

The Committee Chair confirmed that the Committee would be dissolved and its functions absorbed by the new governance structures and expressed his appreciation for his time on the Board and intention to continue contributing to the ICB in their new role.

RESOLVED:

The Board **RECEIVED** the confirmed minutes from the meetings held on 4 December 2025, 15 January 2026, 22 January 2026, 29 January 2026 and 5 February 2026 for assurance.

B/2026/8 Any other business (agenda item 8)

There were no items of any other business to discuss.

The meeting closed at 10:17

Log updated: 09/06/2026							
No:	Date of meeting	Minute reference	Agenda Item	Action Point	Lead	Timescale	Current status
77	31/03/2026	B/2025/119	NHS Medium Term Planning Submission	The Chief Finance Officer to initiate scenario modelling exercises to assess potential inflation and related risks.	D Chandler	28 July 2026	In progress
78	16/04/2026	B/2026/6	Governance Handbook	The scope and accountability of the Quality and Safety Committee to be added to the risk register.	H Lloyd	2 June 2026	In progress

Item: 8

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

BOARD

16 JUNE 2026

Report Title:

**Board Assurance Framework and Risk Management Report
Quarter 4, 2025/26**

Purpose of report

The purpose of this report is to provide the Board with a refreshed Board Assurance Framework for quarter 4, 2025/26 and an updated corporate risk register for review and consideration.

Key points

The Board has overall responsibility for ensuring systems and controls are in place and sufficient to mitigate any significant risks which may threaten the achievement of the ICB's strategic aims and objectives. The Board achieves this primarily through the work of its committees, through use of audit, independent inspections and by systematic collection and scrutiny of performance data.

The Board Assurance Framework (BAF) is used to provide assurance on the management of key risks to the delivery of the ICB's strategic aims and objectives as well as the wider strategic goals of the Integrated Care Partnership. The BAF is reviewed by the Executive Committee, Audit Committee, Quality and Safety Committee and the Finance, Performance and Investment Committee before submission to the Board.

The BAF is intended to provide a visible strategic risk summary, supported by the full detail of the corporate risk register.

The Board also receives the corporate risk register on a quarterly basis which includes risks identified by the ICB and via committee risk registers as being 'high or very high' and risks identified at a place-based level scored 12 and above.

The risk management strategy has been refreshed to ensure risk reporting and assurance is aligned to the ICB's new operating model. The updated strategy document is attached at appendix 4 for approval by the Board. Minor changes have been made to the risk reporting schedule to reflect the change in the ICB's committee structure and the addition of the newly formed Leadership Committee and Strategic Commissioning Assurance Committee.

A review of the ICB's risk appetite statement has also taken place in quarter one of 2026/27 to ensure continued alignment to the operating model. No amendments have been suggested and the Board are invited to review and approve the risk appetite statement included at appendix 5.

The following appendices are attached to the report:

- Appendix 1 - refreshed BAF for quarter 4 2025/26
- Appendix 2 – corporate risk register, an overview of all ICB risks with a residual risk score of 12 and above

- Appendix 3 – details of ICB place risks with a residual risk score of 12 and above
- Appendix 4 – updated risk management strategy, reflecting changes to the ICB's operating framework
- Appendix 5 – updated 2026/27 risk appetite statement

The corporate risk register is also reviewed regularly by Executive Committee and, depending on the nature of the risk, by the Quality and Safety and Finance, Performance and Investment Committees.

Risks and issues

Risks are mapped to the goals identified in the North East and North Cumbria Integrated Care Partnership strategy 'Better health and wellbeing for all' and from these goals the principal risks to the strategy have been identified as:

- 1. The ICB fails to commission services in a way that tackles the wider causes of ill health, and life expectancy of people within the North East and North Cumbria is not improving.**
The gap between how long people live in the North East and North Cumbria compared to the rest of England is not on track to reduce by 10% by 2030. Overall risk rated as 12 A (high).
- 2. Our health and care services are not delivered in a way in which improves the outcomes of communities who currently have much poorer health outcomes.**
The gap between the inequality in life expectancy and healthy life expectancy at birth between people living in the most deprived and least deprived 20% of communities is not on track to narrow by 10% by 2030. Overall risk rated as 15 A (high).
- 3. The quality of commissioned health and care services varies across the ICB area and in some places falls below our high expectations for our public and patients.**
The ICB does not maintain its good or outstanding rating from the Care Quality Commission (CQC) and the percentage of regulated services across social care, primary care and secondary care that are rated as good or outstanding by the CQC is declining. Overall risk rated as 16 A (high).
- 4. We fail to deliver health and care services which give children the best start in life.**
The percentage of children with good school readiness when they join the reception class (including children from disadvantaged groups) is declining. Overall risk rated as 16 A (high).

Assurances and supporting documentation

The report is in line with the ICB's Risk Management Strategy: [icbp037-risk-management-strategy-5.pdf](#)

Recommendation/action required

The Board is asked to:

- Satisfy itself that the BAF accurately reflects the principal risks to achieving our objectives as well as their current mitigations.
- Approve the BAF for quarter 4 2025/26, noting the development for 2026/27
- Receive and review the corporate risk register for assurance, noting the place risks with a residual rating of 12 and above.
- Approve the updated risk management strategy
- Approve the risk appetite statement for 2026/27

Acronyms and abbreviations explained

BAF – Board Assurance Framework
 CRR – Corporate Risk Register
 AC – Audit Committee
 LMNS - Local Maternity and Neonatal System
 NHSE – NHS England

FOI - Freedom of Information MOU - Memorandum of Understanding VCSE - Voluntary, Community & Social Enterprise SI – Serious Incident LeDeR - Learning from lives and deaths – people with a learning disability and autistic people SVOC - System Vaccination Operations Centre						
Sponsor/approving executive director	C Riley, Chief Corporate Services Officer					
Date approved by executive director	5 June 2026					
Reviewed by	D Cornell, Director of Corporate Governance and Board Secretary					
Report author	N Hawkins, Strategic Head of Corporate Governance					
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						
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	
Key considerations						
Financial implications and considerations	Not applicable					
Digital implications	Not applicable					
Clinical involvement	Not applicable					
Health inequalities	Not applicable					
Patient and public involvement	Not applicable					
Partner and/or other stakeholder engagement	Not applicable					
Other resources	Not applicable					

Board Assurance Framework 2025/26 (Quarter 4 2025/26) and Risk Management Report

1. Introduction

The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the ICB's strategic aims and objectives. Evidence may be gained from a wide range of sources, but it should be systematic, supported by evidence, independently verified and incorporated within a robust governance process. The Board achieves this primarily through the work of its committees, through use of audit, independent inspections and by systematic collection and scrutiny of performance data.

2. Board Assurance Framework for 2025/26

The ICB manages risk across five levels with the principal risks to achieving the ICB's objectives forming the Board Assurance Framework (BAF):

1. Place
2. Area
3. Directorate
4. Executive directors (corporate risks)
5. Board Assurance Framework

Risks are considered at their corresponding committees to provide the Board with assurance that risks are reviewed individually by risk owners and also collectively by an oversight committee.

The ICB's risks have been assessed against the North East and North Cumbria Integrated Care Partnership (ICP) strategy, *Better Health and Wellbeing for All*, to determine their impact on achieving the vision and goals of the strategy. The outcome of the assessment was incorporated into the BAF for 2025/26.

Each goal has been reviewed to determine an overarching or principal risk to its achievement and then each corporate risk has been aligned to one of the four risks to determine the overall risk score.

In summary, the risks to each goal are:

ICS Goal	Previous overall score	Current overall score
Longer and healthier lives	12	12
Fairer outcomes for all	20	15
Better health and care services	20	16
Giving children and young people the best start in life	16	16

The updated BAF for Q4 2025/26 is available at Appendix 1.

The BAF is monitored through the Executive Committee, Audit Committee, Quality and Safety Committee and the Finance, Performance and Investment Committee before submission to the Board.

3. Developing the Board Assurance Framework for 2026/27

The BAF and risk register have been reviewed to ensure alignment with the recently published [NENC Five Year Strategic Commissioning Plan](#) and also the ICB's developing role to become a strategic commissioner (including the three left shifts – from hospital to community; from analogue to digital; and, from sickness to prevention).

The BAF is well aligned to the five-year strategic commissioning plan, which is already structured around the 10-year ICP strategy. The five-year plan and BAF continue to align to our four strategic outcomes which set ambitious improvement targets for 2030:

- Goal 1: Longer and healthier lives
- Goal 2: Fairer outcomes for all
- Goal 3: Better health and care services
- Goal 4: Giving children and young people the best start in life

Further work is underway to review the BAF and risk register to reflect the changes to the ICB operating model, including changes to committee and staffing structures.

Additional work is being undertaken within regards to the ICB's risk management system (SIRMS) to support the risk reporting changes needed. Currently NECS host the licence for SIRMS and the ICB accesses this system via a service level agreement. The ICB has recently procured its own licence for SIRMS and is working on transferring the data from the NECS system as it transitions towards closedown and improving the system functionality.

4. Risk management strategy and risk appetite statement updates

The risk management strategy has been refreshed to ensure risk reporting and assurance is aligned to the ICB's new operating model. The updated strategy document is attached at appendix 4 for approval by the Board. Minor changes have been made to the risk reporting schedule to reflect the change in the ICB's committee structure and the addition of the newly formed Leadership Committee and Strategic Commissioning Assurance Committee.

A review of the ICB's risk appetite statement has also taken place in quarter one of 26/27 to ensure continued alignment to the operating model. No amendments have been suggested, and the Board are invited to review and approve the risk appetite statement included at appendix 5.

5. Risk movement

- **NENC/0004** – Delivery of financial position. There is a risk that the ICB is unable to deliver its planned financial position, together with a risk around delivery of the wider ICS financial position. Risk owner has reviewed the risk and reduced the score to 12 (from 20). Reduced risk score is as a result of increased confidence of delivery of financial position.
- **NENC/0023** - Risk that delayed ambulance handovers impact negatively on patient safety and patient flow. Risk owner has reviewed the risk and reduced the risk score to 9 (was

12), reflecting the latest information on ambulance delays across the system. As the risk is scored below 12, the risk is below the threshold to be included on the corporate risk register and will be monitored locally by the risk owner and responsible director.

- **NENC/0065** - Medium term financial plan (MTFP). There is a risk that both the ICB and wider ICS are unable to agree a robust, and credible, medium term financial plan which delivers a balanced financial position in future years. There is also a risk that the challenging financial position impacts on the delivery of ICB strategic priorities. Risk owner has reviewed the risk and reduced the risk score to 12 (was 20). Updated to reflect system plans are no longer required from 26/27 and ICB MTFP demonstrates breakeven financial position, therefore risk score reduced accordingly. Plans not yet agreed by NHSE and deficits remain in provider organisations hence some level of risk remains as further actions may be required.
- **NENC/0098** – Practice Level Support Operating and Commissioning Model for 26/27 (General Practice Improvement Programme). Proposed delegation of support from NHSE to ICB has no identified resource to undertake - resulting in significant implications for staffing and delegation of duties to ICB in 26/27. Risk owner has reviewed the risk and reduced the risk score to 9 (was 12). As the risk is scored below 12, the risk is below the threshold to be included on the corporate risk register and will be monitored locally by the risk owner and responsible director.
- **NENC/0102** - ICB transition programme. As a result of the pace of change required to meet the ICB transition programme timescales, alongside staff capacity to deliver the requirements, there is risk that the ICB fails to deliver a revised ICB operating model within the timescales required. Staff morale and capacity could be adversely affected, alongside pressure on the delivery of ongoing ICB statutory responsibilities. Risk reviewed and residual risk score reduced to 10 (was 15) due to reduced expectation of compulsory redundancies because of the voluntary redundancy process and in light of further revisions of proposed structures following consultation feedback. As the risk is scored below 12, the risk is below the threshold to be included on the corporate risk register and will be monitored locally by the risk owner and responsible director.

6. New corporate risks

There were two new corporate risks added to the corporate risk register this reporting period:

- **NENC/0123** - Capacity to deliver procurement Workplan 2026/27. Risk that the available capacity to deliver the 2026/27 procurement work programme is insufficient, leading to lapses in reprocurring services and resulting legal challenges. Risk is scored 12 (high).
- **NENC/0129** - Failure to secure ongoing funding for Connect NENC digital referral system. Connect NENC has been in place one year and provides a secure digital portal to support safe, structured referrals between specialist services across the region (for example, from district general hospitals to tertiary specialist units). The system enables specialties to configure bespoke referral forms, ensuring that the correct and complete clinical information is provided at the point of referral. It also creates a clear, auditable record of requests and specialist responses, allowing advice and decisions to be accurately documented and reliably actioned. Funding needs to be confirmed by to allow the service to continue. Termination of Connect NENC would result in a reversion to telephone-based referrals and advice seeking. Risk is scored 12 (high).

7. Closed risks

No corporate risks have been closed during this reporting period.

8. Place high and extreme risks

There are a total of three place risks with a current residual score of 12 or above. Appendix 3 provides full detail of all place risks that are with partial or limited control of the ICB with a current residual score of 12 or above.

9. Recommendations

The Board is asked to:

- Satisfy itself that the BAF accurately reflects the principal risks to achieving our objectives as well as their current mitigations.
- Approve the BAF for quarter 4 2025/26, noting the development for 2026/27
- Receive and review the corporate risk register for assurance, noting the place risks with a residual rating of 12 and above.
- Approve the updated risk management strategy
- Approve the risk appetite statement for 2026/27.

Name of Sponsoring Director: Claire Riley, Chief Corporate Services Officer

Reviewed by: Deb Cornell, Director of Corporate Governance,
Communications and Involvement (Board Secretary)

Name of Author: Neil Hawkins, Senior Head of Corporate Governance

Date: 1st June 2026.

NHS North East and North Cumbria
Board Assurance Framework 2025-26 (Q4 25/26 position)

Background

The Board Assurance Framework aligns to the Integrated Care Strategy which is a joint plan between our local authorities, the NHS and our partners including the community, voluntary and social enterprise sector who form our Integrated Care Partnership (ICP). The ICP is responsible for setting and developing our strategy for health and care in the region and therefore the risks to delivery of the strategic goals have been used to inform the Board Assurance Framework. The Board Assurance Framework has been completed in line with the ICB's risk management strategy which can be accessed here: [risk-management-strategy-v4-jan.pdf](#)

NHS North East and North Cumbria – Board Assurance Framework 2025-26 – principal risks

Four principal risks to achieving the ICB's strategic goals have been identified against which current ICB risks are mapped:

Strategic goal	Overarching risk	Current score (highest score of current risks)	Aligned risks in corporate risk register		Responsible committee
 Longer & healthier lives	The ICB fails to commission services in a way that tackles the wider causes of ill health, and life expectancy of people within the North East and North Cumbria is not improving. The gap between how long people live in the North East and North Cumbria compared to the rest of England is not on track to reduce by 10% by 2030.	12 (was 12 in Q3)	NENC/0001 NENC/0009 NENC/0024	NENC/0047 NENC/0116	QSC EC
 Fairer outcomes for all	Our health and care services are not delivered in a way in which improves the outcomes of communities who currently have much poorer health outcomes. The gap between the inequality in life expectancy and healthy life expectancy at birth between people living in the most deprived and least deprived 20% of communities is not on track to narrow by 10% by 2030.	15 (was 20 in Q3)	NENC/0004 NENC/0006 NENC/0028	~~NENC/0098~~	QSC FPIC
 Better health & care services	The quality of commissioned health and care services varies across the ICB area and in some places falls below our high expectations for our public and patients. The ICB does not achieve a good or outstanding rating from the Care Quality Commission (CQC) and the percentage of regulated services across social care, primary care and secondary care that are rated as good or outstanding by the CQC is declining.	16 (was 20 in Q3)	NENC/0021 ~~NENC/0023~~ NENC/0031 NENC/0065 NENC/0075 NENC/0084	~~NENC/0102~~ NENC/0109 NENC/0112 NENC/0119 ~~NENC/0123~~ ~~NENC/0129~~	FPIC EC
 Giving children and young people the best start in life	We fail to deliver health and care services which give children the best start in life. The percentage of children with good school readiness when they join the reception class (including children from disadvantaged groups) is declining.	16 (was 16 in Q3)	NENC/0066	NENC/0111 NENC0118	QSC EC

QSC – Quality and Safety Committee
FPIC – Finance, Performance and Investment Committee
EC - Executive Committee

NENC Board Assurance Framework 2025-26				Q4 25/26 position		Date: 20 March 2026	
Goal 1	Longer and healthier lives for all			Lead director(s)	Hilary Lloyd; Neil O'Brien		
Risk category	Quality; System recovery				Jacqueline Myers		
Principal risk	The ICB fails to commission services in a way that tackles the wider causes of ill health, and life expectancy of people within the North East and North Cumbria is not improving.			Lead Committee(s)	Quality and Safety Committee Executive Committee		
	The gap between how long people live in the North East and North Cumbria compared to the rest of England is not on track to reduce by 10% by 2030.		Rationale for current score System Resilience, Escalation Planning and Management and Business Continuity arrangements Primary care services pressures Quality of commissioned services that fall below the required standards, putting patient health, safety and welfare at risk. High rates of suspected suicides Out of Hospital Team redeployment to All-Age Continuing Care (AACC)				
Risk scores							
Consequence	4	12					
Likelihood	3						
Key controls		Assurances		Gaps			
System-wide surge and escalation plan; ICB Business Continuity Plan; Emergency Planning, Resilience and Response (EPRR) compliance; requirement for providers to notify ICB if Operational Pressures Escalation Levels (OPEL) status is escalated. Place Based Delivery Urgent and Emergency Care groups. Corporate business continuity plan in place.		Annual business continuity cycle. Annual Emergency Planning, Resilience and Response (EPRR) submission to NHS England (NHSE). NHSE regional operational centres provide regional scrutiny and challenge. Addressed in contract meetings if Operational Pressures Escalation Levels (OPEL) status is repeatedly escalated. Escalation process includes close liaison with place-based teams. NHSE regional operational centre provides scrutiny and challenge.		ICB business continuity currently being reviewed in line with changes during ICB 2:0			
Strategic Data Collection Service (SDCS) reporting system to monitor Workforce; Primary Care Network (PCN) transformation agenda linked to Long Term Plan; Primary Care Access Recovery Plan (PCARP); System Overview Group; ICB Primary Care Strategy and Delivery Subcommittee		Monitoring at place-based delivery primary care commissioning groups; Single OPEL framework agreed to ensure consistency across the ICB and promote increased reporting of OPEL levels; monitoring at place-based delivery primary care commissioning groups		None identified.			
Main provider contracts contain clear performance expectations. All large providers on NHS Standard Contract and have CQUIN schemes. ICB designated posts to drive quality. Care Quality Commission (CQC) inspections.		Quality and Safety Committee agenda and minutes. ICB Board agenda and minutes. Audit committee agenda and minutes. Executive committee agenda and minutes. CQC inspection reports and HealthWatch		None identified.			
Quality and accountability of commissioned services; Tackling means and methods of suicide; improving services through listening and learning from individuals and families; equitable, effective and targeted treatment and support for groups known to be at high risk of suicide; Programme group established; Support and training for NHS staff to increase skills and capability; providing effective and appropriate crisis support.		Mental health learning disabilities and autism (LDA) subcommittee terms of reference, minutes, programme reports, performance report; Suicide audit in Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) footprint initially; CNTW/ Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) peer network and volunteer bank support; ICP strategy and NHS England national suicide prevention strategy now available; suicide prevention strategy		Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) footprint for audit cluster and increasing trend response not consistent across local authorities. Availability of data and funding for training and post intervention support services, specifically children and young people			
Inbox being monitored with triage process in place any issues will be prioritised.		Can recall team for quality assurance issues.		New risk identified - actions in development to address identified gaps.			
Linked Risks							
Ref	Category	Description			Previous Score	Current score	Movement
NENC/0001	System recovery	System resilience, escalation planning and management and business continuity arrangements could lead to communities not receiving level of care needed during an incident, increased pressure across the system and inability to delivery core services			12	12	◀▶
NENC/0009	System recovery	As a result of workforce pressures, increased demand, infrastructure or technology issues, failure of or challenges to PCNs' ability to meet transformation agenda there is a risk that primary care is unable to provide long term, sustainable and reliable quality care services to patients			12	12	◀▶
NENC/0024	Quality	The ICB commissions services that fall below the required standards, putting patient health, safety and welfare at risk.			12	12	◀▶
NENC/0047	Quality	The rates of suicide in the North East and North Cumbria are the highest in the country at 13.4 per 100,000 people. The risk to the ICB is that we do not suicide rate for people in contact with NHS commissioned and health care delivery services who may be amendable to healthcare preventative efforts.			12	12	◀▶
NENC/0116	Quality	Out of Hospital Team redeployment to All-Age Continuing Care (AACC)			12	12	◀▶

NENC Board Assurance Framework 2025-26				Q4 25/26 position		Date: 20 March 2026		
Goal 2	Fairer outcomes for all			Lead director(s)		Claire Riley		
Risk category	Finance; Quality; Workforce					Levi Buckley; David Chandler		
Principal risk	Our health and care services are not delivered in a way in which improves the outcomes of communities who currently have much poorer health outcomes.			Lead Committee(s)		Quality and Safety Committee; Finance, Performance and Investment Committee		
	The gap between the inequality in life expectancy and healthy life expectancy at birth between people living in the most deprived and least deprived 20% of communities is not on track to narrow by 10% by 2030.							
Risk scores				Rationale for current score Risk that the ICB is unable to deliver its planned financial risk alongside a risk around wider ICS' financial position. Reputational risk due to poor access to adult mental health services. Widespread challenges to recruitment particularly of clinical and social care staff. ~~Practice Level Support Operating and Commissioning Model for 26/27 (General Practice Improvement Programme)~~				
Consequence	5	15						
Likelihood	3							
Key controls				Assurances		Gaps		
Financial plan; efficiency plan in place with financial sustainability group established; financial reporting and monitoring; financial governance arrangements, financial policies and scheme of delegation; NHS Provider FT efficiency plans and system efficiencies co-ordinated via System Recovery Board				Finance plan in place. Scheme of Delegation approved annually. Financial policies reviewed and updated annually. Vacancy control process in place and panel in place for approval of any discretionary non-pay spend. System Recovery Board ICB sighted on Foundation Trust (FT) efficiency plans Monthly reports to NHS England and a review of position with NHSE. Assurances received from each Integrated Care System (ICS) FT provider on review of financial controls. NHS Provider FT finance committees.		Underlying financial position work illustrates significant potential financial pressures		
Standard NHS contracts in place with two main providers: Cumbria, Northumberland, Tyne and Wear (CNTW) FT and Tees Esk and Wear Valleys (TEWV) FT and also with all NHS Talking Therapies anxiety and depression providers.				Contract management process Performance management process OPEL status NHS England quarterly assurance meeting Workforce planning from NHSE and providers		Contract management and performance oversight systems and processes under review.		
Workforce People group People and Culture strategy				Terms of reference, meeting notes, action plans, reports. Chief Nurse meetings with counterparts in NHS England and ICB workforce team have regular meetings with counterparts at NHS England. Plan developed in consultation with and cooperation of the wider system.		Funding of NHS long term workforce plan could impact on ability to deliver strategy.		
~~NHS England announcement that £10m has been secured to support the programme nationally. Further detail is currently awaited regarding the ICBs funding allocation and a proportion of the funding is expected to support the peer ambassadors programme and development of support for ICBs.~~				Monitoring funding allocation		~~Further update received from NHS England suggested an increased likelihood of the ICB becoming responsible for the programme in 26/27 via a new framework, including responsibility for funding and undertaking procurement to initiate a contract with a delivery partner. Confirmation is still awaited from NHS England to confirm the ICB's responsibilities, this therefore delays the timescales for procurement. Funding would also need to be identified by the ICB.~~		
Linked risks								
Ref	Category	Description				Previous Score	Current score	Movement
NENC/0004	Finance	Delivery of financial position. There is a risk that the ICB is unable to deliver its planned financial position, together with a risk around delivery of the wider ICS financial position.				20	12	▼
NENC/0006	Quality	Reputational risk due to poor access to adult mental health services.				12	12	◀▶
NENC/0028	Workforce	Widespread clinical and social care workforce challenges could impact on delivery of safe services, drive up witing times and lead to poorer outcomes for patients				15	15	◀▶
NENC/0098	Quality	~~Practice Level Support Operating and Commissioning Model for 26/27 (General Practice Improvement Programme). Proposed delegation of support from NHSE to ICB to begin transfer in 25/26 with no identified resource to undertake.~~				12	9	▼

NENC Board Assurance Framework 2025-26				Q4 25/26 position	Date: 20 March 2026
Goal 3	Better health and care services			Lead director(s)	Hilary Lloyd; Neil O'Brien; Jacqueline Myers; Levi Buckley.
Risk category	Finance; Quality; System Recovery; Workforce				David Chandler; Dave Gallagher; Claire Riley
Principal risk	The quality of commissioned health and care services varies across the ICB area and in some places falls below our high expectations for our public and patients.			Lead Committee(s)	Finance, Performance and Investment Committee Executive Committee
	The ICB does not maintain its good or outstanding rating from the Care Quality Commission (CQC) and the percentage of regulated services across social care, primary care and secondary care that are rated as good or outstanding by the CQC is declining.		Rationale for current score ~~Risk that delayed ambulance handovers impact negatively on patient safety and patient flow~~ Medium term financial plan Choice Accreditation Local Authority strategy in relation to case management and associated functions (Continuing Healthcare) ~~ICB transition programme~~ Implementation of new finance and accounting system for ICBs (ISFE 2) NECS closure impact ICB Blueprint consultation, NHS England Screening and Immunisation Transfer Undertakings (Protection of Employment) to the ICB and closure of the North of England Commissioning Support service (NECS) closure following NHSE Transition team announcements GP out of hours transfer to PHL (previously Vocare) Risk that ICS is not able to manage capital spend within the confirmed capital funding allocation Capacity to deliver procurement workplan 2026/27 Failure to Secure Ongoing Funding for Connect NENC Digital Referral System		
Risk scores					
Consequence	4	16			
Likelihood	4				
Key controls			Assurances	Gaps	
~~Local A&E Delivery Boards~~ ~~System agreement to no delays over 50 minutes (from Feb 2023)~~ ~~ICB winter plan and surge plan~~ ~~System resilience meetings~~ ~~ICB Quality and Safety Committee and Area Quality and Safety Subcommittees~~ ~~Urgent and Emergency Care Network (UECN).~~			~~Minutes/actions from Local A&E delivery boards.~~ ~~NHS England North East and Yorkshire region reviewing ambulance delays~~ ~~Analysis of any serious incidents resulting from delays.~~ ~~System situation reports (SitReps) during surge periods.~~ ~~Notes/actions from monthly meetings.~~ ~~ICB Quality and Safety Committee minutes, papers and actions.~~ ~~Weekly reporting template of % of handovers over 50 minutes.~~ ~~Urgent and Emergency Care Network minutes and action plans.~~ ~~NHS England reporting arrangements.~~	~~None identified.~~	
Medium Term Financial Plan development programme agreed across the ICS with external support and agreed governance arrangements. System Recovery Board now established with workforce, elective, procurement and urgent and emergency care agreed as the live opportunities with a pipeline of workstreams being matured. Plans being developed for each live workstream Efficiency plan in place with ICB financial sustainability group established			Updates on progress reported to Finance Performance and Investment Committee, Chief Executives, ICS Directors of Finance, Executive Committee Efficiency delivery included in monthly finance reports. Monitored by financial sustainability group with Programme Management Office support in place Reports received from NHS Provider Foundation Trust finance committees Scheme of Delegation approved annually Financial policies reviewed and updated annually Audit committee review Vacancy control process in place and panel in place for approval of any discretionary non-pay spend Audit One internal audit of key financial controls 24/25 – substantial assurance.	Medium Term Financial Plan (MTFP) highlights significant financial deficit with deliverable opportunities / efficiencies to be identified Efficiency plan to be developed.	
Established accreditation process. Prioritisation of elective service specification and pathway development. North East and North Cumbria ICB Contract Group established.			North East North Cumbria (NENC) ICB Contract Group and Executive Committee oversight. Elective service specification and pathway development being prioritised as far as possible within available resource.	None identified.	
Meetings have taken place with some local authorities (South Tyneside and Sunderland) to understand their initial intentions.			Internal strategy to be set in relation to ICB direction of travel in relation to case management and back office functions ICB Place Directors and Directors of Nursing have been involved in initial meetings.	LA's may still serve notice on the Section 75	

We have been transparent that we are still in the implementation phase of the ICB 2.0 restructure and need to consider HR/employment implications whilst still securing people in roles. We are committed to work together and ensure that citizens are not put at risk. We will seek to establish an ICB strategy. We will continue to meet with and discuss with the Local Authorities.									
~~ICB Transition Committee established to meet fortnightly to guide transition.~~ ~~Transition programme team established with dedicated senior responsible officer (SRO).~~ ~~National guidance – e.g. Model Integrated Care Board – Blueprint v1.0 –~~ ~~Strategic commissioning transition programme steering group – established, meeting weekly to guide transition programme, reporting into the Transition Committee.~~ ~~Comprehensive staff support offer in place and updated/reviewed regularly.~~ ~~Regular staff communication in place through all staff webinars and senior leaders cascade.~~			~~Minutes, papers and highlight reports from Transition Committee.~~ ~~External reporting to NHS England as required.~~ ~~Highlight reports to Transition Committee.~~			~~None identified.~~			
Detailed project plan in place. Project Board established for the ICB with senior responsible officer (SRO) and project team Monthly regional meetings with NHS England to oversee progress Detailed user acceptance testing taking place nationally on new system			Project Board in place with agreed Terms of Reference Regional meetings with NHS England to track progress and escalate issues Project leads and resource identified within ICB finance team along with support from ISFE 2 programme implementation team National ISFE2 Change Champions and other networks Training programme in place with national training sessions, recordings and other resources. Monitoring training uptake by ICB staff.			None identified.			
Strategic Transition programme steering group sighted on the issue and considering risk and opportunities. Ongoing programme of work with North of England Commissioning Support (NECS) to review both recurrent and non-recurrent SLAs and determine future need for service (including cessation where appropriate) Continuation of NECS SLA (contract) meeting covering any delivery issues in relation to commissioned services			Notes and actions from Strategic Transition programme steering group. Notes and actions from NECS SLA (contract) meetings. Regular meetings with NECS Executive Team throughout transfer.			None identified.			
Stage 1 of the procurement process is now complete and the network has good provision for all aspects of the COVID programme. Systems Vaccination Operation Centre (SVOC) has completed Stage 1 onboarding of 37 new community pharmacy and 5 primary care networks to the network for Spring 25 campaign. System engagement sessions have now been completed.			Risk and impact to service delivery is monitored daily by SVOC and highlighted to the Senior Leadership Team weekly for decision making.			None identified			
Provider (PHL – previously Vocare) is undergoing due diligence to ensure contract can be put in place, however they have failed previous 2 submissions.			Following current contracting guidance and working with provider to put assurances in place to ensure fluidity of current provision.			Gaps in financial assurance from provider			
Capital Plan Monthly financial reporting and forecasting against capital plans and funding application. Provider collaborative process for managing capital spend.			Agreed Integrated Care System (ICS) capital plan with variance reported monthly. AuditOne – internal audit of key financial controls 24/25 – substantial assurance. Monthly finance reports, reported to Finance, Performance and Investment Committee. North East and North Cumbria Infrastructure Board and Capital Collaborative Group established. Updates to monthly ICS Directors of Finance group.			None identified.			
Considering the impact of the Medium-Term Planning Framework for 2026/27 onwards which will allow the ICB to move to award 3-year contracts. We will need to consider the impact and seek NHSE / DHSC support on the breach of PSR regulations. Would have to support this financial year but would decrease impact for future years.			Continued monitoring and escalation from Contracting subcommittee			Gap in assurance due to move to strategic commissioning structures. To review once structures in place.			
Connect NENC currently provides structured referrals, an auditable advice trail, and demonstrable improvements in clinical safety. Widespread use of the system and clinician familiarity with its safety benefits.			Escalation as required to Chief Officer.			No fully agreed funding model across all Trusts. Time-critical dependency on funding being confirmed by the end of March.			
Linked risks									
Ref	Category	Description					Previous Score	Current score	Movement
NENC/0023	Quality	Risk that delayed ambulance handovers impact negatively on patient safety and patient flow					12	9	▼

NENC/0065	Finance	Risk that both the ICB and wider ICS are unable to agree a robust, and credible, medium term financial plan which delivers a balanced financial position	20	12	▼
NENC/0075	System recovery	Choice accreditation – risk that the ICB is required to contract unaffordable levels of Independent Sector (IS) provider capacity.	16	16	◀▶
NENC/0084	Quality	Local Authority strategy in relation to case management and associated functions (Continuing Healthcare)	12	12	◀▶
NENC/0102	Finance	ICB transition programme	15	10	▼
NENC/0109	Finance	Implementation of new finance and accounting system for ICBs (ISFE 2)	16	16	◀▶
NENC/0112	Workforce	NECS closure impact	15	15	◀▶
NENC/0021	Quality	ICB Blueprint consultation, NHS England Screening and Immunisation Transfer Undertakings (Protection of Employment) to the ICB and the North of England Commissioning Support (NECS) closure following NHS England Transition team announcements	15	15	◀▶
NENC0119	Finance	GP out of hours transfer to PHL (previously Vocare). PHL have taken over Vocare contract for out of hours provision in the North affecting Northumberland, Newcastle and North Tyneside. Risk of failure of financial due diligence and valid contract for provision in place until resolved.	12	12	◀▶
NENC/0031	Finance	There is a risk that the ICS is not able to manage capital spend within the confirmed capital funding allocation	12	12	◀▶
NENC/0123	Legal and regulatory	Capacity to deliver procurement workplan 2026/27	NEW	12	NEW
NENC/0129	Quality	Failure to Secure Ongoing Funding for Connect NENC Digital Referral System	NEW	12	NEW

NENC Board Assurance Framework 2025-26					Q4 25/26 position		Date: 20 March 2026		
Goal 4	Giving children and young people the best start in life					Lead director(s)		Hilary Lloyd; Levi Buckley	
Risk category	Quality; System Recovery								
Principal risk	We fail to deliver health and care services which give children the best start in life.					Lead Committee(s)		Quality and Safety Committee Executive Committee	
	The percentage of children with good school readiness when they join the reception class (including children from disadvantaged groups) is declining.		Rationale for current score Ineffective Transformation of ADHD and Autism Pathways. Local Maternity and Neonatal System (LMNS) funding allocations Missing maternity records incident - System C (BadgerNet)						
	Risk scores								
	Consequence	4							
Likelihood	4								
Key controls			Assurances			Gaps			
ICS Autism statement. Place-based autism strategies Regional network Autism Statement Development Group			Working with Brain in Hand to develop evaluation tools. Notes and actions from Autism Statement Development Group			ICB autism statement not yet in place. Regional network not yet established.			
The Local Maternity Neonatal System (LMNS) has reviewed its advised allocation and built a new budget in respect of this. Allocations received by Trusts have not changed in 25/26. However, these have not been confirmed beyond this.			LMNS Programme Delivery Group LMNS Board Maternity and Neonatal Regional Board Regional Perinatal Quality Surveillance			Unable to confirm future Trust funding.			
Clinical harm reviews being undertaken on all women who have been affected by the issue and necessary action to be taken. System C have rolled out an update which will stop this from happening to future records.			Findings will be reported to the ICB and NHS England regional team as part of the ongoing monitoring and assurance.			None identified			
Linked risks									
Ref	Category	Description					Previous Score	Current score	Movement
NENC/0066	System recovery	Ineffective Transformation of ADHD and Autism Pathways.					16	16	◀▶
NENC/0111	Quality	Local Maternity and Neonatal System funding allocations					12	12	◀▶
NENC/0118	Quality	Missing maternity records incident - System C (BadgerNet)					12	12	◀▶

NHS North East and North Cumbria – Board Assurance Framework 2025-26 – Place risk heatmap

Key risk	Reference	Title	Current score	Place	Category
Our health and care services are not delivered in a way in which improves the outcomes of communities who currently have much poorer health outcomes.	PLACE/0042	Autism diagnosis and post diagnosis support	12	Newcastle Gateshead	System Recovery
The quality of commissioned health and care services varies across the ICB area and in some places falls below our high expectations for our public and patients.	PLACE/0159	Phlebotomy services local incentive scheme - North Cumbria. 18 practices have not signed up to the 12 month North Cumbria local incentive scheme (LIS) agreement which provides some phlebotomy services and other care on behalf of secondary care.	12	North Cumbria	Quality
We fail to deliver health and care services which give children the best start in life.	PLACE/0114	Sensory processing disorder service	12	North Tyneside Northumberland	System Recovery

Risk category Strategic aim	Risk ref	Date identified Director Risk owner	Directorate Level of control Committee	Description	Initial			Controls	Gaps in control	Internal assurances	External assurances	Gaps in assurance	Actions Action owner Details Progress	Residual			Reviews	Risk Appetite
					C	L	Score							C	L	Score		

Key risk: The ICB fails to commission services in a way that tackles the wider causes of ill health, and life expectancy of people within the North East and North Cumbria is not improving.

Goal 1 Longer And Healthier Lives For All	NENC/0024	01/07/2022	NENC Chief Nurse And AHP	Quality of commissioned services that fall below the required standards, putting patient health, safety and welfare at risk. As a result of the quality of commissioned services not being assessed and monitored within a structured and coordinated process of assurance (including acute, mental health, learning disability, community and all age continuing care services), there is a risk that the ICB remains unaware of any quality issues or concerns and associated action plans to address them which could result in patient harm and reputational damage.	5	4	20	All large providers on NHS Standard Contract with clear performance expectations and CQUIN schemes.	None	Agendas and minutes for ICB Quality and Safety Committee, Area Quality and Safety subcommittees and Provider Quality Committees Incident reports Commissioner assurance reports Agendas and minutes of ICB Board, Audit Committee and Executive Committee Safeguarding partnership minutes	Care Quality Commission inspection reports	None	01/12/2024	26/03/2026	4	3	12	(5). Quarterly	Outside			
		Hilary Lloyd						Ann Fox			NENC ICB Partial Control		ICB designated posts to drive quality, safety and assurance agenda.	Healthwatch reports and reviews				Ann Fox		03/03/2026		
											3. NENC Quality And Safety Committee		ICB Quality and Safety Committee and area quality and safety subcommittees	Information sharing from local authorities - commissioning and safeguarding partnerships				Risk controls and assurances in place - no further actions required at last review		Ann Fox		
													Provider Quality Committees					Risk and controls in place, new action added				
													Care Quality Commission inspections					Date Entered : 03/03/2026 16:19 Entered By : Ann Fox				
													ICB internal audit annual programme					12/06/2025		26/03/2026		
													Quality Strategy					Ann Fox				
													Commissioner quality assurance visits					Agree governance and quality assurance framework for ICB following consultation and during implementation of new ICB operating model				
													Local authority information sharing					02/02/2026		26/03/2026		
													Safeguarding activity					Ann Fox				
													Performance information					ICB Quality Management Framework in Development (alongside new governance arrangements) to reflect Strategic Commissioning responsibilities and align with NHSE to avoid duplication				
													Clinical networks and improvement activity									
		Goal 1 Longer And Healthier Lives For All	NENC/0009					06/07/2022			NENC Strategy And System Oversight		Primary care services As a result of pressure on general practice services there is a risk that services cannot be provided to patients resulting in patient harm, increased attendance at hospital settings and compromised patient flow. This would mean the ICB cannot fulfil its statutory responsibility to deliver primary medical care services and be damaging to the reputation of the ICB.	4				4		16	Strategic Data Collection Service (SDCS) reporting system to monitor workforce.	None
Jacqueline Myers						Alex Sinclair	NENC ICB Limited Control	Modern General Practice transformation agenda linked to Long Term Plan	Single OPEL framework agreed to ensure consistency across the ICB and promote increased reporting of OPEL levels.	NHS Long Term Plan	Ongoing actions and initiatives to support Modern General Practice, the fuller and Long Term Workforce Plan (including ARRS workshops, training hubs, retention and recruitment initiatives, improving links with PCNs and community pharmacy, and digital programme of work).											
							3. NENC Quality And Safety Committee	Operational Pressures Escalation Levels (OPEL) status for practices reported via UEC-RAIDR App	Monitoring at place-based delivery primary care commissioning groups	None	None											
								Modern General Practice	Support from place-based delivery primary care teams to practices	None	None											
								System Overview Group	Oversight of Modern General Practice and Primary Care Collaborative delivery through System Overview Group and Primary Care Transformation team	Strategic Data Collection Service (SDCS) reporting	None											
								ICB Primary Care Subcommittee	Minutes and reports for the ICB Primary Care Subcommittee.	NHS Long Term Plan												
								Placed based delivery primary care teams and Support Level Framework aligned to delivery of Modern General Practice Access Recovery	Board and Executive Committee review of Modern General Practice and Primary Care / Secondary Care Interface System Plan.	NHS Long Term Workforce Plan												
									Monitoring at place-based delivery primary care commissioning groups, co-ordinated by an overview group.	System workforce retention reporting												
									Initiatives to support Modern General Practice, the fuller and Long Term Workforce Plan (including	None	Oversight of Modern General Practice and Primary Care Collaborative delivery through System	Strategic Data Collection Service (SDCS) reporting			None							

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Risk category Strategic aim	Risk ref	Date identified Director Risk owner	Directorate Level of control Committee	Description	Initial			Controls	Gaps in control	Internal assurances	External assurances	Gaps in assurance	Actions Action owner Details Progress	Residual			Reviews	Risk Appetite
					C	L	Score							C	L	Score		
									only support those in contact with secondary mental health services not community interface evaluation of near mis creative arts ethics approval required emergency services data not flowing to enable near mis programme to function Near mis suicide data is still not flowing to allow analysis of higher risk groups and pathways									
								Equitable, effective and targeted treatment and support for groups known to be at high risk of suicide. Programme group established.	Availability of data and funding for training and post intervention support services, specifically children and young people. Training funded and will be available from July 25 to primary care, NHS FT's and emergency responders Postvention service for CYP pilot delayed evaluation presents risk for contract April 26	Population health management. Mental Health Learning Disabilities and Autism Sub-committee reports and minutes. Emergency responders suicide prevention training. Review of post intervention support services. Project outputs to reduce self-harm (prevention and support for near miss.) Emergency services data. Scoping within the programme group of what good support looks like for people impacted by a near miss suicide.	NHS England and suicide prevention strategy	emergency responder training for 2026 to be confirmed Evaluation of CYP postvention support						
								Support and training for NHS staff to increase skills and capability.	Training available from July 25 and into 26/27	Mental health, Learning Disability and Autism Sub-committee reports and minutes. Plans to delivery training.	Suicide prevention strategy	national e-learning suicide safer programme not monitored through contracting and therefore assurance isnt provided to NHSE quarter assurance returns - linked to contracting						
								Providing effective and appropriate crisis support.	Lack of funding - added to commissioning intentions however pressures on SDF has meant no full coverage of alternative to crisis provision in NENC, specifically Durham Pilot of hub and spoke model for James Place will run Autumn 25 RCRP established	Mental health, learning disability and neurodiversity subcommittee	ICP strategy and NHS England	Funding to establish full coverage of alternative to crisis provision						

Risk category Strategic aim	Risk ref	Date identified Director Risk owner	Directorate Level of control Committee	Description	Initial			Controls	Gaps in control	Internal assurances	External assurances	Gaps in assurance	Actions Action owner Details Progress	Residual			Reviews	Risk Appetite
					C	L	Score							C	L	Score		
								Gap in treatment for children and young people aged 0-24 years who self harm and therefore at higher risk of suicide	across NENC County Durham and Teesside currently have no safe haven established There is no current agreed implementation plan to reduce the gap between those with mental health conditions aged 0-24 years and those receiving treatment. This treatment gap has been identified in 2 local areas covering both CNTW FT and TEWV FT.	Details submitted to Quality and Safety Subcommittee and Mental Health, Learning Disability and Neurodiversity Subcommittee with recommendation that further health needs assessments are undertaken and that an implementation plan is developed based on evidence based interventions.	NHS England	No agreed strategic implementati on plan to close the treatment gap for 0-24 year olds						
				Hub and spoke model of James Place crisis provision for men aged 18 + established in Darlington				provision is only 2 days per week - referrals low and requested provider to open referrals to primary care	Suicide prevention programme and MHLDN Sub-committee Evaluation scoped and seeking ethics approval	NHSE		Evaluation protocol						
Goal 1 Longer And Healthier Lives For All	NENC/0116	20/08/2025 Hilary Lloyd Richard Scott	NENC Chief Nurse And AHP NENC ICB Full Control 3. NENC Quality And Safety Committee	Out of Hospital Team redeployment to All-Age Continuing Care (AACC) Three members of out of hospital team have been redeployed into AACC. This increases the risk that we would be unable to triage/respond to issues concerns raised across care home nursing environments and primary medical care. Resulting in reduction in patient care and increased risk of safeguarding issues.	4	4	16	Inbox being monitored with triage process in place any issues will be prioritised	Capacity of Nursing staff within ICB due to recruitment freeze	Can recall team for quality assurance issues	None identified.	None identified.	01/09/2025 31/03/2026 Richard Scott Actions in development to address identified gaps.	4	3	12	(5). Quarterly 12/01/2026 Richard Scott Risk taken to the Directors of Nursing meeting for review	Outside
Goal 1 Longer And Healthier Lives For All	NENC/0001	06/07/2022 Jacqueline Myers Marc Hopkinson	NENC Strategy And System Oversight NENC ICB Full Control 1. NENC Executive Committee	System Resilience, Escalation Planning and Management and Business Continuity arrangements There is a risk that a lack of robust planning for surge management, and response to business continuity critical and major incidents, mean that: 1) impacted communities do not receive the required level of care needed during any incident 2) urgent and emergency care pressures increase, resulting in rises in A&E activity and multiple system demands including ambulance, community, acute and primary care services, and an inability to deliver core services.	4	4	16	System-wide surge and escalation plan agreed between all stakeholders NENC ICB Business Continuity Plan	None None identified.	Plan reviewed and regularly tested Business continuity policy and plans and review process	None Annual assurance undertaken by NHSE Audit One - internal audit of business continuity and EPRR 22/23 - reasonable assurance	None None identified.	01/04/2025 31/03/2026 Marc Hopkinson Action plan in place which is regularly monitored and reviewed following any significant incident 10/12/2025 30/04/2026 Marc Hopkinson	4	3	12	(5). Quarterly 12/01/2026 Marc Hopkinson Risk reviewed - controls and assurances updated.	Outside
				Emergency Planning, Resilience and Response (EPRR) compliance				None	Annual EPRR self-assessment signed off by ICB	Annual EPRR self-assessment signed off by ICB	EPRR submission to NHSE/I Audit One - internal audit of business continuity and EPRR 22/23 - reasonable assurance	None	Action plan needs to be revised to be fit for purpose for the new ICB structure from 1 May 2026.					
				Requirement for providers to notify the System Coordination Centre (SCC)/ICB if Operational Pressures Escalation Levels (OPEL) status is escalated				None	SCC to monitor and provide system leadership and coordination when necessary to ensure appropriate and proportionate response. Liaison with providers and ICB/EPRR when incidents occur. Performance addressed with providers during contract discussions.	SCC to monitor and provide system leadership and coordination when necessary to ensure appropriate and proportionate response.	NHS England regional operational centre provide regional scrutiny and challenge.	None						
				Place Based Delivery Urgent and Emergency Care groups				None	ICB escalation process	ICB escalation process	None	None						
				Have a corporate business continuity plan in place.				During restructure	All business continuity arrangements continue to	All business continuity arrangements continue to	Monthly EPRR meetings continue	Business impact						

Risk category Strategic aim	Risk ref	Date identified Director Risk owner	Directorate Level of control Committee	Description	Initial			Controls	Gaps in control	Internal assurances	External assurances	Gaps in assurance	Actions Action owner Details Progress	Residual			Reviews	Risk Appetite
					C	L	Score							C	L	Score		
								The ICB have managed a number of system impacts in recent months and have shown to be able to put mitigation in place to reduce risk.	some business continuity gaps remain until a review takes place on conformation of new structures.	be regularly reviewed by the EPRR resilience team.	to be held with all providers.	analysis gaps exist in some service areas to be addressed after restructure.						

Key risk: Our health and care services are not delivered in a way in which improves the outcomes of communities who currently have much poorer health outcomes.

Goal 2 Fairer Health Outcomes For All	NENC/0028	21/10/2022	NENC People Directorate	Clinical and social care workforce across the region There are widespread challenges to recruitment nationally and particularly of clinical and social care staff as a result of many factors including staff burnout, ageing workforce, National Financial Challenges in the Public Sector. This will impact on the delivery of safe services and could lead to lack of access to specific services, drive up waiting times leading to poorer outcomes for patients. This will cause further workload pressures on existing staff which could cause retention issues and potentially lead to staff ill health.	5	4	20	ICS People Partnership Forum. ICS People Strategy Group (on hold) People governance to be reviewed in-line with upcoming changes to ICB staffing structures. NHS England workforce functions emerging (understanding of responsibilities still being explored).	None	Terms of reference, meeting notes, action plans. Terms of reference (developed - awaiting sign off).	External partners across the health and care system are part of the two groups membership.	None	01/06/2025	30/06/2026	5	3	15	(5). Quarterly	Outside
		Claire Riley	NENC ICB Partial Control							Jayne Aitken		Jayne Aitken							
		Jayne Aitken	3. NENC Quality And Safety Committee					None within the ICB control.	Chief Nurse meetings with counterparts in NHS England. ICB workforce team have regular meetings with counterparts at NHS England. ICB workforce team regular meetings with counterparts at NHS England. Regional meetings on productivity and workforce planning are in place.	None	None.	Risk controls and assurances in place - no further actions identified at last review.							
			People and Culture Strategy.					Funding of NHS long term workforce plan could impact on ability to deliver Strategy.	Development of a system-wide plan to reduce the risk raised. Reporting arrangements on delivery of the plan being finalised. Executive Committee sign-off Developing communications launch after board sign off.	Developed in consultation with and co-operation of the wider system with comments incorporated in the strategy. Socialising final draft with system colleagues.	None.								
			Health & Growth Accelerator now live	Staff stress and burnout	No longer in development Health and Growth Accelerator now live and under cycles of review	Reduce stress and burnout	N/A												
				System Recovery meetings taking place across the system with NHS providers.	Understanding affordability of future workforce	System recovery board chaired by ICB Chief Executive with System Partners from NHS providers in attendance.	Chief people officers from NHS providers report into system recovery board	N/A											
Goal 2 Fairer Health Outcomes For All	NENC/0006	06/07/2022	NENC Delivery Directorate	Reputational Risk Due to Poor Access to Adult Mental Health Services There is a risk of reputational damage to the Integrated Care Board (ICB) due to challenges in ensuring timely and effective access to adult mental health services. Contributing factors include limited-service capacity, inconsistent treatment thresholds and inefficient referral processes. Increased demand following the pandemic and workforce pressures exacerbate these issues. This could result in negative perceptions of the ICB's ability to meet population needs, diminished stakeholder confidence, and adverse outcomes for patients, including delayed or inadequate care and potential escalation to crisis situations.	4	4	16	Standard NHS contracts in place with two main providers: Cumbria, Northumberland, Tyne and Wear (CNTW) FT and Tees Esk and Wear Valleys (TEWV) FT, and also with all NHS Talking Therapies anxiety and depression providers. Ensure that the number of people who receive two or more contacts from commissioned community mental health services is compliant.	None	Contract management process Mental health oversight performance group OPEL status Data and digital steering group	NHS England quarterly performance submissions and assurance meeting Workforce planning from NHS England and providers	Review of contract management and performance oversight systems and processes through MH oversight and performance group.	01/04/2025	31/05/2026	4	3	12	(5). Quarterly	Approaching
		Levi Buckley	NENC ICB Partial Control					Linda Reiling			A review of the outcome of the full system NHS Talking Therapies review to identify any impact for the ICB.								
		Peter Rooney	3. NENC Quality And Safety Committee					Contract management and performance oversight systems and processes. NHS 111 select 2 was deployed from April 2024. This will change how patients access support and provision across NENC.	Risk that ASD population may not utilise this provision.	MH and Ambulance Transformation Group has now been closed down due to the successful implementation and therefore this moves into business as usual.	Evaluation going through subcommittee in December and plans to move business as usual into UEC programme in the new year.	None identified.	NENC talking therapies transformation event taking place on Monday 8th December. The purpose of the event through facilitated discussions is to examine three key priority areas which are: 1) core model delivery 2) workforce expansion 3) digital innovation The proposed outcomes: 1) agree a draft overarching vision and key guiding principles for system wide talking therapies. 2) identify areas for current system level improvements (including addressing current risks and issues) in relation to the above three priority areas 3) what are the challenges, risks and issues for planning the future state						
			There is a signed MoU agreement between providers around how they will collectively deliver this provision.						Currently conversations are taking place with the emergency urgent care board who link this work		Update from above transformation event scheduled to be presented at the subcommittee on the 20 February.								

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					C	L	Score							C	L	Score		
								Providers are currently undertaking an evaluation which will be presented to the MHLDA subcommittee. A full system NHS Talking Therapies review has been concluded. This has set out the clinical, contractual and financial challenges for achieving the access targets.	None.	into that remit as part of business as usual. NENC ICB NHS talkies therapies transformation group. Mental health performance oversight group monitors data. MHLDA subcommittee.	Mental health performance oversight group and MHLDA subcommittee has partner members who attend from mental health providers.	None at present.	Due to the organisational restructure a paper may need to return through the new governance post-reorganisation. Date Entered : 09/02/2026 13:19 Entered By : Neil Hawkins 01/04/202531/05/2026 Linda Reiling					
								Local interface meetings with all place delivery teams. This is to promote effective All Age clinical collaboration which maintains and strengthens relationships between place delivery teams, local GP providers and our two largest mental health trusts (CNTW; TEWV)	Northumberland and North Tyneside meetings to be established.	Strong links through local delivery teams, with strong clinical lead involvement across the ICB and Trusts.	None at present.	None.	Review of utilisation to be undertaken and any communications needs identified as a result.					
Goal 2 Fairer Health Outcomes For All	NENC/0004	06/07/2022	NENC Finance Directorate	Delivery of financial position There is a risk that the ICB is unable to deliver its planned financial position, together with a risk around delivery of the wider ICS financial position.	5	5	25	Financial plan	None	Finance plan in place.	Audit One - internal audit of key financial controls 22/23 - substantial assurance	None	06/10/202531/03/2026 Richard Henderson	4	3	12	(5). Quarterly	Approaching
		David (ICB) Chandler	NENC ICB Partial Control															
		Richard Henderson	2. NENC Finance, Performance And Investment Commit	For 2025/26, a balanced financial plan has been agreed across the ICS, including a planned ICB surplus of £11.8m. Delivery of that planned position will be extremely challenging and there are still significant risks across the system . For the ICB the key risks include: - Prescribing cost growth and delivery of efficiency targets - All-age continuing care costs including substantial efficiency targets - Elective activity growth now that elective recovery funding is capped - Growth in ADHD/ASD activity at Right to Choose providers Actions taken during the year have helped to mitigate risk across the system with improvements in the ICB forecast surplus helping to offset pressures in provider trusts. Based on latest forecasts, unmitigated net risk has reduced significantly and there is now greater confidence the ICB and ICS positions can be delivered for 2025/26.				Efficiency plan in place with financial sustainability group established	None	Efficiency delivery included in monthly finance reports. Monitored by financial sustainability group with PMO support in place. Audit One - internal audit of key financial controls 22/23 - substantial assurance	Reported to NHSE each month.	None	Action plans agreed following mid-year review process 01/04/202531/03/2026 Richard Henderson					
								Financial reporting and monitoring process	None	Monthly finance reports. Audit One - internal audit of key financial controls 22/23 - substantial assurance	Review of position with NHSE	Underlying financial position work illustrates significant potential financial pressures						
								Financial controls reviewed and strengthened where relevant across the ICS, including vacancy control processes and approval of non-pay spend	None	Vacancy control process in place and panel in place for approval of any discretionary non-pay spend	Independent review of financial controls across the ICS	None						
								Monthly forecasting and variance reporting and plan to date	Latest forecasts show a potential net risk across the ICS for 2025/26, although this has reduced compared to plan	Reported to Finance, Performance and Investment committee. Audit One - internal audit of key financial controls 22/23 - substantial assurance	Monthly review with NHSE regional team and processes in place to highlight variances. Mid-year review process to take place with NHSE	None						
								NHS Provider FT efficiency plans and system efficiencies co-ordinated via System Recovery Board	None	System Recovery Board ICB sighted on FT efficiency plans	NHS Provider FT finance committees	None						
								Financial governance arrangements, financial policies and scheme of delegation	None	Scheme of Delegation approved annually Financial policies reviewed and update annually Audit committee review.	Audit One - internal audit of key financial controls 22/23 - substantial assurance	None						
								Indicative Activity Plans developed for all relevant contracts with Activity Management Plan process to be invoked to support management of activity within affordable levels	None	Activity Management Process implemented with indicative activity plans developed	None	Risks for challenges to IAPs from some providers and uncertainty in how effective						

Risk category Strategic aim	Risk ref	Date identified Director Risk owner	Directorate Level of control Committee	Description	Initial			Controls	Gaps in control	Internal assurances	External assurances	Gaps in assurance	Actions Action owner Details Progress	Residual			Reviews	Risk Appetite	
					C	L	Score							C	L	Score			
												activity management process will be given the process is new							
Key risk: The quality of commissioned health and care services varies across the ICB area and in some places falls below our high expectations for our public and patients.																			
Goal 3 Improving Health And Care Services	NENC/ 0075	18/12/2023	NENC Contracting And Procurement	Choice Accreditation There is a risk that the ICB is required under legislation and NHS E policy direction to contract unaffordable levels of independent sector (IS) provider capacity resulting in a risk of achieving financial balance and also an opportunity cost of not being able to prioritise commissioning activities in areas of greatest need.	4	5	20	Established accreditation process in place. Elective service specification and pathway. ICB Executive Committee oversight NENC Contract Group oversight	None	Updated process in place following agreement at Executive Committee. Work underway to maximise use of process to minimise risk. Elective service specification and pathway development being prioritised as far as possible within available resource.	None	None	02/09/2024	31/03/2026	4	4	16	(5). Quarterly 15/01/2026 Paul Turner Actions on-going. No change needed	Outside
		David Gallagher											Paul Turner						
		Paul Turner	NENC ICB Partial Control											Work underway to maximise use of process to minimise risk. Elective service specification and pathway development being prioritised as far as possible within available resource.					
			1. NENC Executive Committee																
Goal 3 Improving Health And Care Services	NENC/ 0109	25/06/2025	NENC Finance Directorate	Implementation of new finance and accounting system for ICBs (ISFE 2) ISFE 2, the new national finance and accounting system for ICBs went live on 1 October 2025.	5	4	20	Detailed project plan in place. Project Board established for the ICB with SRO and project team	None	Project Board in place with agreed Terms of Reference	Regional meetings with NHSE to track progress and escalate issues	Ongoing issues with reporting functionality and accuracy	01/09/2025	31/03/2026	4	4	16	(4). 2 Monthly 12/02/2026 Richard Henderson	Outside
		David (ICB) Chandler	NENC ICB Partial Control										Training programme in place with national training sessions, recordings and other resources. Monitoring training uptake by ICB staff.						
		Richard Henderson	2. NENC Finance, Performance And Investment Commit	There is a risk around the resource and capacity within the ICB to manage the implementation of the system at a time of significant change, together with a risk around continued delays in the national process which could result in system issues following go-live and potential delays in payments to suppliers. Whilst the system has now gone live and is functioning, there continue to be certain issues and delays within the system which present a risk around prompt payment of suppliers and the accuracy of reporting within the system for example. Significantly a number of potential governance / control issues within the system have been highlighted which present a potential risk to the ICB in terms of compliance with SFIs and assurance around appropriate approval of ICB spend.				Monthly regional meetings with NHSE to oversee progress	None	Project leads and resource identified within ICB finance team along with support from ISFE 2 programme implementation team	National ISFE2 Change Champions and other networks	Further assurance requested from NHSE / SBS around governance and controls within the system, including ability to code invoices to other organisations, unapproved invoices appearing on payment runs and user approval limits being reassigned with invoices. NA	21/11/2025	31/03/2026				Risk reviewed - No change required	
									Additional checks taking place within finance team including spot check of payment runs and monitoring position on non-PO invoices / approvals	NA	Review of payment runs and invoice coding / approvals	NA		Issues escalated to NHSE (to the SRO for the ISFE2 implementation)					
Goal 3 Improving Health And Care Services	NENC/ 0112	02/07/2025	NENC Strategy And System Oversight	NECS closure impact. As a result of the decision to close all Commissioning Support Units (CSUs) nationally, there is a risk that the services currently provided by the North of England Care System Support (NECS) through the agreed service level agreement (SLA) with the ICB do not transfer successfully to the ICB before NECS closure. In addition, the capacity and skills within NECS may be lost through staff leaving the organisation, leaving vital systems vulnerable (e.g. GPIT, RAIDR, SIRMS).	5	4	20	Strategic Transition programme steering group sighted on the issue and considering risk and opportunities.	None identified.	Notes and actions from Strategic Transition programme steering group.	Regular meetings with NECS Executive Team throughout transfer.	None identified.	17/07/2025	30/06/2026	5	3	15	(5). Quarterly 10/02/2026 Craig Blair Risk reviewed - updated in terms of VR scheme NECS are running	Outside
		Jacqueline Myers											Ongoing monitoring and escalation to Executive as required.						
		Craig Blair	NENC ICB Limited Control						Ongoing programme of work with NECs to review both recurrent and non-recurrent SLAs and determine future need for service (including cessation where appropriate)		Notes and actions from NECS SLA (contract) meetings.		Currently there is lack of clarity over the process for "CSU Closedown" and what if any services may be provided once/nationally etc.						
			1. NENC Executive Committee						Continuation of NECS SLA (contract) meeting covering any delivery issues in relation to commissioned services NECS have commenced a VR process and are currently working through approvals, this is directly impacting on business continuity.	NA	The ICB has informed NECS of business critical services where staff retention is essential. NECS are feeding this information into the	NA	The national panel can still chose to support the VR applications.						

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					C	L	Score							C	L	Score		
										national VR panel. in addition the ICB have established a CSU closure project group, that reports into the ICB Transition Programme. The group has developed a programme of work to support to the transition of those CSU services that are required in the future.								
Goal 3 Improving Health And Care Services	NENC/0021	06/09/2022 Neil O'Brien Alex Holloway	NENC Medical Directorate NENC ICB Partial Control 1. NENC Executive Committee	ICB Blueprint consultation, NHSE Screening and Immunisation TUPE to ICB and NECS CSU closure following NHSE Transition team announcement. For delivery of COVID programme in FY 26/27, the ICB will need to manage the risk associated with Spring / Autumn delivery considering ICB Blueprint consultation, Model Region and the Office of Pan ICB Commissioning. NHSE has confirmed that FY 26/27 50% reduction in COVID programme funding which will see a reduced level of service from the SVOC. Following ICB consultation on new structures (concluding in Q4) ICB will need to decide on future recipient organisation of NECS CSU programme team. ICB Transition Team have been provided with an options appraisal. ICB have been informed by NEY, that no NENC aligned NHSE Screening and Immunisation colleagues can be used as mitigation to delivery in FY 26/27. JCVI have confirmed a Spring 2026 COVID campaign and Section 7a delegation for full immunisation schedule, will now occur FY 27/28.	4	5	20	Stage 1 of the procurement process is now complete and the network has good provision for all aspects of the COVID programme. SVOC has completed Stage 1 onboarding of 37 new CP and 5 PCN to the network for Spring 25 campaign. This brings the total fixed site network for NENC to 18 FT / 3 Fed / 68 PCN / 348 CP / 7 DE (444 service providers). SVOC, with NHSE contracting, will complete Stage 2 evaluation of 14 Lots associated with PCN and CP delivering from non core premises W/C 20th Jan to be successfully be onboarded for the Spring campaign. System engagement sessions have now been completed and also coordination with the 8 FT that form part of the LMNS network for maternity offer in Family hubs. The network to deliver COVID for NENC includes 18 FTs / 4 Federations / 64 PCNs / 315 CPs / 4 Outreach (Roving) providers. Overall, from AW 23 and the running of the new procurement of an 18 month contract the network has grown by 16%, primarily in Pharmacy. NENC has developed System SOPs for delivery of CH, HB, Walk in and Outreach all seeking to optimise delivery before the final 2 weeks of an active campaign. We have confirmed with all of our FTs on their HSCW Och plan, position on long stay in patients and those requiring complex clinics. NENC has 614 CH, 459 (75%) with an aligned Provider and 398 (65%) with a scheduled first visit across older adult and dual registered CQC organisations. 3 CH meet exclusion criteria. Compared to AW 23, we have more CH with a Provider and a scheduled date at time of submission. This is in part due to the early publication and release of PGD, NP and elfh module for COVID.	None identified.	Any risk and impact to service delivery is monitored daily by SVOC and highlighted to Senior Leadership Team weekly for decsion making. Any urgent actions are reported to SRO, CMO Dr Neil O'Brien and Dr Cath Monaghan as lead MD. There are minutes and action logs for these meetings. Daily call with SVOC flags concerns to Programme Director and Senior Operations Manager for decisions and actions.	Public health intelligence health protection reporting. National Flu and COVID surveillance reports	None	01/04/2025 31/03/2026 Alex Holloway Risk controls and assurances in place - no further actions required at last review. 01/07/2025 31/03/2026 Catherine Monaghan Spring campaign has now concluded and SVOC is managing the transition to year-round offer to newly SIS patients. A fill campaign closedown will be completed and fully evaluated before preparation for AW. JCVI and System letter expected by COP July. A NHSE procurement for Outreach provider is how active and consensus has been completed. This will see 3 NENC providers with contracts out to April 2026. NHSE Transition team have now published Model ICB guidance as of 2nd May which directs that vaccinations will be a core function for the ICB from 1st April 2026, which includes COVID. ICB proposed efficiency plans have been submitted to NHSE NEY at the end of May. This will then provide the necessary planning guidance to inform efficiencies to be made by Q3 for the ICB for the non-recurrent SLA. NHSE have established quarterly review of COVID programme budget with the first concluded on 12th May, and the next planned for 19th Aug. Currently the impact to CSU, and NECS specifically for the SVOC, are not known. If CSUs were also asked to achieve 50% efficiencies, then a consultation process would need to be announced and SVOC could be in scope for 1st April 2026 and beyond. Spring campaign has now concluded and SVOC is managing the transition to year-round offer to newly SIS patients. A fill campaign closedown will be completed and fully evaluated before preparation for AW. JCVI and System letter expected by COP July. A NHSE procurement for Outreach provider is how active and consensus has been completed. This will see 3 NENC providers with contracts out to April 2026. NHSE Transition team have now published Model ICB guidance as of 2nd May which directs that vaccinations will be a core function for the ICB from 1st April 2026, which includes COVID. ICB proposed efficiency plans have been submitted to NHSE NEY at the end of May. This will then provide the necessary planning guidance to inform efficiencies to be made by Q3 for the ICB for the non-recurrent SLA. NHSE have established quarterly review of	3	5	15	(3). Monthly 03/03/2026 Alex Holloway JCVI have confirmed a Spring 2026 COVID campaign and Section 7a delegation for full immunisation schedule, will now occur FY 27/28. NHSE has now published the new combined Enhanced Service for Flu and COVID 26/27 and the PCN DES for seasonal and routine immunisations. In addition NHSE has now published the Direct Commissioning update which will see NENC ICB host the NHSE NEY OPIC from Apr 27 once primary legislation has been passed. The SVOC submitted the programme plan for 26/27 30th January and a subsequent reflection was requested by NEY team. Final plan was submitted to NHSE 26th February. This will go to PHCC 17th March for agreement. This service optimises flexibility to deliver a Spring and Autumn campaign within new operating model at 50% and factoring the new changes to vaccine supply and emergence of the OPIC. Over April and May the SVOC will need to coordinate with ICB new operating model ton agree to governance relationships with	Outside

Risk category Strategic aim	Risk ref	Date identified Director Risk owner	Directorate Level of control Committee	Description	Initial			Controls	Gaps in control	Internal assurances	External assurances	Gaps in assurance	Actions Action owner Details Progress	Residual			Reviews	Risk Appetite
					C	L	Score							C	L	Score		
								Stage 2 procurement of Community Outreach and Roving services has yet to be authorised by NHSE, as they are awaiting confirmation from HMT on approvals of the 25/26 Access and Inequalities budgets for ICBs. Based on current planning assumptions, the 4 services for NENC (Village Surgery, West Northumberland PCN, HASH and Well Pharmacy) will not be authorised to undertake these funded services (£500 per pre approved clinic) to underserved communities ready for the start of the Spring campaign. NENC Account Director engaged with Craig Blair, Director of Strategy Planning and Performance. Programme lead liaising with ICB CMO, Dr Neil O'Brien, Programme SRO Programme SRO engaged with NEY NHSE quarterly	With procurement, evaluation, approvals and onboarding yet to start it is highly unlikely the programme will have the ability to undertake these services for the first 2 months of the campaign. This increases the likelihood of MP enquiries, patient complaints and there associated management by the programme. Time line of NHSE Screening and Immunisation TUPE to ICB and scale of efficiencies before transfer at 50%	Communication to MPs and Place leads before active campaign.	Stage 1 complete, communications on going with NHSE around stage 2	With procurement, evaluation, approvals and onboarding yet to start it is highly unlikely the programme will have the ability to undertake these services for the first 2 months of the campaign.	COVID programme budget with the first concluded on 12th May, and the next planned for 19th Aug. Currently the impact to CSU, and NECS specifically for the SVOC, are not known. If CSUs were also asked to achieve 50% efficiencies, then a consultation process would need to be announced and SVOC could be in scope for 1st April 2026 and beyond. Date Entered : 04/07/2025 07:37 Entered By : Rachel Rooney 05/08/202531/03/2026 Craig Blair Future function of vaccination commissioning and operational delivery with the ICB as strategic commissioner. 02/02/202627/03/2026 Alex Holloway SVOC liaising with NEY NHSE on data accuracy of sign up information. Scoping an options appraisal to address gaps in provision to care homes, housebound and 6 month to 18 with immunosuppression				Commissioning Groups, Local Immunisation Steering Groups and Place leads for sub ICB and LA with North, Centre and South Groups.	
Goal 3 Improving Health And Care Services	NENC/0084	09/07/2024 Hilary Lloyd Richard Scott	NENC Chief Nurse And AHP NENC ICB Limited Control 1. NENC Executive Committee	Local Authority strategy in relation to case management and associated functions As a result of the decisions being taken by some LA's (South Tyneside and Sunderland)with regard to intention to cease to undertake activities on our behalf, i.e., CHC Case management and associated functions (i.e legal, brokerage, financial transactions) there is a risk that ICB teams may become overwhelmed , capacity to deliver the function may not transfer with the responsibility and additional pressure /risk may be incurred (particularly if additional LA's make similar strategic business decisions) which could result in reduced oversight of vulnerable citizens and potential harm, additional pressures within ICB teams and reputational risk/damage to the ICB.	4	5	20	Meetings have taken place with LA in South Tyneside and Sunderland to understand their initial intentions. We have been transparent that we are still in the implementation phase of the ICB 2.0 restructure and need to consider HR/employment implications whilst still securing people in roles. We are committed to work together and ensure that citizens are not put at risk. We will seek to establish an ICB strategy. We will continue to meet with and discuss with the Local Authorities.	The LA's may decide to serve notice on Sec 75 arrangements regardless.	Internal strategy to be set in relation to ICB direction of travel in relation to case management and back office functions ICB Place Directors and Directors of Nursing have been involved in initial meetings. Finance aware and to have continued involvement to measure risk.	We need to understand the activity, funding budget and workforce issues the LA;s describe as otherwise risk of taking back an underfunded function. All cases would need to be up to date in terms of reviews, DoLS, COP DoLS Continued commitment to meeting	LA's may still serve notice on the Section 75	01/04/202530/06/2026 Ann Fox Chief Nurse, Deputy Chief Nurse will need to liaise with ICB Exec and Director colleagues and establish a direction of travel and strategy and approach to potential transformation of AACC case management functions across the ICB.	3	4	12	(4). 2 Monthly 26/02/2026 Richard Scott Further meetings taken place between Chief Nurse and LA Director - process of work agreed to work to a solution	Outside
Goal 3 Improving Health And Care Services	NENC/0031	16/11/2022 David (ICB) Chandler Richard Henderson	NENC Finance Directorate NENC ICB Full Control 2. NENC Finance, Performance And Investment Commit	There is a risk that the ICS is not able to manage capital spend within the confirmed capital funding allocation. There is a risk that the ICS is not able to manage capital spend within the confirmed capital funding allocation. Currently there are particular pressures on in-year delivery of the capital position and also delays in national approval of Return to Constitutional Standards funding. Mitigations are being identified but there is a risk of an overspend or schemes not being able to progress as planned.	4	5	20	Capital plan Monthly financial reporting and forecasting against capital plans and funding allocation Provider collaborative process for managing capital spend	None None None	Agreed ICS capital plan with variance reported monthly. Audit One - internal audit of key financial controls 24/25 - substantial assurance Mitigations identified to manage potential pressure Monthly finance reports, reported to FPI Committee. Audit One - internal audit of key financial controls 24/25 - substantial assurance NENC Infrastructure Board and Capital Collaborative Group established. Updates provided to FPIC Updates to monthly ICS Directors of Finance group.	None None None	None None None	01/06/202531/07/2026 Richard Henderson Controls and assurances in place. No additional actions identified at last review.	3	4	12	(5). Quarterly 12/02/2026 Richard Henderson Risk reviewed and no changes required	Approaching

Risk category Strategic aim	Risk ref	Date identified Director Risk owner	Directorate Level of control Committee	Description	Initial			Controls	Gaps in control	Internal assurances	External assurances	Gaps in assurance	Actions Action owner Details Progress	Residual			Reviews	Risk Appetite		
					C	L	Score							C	L	Score				
										Audit One - internal audit of key financial controls 24/25 - substantial assurance										
Goal 3 Improving Health And Care Services	NENC/0065	07/11/2023	NENC Finance Directorate	Medium term financial plan There is a risk that both the ICB and wider ICS are unable to agree a robust, and credible, medium term financial plan which delivers a balanced financial position in future years. There is also a risk that the challenging financial position impacts on the delivery of ICB strategic priorities. The current underlying financial position is a significant deficit across the ICS. Previous MTFP do nothing modelling suggests a deficit risk of c.£1.2bn by 2027/28. Delivery of a balanced financial position across the ICS in the short to medium term will require delivery of significant efficiencies and transformational change and presents a huge challenge. From 2026/27, all organisations have been set individual financial plan limits and there is no longer a system financial plan. Although the ICB MTFP now demonstrates a breakeven position, this has not yet been agreed by NHSE and there are still financial deficits in a number of provider organisations within NENC and a risk that further action will be required to improve the position, which could impact on the ICBs financial plan.	5	5	25	MTFP development programme agreed across the ICS with external support and agreed governance arrangements.	None	Updates on progress reported to FPIC, Chief Executives, ICS DoFs, Exec Committee	Regular review meetings with NHSE regional and national team	Final MTFP submission expected in February 2026	01/04/202530/04/2026	4	3	12	(3). Monthly	Approaching		
		David (ICB) Chandler	NENC ICB Partial Control																Richard Henderson	18/03/2026
		Richard Henderson	2. NENC Finance, Performance And Investment Commit																Final MTFP submission made in Feb 2026. Awaiting formal agreement from NHSE.	Updated to reflect system plans no longer required from 26/27 and ICB MTFP demonstrates breakeven financial positio, therefore risk score reduced accordingly. Plans not yet agreed by NHSE and deficits remain in provider organisations hence some level of risk remains as further actions may be required.
Goal 3 Improving Health And Care Services	NENC/0123	13/01/2026	NENC Contracting And Procurement	Capacity to deliver procurement Workplan 2026/27 Currently the procurement work programme for 2026/27 for definite procurements that have requests to proceed, stands at 43 projects (approx. 10 per procurement lead - average expectation is 7 competitive / MSP projects per lead and 4 within the team). A further 81 projects are not yet confirmed (either contract end date not confirmed or further funding not yet confirmed) or may be undertaken by commissioners (i.e. via a framework call-off) with little to no support required from	4	4	16	Risk = no capacity as approx. 600 plus contracts would require procurement advice, due diligence and transparency as part of the renewal process under PSR.	Unknown capacity due to move to Strategic Commissioning	Continued monitoring and escalation from Contracting subcommittee	N/A	Gap in assurance due to move to strategic commissioning structures. To review once structures in place.	13/01/202631/07/2026	4	3	12	(4). 2 Monthly	Approaching		
		David Gallagher	NENC ICB Full Control																Julie Parkinson	16/03/2026
		Julie Parkinson	1. NENC Executive Committee																Consider the impact of the Medium-Term Planning Framework for 2026/27 onwards which will allow the ICB to move to award 3-year contracts. Need to consider the impact and seek NHSE / DHSC support on the breach of PSR regulations. Would have to support this financial year but would decrease impact for future years.	Risk reviewed - no changes needed

Risk category Strategic aim	Risk ref	Date identified Director Risk owner	Directorate Level of control Committee	Description	Initial			Controls	Gaps in control	Internal assurances	External assurances	Gaps in assurance	Actions Action owner Details Progress	Residual			Reviews	Risk Appetite
					C	L	Score							C	L	Score		
				procurement other than ad hoc advice, leading to lapse in NHS contracts and legal challenges from providers.				direction, we will need to consider the impact and seek NHSE / DHSC support on the breach of PSR regulations. Would have to support this financial year but would decrease impact for future years.										
Goal 3 Improving Health And Care Services	NENC/0119	15/10/2025	NENC Delivery Directorate	GP out of hours PHL (Vocare)	3	5	15	Provider is undergoing due diligence to ensure contract can be put in place, however they have failed previous two submissions.	Gaps in financial assure from provider	Following current contracting guidance and working with provider to put assurances in place to ensure fluidity of current provision	Provider has current contracts in place with other NHS providers. Provider has been able to fulfill service requirements since taken over from vocare in line with implied NHS standard contract.	Gaps in financial assure to address	03/03/202631/07/2026	3	4	12	(3). Monthly	Approaching
		Levi Buckley	NENC ICB Limited Control	PHL have taken over Vocare contract for out of hours provision in the North affecting Northumberland, Newcastle and North Tyneside. Risk of failure of financial due diligence and valid contract for provision in place until resolved.				The Finance Team have conducted financial due diligence based on the information that PHL was able to provide. It is recognised that the first year of accounts have not yet been published and won't be until later in the next financial year.	Awaiting first year of accounts	Finance team considering a proposal which will enable a contract to be awarded to PHL until a more robust financial due diligence can take place following publication of the accounts. This is in line with the approach we understand is being taken in other ICBs where the GP Out of Hours Contract novated to PHL following Vocare and Totally PLC entering into administration.	Agreed to pay PHL in arrears instead of in advance until such time a full set of accounts will be published by PHL when they can then undergo financial due diligence. Payment in arrears reduces the financial risk for the ICB.	Risk reviewed - No changes required but it has been agreed to pay PHL in arrears instead of in advance until such time a full set of accounts will be published by PHL when they can then undergo financial due diligence. Payment in arrears reduces the financial risk for the ICB.				03/03/2026 Anya Paradis		
Goal 3 Improving Health And Care Services	NENC/0129	13/01/2026	NENC Digital And Infrastructure Directorate	Failure to Secure Ongoing Funding for Connect NENC Digital Referral System	4	4	16	Connect NENC currently provides structured referrals, an auditable advice trail, and demonstrable improvements in clinical safety. Widespread use of the system and clinician familiarity with its safety benefits.	No fully agreed funding model across all Trusts. Time-critical dependency on funding being confirmed by the end of March.	Escalation and required to Chief Officer.	None identified.	None identified.	13/01/202601/04/2026	4	3	12	(5). Quarterly	Outside
		Claire Riley	NENC ICB Limited Control	Connect NENC has been in place one year and provides a secure digital portal to support safe, structured referrals between specialist services across the region (for example, from district general hospitals to tertiary specialist units). The system enables specialties to configure bespoke referral forms, ensuring that the correct and complete clinical information is provided at the point of referral. It also creates a clear, auditable record of requests and specialist responses, allowing advice and decisions to be accurately documented and reliably actioned.							Urgent agreement and confirmation of Trust funding contributions to enable service continuation. ICB level support if progress is not achieved to deliver resolution, recognising the regional patient safety implications.	Neil Hawkins						
				The ICB position is that it cannot directly fund this product, and that ongoing costs must therefore be met by individual Trusts. The ICB currently doesn't have the capacity to top slice from providers even if Trusts agree to this. Progress in agreeing and enacting Trust contributions has been slow and remains unresolved. Funding needs to be confirmed by 31/03/26 to allow the service to continue into 2026-27. If funding is not agreed, the service will need to be terminated.														
				Termination of Connect NENC would result in a reversion to telephone-based referrals and advice seeking. This is inefficient, difficult to audit, and introduces significant clinical risk due to delays, incomplete information transfer, and the potential for														

Risk category Strategic aim	Risk ref	Date identified Director Risk owner	Directorate Level of control Committee	Description	Initial			Controls	Gaps in control	Internal assurances	External assurances	Gaps in assurance	Actions Action owner Details Progress	Residual			Reviews	Risk Appetite
					C	L	Score							C	L	Score		
				miscommunication between clinicians. The system is predominantly used for patients with high-risk, time-critical conditions (for example acute renal failure, major trauma, and other specialist emergencies). In this context, delays, omissions, or misinterpretation of clinical advice could plausibly lead to serious patient harm or death. In addition, loss of an auditable referral and advice trail increases exposure to medico-legal challenge, financial liability through litigation, and reputational damage to both Trusts and the wider system.														

Key risk: We fail to deliver health and care services which give children the best start in life.

Goal 4 Best Start In Life For Children+Young People	NENC/0066	13/10/2023	NENC Delivery Directorate	Ineffective Transformation of ADHD and Autism Pathways. The rising demand for ADHD and autism diagnostic assessments, combined with insufficient service capacity, creates a significant risk of prolonged waiting times, inequitable access, and unmet needs for individuals requiring care. Reliance on self-funded and non-NHS pathways raises concerns about quality, continuity, and integration with NHS services. Additionally, resource constraints, workforce shortages, and challenges in stakeholder coordination may hinder the effective implementation of the proposed all-age neurodivergence group and pathway transformation. Failure to address these issues could result in poorer health outcomes, increased health inequalities, reputational damage to the ICB, and long-term financial pressures on the system.	4	5	20	ICS Autism Statement.	ICS Autism Statement not yet in place.	None	None	None	01/04/2025	31/05/2026	4	4	16	(5). Quarterly	Outside
		Levi Buckley						Place based Autism Strategies	Data analysis in relation to outcomes identified in different strategies	ICB review of all place based autism strategies.	Working with Brain in Hand in relation to strategy evaluation tools and evaluations of 'what is good practice'.	None	Peter Rooney						
		Peter Rooney	NENC ICB Partial Control										Autism Statement to be developed by ICB Place Based Commissioners and Place Based Case Managers						
			1. NENC Executive Committee					Regional Network to evaluate areas of good practice - from health and social care services.	Network not yet established.	None	None	None	The responsibly for this currently sits with place delivery teams and not within the central transformation team. Pending the future new proposed structure this may be an area that requires consideration, triangulation and gaps addressed if deemed a priority.						
								Autism Statement Development Group.	None	Group notes and actions. Current gaps in support being identified that could potentially be addressed at an ICS level.	Working with Brain in Hand in relation to strategy evaluation tools and evaluations of 'what is good practice'.	None	Date Entered : 09/02/2026 13:32 Entered By : Neil Hawkins						
							Establishment of the All-Age Neurodivergence Group: The group will oversee the transformation program, providing leadership, setting priorities, and ensuring alignment with the ICB's strategic goals.	None identified.	Notes and actions from the All-Age Neurodivergence Group and teak and finish groups.	None identified.	None identified.	01/04/2025	31/05/2026						
								Defined Scope and Objectives: Ensure the scope of the program is realistic, with clear, phased objectives and milestones, to avoid overcommitment and ensure achievable progress.											
								Stakeholder Coordination via Task-and-Finish Groups: Use task-and-finish groups to address specific elements of the pathway transformation, ensuring focus on high-priority areas while maintaining oversight by the steering group.											
													We have a weekly ICB operational group meeting every Monday, every Thursday at 8am we have a weekly Chief Exec task and finish group around the ICB's ADHD and autism programme.						
													The weekly Chief Exec meeting commenced in January 2026 however there is a clear terms of reference, programme plan, assurance and governance in place.						
													There is a commissioning policy and a proposed budget which is under Exec Committee consideration. The outcome of this will enable us to strategically move forward and be clear with our intent as an ICB.						
													Date Entered : 09/02/2026 13:28 Entered By : Neil Hawkins						
													01/08/2025	31/05/2026					
													Linda Reiling						
													Briefing report to outline the significant challenges across Autism and ADHD pathways within NENC. While many of these challenges reflect national trends the local trajectory is unsustainable without urgent system-wide intervention. This report presented proposed actions and next steps for ICB Executives to consider in August 2025. The Executives supported the proposed actions and						

Risk category Strategic aim	Risk ref	Date identified Director Risk owner	Directorate Level of control Committee	Description	Initial			Controls	Gaps in control	Internal assurances	External assurances	Gaps in assurance	Actions Action owner Details Progress	Residual			Reviews	Risk Appetite
					C	L	Score							C	L	Score		
													next steps in principle and that work will be undertaken and prioritised in the coming weeks/months. We have a weekly ICB operational group meeting every Monday, every Thursday at 8am we have a weekly Chief Exec task and finish group around the ICB's ADHD and autism programme. The weekly Chief Exec meeting commenced in January 2026 however there is a clear terms of reference, programme plan, assurance and governance in place. There is a commissioning policy and a proposed budget which is under Exec Committee consideration. The outcome of this will enable us to strategically move forward and be clear with our intent as an ICB. Date Entered : 09/02/2026 13:30 Entered By : Neil Hawkins					
Goal 4 Best Start In Life For Children+Young People	NENC/0111	06/05/2025	NENC Chief Nurse And AHP	Local Maternity and Neonatal System (LMNS) Funding Allocations Although 25/26 LMNS funding has been confirmed, there is a reduction in the funding advised by the NHS England national team vs the allocations actually received.	4	4	16	The LMNS has reviewed its advised allocation and built a new budget in respect of this. Allocations received by Trusts have not changed in 25/26. However, these have not been confirmed beyond this.	Unable to confirm future Trust funding.	LMNS Programme Delivery Group LMNS Board	Maternity and Neonatal Regional Board Regional Perinatal Quality Surveillance	N/A	06/05/202531/03/2026	4	3	12	(3). Monthly	Approaching
		Hilary Lloyd											Michael Dunn				17/03/2026	
		Michael Dunn	NENC ICB Full Control	3. NENC Quality And Safety Committee									The 25/26 LMNS budget has now been confirmed and agreed by the Chief Nursing and AHP Officer. The LMNS have been able to meet their efficiency requirement. However, this will impact of the implementation of the equity and equality plan year 4.				Michael Dunn	LMNS funding allocations are subject to ICB Executive approval, upon confirmation risk will be fully reviewed. Expected end of March 2026.
Goal 4 Best Start In Life For Children+Young People	NENC/0118	22/09/2025	NENC Chief Nurse And AHP	Missing maternity records incident - System C (BadgerNet)	4	4	16	Clinical harm reviews being undertaken on all women who have been affected by the issue and necessary action to be taken	N/A at this time.	Completed by Trust	Findings will be reported to ICB and NHSE regional team as part of ongoing monitoring and assurance	N/A at this time	22/09/202531/03/2026	3	4	12	(3). Monthly	Outside
		Hilary Lloyd											Michael Dunn				17/03/2026	
		Michael Dunn	NENC ICB Limited Control	3. NENC Quality And Safety Committee				System C have rolled out an update which will stop this from happening to future records.	N/A	Completed by provider	Reported to ICB and NHSE regional team.	N/A	Clinical harm reviews been undertaken with Trusts that are affected. No further data loss/ notifications identified following system upgrade in September 2025. Final review of risk at April 2026 LMNS Programme Delivery Group.				Michael Dunn	No further data loss/ notifications identified following system upgrade in September 2026. Final review of risk at April LMNS Programme Delivery Group.

Risk category Strategic aim	Risk ref	Date identified Director Risk owner	Directorate Level of control Committee	Description	Initial			Controls	Gaps in control	Internal assurances	External assurances	Gaps in assurance	Actions Action owner Details Progress	Residual			Reviews	Risk Appetite
					C	L	Score							C	L	Score		
				to explain about missing notes and explain about the clinical harm review. Data which is used in the Maternity Service Data Set (MSDS) which subsequently is used for dashboards and for evidence which Trusts submit for the maternity incentive scheme year 7. There is a risk, missing MSDS data, could affect alert and alarm indicators on clinical dashboards (where Trusts have data above 95% confidence limits) and potentially could lead to our Trusts being non-compliant with a safety action which has financial and reputational implications.														

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ICP Goal Strategic aim	Risk ref	Date identified Director Risk owner	Directorate Level of control Committee	Description	Initial			Controls	Gaps in control	Internal assurances	External assurances	Gaps in assurance	Residual			Reviews	Risk Appetite
					C	L	Score						C	L	Score		
Goal 3 Improving Health And Care Services 2. Tackle Inequalities In Outcomes, Experience And Access	PLACE /0159	30/04/2025 Anita Barker Philippa Dodds	NENC Delivery Directorate NENC ICB Limited Control NENC Delivery	Phlebotomy services local incentive scheme - North Cumbria 18 practices have not signed up to the 12 month North Cumbria local incentive scheme (LIS) agreement which provides some phlebotomy services and other care on behalf of secondary care. This will result in patients being asked to present at secondary care clinics for routine blood tests resulting in increased appointments, travel times and potential cancelled interventions.	3	5	15	Local Delivery Team (LDT) and Delivery Director having regular meetings with the Local Medical Committee (LMC) to continue to discuss the issues. The LDT have agreed a shorter version of the agreement be circulated to relevant practices with a set end date of 31st July 2025. This has been extended by a further month to end of August 2025. Informal and formal conversations with colleagues in the Trusts continue to develop short term mitigating strategies with a view to also developing longer term replacement services. Regular meetings with NCIC Senior Management to ensure mitigating actions and long term solution is developed in a timely manner.	None identified. None	Notes/minutes from LDT and Place subcommittee. Delivery Director and Medical Director are directly involved in meetings. LDT clinical leads are involved and working with colleagues in the Trust to work up solutions. business case developed by Trust and sent to ICB for agreement. ICB Commissioned services review to provide a clear framework for standardisation of investment into Primary Care in Sept. Email audit trail and draft business case for proposals	None identified.	None identified.	3	4	12	(5). Quarterly 13/01/2026 Anita Barker Risk reviewed as part of Chief Delivery Officer's report to Exec on 13 January. Owner reviewing detail of controls and assurances.	Outside
Goal 4 Best Start In Life For Children+Young People 1, Improve Outcomes In Population Health And Healthcare	PLACE /0114	26/04/2023 Rachel Mitcheson Janet Arris	NENC Delivery Directorate NENC ICB Partial Control NENC Delivery	Sensory processing disorder service Lack of service from paediatric Occupational Therapy (OT) for sensory processing available in schools. Increasingly highlighted by families, schools and nurseries.	4	4	16	Meet with commissioners who already have an established service and discuss business model and service spec	Explore local options with any additional costs	ICB and LA commissioners to meet with other providers with an established service, met with Sheffield to review model.	Meet with Local Providers	Identify finance model	4	3	12	(5). Quarterly 13/01/2026 Neil Hawkins Risk reviewed as part of Chief Delivery Officer's report to Executive Committee on 13 January. Owner reviewing detail of controls and assurances. The mobilisation plan is for the service to be up and running by end January 2026, recruitment is underway but there may be some slippage with the start date due to notice periods for staff. Risk score dropped will re-review once recruitment complete and slippage reviewed.	Outside

Corporate	ICBP037 Risk Management Strategy

Version Number	Date Issued	Review Date
V ~~6~~ 5	~~November 2025~~ <u>June 2026</u>	~~November 2027~~ <u>June 2028</u>

Prepared By:	~~Governance and Assurance Manager, North of England Commissioning Support Unit.~~ <u>Senior Head of Corporate Governance</u>
Consultation Process:	
Formally Approved:	~~November 2025~~ <u>June 2026</u>
Approved By:	Board

EQUALITY IMPACT ASSESSMENT

Date	Issues
Reviewed and updated Nov 2025	None

STRATEGY VALIDITY STATEMENT

Strategy users should ensure that they are consulting the currently valid version of the documentation. The strategy will remain valid, including during its period of review. However, the strategy must be reviewed at least once in every 3-year period.

ACCESSIBLE INFORMATION STANDARDS

If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact nencicb.comms@nhs.net

Version Control

Version	Release Date	Author	Update comments
1	July 2022	Governance Manager, NECS	First Issue
2	March 2023	Governance and Assurance Manager, NECS	Refresh
3	June 2023	Governance and Assurance Manager, NECS	To reflect recommendations made by AuditOne
4	June 2024	Strategic Head of Corporate Governance	Update reporting frequency for committees (section 6.2). Updates to job titles.
5	November 2025	Strategic Head of Corporate Governance	Update – minor updates following agreement of risk appetite statement in July 2025.
<u>6</u>	<u>June 2026</u>	<u>Senior Head of Corporate Governance</u>	<u>Updated to reflect new ICB operating model and committee structures.</u>

Approval

Role	Name	Date
Approver	Board (delegated authority to Executive Committee going forward)	July 2022
Approver	Executive Committee	April 2023
Approver	Executive Committee	July 2023
Approver	Board	July 2024
Approver	Board	November 2025
<u>Approver</u>	<u>Board</u>	<u>June 2026</u>

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1. Introduction

For the purposes of this strategy, NHS North East and North Cumbria Integrated Care Board will be referred to as “the ICB”.

The strategy sets out the ICB approach to risk and the management of risk in fulfilment of its overall objectives. The principles are consistent with those within the NHS England’s (NHSE) risk management framework and NHSE’s risk management strategy issued in 2019. The adoption and embedding within the organisation of an effective risk management framework and processes will ensure that the reputation of the ICB is enhanced and maintained, and its resources are used effectively to ensure business success, continuing financial strength and continuous quality improvement in its operating model.

As part of this strategy, it is also acknowledged that not all risks can be eliminated. Ultimately it is for the organisation to decide which risks it is prepared to accept based on the knowledge that an effective risk assessment has been carried out and the risk has been reduced to an acceptable level as a consequence of effective controls.

At its simplest, risk management is good management practice and risk assessment provides an effective management technique for managing the organisation (through the identification of risks and the development of mitigating action). Through this strategy the ICB is keen to ensure that risk management is not seen as an end in itself, but rather a part of an overall management approach that supports the organisation in developing achievable management action.

1.1 Status

This strategy is a corporate strategy.

1.2 Purpose and scope

The purpose of this strategy is to provide a support document to enable staff to undertake effective identification, assessment, control and action to mitigate or manage the risks affecting the normal business.

The strategy sets out an organisation wide approach to managing risk, in a simple, straightforward, clear manner and the intentions of the ICB for timely, efficient and cost-effective management of risk at all levels within the organisation.

The strategy aims to:

- Ensure that risks to the achievement of the ICB’s objectives are understood and effectively managed
- Ensure that the risks to the quality of services that the organisation commissions from healthcare providers are understood and effectively

managed

- Assure the public, patients, staff and partner organisations that the ICB is committed to managing risk appropriately
- Protect the services, staff, reputation and finances of the ICB through the process of early identification of risk, risk assessment, risk control and elimination.

This strategy applies to all employees and contractors of the ICB.

Managers at every level have an objective to ensure that risk management is a fundamental part of the approach to integrated governance. All staff at every level of the organisation is required to recognise that risk management is their personal responsibility.

NHS providers and independent contractors are responsible for ensuring compliance with relevant legislation and best practice guidelines and for the development and management of their own procedural documents.

Independent contractors are also required to demonstrate compliance with risk management processes which are compatible with this strategy.

2. Definitions of risk

To ensure consistency and understanding across the ICB, a glossary of risk management terms and definitions can be found in Appendix 2. These are based on the definitions in the NHS England and NHS Improvement Risk Management Framework 2019.

Key definitions are highlighted below:

Term	Definition
Risk	‘effect of uncertainty on objectives’
Risk management	‘co-ordinated activities to direct and control an organisation with regard to risk’
Controls	‘measure, currently in place, that maintains and/or modifies a risk’s likelihood and/or impact’
Actions	‘planned / future controls not yet implemented’
Impact (also referred to as ‘consequence’)	‘outcome of an event affecting objectives’ / ‘the effect (i.e., on the organisations finances, infrastructure, and/or reputation etc.) when a risk materialises’

Term	Definition
Likelihood (also referred to as 'probability' or 'frequency')	'chance of something happening' / 'evaluation or judgement regarding the chances of a risk materialising'
Risk appetite	'the amount of risk that we are willing to seek or accept in the pursuit of long-term objectives'
Inherent risk (also known as initial risk)	'uncontrolled or unmitigated level of risk' i.e. the level of a risk before any control activities are applied to change the likelihood or impact of the risk
Residual risk (sometimes referred to as net risk, managed risk or current risk)	'existing level of risk taking into account the current controls in place'
Target risk	'ultimate level of risk that is desired by executive and within resource capabilities, after planned additional actions and controls have been implemented' i.e., the position taking into account successful delivery of all mitigating actions and controls

2.1 Examples of risk

Examples of the types of risk that the ICB might encounter and need to mitigate against include:

- **Corporate risks** – operating within powers, fulfilling responsibilities, ensuring accountability to the public, governance issues.
- **Clinical risks** – associated with our commissioning responsibilities and including service standards, competencies, complications, equipment, medicines, staffing, patient information.
- **Reputational risks** – associated with quality of services, communication with public and staff, patient experience.
- **Financial** – associated with achievement of financial targets, commissioning decisions, statutory issues and delivery of the Quality, Innovation, Productivity and Prevention (QIPP) programme.
- **Environmental including health and safety** – ensuring the well-being of staff and visitors whilst using our premises.

3. Approaches to risk management: principles, aims and objectives

The strategy sets out the ICB's approach to the way in which, in general terms, risks are managed. This will be achieved by having a thorough process of risk assessment in place. It will provide a useful tool for the systematic and effective management of risk and will inform and guide staff as to the way in which all significant risks are to be controlled.

The strategy will:

- Ensure that risks to the achievement of ICB's objectives are understood and effectively managed
- Maintain a risk management framework to assure the ICB that strategic and operational risks are being effectively managed
- Ensure that risk management is a cohesive element of the internal control systems within the ICB's corporate governance framework
- Ensure that risk management is an integral part of the ICB culture and its operating systems
- Ensure that the ICB meets its statutory obligations including those relating to health and safety and data protection
- Assure all stakeholders, staff, and partner organisations that the ICB is committed to managing risk appropriately.

To achieve this, the ICB is committed to ensuring that:

- Risk management is embedded as an integral part of the management approach to the achievement of objectives
- The management of risk is seen as a collective and individual responsibility, managed through the agreed committee and management structures
- Patient feedback, complaints and staff feedback are used as an integral part of the approach to risk management
- Risk management support, training and development will be provided by the ~~NEGS~~ Governance Team.

4. Risk management framework

This strategy sets out the ICB's risk management framework for how risk management will be implemented throughout the organisation to support the realisation of the strategic objectives. This includes the processes and procedures adopted by the ICB to identify, assess and appropriately manage risks and detailed roles and responsibilities for risk management.

4.1 Risk assessment

Whenever risks to the achievement of ICB's objectives have been identified, it is important to assess the risk so that appropriate controls are put in place to eliminate the risk or mitigate its effect. To do this, a standard risk assessment matrix is used, details of which are provided in **Appendix 2** of this strategy.

This risk matrix is based on current national guidance which has been adapted to suit the ICB's agreed risk appetite. Using this standardised tool will ensure that risk assessments are undertaken in a consistent manner using agreed definitions and evaluation criteria. This will allow for comparisons to be made between different risk types and for decisions to be made on the resources needed to mitigate the risk.

Risks are assessed in terms of the likelihood of occurrence/re-occurrence and the consequences of impact. An initial risk rating is applied to the risk based on current controls. An action plan should be developed based on any gaps identified in putting control measures in place.

The risk action plan will identify further mitigating action to ensure adequate controls are in place. Risks are reassessed to take account of the effectiveness of the controls i.e. whether they are considered to be satisfactory, have some weaknesses or to be weak. Reassessment will determine a residual risk rating.

4.2 Categories of risk:

- **Extreme** – the consequence of these risks could seriously impact upon the achievement of the organisations' objectives, its financial stability and its reputation. Examples include loss of life, extended cessation or closure of a service, significant harm to a patient(s), loss of stakeholder confidence, failure to meet national targets and loss of financial stability
- **High** – these are significant risks that require prompt action. With a concerted effort and a challenging action plan, the risks could be reduced within a realistic timescale
- **Moderate** – these risks can be reduced within a realistic timescale through reasonably practical measures, such as reviewing working arrangements, purchase of small pieces of new equipment, raising staff/patient awareness etc. These risks should be managed through the existing line management arrangements
- **Low** – these risks are deemed to be low level or minor risks which can be managed and monitored within the individual department

Once the category of risk has been identified, this will be entered onto the ICB's risk register. Please refer to 'section 7' below for further guidance on risk registers.

Any risk identified through the risk assessment process (or the incident reporting process), which the ICB is required legally to report, will be reported accordingly to the appropriate statutory body, e.g. Health and Safety Executive or Information Commissioner.

4.3 Degrees of control

The ICB can exert different levels of control or influence over risks depending on their source and type. Some risks can be largely mitigated or eliminated, however not all types of risk can be adequately or effectively dealt with in this manner. The risk management process will therefore be tailored to different risks depending on the perceived level of control and to some degree the risk appetite (how much more control to exert).

The ICB predominantly focuses on risks that are fully or partially within its sphere of control or influence (financial, operational, regulatory, compliance and strategic risks). However, there may be occasion where the source of a risk event threatening objectives is external. The ICB cannot prevent such external events from occurring and therefore management efforts will focus on the identification and mitigation of their impact, for example by putting contingency plans in place where significant external risks are identified.

The categories of control are as follows:

Risk category	Description
Category A: Full control	Preventable internal risks that can be controlled by the ICB (e.g. Health and Safety or payment processing)
Category B: Partial control	Strategic risks taken on by the organisation to achieve its corporate objectives. These risks may be partially within the control of the ICB (e.g. the risk associated with transformational change, or from investment in new sector improvement initiatives).
Category C: Limited or no control	External risk events and/or system-wide risks largely beyond the sole control or influence of the ICB. Examples may be the increasing risk of political uncertainty, a terrorist event or natural disaster; or from risk interdependencies across the wider health and social care system.

4.4 Fraud, bribery and corruption risks

The ICB recognises the risk that fraud, bribery and corruption pose to its resources. This risk is included in the corporate risk register with an appropriate internal risk owner identified. Operational management and recording of detailed fraud, bribery and corruption risks will be carried out by the ICB's counter fraud provider and as agreed in the counter fraud workplan and using a bespoke fraud, bribery and corruption risk planning toolkit.

Regular meetings will be held between key ICB staff and the counter fraud specialist to review existing and emerging risks. Regular reports will be provided to the Audit Committee or equivalent to ensure effective executive and non-executive level monitoring of fraud, bribery and corruption risks.

4.5 Risk management process as a commissioner

As the ICB focuses on its role as a commissioner of safe and high-quality services, it seeks to embed the principles and practice of risk management into its commissioning function. As a commissioner, the ICB seeks to ensure that all services commissioned meet nationally identified standards which are managed through the contracting process.

4.6 Partnership working

The ICB may establish partnership working relationships with other agencies, including but not limited to other NHS organisations, local authorities, the voluntary sector, patient representatives and other ICBs.

In some cases, these arrangements will be intended to manage and reduce risk across the wider health and social care economy, for example arrangements around safeguarding. However, in other cases the existence of joint working arrangements may pose challenges that need to be managed to ensure that objectives can be delivered.

Where such partnership arrangements exist, the ICB will ensure that they work closely and collaboratively with partners to ensure that risk management is fully integrated into joint working arrangements and to identify any risks that need to be captured and reported within the ICB's internal processes.

5. **Risk appetite**

Risk appetite is the amount of risk that the ICB is prepared to accept, tolerate, or be exposed to at any point in time. It can be influenced by personal experience, political factors, and external events. Risks need to be considered in terms of both opportunities and threats and the consequent impact on the capability of the ICB, its performance, and its reputation.

The ICB will determine and continuously assess the nature and extent of the risks that the organisation is exposed to and is willing to take to achieve its objectives, in other words, its risk appetite, and ensure that planning and decision-making reflects this assessment. Effective risk management should support informed decision-making in line with this risk appetite, ensure confidence in the response to risks, and provide transparency over the principal risks faced and how these are managed.

The ICB aims to reduce risks to the lowest possible level reasonably practicable. Where risks cannot reasonably be avoided, every effort will be made to mitigate the remaining risk. However, it is not always practical or affordable to manage risks to the level of the ICB's optimal position. Where risks are managed that sit outside of appetite, the controls, assurances and actions in place to manage the risk towards agreed appetite levels should be documented within the risk

record. The risk register will include a column to indicate whether the residual score is within; approaching; or, outside of agreed risk appetite levels.

5.1 Risk tolerance

Risk tolerance is the threshold level of risk exposure which, when exceeded, will trigger an escalation to bring the situation to the attention of a senior manager.

Any risks with a residual score of 12 or above (i.e., high or extreme) should be added to the ICB corporate risk register in order for the appropriate committee to review and monitor the risk.

Any Place/Neighbourhood risk that has a residual score of 12 or higher will be escalated initially to the relevant ICB committee via the normal reporting process with details appended to the main committee risk report.

Moderate and low risks with a score ~~between 8 and below~~ 10 will be managed and monitored at team level (through the risk owner review process).

Any risks of concern, even if not scored as a high risk, can be highlighted to the ~~Executive~~/appropriate Committee for further consideration.

6. Risk register

Current and potential risks are captured in the ICB's risk register and include actions identified to minimise such risks. The risk register is a log of risks that threaten the organisation's success in achieving its aims and objectives and is populated through the risk assessment and evaluation process.

The register contains a record of current and potential risks to the achievement of the corporate objectives as identified. The register is updated and reviewed on a quarterly basis at a minimum as requested by the ICB.

6.1 Corporate risk register

The ICB maintains a corporate risk register, which is a management tool to provide it with an overview of all significant 'live' risks facing the organisation and the action being taken to reduce them. The corporate risk register is underpinned by a place-based/neighbourhood level risk registers, used to monitor and manage risks at a ~~place-based~~-neighbourhood level within the organisation.

The risks included within the corporate risk register are varied and cover the entirety of the ICB's activities, from health and safety risks to risks around the delivery of services and achieving financial balance. The corporate risk register is therefore populated from a number of different sources, including:

- Principal risks identified in the assurance framework in relation to corporate objectives where action needs to be taken to close an identified gap in control measures

- Risks identified by the ICB and via committee risk registers as being high or extreme and requiring escalation
- Risks that have been identified at a place ~~based~~ /neighbourhood level that require escalation to the ICB
- Any risks arising out of the annual operating framework and the development of related action plans
- Risks identified through evaluation of incident and complaints reporting
- Risks identified through the evaluation of national incident reports.

The corporate risk register is a live document, maintained on an on-going basis by the governance leads and regular reports are provided to the ICB and relevant committees. The corporate risk register is reviewed by the Audit Committee at least quarterly, or more frequently as required, with issues escalated to the Board as appropriate.

~~Each Place/Area is responsible for maintaining its own place-based risk register, ensuring at a minimum quarterly updating. The place/neighbourhood risks are aggregated into the wider Area (North/South) risk register which are prepared on a quarterly basis, and shared with the Chief Delivery Officer and Delivery Directors. Each place-based risk register underpins the corporate risk register and records all relevant risks facing each place, along with supporting action plans to mitigate these as far as possible.~~

The process for escalating ~~p~~Place ~~or Area~~ /neighbourhood risks is set out in Appendix 4

6.2 Risk oversight at corporate level

The table below sets out the formal ICB committees with responsibility for risk oversight and the frequency of risk management activities aligned with their cycle of business. This oversight provides assurance to the Board that risk management processes are in place and remain effective.

Committee Name	Remit of the Committee	Suggested Frequency	Risk Reports
Audit Committee	Responsible for oversight and assurance of the effectiveness of risk.	Quarterly	Corporate risk register Place/ <u>neighbourhood</u> ~~directorate~~ risk register (12 and above) <u>Board Assurance Framework (BAF)</u>
~~Executive Leadership~~ Committee	Responsible for day to day running of the ICB (operational and strategic)	Quarterly	Corporate risk register Place/ <u>neighbourhood</u> risk register ~~(12 and above)~~ <u>Board Assurance Framework (BAF)</u>
~~Finance, Performance and Investment (FPI) Strategic Commissioning Assurance~~ Committee	~~Specific responsibility for financial risks~~ Provided assurance concerning the ICB's strategic <u>commissioning role</u>	Quarterly	Corporate risk register <u>Place/neighbourhood risk register (12 and above)</u> ~~FPI Committee risk register~~ <u>Board Assurance Framework (BAF)</u>

Quality and Safety Committee	Risks specific to quality, safety, patient care etc	Quarterly	Corporate risk register ~~Place/neighbourhood risk register (12 and above)~~ ~~Quality and safety risks below 12~~ ~~Place quality and safety risk register (12 and above)~~ ~~Board Assurance Framework (BAF)~~
Board	Overall accountable for the delivery of the ICB's strategic priorities.	Quarterly	~~Board Assurance Framework (BAF)~~ Corporate risk register ~~Place/neighbourhood risk register (12 and above)~~
~~Place/Area risks (reported within the Chief Delivery Officer's report to Executive Committee)~~	~~Operational management responsibility for place/area specific risks~~	Quarterly	~~Place-based risk reports—North and South registers prepared quarterly and reported to Executive Committee via Chief Delivery Officer's report.~~

7. Risk Materialisation

If a risk materialises whilst being managed through the risk register, it should be recorded as an incident as per the agreed ICB process. Management of risks and incidents is interdependent since risks can be identified through the monitoring of incident themes and trends. If a particular type of incident continues to occur, this is an indication that there is a risk that requires management through the risk register.

If a risk materialises whilst being managed through the risk register, it should be considered whether it needs removing from the risk register. Reasons for occurrence should be analysed and evidence established as to whether a trend of similar incidents exists, that need to be managed through the risk register. If the risk is certain to materialise again or has the potential to re-occur, the risk should remain open on the risk register for on-going management in order to ensure that underlying causes are addressed. If there is no chance it could happen again, the risk should be closed with an explanation that the incident management process is being followed in order to invoke actions to deal with consequences.

8. Assurance framework

All government departments, including NHS organisations, are required to provide an annual assurance statement that they have robust systems in place across their organisation to manage risk. This assurance forms part of the organisation's statutory accounts and annual report.

In order to produce an annual assurance statement as part of the annual report, the Board must be able to demonstrate that they have been kept properly informed about the risks facing the organisation and has received assurances that these risks are being managed in practice, including that any gaps in controls intended to manage risks have been identified and action taken to address them. The Board will be able to demonstrate that it has met this requirement through the establishment of a robust and formal assurance framework.

Together with this strategy and the risk register, the assurance framework is the key document used by the Board to monitor the position in relation to risk management, providing it with a sound understanding of not only the key risks facing the organisation but also the action being taken to manage and reduce them.

The assurance framework is firmly connected to the organisation's principal objectives as set by the Board, and is a live document, maintained on an on-going basis by the governance lead. The assurance framework is monitored by the Audit Committee and Board on a quarterly basis.

The assurance framework sets out:

- the organisation's principal objectives
- any significant risks that may threaten the achievement of those objectives (detailed in the supporting corporate risk register)
- the key controls intended to manage these risks
- the assurance available to demonstrate that controls are working effectively in practice to manage risks together with the source of that assurance. Any areas where there are gaps in controls and/or assurances; and how the organisation plans to take corrective action where gaps have been identified in either controls or the assurances available.

9. Implementation

This strategy will be available to all staff to use through the public website for the ICB. It will also be available from the Corporate Governance team. All directors and managers are responsible for ensuring that relevant staff within their own directorates and teams have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

10. Training Implications

The Chief Executive (supported by the Chief Corporate Services Officer) will ensure that the necessary training or education needs, and methods needed to implement this strategy and supporting procedure(s) are identified and resourced as required. This may include identification of external training providers or development of an internal training process.

Training will be available as required on an ad hoc basis and will be tailored to individual requirements. An [online risk management training video](#) tutorial is also ~~in development and hoped to be~~ available to staff ~~soon~~.

11. Documentation

Other related strategy documents:

- ICBP020 Incident reporting and management strategy
- ICBP009 Counter fraud, bribery and corruption strategy 2023

- AuditOne Counter fraud and risk management working protocol 2023

Legislation and statutory requirements:

- NHS England Risk Management Strategy 2017
- NHS England Risk Management Framework 2019
- Health & Safety: Strategy & Corporate Procedures NHS England 2015
- NHS England Business Continuity Management Framework 2016
- Data Protection Act 2018
- Data Security and Protection toolkit
- General Data Protection Regulation (GDPR) 2016.

Best practice guidance:

- NHS Audit Committee Handbook, 4th edition (2018)
- The Healthy NHS Board: Principles for Good Governance (2013)
- Building the Assurance Framework: A practical guide for NHS Boards March 2003. Gate log Reference1054

12. Monitoring, review and archiving

13.1 Monitoring

The ICB will review the strategy in accordance with the specified review date, unless legislation or new guidance to ensure it continues to be compliant with good practice.

Risk management assurance will be reported to the appropriate ICB committee via the ~~governance assurance~~quarterly risk management reports. ~~Senior leads~~Risk owners will ensure that ~~teams~~they review their risks ~~registers~~ on a quarterly basis (or within individually agreed review times).

The ICB's internal auditors carry out an annual audit of governance and risk management. The effectiveness of the ICB's controls in relation to risk is considered as part of this audit, the outcome of which is reported to Audit Committee.

13.2 Review

The ICB will ensure that this strategy document is reviewed in accordance with the specified review date. No strategy will remain operational for a period exceeding two years without a review taking place.

Staff who become aware of any change which may affect the strategy should advise the Chief Corporate Services Officer who will then consider the need to review the strategy or procedure outside of the agreed timescale for revision. For ease of reference for reviewers or approval bodies, changes should be noted in the 'document history' table on the front page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the sponsor director and a revised document may be

issued. Review to the main body of the strategy must always follow the original approval process.

13.3 Archiving

The ICB will ensure that archived copies of superseded strategy documents are retained in accordance with Records Management: A guide to the management of health and care records 2021.

Appendix 1: Schedule of Duties and Responsibilities

ICB	The ICB is responsible for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.
Chief Executive	The Chief Executive has overall responsibility for the strategic direction and operational management, including ensuring that ICB process documents comply with all legal, statutory and good practice guidance requirements - ensuring the implementation of an effective risk management framework, supporting risk management systems and internal control - continually promote risk management and demonstrate leadership, involvement and support - ensuring an appropriate committee structure is in place and developing the corporate governance and assurance framework ensuring all directors and senior leads are appointed with managerial responsibility for risk management.
Chief Finance Officer	The Chief Finance Officer has a responsibility for: - providing expert professional advice to the ICB on the effective, efficient and economic use of the ICB's allocation to remain within that allocation and identify risks to the delivery of required financial targets and duties - ensuring robust risk management and audit arrangements are in place to make appropriate use of the ICB's financial resources - ensuring appropriate arrangements are in identify risks and mitigating actions to the delivery of QIPP and resource releasing initiatives incorporating risk management as a management technique within the financial performance management arrangements for the organisation.
Chief Corporate Services Officer	The Chief Corporate Services Officer is the lead for risk management and has a responsibility for: - ensuring risk management systems are in place throughout the ICB, co-ordinating risk management in accordance with this strategy - ensuring the assurance framework is regularly reviewed and updated - ensuring that there is an appropriate external review of the ICB's risk management systems and that these are reported to the Board - overseeing the management of risks as identified by the quality, safety and risk committee, ensuring risk action plans are put in place, regularly monitored and implemented - incorporating risk management as a management technique within the performance management arrangements for the organisation - ensuring that systems are place for assuring the commissioning of high quality and safe services, and the on-going monitoring of the same ensure incidents, claims and complaints are and managed used the appropriate procedures.
Executive Leadership Team	Members of the Executive Leadership Team will: - Maintain awareness of the main risks facing the organisation - Take ownership where relevant of principal (strategic) risks that pose a threat to the achievement of strategic objectives and ensure appropriate action is taken to mitigate and manage risks ensuring regular updates to the ICB - Take or delegate ownership, where relevant, of risks that pose a threat to the achievement of objectives or the business of the ICB and ensure appropriate action is taken to mitigate and manage risks ensuring regular updates are added to the risk register - Ensure the processes for managing risk within the ICB are clearly understood, appropriately delegated and effective.

Senior Information Risk Officer (SIRO)	The SIRO will: • Be accountable to the Chief Executive for coordinating the development and maintenance of information risk management policies, procedures and standards for the ICB • Be responsible for the ongoing development and day-to-day management of the ICB's programme for data security and protection • Ensure the ICB's approach to information risk is effective in terms of resource, commitment and execution and that this is communicated to all staff • Provide a focal point for the resolution and/or discussion of information risk issues • Ensure the Board is adequately briefed on information risks.
Audit Committee	The Audit Committee has overall responsibility for overseeing the implementation of this strategy and will: • Review all risks on the corporate risk register and monitor progression of stated action on a quarterly basis. Ensure the established processes to manage risk is in place and provide support for action where necessary • Ensure the processes for managing risk within the ICB are clearly understood, appropriately delegated and effective. Escalate issues to the Board as appropriate, in particular the identification of new, significant risk or areas of concern of risks graded very high or high to the ICB.
Senior Leads	All senior leads have a responsibility to incorporate risk management within all aspects of their work and are responsible for ensuring the implementation of this strategy by: • demonstrating personal involvement and support for the promotion of risk management • ensuring staff under their management are aware of their risk management responsibilities in relation to this framework • setting personal objectives for risk management and monitoring their achievement • ensuring risk are identified, managed and mitigating actions are implemented in functions for which they are accountable • ensuring a risk register is established and maintained that relates to their area of responsibility, ensuring risks are escalated where they are of a strategic in nature.
Risk owners	Responsible for managing individual risks and providing updates on the management of those risks and identifying and carrying out action plans to mitigate risks.
All Staff	Risk management is everybody's responsibility and all staff must be familiar with the main risks in their area of activity
NECS Staff	Whilst working on behalf of the ICB, CSU staff will be expected to comply with all policies, procedures and expected standards of behaviour within the ICB, however they will continue to be governed by all policies and procedures of their employing organisation.
Counter Fraud Specialist	Manages counter fraud, bribery and corruption activities on behalf of the ICB.

Appendix 2: Glossary of terms

Defined Term	Definition
Action plan (See also Risk Action Plan)	'Planned / future controls not yet implemented' I.e. actions taken to address gaps or weaknesses in controls or the management of the risk.
Assurance	An evaluated opinion, based on evidence gained from review e.g., relating to governance, risk management and the internal controls framework. In relation to controls, assurance is the internal or external evidence that risks are being managed effectively.
Board assurance framework (See Principal Risks)	The Board Assurance Framework (BAF) is developed each year once the ICB's objectives are approved. It enables the Board to consider where there are gaps in delivery and includes the key sources of assurance. The BAF is developed by mapping the ICB's risks as detailed on the Risk Register, with consideration of the controls currently in place to mitigate the risks and any further actions identified to minimise them. This process then identifies the principal or key risks to the organisation achieving its strategic objectives.
Communication	A continual and iterative dialogue across the ICB and with stakeholders. It is a two-way process that involves both sharing and receiving information about the management of risk. Discussions could be about risks, their nature, form, likelihood, and significance, and whether risks are acceptable or should be treated, and what treatment options should be considered.
Consequence	Outcome of event affecting objectives. Note: an event can lead to a range of consequences.
Context	To establish the context means to define the external and internal parameters that the ICB must consider when they manage risk. Internal context includes staff structures, governance and systems, contractual relationships, and its capabilities, culture, and standards. The ICB's external context includes all of the external environmental parameters and factors that influence how it manages risk and how it tries to achieve its objectives. It includes external stakeholders, local, national, and international environment, as well as key drivers and important trends that influence its objectives. It also includes stakeholder values, perceptions, and relationships, as well as its social, cultural, political, legal, regulatory, technological, economic, natural, and competitive environment. The ICB's external context includes patients and the public, NHS England requirements, regional local authorities and care providers, the wider NHS as well as any external factors that influence its objectives. Risks can arise from the external context from events outside the ICB's direct control/influence. For example, long-term impact of political shifts, such as EU Exit, major health policy changes or changes to the structure of the NHS; and/or the risk of immediate impact from a major incident such as a natural disaster.
Control	Measure currently in place that maintains and/or modifies a risk's likelihood and/or impact'.
Corporate risk	Corporate risks represent the ICB's most significant risks. Corporate risks tend to be broad in impact (that is, they have the potential to impact extensively on the capability, vitality or success of the organisation as a whole) or deep in impact (the effects of the risk event occurring are limited to a given area but especially serious).

Defined Term	Definition
	A corporate risk is likely to have one or more of the following characteristics: • strategic and cross-cutting, with the potential to impact on a range of different areas or functions, • related to the ICB's ability to successfully deliver one or more high priority objectives, • affects the outcomes sought from one of the organisation's major programmes, • operates over the medium or long-term, • has the potential to weaken the organisation's capacity, for example by limiting, reducing or failing to maximise financial or human resources, • linked to the organisation's ability to successfully deliver transformational change and major initiatives, while continuing with business as usual, • concerned with the wellbeing of patients and/or staff; and • may impact significantly on the ICB's reputation. The number of corporate risks will vary but in normal circumstances it is helpful to think of corporate risks as the top ten to 20 most serious risks faced by the ICB. Corporate risks are captured on the corporate risk register, which is reported to the Audit Committee.
Cumulative risk (may also be referred to as aggregate risk or total risk exposure)	Cumulative risk is the combined impact of risks when considered alongside each other, and where the aggregate across different risks is greater than the sum of the individual parts. Often risks are assessed individually without considering if they are correlated.
Emerging risk	A new risk that is in the process of being understood and quantified or risks that are poorly understood but are expected to grow greatly in significance. Note: Unlike other risks, emergent risks do not have a track record that can be used to estimate likelihood and impact. An important consideration when thinking about emerging risks is the speed at which they can become significant. Sometimes referred to as risk velocity or proximity.
Exposure	The consequences, as a combination of impact and likelihood, which may be experienced by the organisation if a specific risk is realised.
Impact	See consequence.
Incident	An incident is any unexpected, unplanned or uncontrolled event (i.e. something has actually happened or would have but for chance - "a near miss"). See the Incident Reporting and Management Policy for details. An incident can occur once or multiple times and can have several causes and several impacts/consequences. They can be linked to risks (although not always as it may only be a small part of a risk).
Inherent risk	The exposure arising from a specific risk before any action has been taken to manage it (or the risk that would crystallise if controls failed in their entirety). This is often referred to as the 'initial' risk.
Issue	All or part of the risk has begun to materialise (e.g. controls or procedures have failed, a problem has arisen which needs resolving). The approach to managing issues may well be different from management of risks, which only have the potential to happen in the future. Once a risk occurs it becomes an issue.

Defined Term	Definition
Internal Control System (ICS)	The Internal Control System (ICS) consists of a set of rules, procedures and organisational structures which aim to ensure that corporate strategy is implemented; achieve effective and efficient corporate processes; safeguard the value of corporate assets; ensure the reliability and integrity of accounting and management data; and ensure that operations comply with all existing rules and regulations.
Likelihood (also referred to as 'probability')	Chance of something happening. In risk management terminology, the word "likelihood" is used to refer to the chance of something happening, whether measured quantitatively or determined subjectively, or described mathematically (such as a probability or a frequency over a given time period).
Monitoring	To monitor means to supervise and to continually check and critically observe. It means to determine the current status and to assess whether or not required or expected performance levels are being achieved.
Operational risks (Normally these would fall under the category of 'full control')	The risk of loss resulting from inadequate or failed internal processes, people and systems, or from external events. Examples: • Process risks: payment failures, documentation which is not fit for purpose, errors in models and processes, project management failures, internal/external reporting. • People risks: fraud, breaches of employment law, loss or lack of key personnel, inadequate training, inadequate supervision. • Systems risk: failures during the development and systems implementation process, as well as failures of the system itself. • External events: external crime, outsourcing (and insourcing) risk, natural and other disasters, regulatory change risk, utilities failures etc.
Opportunity	An uncertain event that would have a favourable impact on objectives or benefit it if occurs.
Principal risks (see Board Assurance Framework)	Principal risks are defined as those that threaten the achievement of the organisation's priorities and therefore oversight by the Board through the Board Assurance Framework is essential. A principal risk is identified from a review of the organisation's risk register and is usually made up of a combination of similar risks that all relate to the achievement of a specific objective.
Programme and Project risks	The risk of loss (financial, opportunity or reputational loss) and/or disruption to business activities as a result of inability to manage magnitude of change being undertaken / risks that transformational change, improvement initiatives and other major programmes/projects (including for customers) are not aligned with strategic priorities; do not successfully and safely deliver requirements and intended benefits to time, cost and quality; and/or negatively impact business as usual (BAU) activities.
Residual risk (also known as current risk)	Existing level of risk exposure taking into account the current controls and any actions which have already been completed.
Risk	Effect of uncertainty on objectives. Note: This definition relates to uncertainty of outcome, whether positive opportunity or negative threat, of actions and events. It is the combination of likelihood and impact, including perceived importance. It recognises that we operate in an uncertain world and that potential threats, actions or events may occur (internally or externally) which could adversely or beneficially affect our ability to deliver our

Defined Term	Definition
	commitments/objectives. Objectives can have different aspects and categories and can be applied at different levels (i.e. strategic, service line or programme/project objectives).
Risk action plan (also referred to as mitigation, risk treatment plan, risk response or risk management plan)	Risk treatment is a risk modification process. It involves selecting and implementing one or more treatment options. Once a treatment has been implemented, it becomes a control, or it modifies existing controls. Note: There are many treatment options. You can avoid the risk, you can reduce the risk, you can remove the source of the risk, you can modify the consequences, you can change the likelihood, you can share the risk with others, you can simply retain the risk, or you can even increase the risk in order to pursue an opportunity.
Risk analysis	Risk analysis is a process used to understand the nature, sources, and causes of the risks that you have identified and to estimate the level of risk. It is also used to study impacts and consequences, likelihood and to examine the controls that currently exist. How detailed the risk analysis ought to be will depend upon the risk, the purpose of the analysis, the information and resources available.
Risk appetite (also known as risk tolerance or risk criteria)	The amount of risk that we are willing to seek or accept in the pursuit of long-term objectives. Note: Risk appetite represents a balance between the potential benefits of innovation and the threats that change inevitably brings. It is used to determine whether a specified level of risk is acceptable or tolerable; and should reflect organisational values, policies, and objectives, be based on external and internal context, should consider the views of stakeholders, and should be derived from standards, laws, policies, and other requirements such as delegations of authority and operating limits/thresholds.
Risk attitude/risk culture	An organisation's risk attitude defines its general approach to risk. It influences how risks are assessed and addressed. An organisation's attitude towards risk affects whether or not risks are taken, tolerated, retained, shared, reduced, or avoided, and whether or not treatments are implemented or postponed. Note: The ICB aspires to risk management becoming part of our culture and aim to achieve this by, for example: raising awareness through workshops, training, and communications; documenting risk assessment in decision-making; reviewing risk management arrangements; the corporate governance team's oversight and support; internal audit's independent assurance; promoting risk management 'top-down' and 'bottom up'; and regularly reporting risk exposures.
Risk control effectiveness rating	This is a measure that defines how effectively the risk management controls are managing the risk. Additionally, this rating is used to measure how effective further risk treatments have been in addressing the short comings of current controls when the current control had been rated as 'weak' or 'some weakness' The measurements used are: • Satisfactory: Nothing more to be done except continue to review and monitor the control. The control is well designed for the risk. • Some Weakness: The control is either not designed correctly or is not very effective. There may be an over-reliance on reactive controls. More work is needed to improve operating effectiveness or management have doubts about operational effectiveness and reliability. • Weak: The control has significant control gaps or is not fit for purpose. Either it fails to treat the root causes of the risk, or does not operate at all effectively. Note: Well-designed controls should include a blend of preventative and detective controls and address the root causes of the risk. Management should ensure these controls are effective and reliable at all times. Reactive controls exist only in support of other controls.

Defined Term	Definition
Risk evaluation	Risk evaluation involves deciding the risk level and the priority for attention. Not all risks are equally important, so we need to filter and prioritise them, to find the worst threats (and the best opportunities). This will help us decide how to respond. When prioritising risks, we could use various characteristics, such as how likely they are to happen, what they might do to our objectives, how easily we can influence them, when they might happen, and how might they be amplified etc.
Risk identification	Risk identification is a process that involves finding, recognising, and describing the risks that could influence the achievement of objectives. It is used to identify possible sources of risk in addition to the events and circumstances that could influence the achievement of objectives. It also includes the identification of possible causes and potential consequences. Historical data, theoretical analysis, informed opinions, expert advice, and stakeholder input can help to identify risks.
Risk management	All the processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate or anticipate them, and monitoring and reviewing progress. Risk management can be defined as “a process which provides assurance that an organisation’s objectives are more likely to be achieved; that damaging things will not happen or are less likely to happen; and beneficial things will be or are more likely to be achieved.” Risk Management is not limited to identifying and mitigating negative risks. It is also concerned with recognising opportunities that may involve some risk but could lead to positive outcomes that help achieve objectives.
Risk management framework	A set of components that support and sustain risk management throughout an organisation, including risk management objectives, mandate and commitment, as well as relationships, accountabilities, and resources.
Risk matrix	Tool for ranking and displaying risks by defining ranges for consequence and likelihood.
Risk monitoring and review	Monitoring and review must be continual and repeated, so that appropriate action can be taken as new risks emerge and existing risks alter due to changes in the organisation’s objectives or the internal and external environment. This may involve environmental scanning by risk owners, control assurance, noting newly available information and learning lessons about risks and controls from analysing successes and failures.
Risk Owner	A risk owner is the person who has been given the authority to manage a particular risk and is accountable for doing so.
Risk Profile	The documented and prioritised overall assessment of the range of specific risks faced by the organisation. A risk profile is a written description of a set of risks. A risk profile can include the risks that the entire organisation must manage or only those that a particular function or part of the organisation must address.
Risk Proximity	The estimate of timescale as to when the risk is likely to occur. It helps prioritise risk and to identify the appropriate response
Risk Register	The Risk Register is a log of risks that threaten an organisation’s success in achieving its declared aims and objectives (including legislative duties, strategic priorities, major programmes, business plan objectives and business-as-usual activities). It is a dynamic living document, which is populated through the organisation’s risk management process (namely, the identification, assessment, treatment, monitoring and review of risk). This enables risk to be quantified and ranked (in terms of likelihood of occurring and seriousness of impact).
Risk source (or risk causes or drivers)	Element which alone or in combination has the potential to give rise to risk.

Defined Term	Definition
Stakeholder	Person or organisation that can affect, be affected by, or perceive themselves to be affected by a decision or activity. Stakeholders can be internal or external.
Strategic risks (usually partial control or limited control risks)	Risks arising from identifying and pursuing a strategy. This could include a strategy which is poorly defined, is based on flawed or inaccurate data and/or assumptions, is outdated or declines due to a changing external environment, fails to support the delivery of commitments, plans or objectives, and/or does not meet legal or regulatory requirements.
Target risk	Target risk provides an indication of whether following existing or planned mitigating actions that the resulting risk status will be within acceptable levels for the organisation or if there is a desire to reduce the risk further and that additional work will likely be required beyond that already in place or planned.
Uncertainty	Uncertainty is a state of being that involves a deficiency of information and leads to inadequate or incomplete knowledge or understanding. In the context of risk management, uncertainty exists whenever your knowledge or understanding of an event, consequence, or likelihood is inadequate or incomplete.

Appendix 3: Risk Assessment

To manage risks effectively, it is crucial to ensure that both the initial (inherent) and residual risk is assessed.

The initial (inherent) risk assessment gives an indication of the impact of the risk should controls fail. The residual risk assessment shows the current level of the risk remaining after mitigating controls are applied.

A standardised approach is taken across the ICB to analyse and measure risk, this is detailed below. Managers must ensure that, for their area, risk assessments are carried out and documented, and that the necessary control measures are implemented in order to reduce risks. The level of detail in the risk assessments and any subsequent action taken should be proportional to the risk.

Step 1: Determine the consequence score

This is offered as guidance when completing a risk assessment, either when an incident has occurred or if the consequence of potential risks is being considered.

Choose the most appropriate domain for the identified risk from the left hand side of the table. Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column. Note consequence will either be negligible, minor, moderate, major or catastrophic.

Table 1: Consequence score

Official

Impact	1. Very Low	2. Low	3. Moderate	4. High	5. Very High
A. Injury	Minor injury not requiring first aid.	Minor injury or illness, first aid treatment needed.	RIDDOR / Agency reportable.	Major injuries or long-term incapacity / disability.	Death or major permanent incapacity.
B. Patient experience	Unsatisfactory patient experience not directly related to patient care.	Unsatisfactory patient experience – readily resolvable.	Mismanagement of patient care.	Serious mismanagement of patient care.	Totally unsatisfactory patient outcome or experience.
C. Service / business interruption	Loss / interruption > 1 hour.	Loss / interruption > 8 hours.	Loss / interruption > 1 day.	Loss / interruption > 1 week.	Prolonged loss of service or facility.
D. Staffing and skill mix	Short term low staffing level temporarily reducing service quality	Ongoing low staffing level reducing service quality.	Late delivery of key objective / service due to lack of staff. Ongoing unsafe staffing	Uncertain delivery of key objective / service due to lack of staff.	Non-delivery of key objective / service due to lack of staff.
E. Financial / asset	Funded/partially funded between £0 and £10k. Unfunded between £0 and £10k	Funded/partially funded between £10k and £50k. Unfunded between £10k and £25k	Funded/partially funded between £50k and £100k. Unfunded between £25k and £50k	Funded/partially funded between £100k and £1m. Unfunded between £50k and £500k	Funded/partially funded over £1m. Unfunded over £500k
F. Inspection / audit	Minor recommendations. Minor noncompliance with standards and/or policies.	Recommendations given. Non-compliance with standards and/or policies.	Reduced rating. Challenging recommendations. Non-compliance with core standards and/or policies.	Enforcement action. Critical report and Low rating. Major noncompliance with core standards and/or policies.	Prosecution. Zero rating Severely critical report.
G. Adverse publicity / reputation	Rumours.	Short term damage with stakeholders Minor effect on staff morale.	Longer term damage with individual stakeholders Significant effect on staff morale.	Widespread stakeholder damage Local media > 3 days	Sustained and widespread stakeholder damage National media > 3 days
H. Data Security and Protection	There is absolute certainty that no adverse effect can arise from the breach	A minor adverse effect must be selected where there is no absolute certainty. A minor adverse effect may be: The cancellation of a procedure but does not involve any additional suffering. Disruption to those who need the data to do their job.	An adverse effect may be: Release of confidential information into the public domain leading to embarrassment. Unavailability of information leading to the cancellation of a procedure that has the potential of prolonging suffering but does not lead to a decline in health. Prevention of someone doing their job such as cancelling a procedure that has the potential of prolonging suffering but does not lead to a decline in health.	Potential pain and suffering / financial loss: Reported suffering and decline in health arising from the breach. Some financial detriment occurred. Loss of bank details leading to loss of funds. Loss of employment.	Death / catastrophic event: A person dies or suffers a catastrophic occurrence.

Step 2: Determine the likelihood score

Now determine what is the likelihood of the impact occurring. The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency. The frequency-based score will either be classed as rare, unlikely, possible, likely or almost certain.

Table 2: Likelihood score

Likelihood score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency How often might it/does it happen	Only occurs in exceptional circumstances, > 5-year period	Could occur at sometime within 1 to 5 years	Could occur in the next 12 months	Will probably occur in the next 6 months	Expected to occur in the next 3 – 6 months

Step 3: Assigning a risk rating

Now apply the consequence and likelihood ratings to give you a risk rating for each of the risks you have identified. Calculate the risk rating by multiplying the consequence by the likelihood: $C \text{ (consequence)} \times L \text{ (likelihood)} = R \text{ (risk score)}$

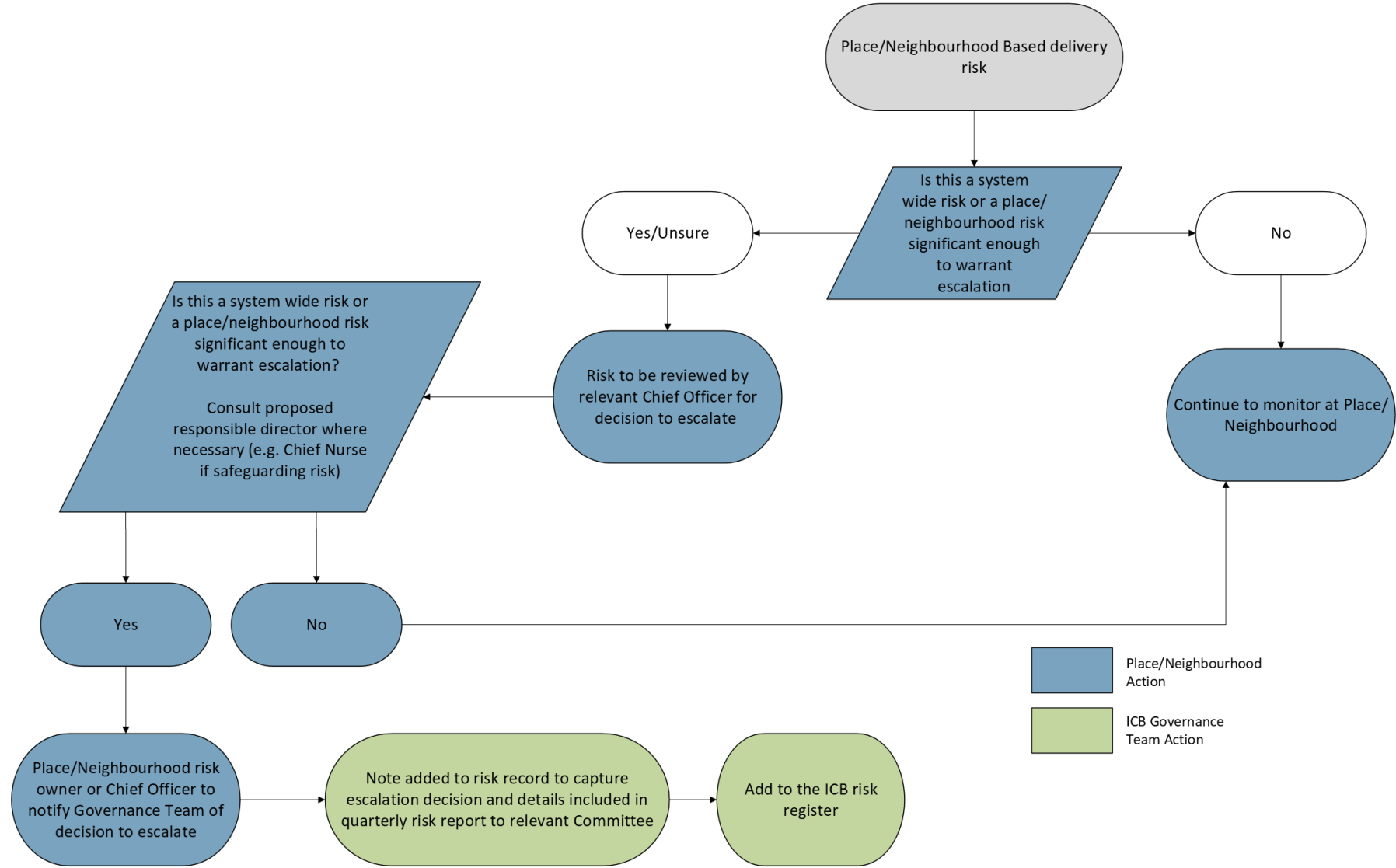
Table 3: Risk rating = consequence x likelihood (C x L)

	Likelihood				
	1	2	3	4	5
Consequence	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Low	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

	1 - 6	Low risk
	8 - 10	Moderate risk
	12 - 16	High risk
	20 - 25	Extreme risk

Appendix 4 Escalation of Place/Neighbourhood risks



Appendix 5: EQIA initial screening tool

Title																															
Risk Management Strategy – minor amends																															
Directorate																															
Corporate Governance																															
Brief Description of the proposed change																															
Minor amends are being made to the risk management strategy following the approval of the risk appetite statement for 2025/26 and the proposal to remove target risk scoring with an indicator which describes whether the residual risk score is within; approaching; or, outside of agreed risk appetite levels.																															
Who will the project/service/policy/decision impact?																															
Staff	☒																														
Service User / Patients	☐																														
Carers	☐																														
Other Public Sector Organisations	☐																														
Voluntary / Community groups / Trade Unions	☐																														
Others, please specify below:	☐																														
Integrated Impact Assessment Review Panel																															
Members of the panel:	Corporate governance, quality and equality and inclusion teams.																														
Date:	04/11/25																														
Equalities Impact																															
For each protected characteristics group, consider whether the proposed change has: No Impact: N , Negative Impact: N , Neutral Impact: Ne , Positive Impact: P , Unknown: U																															
<table border="1"> <thead> <tr> <th>Impact</th> <th>No Impact</th> <th>Negative</th> <th>Neutral</th> <th>Positive</th> <th>Unknown</th> </tr> </thead> <tbody> <tr> <td>Age</td> <td>☒</td> <td>☐</td> <td>☐</td> <td>☐</td> <td>☐</td> </tr> <tr> <td>Disability</td> <td>☒</td> <td>☐</td> <td>☐</td> <td>☐</td> <td>☐</td> </tr> <tr> <td>Gender Re-assignment</td> <td>☒</td> <td>☐</td> <td>☐</td> <td>☐</td> <td>☐</td> </tr> <tr> <td>Marriage/Civil Partnership</td> <td>☒</td> <td>☐</td> <td>☐</td> <td>☐</td> <td>☐</td> </tr> </tbody> </table>	Impact	No Impact	Negative	Neutral	Positive	Unknown	Age	☒	☐	☐	☐	☐	Disability	☒	☐	☐	☐	☐	Gender Re-assignment	☒	☐	☐	☐	☐	Marriage/Civil Partnership	☒	☐	☐	☐	☐	
Impact	No Impact	Negative	Neutral	Positive	Unknown																										
Age	☒	☐	☐	☐	☐																										
Disability	☒	☐	☐	☐	☐																										
Gender Re-assignment	☒	☐	☐	☐	☐																										
Marriage/Civil Partnership	☒	☐	☐	☐	☐																										

Pregnancy and Maternity	☒	☐	☐	☐	☐
Race and ethnicity	☒	☐	☐	☐	☐
Religion or belief	☒	☐	☐	☐	☐
Sex	☒	☐	☐	☐	☐
Sexual Orientation	☒	☐	☐	☐	☐
Other (see appendix 6 and provide detail)	☒	☐	☐	☐	☐
Summarise the overall impact:					
No impact to protective characteristics as a result of the minor changes proposed.					
Summarise the evidence used to make the judgement:					
Updated risk management strategy includes on very minor changes to the process for recording and updating risks that will have negligible impact on protected characteristics.					
If there are negative impacts; how might these be mitigated:					
Not applicable.					
Health Inequalities Impact					
For each listed group at risk of health inequalities, consider whether the proposed change has: No Impact: N , Negative Impact: N , Neutral Impact: Ne , Positive Impact: P , Unknown: U					
Impact	No Impact	Negative	Neutral	Positive	Unknown
CORE 20	☒	☐	☐	☐	☐
CORE 20 PLUS	☒	☐	☐	☐	☐
Health Inclusion Groups	☒	☐	☐	☐	☐
Combined Overall	x				
Summarise the overall impact:					
No impact to health inequalities as a result of the minor changes proposed.					
Summarise the evidence used to make the judgement:					
Updated risk management strategy includes on very minor changes to the process for recording and updating risks that will have negligible impact on health inequalities as a result.					
If there are negative impacts; how might these be mitigated:					
Not applicable.					
Quality Impact Assessment					

For each domain of quality, consider whether the proposal has:

No Impact: **N**, Negative Impact: **N**, Neutral Impact: **Ne**, Positive Impact: **P**, Unknown: **U**

Impact	No Impact	Negative	Neutral	Positive	Unknown
Patient Safety	☐	☐	☐	☒	☐
Clinical Effectiveness	☐	☐	☐	☒	☐
Patient Experience	☐	☐	☐	☒	☐
System/ Operational Impacts	☐	☐	☐	☒	☐
Combined Overall				X	

Summarise the overall impact:

The inclusion of an indicator which describes whether the residual risk score is within; approaching; or, outside of agreed risk appetite levels provides risk owners, directors and committee members a clear indication of whether current risks are within agreed appetite levels. This helps to bring all risks within agreed appetite levels and removes some of the variation within how the current target risk scores have been applied in some cases – further improving the risk management process.

Summarise the evidence used to make the judgement:

Updated risk management strategy includes on very minor changes to the process for recording and updating risks that will improve the process for identifying of risks are within agreed risk appetite levels.

If there are negative impacts; how might these be mitigated:

Not applicable.

Overall Conclusion

Summarise the overall outcome of the screening tool, any key potential impacts identified, and any key mitigations, and tick the relevant score under each domain below.

Impact	No Impact	Negative	Neutral	Positive	Unknown
Equality	☒	☐	☐	☐	☐
Health Inequality	☒	☐	☐	☐	☐
Quality	☐	☐	☐	☒	☐
Combined Overall				X	

Any negative impact outcomes will need a full impact assessment.

Recommendation	Tick Applicable
Proceed	☒

More information needed	☐	
Full Impact Assessment required	☐	
Stop	☐	
Any other key issues to record		
Completion		
Name and Job Title of the person completing the screening tool:		
Neil Hawkins, Strategic Head of Corporate Governance		
Date:	04/11/25	
Authorisation		
Name and Job Title of the Accountable Lead:		
Deb Cornell, Director of Corporate Governance and Board Secretary		
Date:	04/11/25	

Risk Appetite Statement 2026/27

1. Definition

- 1.1 The Good Governance Institute (GGI) defines risk appetite as 'the amount and type of risk that an organisation is prepared to pursue, retain or take in pursuit of its strategic objectives, is key to achieving effective risk management. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings, and therefore should be at the heart of an organisation's risk management strategy.'

Good Governance Institute: Board guidance on risk appetite, 2020¹.

2. Risk appetite levels

- 2.1 NHS North East and North Cumbria Integrated Care Board (the ICB) accepts there will always be an element of risk in the pursuit of its aims and objectives. It has determined, and will continuously assess, the nature and extent of the risks that the organisation is exposed to and is willing to take (its risk appetite) to achieve its objectives and ensure that planning and decision-making reflects this assessment.
- 2.2 Risk tolerance reflects the boundaries within which the executive team is willing to allow the day-to-day risk profile of the organisation to fluctuate while they are executing strategic objectives in accordance with the agreed risk appetite, in other words the residual risk. The Board has set specific limits (risk ratings) for the levels of risk that the organisation is able to tolerate. In setting these, risk factors in both the external and internal business environments have been considered.
- 2.3 The ICB has applied the following risk appetite levels which are based on the UK Government's The Orange Book, Management of Risk – Principles and Concepts² and its supporting Risk Appetite Guidance Note, 2021³:

Appetite level	Definition
Averse	All precautions and mitigations in place with very low appetite for risk (likelihood of risk is rare but not impossible).
Cautious	Preference for safe delivery options that have a low degree of inherent risk, and which may only have limited potential for reward.
Balanced	Accepting that there is a degree of risk in activities and prepared to put resource in place to monitor and mitigate risks where the benefits of the activities outweigh the risk.
Open	Receptive to activities which carry a degree of risk where these will result in successful delivery and measurable improvements while also providing value for money.

¹ [Board guidance on risk appetite | Good Governance \(good-governance.org.uk\)](https://www.good-governance.org.uk/guidance-on-risk-appetite/)

² [The Orange Book – Management of Risk – Principles and Concepts \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/90100/the-orange-book-management-of-risk-principles-and-concepts.pdf)

³ [20210805 - Risk Appetite Guidance Note v2.0.pdf](https://www.nhs.uk/consult/20210805-risk-appetite-guidance-note-v2.0.pdf)

- 2.4 The appetite level informs the target or acceptable level of risk to the organisation. Where risks cannot reasonably be avoided, every effort will be made to mitigate the remaining risk to the lowest possible level that is reasonably practicable.
- 2.5 As a minimum, the ICB will aim to operate organisational activities at the defined levels. Where activities are projected to exceed the defined levels, these will be addressed through appropriate governance mechanisms and a decision made whether to halt the activities or identify additional resources required to manage the risk to an acceptable level.
- 2.6 The risk levels for each category of risk have been defined through the context of existing organisational risks, issues, and consequences and are as follows:
- **Finance:** We have adopted a cautious stance for financial risks, seeking safe delivery options with little residual risk that only yield some upside opportunities.
 - **Information sharing:** Where the lawful sharing of information is necessary to perform key functions and facilitate appropriate partnership working, we have adopted a balanced stance to risks that might arise from information sharing.
 - **Information security:** We have adopted an averse stance to risks that could lead to the wrongful disclosure of information whether through human error, malice or as the result of cyber threats.
 - **Legal and regulatory compliance:** We have adopted a cautious stance for compliance, seeking a preference for adhering to responsibilities, and safe delivery options with little residual risk.
 - **Partnership working:** We have adopted an open stance to risks with partnership working which is essential to delivering improvements in health improvements and outcomes of our patients and public.
 - **Patient safety and quality of commissioned services:** We have adopted an averse stance to risks which compromise patient safety and quality in the services that we commission.
 - **People and workforce development:** We have adopted an open appetite to invest in our people and their development where it supports the organisational aims and strategy.
 - **Reputational risks:** We have adopted a cautious stance for reputational risks, with a preference for safer delivery options, tolerating a cautious degree of residual risk whilst choosing the option most likely to result in successful delivery of high quality, cost-effective services to the public.
 - **Research and innovation:** We have adopted an open stance for innovation risks that will result in improvements to health and to health and

care services The Board accepts that there will be a degree of risk when introducing new systems, processes and ways of working however where these and is receptive to these activities.

- **Security and health and safety:** We have adopted an **averse** stance for risks which may compromise our people's safety and wellbeing or potentially cause loss, harm or reputational damage to the physical and technical infrastructure and assets, or use of technology within the organisation.

3. **Risk appetite guidance**

3.1 Introduction

3.1.1 The ICB has four levels of appetite: averse, cautious, balanced and open and the appetite statement sets the level of a range of ten risk categories. The table below sets out the appetite level in terms of the acceptable risk score.

Category	Appetite level	Tolerance i.e. within appetite	Approaching appetite	Out of appetite
• Patient safety • Information security • Security/H&S	Averse	1 - 5	6 - 9	10 & above
• Finance • Legal and regulatory • Reputation	Cautious	1 - 6	8 - 12	15 & above
• Information sharing	Balanced	1 - 9	10 - 15	16 & above
• Partnership working • Innovation • Workforce development	Open	1 - 12	15 - 16	20 & above

3.1.2 The tables on the following page show the four appetite levels in relation to the standard risk assessment matrix:

Appetite levels in relation to the standard risk assessment matrix

Key	Within appetite	Approaching appetite	Out of appetite

Averse

Consequence	Likelihood					
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
	5 Very high	5	10	15	20	25
	4 High	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Low	2	4	6	8	10
	1 Very low	1	2	3	4	5

Cautious

Consequence	Likelihood					
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
	5 Very high	5	10	15	20	25
	4 High	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Low	2	4	6	8	10
	1 Very low	1	2	3	4	5

Balanced

Consequence	Likelihood					
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
	5 Very high	5	10	15	20	25
	4 High	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Low	2	4	6	8	10
	1 Very low	1	2	3	4	5

Open

Consequence	Likelihood					
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
	5 Very high	5	10	15	20	25
	4 High	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Low	2	4	6	8	10
	1 Very low	1	2	3	4	5

Report Author: N Hawkins, Strategic Head of Corporate Governance
Date: June 2026

Item: 9.1

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

BOARD	
16 JUNE 2026	
Committee Escalation and Assurance Report	
Committee Name:	Executive Committee
Committee Chair:	Sam Allen, Chief Executive
Dates of Committee Meeting/s:	10 March 2026, 14 April 2026
Alert: <i>Matters that need the Board's attention or action e.g. area of non-compliant, safety issue, new risks identified.</i>	
None	
Advise: <i>Matters to inform the Board of - developments, opportunities or areas subject to ongoing monitoring.</i>	
The Executive Committee met on 10 March 2026 and 14 April 2026. The key points to bring to the Board's attention from each meeting are detailed in accompanying decision logs (Appendix 1). The confirmed minutes from each meeting are also attached for assurance (Appendix 2). 10 March 2026 The following items were submitted to the meeting of the Committee and details are contained within the attached decision log and confirmed minutes: - Specialised Commissioning Delegation Agreement and Memorandum of Understanding Amendments - Women's Health Hub Investment Proposal 2026-29 - Implications of National Special Educational Need and Disabilities Reforms - Research and Evidence Metrics - Manchester Arena Inquiry Update - ICBP033 Procurement Policy - ICB HR018a Sexual Misconduct Policy Amendment 14 April 2026 The following items were submitted to the meeting of the Committee and details are contained within the attached decision log and confirmed minutes: - ICBP026 Internet, Email and Mobile Devices Acceptable Use Policy Update - ICB HR27 Reward and Recognition Policy The confirmed minutes from the Executive Committee meeting held on 10 March 2026 and 14 April 2026 are attached as appendix 2, respectively.	

Assure: Areas of assurance that the Committee has received

The Committee also received several items for assurance, and these included:

- Chief Delivery Officer report – an information and assurance summary report of business within the respective place areas.
- Assurance via a number of subcommittee minutes.
- Finance reports
- NHS Medium Term Financial Planning Update
- Integrated Delivery Report

Executive Committee Annual Review 2025/26

The annual review has identified the Committee has delivered its responsibilities as set out in its terms of reference.

Supporting Documentation

- Decision logs 10 March 2026 and 14 April 2026 (Appendix 1)
- Confirmed minutes 10 March 2026 and 14 April 2026 (Appendix 2)
- Executive Committee Annual Review 2025/26 (Appendix 3)

Conflicts of Interest

Any potential/actual conflicts of interest associated with the paper?

Yes

No

✓

Recommendation / Action Required

The Board is asked to receive the Committee Escalation and Assurance Report and ask any questions of the Committee Chair.

The Board is asked to receive for information and assurance:

- Decision logs 10 March 2026 and 14 April 2026 (Appendix 1)
- Confirmed minutes 10 March 2026 and 14 April 2026 (Appendix 2)
- Executive Committee Annual Review 2025/26 (Appendix 3)

Report author

R Herron, Corporate Governance Officer

Date of Approval

12 June 2026

Appendix 1 - Decisions Log – Public Executive Committee – March 2026

Agenda Item	Description	Decision/action
Specialised Commissioning Subcommittee Minutes	The report provided the Committee with an update regarding amendments to the Specialised Commissioning Delegation Agreement and Memorandum of Understanding. The amendments were described as technical in nature and aligned with national expectations, including links to ongoing Offices for Pan-ICB Commissioning work.	The Committee delegated authority to Chief Contracting and Procurement Officer to review the minor amends to the Delegation Agreement and associated Memorandum of Understanding and sign the updated agreements on the ICB's behalf.
Women's Health Hub Investment Proposal 2026-29	The report provided the Committee with the NENC ICB Women's Health Hubs Investment Proposal for 2026 – 2029. The proposal sought £900k over three years, equating to £150k per hub per year, and was aligned with the imminent publication of the refreshed National Women's Health Strategy.	The Committee approved funding for Women's Health Hubs in Sunderland and Gateshead for an additional 12 months but emphasised that a scalable model must be developed.
Implications of National Special Education Needs and Disabilities (SEND) Reforms	The report provided the Committee with implications for ICBs of the Schools SEND White Paper and the SEND Reforms consultation. The report outlined that the reforms represented a significant restructuring of the SEND system and placed substantial new expectations on NHS bodies, including Integrated Care Boards.	The Committee approved the establishment of a group of senior ICB leads to oversee SEND across Nursing and Commissioning.
NENC ICB and ICS Finance Update Month Ten	The report provided the Committee with an update on Month Eleven financial position. The report outlined the proposal to apply a standard 5% overhead contribution, alongside an additional 5% for indirect costs, to relevant non ringfenced funding allocations and expected payments to NHS Foundation Trusts.	The Committee approved the suggested approach to applying a standard 5% overhead contribution on relevant in year funding allocations and the payments to NHS Foundation Trusts shown in table one, with any adjustments based on final month twelve allocations to be agreed by the Chief Finance Officer and Chief Executive Officer as required.
Policies	The following policies were presented to the Committee following an annual review and minor updates: The following Policies were reviewed and agreed: • ICBP033 Procurement Policy • ICB HR018a Sexual Misconduct Policy	The Committee approved the ICBP033 Procurement Policy and the ICB HR018a Sexual Misconduct Policy Amendment.

Appendix 1 - Decisions Log – Public Executive Committee – April 2026

Agenda Item	Description	Decision/action
NENC ICB and ICS Finance Update Month Eleven	The report provided the Committee with an update on Month Eleven financial position. The report outlined the application of non-recurrent deficit support funding to NHS Foundation Trusts.	The Committee approved the expected payments to NHS Foundation Trusts, with delegated authority to the Chief Finance Officer and the Chief Executive to transact final national deficit support funding payments once received from NHSE, including an additional £1m each for both North Cumbria Integrated Care and County Durham and Darlington Foundation Trust.
Policies	The following policies were presented to the Committee following an annual review and minor updates: The following Policies were reviewed and agreed: • ICBP026 Internet, Email and Mobile Devices Acceptable Use Policy • ICB HR27 Reward and Recognition Policy	The Committee approved the ICBP026 Internet, Email and Mobile Devices Acceptable Use Policy and the ICB HR27 Reward and Recognition Policy.

Item: 4
Enclosure:



**North East and
North Cumbria**

**North East and North Cumbria Integrated Care Board
Executive Committee (Public)**

**Minutes of the meeting held on Tuesday 10 March 2026, 11:10hrs in the
Tom Cowie Suite, Pemberton House, Colima Avenue, Sunderland**

- Present:** Sam Allen, Chief Executive (Chair) until 12:11pm
Levi Buckley, Chief Delivery Officer
David Chandler, Chief Finance Officer
Michelle Evans, Director of Workforce
Dave Gallagher, Chief Contracting and Procurement Officer
Hilary Lloyd, Chief Nurse and AHP Officer
Jacqueline Myers, Chief Strategy Officer
Dr Neil O'Brien, Chief Medical Officer (Vice Chair)
Claire Riley, Chief Corporate Services Officer
- In attendance:** Rebecca Herron, Corporate Committees Manager (Committee Secretary)
Dr Mark Dornan, Chief Clinical Information Officer
Deb Cornell, Director of Corporate Governance and Board Secretary
- EC/2025-26/277 Agenda Item 1 - Welcome and introductions**
- The Chair welcomed all those present to the meeting and confirmed the meeting was quorate.
- EC/2025-26/278 Agenda Item 2 - Apologies for absence**
- No apologies for absence were received.
- EC/2025-26/279 Agenda Item 3 - Declarations of interest**
- Members had submitted their declarations prior to the meeting which had been made available in the public domain.
- **NENC ICB and ICS Finance Update M10 (Item 11.1)**
- A number of the Chief Officers are conflicted on this item due to having relatives working in FTs.
- As the proposal does not favour any FT over any others all Chief Officers can receive the paper, attend the meeting and take part in the decision making for this item

There were no additional declarations of interest made at this point in the meeting.

EC/2025-26/280 Agenda Item 4 - Minutes of the previous meeting held on 10 February 2026

RESOLVED:

The Committee AGREED that the minutes of the meeting held on 10 February 2026, were a true and accurate record.

EC/2025-26/281 Agenda Item 5 - Matters arising from the minutes and action log

The Chair noted that the action log had been updated and circulated to members.

EC/2025-26/282 Agenda Item 6 - Notification of urgent items of any other business

Item 16.1 Sexual Safety Policy Amendment was previously requested by the Director of Workforce.

No further items of any urgent business were received at this point in the meeting.

EC/2025-26/283 Agenda Item 7 – Governance and Risk Management

No update for this item.

EC/2025-26/284 Agenda Item 8.1.1 – All Ages Continuing Care Strategic Transformation Group Highlight Report

The Chief Nurse and AHP Officer introduced the report which provided the Committee with the All Ages Continuing Care (AACC) Strategic Transformation Group Highlight Report.

RESOLVED:

The Committee RECEIVED the report for assurance

EC/2025-26/285 Agenda Item 8.1.2 – Clinical Effectiveness and Governance Subcommittee Highlight Report

The Chief Medical Officer introduced the report which provided the Committee with the Clinical Effectiveness and Governance Subcommittee Highlight Report.

The Chief Medical Officer highlighted key points from the Clinical Effectiveness and Governance Subcommittee, including:

- Ongoing review of nationally approved audits,
- Identification of audits requiring enhanced surveillance,

- The need for clarity on how enhanced surveillance would be operationalised within the ICB's quality framework

The Chief Delivery Officer noted a recent visit to County Durham and Darlington Foundation Trust (CDDFT) in relation to Summary Hospital-level Mortality Indicator (SHIMI), advising that further work was underway and that a plan was being developed.

RESOLVED:

The Committee RECEIVED the report for assurance

EC/2025-26/286 Agenda Item 8.2 - Place Subcommittee Minutes

County Durham - noted for information and assurance only
 South Tyneside - noted for information and assurance only
 Sunderland - noted for information and assurance only
 Darlington - noted for information and assurance only
 South Tees - noted for information and assurance only
 Gateshead - noted for information and assurance only
 North Cumbria - noted for information and assurance only
 Northumberland - noted for information and assurance only

RESOLVED:

The Committee RECEIVED the Subcommittee minutes as listed above for assurance

EC/2025-26/287 Agenda Item 8.3 - Pharmaceutical Service Regulatory Subcommittee Minutes

Noted for information and assurance only.

RESOLVED:

The Committee RECEIVED the Pharmaceutical Service Regulatory Subcommittee Minutes for assurance

EC/2025-26/288 Agenda Item 8.4 - Primary Care Subcommittee Minutes

Noted for information and assurance only.

RESOLVED:

The Committee RECEIVED the Primary Care Subcommittee Minutes for assurance

EC/2025-26/289 Agenda Item 8.5 - Specialised Commissioning Subcommittee Minutes

The Chief Contracting and Procurement Officer drew attention to the Specialised Commissioning Subcommittee, confirming that NHS England had made minor amendments to the Delegation Agreement and

Memorandum of Understanding. These changes were described as technical and time limited, extending current arrangements to April 2027.

The amendments were described as technical in nature and aligned with national expectations, including links to ongoing OPIC work.

The Chief Contracting and Procurement Officer confirmed that the Subcommittee had scrutinised the amendments to ensure that they did not materially alter risk, accountability, or financial exposure for the ICB.

The Committee were assured that the amendments supported continuity of commissioning arrangements while national reforms continued to evolve.

The Chief Finance Officer noted that the continuation of delegated arrangements provided financial stability and avoided unnecessary disruption to specialised services. The Chief Medical Officer added that maintaining consistent commissioning arrangements was clinically important, particularly for high cost, low volume services.

Members agreed that the Subcommittee had appropriately discharged its responsibilities and that the recommendations were reasonable and proportionate. It was agreed that the information provided gave sufficient assurance at this stage.

RESOLVED:

- 1) The Committee RECEIVED the Specialised Commissioning Subcommittee Minutes for assurance**
- 2) The Committee APPROVED the minor changes to the Delegation Agreement and Memorandum of Understanding document to extend current arrangements to April 2027**
- 3) The Committee DELEGATED authority to Chief Contracting and Procurement Officer to review the minor amends to the Delegation Agreement and associated Memorandum of Understanding and signs the updated agreements on the ICB's behalf**

EC/2025-26/290 Agenda Item 9.1 – Chief Delivery Officer Report March

The Chief Delivery Officer presented the monthly report, providing an overview of delivery issues across the ICB footprint. Particular emphasis was placed on the Local Commissioned Service Review (LCSR).

The Chief Delivery Officer reported that LCSR sign up had exceeded 92%, representing 308 practices, with only one remaining practice outstanding in South Tyneside. It was noted during discussion that sign up had since increased further, approaching 95%, which was welcomed by the Committee.

The Chair commended the progress made, highlighting the importance of the LCSR in:

- Reducing unwarranted variation,
- Addressing inequity across the system,
- Establishing greater consistency in service delivery

The Chief Delivery Officer advised that a meeting was scheduled imminently to scope phase two of the work and that a further update would be brought to a future meeting.

The Chair requested that a succinct summary of the achievement, including patient benefits, be included in the forthcoming Board report, noting that this would be valuable for system level assurance and communication.

RESOLVED:

- 1) **The Committee NOTED the updates provided on confidential local issues across the ICB**
- 2) **The Committee NOTED the decisions and assurance logs within appendix 1 of the report**

EC/2025-26/291 Agenda Item 10.1 - Service Reform Closedown Report

The Chief Medical Officer introduced the report which provided the Committee with the Service Reform Workstream 2025/26 review and closedown.

The Chief Medical Officer clarified that the paper formally marked the closure of the service reform programme and provided a consolidated summary of the work undertaken. The purpose of bringing the report to the Committee was to ensure that the programme's achievements, learning, and outcomes were appropriately documented and handed into the new organisational structure.

The Chief Medical Officer highlighted that the programme had delivered significant impact over several years, including the identification and release of approximately £30m per annum in savings, achieved through a combination of pathway redesign, medicines optimisation, procurement efficiencies, and contract realignment. It was emphasised that this work had required sustained leadership and close collaboration across commissioning, finance, clinical leadership, procurement, and the programme management office.

The Chair reflected on the scale and difficulty of the work, noting that many of the decisions taken through the programme had been challenging, attracted external scrutiny, and, in some cases, media attention. However, it was stressed that these decisions were necessary to bring the system more closely in line with national standards and to ensure long term financial sustainability.

The Chief Finance Officer placed the programme into financial context, advising that without the service reform savings delivered, the ICB would likely have been subject to formal intervention by NHS England. The Chief Finance Officer explained that the programme had created the headroom and flexibility required to approve recent investment decisions and to maintain core services that otherwise would not have been affordable.

The Chief Nurse and AHP Officer and Chief Medical Officer both acknowledged the impact on clinical teams, noting that while the work had been difficult, it had also driven improvements in consistency and value.

Members agreed that the contribution of staff across the organisation, particularly the medicines optimisation team, should be recognised.

The Committee discussed the importance of sensitive internal communications, recognising that the benefits of the programme needed to be articulated carefully to staff, focusing on why the work mattered and what it had enabled, rather than solely on financial outcomes.

RESOLVED:

The Committee NOTED the service reform closedown report

EC/2025-26/292

Agenda Item 10.2 – Women's Health Hub Investment Proposal 2026-29

The Chief Corporate Services Officer introduced the report which provided the Committee with the NENC ICB Women's Health Hubs Investment Proposal for 2026 – 2029.

The Chief Corporate Services Officer outlined the request to continue investment in the Sunderland and Gateshead hubs. The proposal sought £900k over three years, equating to £150k per hub per year, and was aligned with the imminent publication of the refreshed National Women's Health Strategy.

It was explained that the Sunderland and Gateshead hubs had been deliberately selected as exemplar sites, with different operating models, to generate evidence on what works best in practice. Embedded research arrangements were in place to evaluate outcomes, cost benefit, and scalability, with the intention of informing future strategic commissioning intentions across the wider system.

The Chief Corporate Services Officer highlighted early benefits, including pathway transformation, reduced duplication, and improved patient experience. Particular reference was made to emerging cost benefit evidence, including an indicative 8:1 return, driven by women being managed more holistically in primary care rather than through multiple secondary care appointments.

The Chair queried how the proposal aligned with previously agreed investment and sought clarification on whether the funding was recurrent or non-recurrent. The Chief Finance Officer raised concerns about committing to three years of funding without a clear prioritisation process and questioned whether the investment should be brought forward as a formal business case rather than a narrative paper.

The Chief Contracting and Procurement Officer raised governance concerns regarding the Sunderland hub, specifically around the contractual arrangement with the GP provider and the role of the named clinical lead. It was confirmed that the original hubs had been selected through an open process with independent scoring, but advice would be sought on the appropriate process for extending funding.

Following extensive discussion, the Committee agreed that while the work was strategically important, further evidence was required before committing to a full three year programme. It was agreed to fund a further year of the Women's Health Hubs with the intention to develop a scalable model for the whole NENC footprint.

It was noted that the Community Growth Fund is currently on hold, pending the issuance of national guidance.

Members highlighted the Men's Health Strategy and agreed that this should be revisited and brought forward for further discussion at a future meeting. Officers will liaise with relevant colleagues to support this work. The Chief Medical Officer noted organisational capacity and acknowledged the associated risks and pressures.

It was noted that the Chief Corporate Services Officer will undertake a review of a number of existing national policies to ensure continued alignment with current priorities.

The Committee noted that a wider strategy refresh is scheduled to take place in early summer. In advance of this, Members agreed that horizon scanning activity should be undertaken to ensure that relevant national and local developments are fully considered. It was agreed to include all NHSE publications within the new ICB Leadership Committee papers.

ACTION:

- 1) The Chief Corporate Services Officer to review all existing national policies to ensure continued alignment with current priorities**
- 2) The Committee Secretary to liaise with the Chief Corporate Services Officer to ensure all NHSE publications within the new ICB Leadership Committee papers**

RESOLVED:

- 1) The Committee NOTED the impact of the Women's Health Hub's in Sunderland and Gateshead and the continued importance of the ICB role in supporting the priorities of the emerging refreshed national Women's Health Strategy
- 2) The Committee NOTED the role of Women's Health Hub's in helping to establish a left shift to specialist care provided in the community for key high-volume pathways
- 3) The Committee NOTED the importance of utilising the learning from our Sunderland and Gateshead Women's Health Hub's, which will help to develop a blueprint for establishing further Women's Health Hub's across NENC
- 4) The Committee APPROVED funding for Women's Health Hubs in Sunderland and Gateshead for an additional 12 months but emphasised that a scalable model must be developed

EC/2025-26/293 Agenda Item 10.3 – Implications of National Special Education Needs and Disabilities (SEND) Reforms

The Chief Nurse and AHP Officer introduced the report which provided the Committee with the implications for ICBs of the Schools SEND White Paper and the SEND Reforms consultation that was published by the Department of Education on 23 February 2026.

The Chief Nurse and AHP Officer noted that the reforms represented a significant restructuring of the SEND system and placed substantial new expectations on NHS bodies, including Integrated Care Boards.

It was reported that 14 Local Area Reform Plans had been received from local authorities across the NENC footprint. Initial review indicated that the plans were heavily weighted towards education, with further work required to ensure appropriate health input and alignment. The Chief Nurse and AHP Officer highlighted key risks, including workforce capacity, financial exposure, and the availability of robust activity and outcomes data, particularly for therapies commissioned through block contracts.

The Chief Nurse and AHP Officer emphasised workforce challenges, particularly in children's speech and language therapy, and stressed the need for proactive engagement with providers and training institutions to mitigate risk.

The Chair underscored the importance of early engagement with Directors of Children's Services to ensure consistency of approach and realistic delivery expectations. It was agreed that the Chief Delivery Officer would communicate the ICB approach to the Directors of Children's Services.

Members discussed the proposed establishment of a senior ICB working group to oversee SEND reforms, ensure alignment between nursing and commissioning functions, and provide coordinated oversight of the reform

plans. It was agreed that the recommendations in the paper were proportionate and necessary.

ACTION:

The Chief Delivery Officer to communicate the ICB approach to Directors of Children's Services

RESOLVED:

The Committee APPROVED the establishment of a group of senior ICB leads to oversee SEND across Nursing and Commissioning

EC/2025-26/294

Agenda Item 11.1 - NENC ICB and ICS Finance Update Month Ten

A number of the Chief Officers noted a conflict on this item due to having relatives/friends working in Foundation Trusts.

The Chair noted the conflicts and agreed that as the proposal does not favour any Foundation Trust over any others all Chief Officers can receive the paper, attend the meeting and take part in the decision making for this item.

The Chief Finance Officer introduced the report which provided the Committee with an update on the financial performance of the North East and North Cumbria Integrated Care Board (NENC ICB) and NENC Integrated Care System (ICS) in the financial year 2025/26 for the nine months to 31 January 2026.

As at 31 January 2026 the ICS is reporting a year-to-date deficit of £11.9m compared to a planned deficit of £19.5m. The favourable variance to plan of £7.6m is an improvement from the previous month largely reflecting an improvement in position for the ICB.

Across the ICS, total year to date efficiencies continue to be behind plan (£16.9m overall) and is now forecasting an under-delivery of just under £21m and is the main reason for the movement in the increased provider deficit reported at month ten.

ICB running costs:

- The ICB is reporting a year-to-date underspend on running cost budgets of £5.8m reflecting current vacancies within the ICB. A forecast underspend of £6m is now being reported against running costs following work to appropriately split expected redundancy costs between running costs and programme budgets

ICB Revenue:

- As at 31 January 2026 the ICB is reporting a year-to-date surplus of £23m compared to a plan of £9.9m, a favourable variance of £13.2m which largely reflects underspends on staffing costs due to

vacancies and other non-recurrent benefits including Private Finance Initiative funding and paused investments.

- There continues to be four main pressure areas to highlight within the ICB position at month nine:
 - 1) Risk around growth in elective activity
 - 2) Significant growth in Right to Choose Attention Deficit Hyper Activity Disorder / Autism Spectrum Disorder (ADHD/ASD) assessments with non-NHS providers
 - 3) Pressure on all-age continuing care (AACC) budgets particularly relating to the challenging efficiency targets
 - 4) Growth in prescribing costs over budget

ICS Capital:

- The ICS capital spending forecasts are £12.1m above the confirmed capital allocation.
- In month eight there was the opportunity for Trusts to bid for additional operational capital for 2025/26 as a result of underspends on nationally funded schemes. Following review and approval of bids by NHSE, over £50m was added to the system's capital allocation in month ten.
- The ICB is forecasting a £0.9m underspend against GPIT and estates schemes.

Net unmitigated risk in the plan amounts to £244m across the system although there was inconsistency in recording of risk across the ICB. Risks largely related to the delivery of required efficiency plans which are higher than those delivered in 2024/25. At month ten, ICS risk has reduced overall with a net unmitigated risk reported of £22m, compared to £63m last month.

The Chief Finance Officer explained the proposal to apply a standard 5% overhead contribution, alongside an additional 5% for indirect costs, to relevant non ringfenced funding allocations. It was emphasised that this approach aimed to ensure that corporate and system support costs were appropriately covered and that the policy had evolved through prior Finance, Performance and Investment Committee discussions.

Members discussed the expected payments to NHS Foundation Trusts outlined in the report, noting that adjustments might be required following final month twelve allocations. The Chair confirmed that the approach was consistent with previous agreements and provided sufficient flexibility.

RESOLVED:

- 1) **The Committee NOTED the draft outturn financial position for 2025/26**
- 2) **The Committee NOTED there are a number of financial risks across the system still to be managed**
- 3) **The Committee NOTED the latest ICB underlying position**

- 4) The Committee **APPROVED** the suggested approach to applying a standard 5% overhead contribution on relevant in year funding allocations,
- 5) The Committee **APPROVED** the payments to NHS Foundation Trusts shown in table one, with any adjustments based on final month twelve allocations to be agreed by the Chief Finance Officer and Chief Executive Officer as required

EC/2025-26/295 Agenda Item 11.2 – NHS Medium Term Financial Plan Update

The Chief Finance Officer and Chief Strategy Officer jointly presented the Medium Term Financial Plan update. It was noted that the position reflected a point in time view and remained subject to national planning guidance.

The Chief Finance Officer reported an indicative £83m system deficit, with significant pressures in North Cumbria Integrated Care Foundation Trust, County Durham and Darlington Foundation Trust, and South Tees Hospitals Foundation Trust. The Committee were assured that ongoing discussions were taking place with several Trusts to support recovery planning.

Members acknowledged the limited opportunities available to close the gap and agreed that the approach being taken was proportionate.

RESOLVED:

The Committee NOTED the update

EC/2025-26/296 Agenda Item 12.1 - Integrated Delivery Report

The Chief Strategy Officer introduced the report which provided the Committee with an overview of quality and performance, highlighting any significant changes, areas of risk and mitigating actions.

The Committee was informed of the key messages as follows:

- Accident and Emergency performance stands at 74.9% Ranking eleventh out of 42 ICBs
- Category two ambulance response times were at 23 minutes 52 seconds, ranking first nationally
- 8.9% of patients are waiting over 12 hours in Accident and Emergency
- For elective care, 70.1% of patients are seen within 18 weeks, and just 1.1% wait over 52 weeks - both better than national averages
- Dementia diagnosis prevalence is 69.5%, consistently meeting targets
- Dental access for unique adult patients stands at 40.4%, now at national target

- 72.8% of patients receive a faster cancer diagnosis, and 71.5% are treated within 62 days
- 68.2% of patients experience reliable improvement in talking therapies, with a 47.3% reliable recovery rate

The Chief Strategy Officer noted areas where data quality issues had temporarily affected reporting, including stillbirth and neonatal metrics.

RESOLVED:

The Committee RECEIVED the report for information and assurance

EC/2025-26/297 Agenda Item 13 - Commissioning

No update for this item.

EC/2025-26/298 Agenda Item 14.1 - Research and Evidence Metrics

The Chief Nurse and AHP Officer introduced the report which provided the Committee with the research, evaluation and evidence work across NENC which is aligned to ICB priorities and statutory duties.

It was acknowledged that the current metrics did not yet fully meet the requirements previously requested by the Committee.

Members discussed the importance of aligning research activity with strategic commissioning priorities and income generation.

RESOLVED:

- 1) **The Committee NOTED the content of the report**
- 2) **The Committee NOTED and the plans for 2026/27 in line with the ICBs strategic commissioning roles and requirements for research and evaluation**

EC/2025-26/299 Agenda Item 14.2 - Manchester Arena Inquiry Update

The Chief Strategy Officer introduced the report which provided the Committee with an update on progress against the Manchester Arena Inquiry recommendations.

It was reported that good progress had been made, with only a small number of actions outstanding due to national dependencies.

Members discussed emergency preparedness, staff mobilisation, and hospital dispersal planning. It was agreed that the Chief Strategy Officer will share the update report with NHS England and highlight outstanding national dependencies.

At 12:11pm the Chair left the meeting and the Chief Medical Officer assumed chairing duties.

ACTION:

The Chief Strategy Officer to share the update report with NHS England and highlight outstanding national dependencies

RESOLVED:

- 1) The Committee NOTED that the NENC ICB System Resilience Team continue to work with partner agencies to implement the recommendations identified in the Manchester Arena Inquiry
- 2) The Committee NOTED that NENC ICB continue to work with NHS England, our ambulance services and acute foundation trusts to rapidly progress one key thematic area of the MAI report: mass casualty patient dispersal plans for the North East and North Cumbria
- 3) The Committee SUPPORTED system partner discussions to assess the capability of the North East NHS Mental Health Trusts to provide a Resilience Hub model, similar to the Manchester Resilience Hub

EC/2025-26/300 Agenda Item 15.1 – ICBP033 – Procurement Policy

The Chief Contracting and Procurement Officer presented proposed amendments to policy ICBP033 – Procurement Policy, explaining that updates were required to reflect recent legal changes and revised national guidance.

The Committee are asked to approve the amendments to the Procurement Policy.

RESOLVED:

The Committee APPROVED the ICBP033 – Procurement Policy

EC/2025-26/301 Agenda Item 16.1 – Any Other Business

ICB HR018a Sexual Misconduct Policy Amendment

The Director of Workforce requested the following proposed amendments to policy ICB HR018a Sexual Misconduct Policy:

- 3.4.8 *You can also make a report anonymously through the Freedom to Speak Up Guardian by completing the [online form](#) on the staff intranet site. The form can be accessed via the Sexual Safety intranet page and the Freedom to Speak Up intranet page. This form is entirely anonymous; it cannot identify you.*
- Flowchart page 21 – add to bullet point 4 the following text in red - Freedom to Speak Up guardian (including an anonymous reporting option)

The Director of Corporate Governance and Board Secretary noted that members will regularly receive an updated list of corporate policies within their directorate, so outdated policies can be promptly revised.

RESOLVED:

The Committee APPROVED the amendments to the ICB HR018a Sexual Misconduct Policy

There were no further items of any other business for consideration.

EC/2025-26/302 Agenda Item 16.2 - New Risks to add to the Risk Register

No new risks were identified.

EC/2025-26/303 Agenda Item 17 - CLOSE

The meeting was closed at 12:20pm.

Date and Time of Next Meeting

Tuesday 14 April 2026 10:30am.



**Samantha Allen
Executive Committee Chair
14 April 2026**

**North East and North Cumbria Integrated Care Board
Executive Committee (Public)**

**Minutes of the meeting held on Tuesday 14 April 2026, 11:35hrs in the
Tom Cowie Suite, Pemberton House, Colima Avenue, Sunderland**

- Present:** Sam Allen, Chief Executive (Chair)
Levi Buckley, Chief Delivery Officer
David Chandler, Chief Finance Officer
Michelle Evans, Director of Workforce
Dave Gallagher, Chief Contracting and Procurement Officer
Hilary Lloyd, Chief Nurse and AHP Officer
Jacqueline Myers, Chief Strategy Officer
Dr Neil O'Brien, Chief Medical Officer (Vice Chair)
Claire Riley, Chief Corporate Services Officer
- In attendance:** Rebecca Herron, Corporate Committees Manager (Committee Secretary)
- EC/2026-27/1 Agenda Item 1 - Welcome and introductions**
- The Chair welcomed all those present to the meeting and confirmed the meeting was quorate.
- EC/2026-27/2 Agenda Item 2 - Apologies for absence**
- Apologies for absence were received from Deb Cornell, Director of Corporate Governance and Board Secretary, Nicola Hutchinson, Chief Executive, Health Innovation NENC (HI NENC), Dr Mark Dornan, Chief Clinical Information Officer.
- No further apologies for absence were received.
- EC/2026-27/3 Agenda Item 3 - Declarations of interest**
- Members had submitted their declarations prior to the meeting which had been made available in the public domain.
- **NENC ICB and ICS Finance Update M11 (Item 11.1)**
- A number of the Chief Officers are conflicted on this item due to having relatives working in Foundation Trusts.

As the proposal does not favour any Foundation Trust over any others all Chief Officers can receive the paper, attend the meeting and take part in the decision making for this item

There were no additional declarations of interest made at this point in the meeting.

EC/2026-27/4 Agenda Item 4 - Minutes of the previous meeting held on 10 March 2026

RESOLVED:

The Committee AGREED that the minutes of the meeting held on 10 March 2026, were a true and accurate record.

EC/2026-27/5 Agenda Item 5 - Matters arising from the minutes and action log

The Chair noted that the action log had been updated and circulated to members.

Minute reference EC/2025-26/150 Strategic Approach to Clinical Services Framework

The Chief Corporate Services Officer informed the Committee this action is still ongoing and will need to transfer to the Leadership Committee. Action ongoing.

Minute reference EC/2025-26/152 Integrated Delivery Report

The Chief Strategy Officer informed the Committee this action is still ongoing and will need to transfer to the Leadership Committee. Action ongoing.

Minute reference EC/2025-26/242 Integrated Delivery Report

The Chief Delivery Officer informed the Committee this action is now complete.

Minute reference EC/2025-26/243 Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance 2025

The Chief Strategy Officer informed the Committee this action is now complete.

Minute reference EC/2025-26/232 All Ages Continuing Care Strategic Transformation Group Highlight Report

The Chief Nurse and AHP Officer informed the Committee this action is now complete.

Minute reference EC/2025-26/256 Digital Update and Ambient Voice Technology (AVT) Overview

The Chief Corporate Services Officer informed the Committee the investment decision is expected this week. Action ongoing.

Minute reference EC/2025-26/271 NENC Five Year Strategic Commissioning Plan

The Chief Strategy Officer informed the Committee these actions are now complete.

Minute reference EC/2025-26/292 Women's Health Hub Investment Proposal 2026-29

The Chief Corporate Services Officer informed the Committee these actions are now complete.

Minute reference EC/2025-26/293 Implications of National Special Education Needs and Disabilities (SEND) Reforms

The Chief Delivery Officer informed the Committee this action is now complete.

Minute reference EC/2025-26/299 Manchester Arena Inquiry Update

The Chief Strategy Officer informed the Committee this action is ongoing.

EC/2026-27/6 Agenda Item 6 - Notification of urgent items of any other business

No items of any urgent business were received at this point in the meeting.

EC/2026-27/7 Agenda Item 7 – Governance and Risk Management

No update for this item.

EC/2026-27/8 Agenda Item 8.1.1 – Long Term Conditions Group Highlight Report

The Chief Medical Officer introduced the report which provided the Committee with the Long Term Conditions Group Highlight Report.

RESOLVED:

The Committee RECEIVED the report for assurance

EC/2026-27/9 Agenda Item 8.2 - Place Subcommittee Minutes

County Durham - noted for information and assurance only
South Tyneside - noted for information and assurance only
Sunderland - noted for information and assurance only
Hartlepool - noted for information and assurance only
South Tees - noted for information and assurance only
Stockton - noted for information and assurance only
Tees Valley Subcommittee in Common - noted for information and assurance only
Gateshead - noted for information and assurance only
Newcastle - noted for information and assurance only
North Cumbria - noted for information and assurance only
North Tyneside - noted for information and assurance only
Northumberland - noted for information and assurance only

RESOLVED:

The Committee RECEIVED the Subcommittee minutes as listed above for assurance

EC/2026-27/10 Agenda Item 8.3 – Healthier and Fairer Subcommittee Minutes

Noted for information and assurance only.

RESOLVED:

The Committee RECEIVED the Healthier and Fairer Subcommittee Minutes for assurance

EC/2026-27/11 Agenda Item 8.4 - Primary Care Subcommittee Minutes

Noted for information and assurance only.

RESOLVED:

The Committee RECEIVED the Primary Care Subcommittee Minutes for assurance

EC/2026-27/12 Agenda Item 8.5 - Specialised Commissioning Subcommittee Minutes

Noted for information and assurance only.

RESOLVED:

The Committee RECEIVED the Specialised Commissioning Subcommittee Minutes for assurance

EC/2026-27/13 Agenda Item 9.1 – Chief Delivery Officer Report March

The Chief Delivery Officer presented the monthly report, providing an overview of delivery issues across the ICB footprint.

The Chief Delivery Officer noted positive progress on health and growth accelerator, neighbourhood team pilots, particularly in Northumberland, and ongoing work on frailty models in Durham.

Members discussed the value of consistent place based reporting and the importance of maintaining oversight of both performance and delivery risks.

The Chair formally thanked the Chief Delivery Officer for the clarity, breadth, and consistency of reporting during their tenure and acknowledged their continued contribution in a revised role.

RESOLVED:

- 1) The Committee NOTED the updates provided on confidential local issues across the ICB**

2) The Committee NOTED the decisions and assurance logs within appendix 1 of the report

EC/2026-27/14 Agenda Item 10 – ICB Delivery

No update for this item.

EC/2026-27/15 Agenda Item 11.1 - NENC ICB and ICS Finance Update Month Eleven

A number of the Chief Officers noted a conflict on this item due to having relatives/friends working in Foundation Trusts.

The Chair noted the conflicts and agreed that as the proposal does not favour any Foundation Trust over any others all Chief Officers can receive the paper, attend the meeting and take part in the decision making for this item.

The Chief Finance Officer introduced the report which provided the Committee with an update on the financial performance of the North East and North Cumbria Integrated Care Board (NENC ICB) and NENC Integrated Care System (ICS) in the financial year 2025/26 for the eleven months to 28 February 2026.

As at 28 February 2026 the ICS is reporting a year-to-date deficit of £13.8m compared to a planned deficit of £17.26m. A favourable variance to plan of £3.46m. There is a slight deterioration to Month Ten mainly relating to one provider.

ICB Running Costs:

- The ICB is reporting a year-to-date underspend on running cost budgets of £6.3m reflecting current vacancies within the ICB. A forecast underspend of £6.4m is now being reported against running costs following work to appropriately split expected redundancy costs between running costs and programme budgets

ICB Revenue:

- As at 28 February 2026 the ICB is reporting a year-to-date surplus of £25.9m compared to a plan of £10.9m, a favourable variance of £15m which largely reflects underspends on staffing costs due to vacancies and other non-recurrent benefits including Private Finance Initiative funding and paused investments.
- There continues to be four main pressure areas to highlight within the ICB position at month nine:
 - 1) Risk around growth in elective activity
 - 2) Significant growth in Right to Choose Attention Deficit Hyper Activity Disorder / Autism Spectrum Disorder (ADHD/ASD) assessments with non-NHS providers
 - 3) Pressure on all-age continuing care (AACC) budgets particularly relating to the challenging efficiency targets

4) Growth in prescribing costs over budget

ICS Capital:

- The ICS is forecasting an underspend against the capital allocation of £4.2m following additional capital allocations which were expected and received in the month
- The ICB is forecasting a £1m underspend against GPIT and estates schemes.

Net unmitigated risk in the plan amounts to £244m across the system although there was inconsistency in recording of risk across the ICB. Risks largely related to the delivery of required efficiency plans which are higher than those delivered in 2024/25. At month eleven, ICS risk has reduced overall with a net unmitigated risk reported of £9m, compared to £22m last month.

The Chief Finance Officer discussed depreciation funding, noting a change in national approach to capital support. Members supported maintaining flexibility given emerging depreciation pressures in certain areas. The proposed approach to depreciation funding was supported, with final decisions delegated to the Chief Executive and Chief Finance Officer once figures were finalised.

The Committee reviewed Table 1, noting expected payments to NHS Foundation Trusts and the application of non-recurrent deficit support funding. The Chief Finance Officer noted there was an additional £1m required for North Cumbria Integrated Care (NCIC) Foundation Trust pressures and £1m for County Durham and Darlington Foundation Trust (CCDFT) following further year end negotiations.

The Chief Finance Officer confirmed that the system had received deficit support funding and that this represented a positive position compared to other systems.

RESOLVED:

- 1) The Committee NOTED the draft outturn financial position for 2025/26
- 2) The Committee NOTED there are a number of financial risks across the system still to be managed
- 3) The Committee NOTED the latest ICB underlying position
- 4) The Committee SUPPORTED the proposed approach to depreciation funding in 2025/26, with final decision once depreciation figures are finalised to be taken by the ICB Chief Executive Officer and Chief Finance Officer (CFO)
- 5) The Committee APPROVED the expected payments to NHS Foundation Trusts shown in Table 1, with delegated authority to the CFO to transact final national deficit support funding payments once received from NHSE, including an additional £1m each for both NCIC and CDDFT

EC/2026-27/16

Agenda Item 12.1 - Integrated Delivery Report

The Chief Strategy Officer introduced the report which provided the Committee with an overview of quality and performance, highlighting any significant changes, areas of risk and mitigating actions.

The Committee was informed of the key messages as follows:

- Accident and Emergency performance stands at 76.8% Ranking ninth out of 42 ICBs
- Category two ambulance response times were at 20 minutes 41 seconds, ranking first nationally
- 6.9% of patients are waiting over 12 hours in Accident and Emergency
- For elective care, 69.7% of patients are seen within 18 weeks, and just 1.1% wait over 52 weeks - both better than national averages
- Dementia diagnosis prevalence is 68.9%, consistently meeting targets
- Dental access for unique adult patients stands at 40.4%, now at national target
- 66.7% of patients receive a faster cancer diagnosis, and 68.1% are treated within 62 days
- 68.5% of patients experience reliable improvement in talking therapies, with a 48% reliable recovery rate

The Committee considered how future reports could better support strategic oversight and agreed that further discussion would be taken at the forthcoming Board development session.

RESOLVED:

The Committee RECEIVED the report for information and assurance

EC/2026-27/17

Agenda Item 13 - Commissioning

No update for this item.

EC/2026-27/18

Agenda Item 14 – Strategic Plans and Partnerships

No update for this item.

EC/2026-27/19

Agenda Item 15.1 – ICBP026 Internet, Email and Mobile Devices Acceptable Use Policy Update

The Chief Corporate Services Officer presented proposed amendments to policy ICBP026 Internet, Email and Mobile Devices Acceptable Use Policy Update.

The Committee are asked to approve the amendments to the Internet, Email and Mobile Devices Acceptable Use Policy Update.

RESOLVED:

The Committee APPROVED the ICBP026 Internet, Email and Mobile Devices Acceptable Use Policy Update

EC/2026-27/20 Agenda Item 15.2 – ICB HR27 Reward and Recognition Policy

The Chief Corporate Services Officer presented the proposed ICB HR27 Reward and Recognition Policy.

The Committee are asked to approve the new Reward and Recognition Policy.

RESOLVED:

The Committee APPROVED the ICB HR27 Reward and Recognition Policy

The Chief Corporate Services Officer noted that the ICB HR28 – Hybrid Working Policy and the ICB HR - Reasonable Adjustments Policy required further updates and will be presented at a later meeting for approval.

EC/2026-27/21 Agenda Item 16.1 – Any Other Business

There were no items of any other business for consideration.

EC/2026-27/22 Agenda Item 16.2 - New Risks to add to the Risk Register

No new risks were identified.

EC/2026-27/23 Agenda Item 17 - CLOSE

The meeting was closed at 13:10pm.



**Samantha Allen
Leadership Committee Chair
12 May 2026**

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

BOARD	
16 JUNE 2026	
Report Title:	Executive Committee Annual Review 2025/26
Purpose of report	
The attached review outlines the achievements and assurances the committee has gained throughout the year to demonstrate its roles and responsibilities and includes any risks identified as part of this work.	
Key points	
As set out in the ICB Constitution, each formal committee of the Board is required to undertake an annual review of its effectiveness against its agreed terms of reference and provide assurance to the Board it has delivered its delegated functions.	
The attached review has been undertaken for the period 1 April 2025 – 31 March 2026 and will be used to inform the accountability report within the ICB annual report for 2025-26. The report includes a review of attendance and any key issues to highlight to the Board.	
Risks and issues	
The key challenges faced by the committee are detailed in the attached report however risks are regularly discussed in the meeting.	
Assurances and supporting documentation	
- The Committee is required to undertake an annual review of its effectiveness against its terms of reference to ensure delivery of the committees required roles and responsibilities - The Committee has met its terms of reference throughout the year for 2025/26	
Recommendation/action required	
The Board is asked to receive the committee annual review 2025/26 for information and assurance.	
Acronyms and abbreviations explained	
ICB - Integrated Care Board	
Sponsor/Approving Executive Director	Samantha Allen, Chief Executive
Date approved by Executive Director	4 June 2026
Report author	Rebecca Herron, Corporate Governance Officer

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						
Note any relevant Acts, regulations, national guidelines etc						
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	N/A					
Contracting and Procurement	N/A					
Local Delivery Team	N/A					
Digital implications	N/A					
Health inequalities	N/A					
Clinical involvement	N/A					
Health inequalities	N/A					
Patient and public involvement	N/A					
Partner and/or other stakeholder engagement	N/A					
Other resources	N/A					

ANNUAL REVIEW OF THE EXECUTIVE COMMITTEE

In line with its terms of reference, the Committee must undertake an annual review of its performance and provide an account of its work to the Board.

Review period	1 April 2025 to 31 March 2026		
Number of Meetings	12		
Members	Number of meetings eligible to attend:	Number of meetings attended by members:	Number of meetings deputy attended: (*n/a – no deputy)
Chief Executive (Chair)	12	10	n/a
Chief Finance Officer (or nominated deputy)	12	9	3
Chief Medical Officer (Vice Chair) (or nominated deputy)	12	10	2
Chief Nurse and AHP Officer (or nominated deputy)	2	2	n/a
Chief Delivery Officer (or nominated deputy)	12	11	1
Chief Contracting and Procurement Officer (or nominated deputy)	12	10	2
Chief Digital and Infrastructure Officer (or nominated deputy)	12	11	n/a
Director of Workforce (or nominated deputy)	4	3	n/a
Chief Strategy Officer (or nominated deputy)	12	11	1
Chief Corporate Services Officer (or nominated deputy)	12	12	n/a

Role and responsibilities of the Committee

The Executive Committee (the Committee) operates as a formal Committee of the Board. The principal purpose of the Executive Committee is to support the Board by overseeing the day-to-day operational management and performance of the ICB in support of the Chief Executive in the delivery of her duties and responsibilities to the Board.

The Committee provides a forum to inform the ICB's strategies and plans and undertakes any commissioning and planning activity on behalf of the Board, helping to secure continuous improvement of the quality of services and implementation of the approved ICB strategies and plans. The Committee contributes to the overall delivery of the ICB objectives by delivering its remit as set out in its terms of reference. The Committee has no executive powers, other than those delegated in the Scheme of Reservation and Delegation (SoRD) and specified in its terms of reference.

Details of main work areas

The Committee's main areas of work are:

Commissioning

- The commissioning of acute services, primary care services and some specialised services
- Oversight of significant service reconfiguration
- Developing system working and strategic planning whilst promoting collaborative working across all providers
- Performance monitoring of provider services
- Provide assurance to the Board on the delivery of performance and outcomes
- Review of ICB performance against the NHS System Oversight Framework

- Recommendations to the Board regarding ICB programme budgets
- Oversight of the development of an annual system plan in conjunction with partner trusts
- Embed population health management approaches and address health inequalities
- Embed place-based working
- Ensure that commissioning activities are underpinned and informed through communications and involvement with partners and that public and key stakeholder engagement is aligned in the development and implementation of ICB strategies and plans

Corporate

- Ensure the ICB fulfils its functions, duties and responsibilities as set out in the organisations Constitution, ensuring a comprehensive system of internal control and the effective operational management of the ICB
- Ensuring the Board is sighted on any emerging strategic issues and risks and that adequate arrangements are in place in relation to the System Oversight Framework
- Delivery of the People Plan and People Promise, workforce planning and sustainability
- Approval of staff recruitment, retention, and development, supporting staff to develop new skills for collaborative working, and ensuring that the Board is advised on compliance with its statutory duties and performance relating to employment
- Advise the Board on compliance with its statutory duties relating to duty in respect of research
- Recommendation of HR policies to the Board for approval
- Approval of corporate, health and safety and information governance policies
- Development and implementation of ICB strategies (e.g., data and digital, communications and engagement and equality and diversity)
- Approve and implement the ICB's arrangements for planning, responding to and leading recovery from incidents (emergency planning, resilience, and response framework)
- Oversee compliance with the management of conflicts of interest as stated in the Constitution and the Standards of Business Conduct Policy and Declarations of Interest Policy
- Embed the ICB's risk management policy and supporting processes

Main achievements and assurances

This Annual Report summarises the activities of the Executive Committee (the Committee). The Committee was consistent in reporting to the Board, providing highlight reports from April 2025 to March 2026, to demonstrate the extent to which the Committee has met its terms of reference and providing assurance regarding key priorities since the establishment of the North East and North Cumbria Integrated Care Board (the ICB).

This report had been informed by a review of the papers presented to the Committee against the responsibilities set out in its terms of reference and priorities outlined in the cycle of business. Some of the key areas of discussion by the Committee are summarised below (further details can be found in the individual highlight reports from each meeting):

8 April 2025

- Strategic Commissioning Transition Programme Initiation Plan and Steering Group Terms of Reference
- NENC ICB People Policies
- Value Based Clinical Commissioning Policy

13 May 2025

- Winter Delivery and Assurance Group Terms of Reference
- Healthcare Inequalities Annual Report
- 2025-26 Operational and Financial Plan
- Digital Inclusion Strategy
- Use of Artificial Intelligence (AI) and Approval Policy

9 June 2025

- Healthier and Fairer Financial Plan
- Learning Disability Network Impact Statement 2024/25
- Decommissioning Policy
- Secure Data Environment (SDE) Disclosure Control, Output Checking and Release Policy

8 July 2025

- Acute Respiratory Infection (ARI) Hubs
- Oliver McGowan Training
- Staff Survey and Audit Response Plan
- Mental Health Assertive and Intensive Community Action Plans
- Northern Cancer Alliance Workplan and Financial Plan 2025/26
- Procurement Strategy
- Foundation Trust Provider Collaborative Agreement
- Health and Growth Accelerator Financial Plan
- Fit and Proper Person Test Policy
- Equality, Diversity and Inclusion Policy
- Statutory Neonatal Care Leave Policy
- Staff Fertility Policy

12 August 2025

- Women's Health Implementation Plan

9 September 2025

- Strategic Approach to Clinical Services Framework
- 2026/27 ICB Medium Term Planning
- All Age Continuing Care (AACC) Client Record System Challenges and Recommendations August 2025
- Strategic Principles for AI in Health

14 October 2025

- Women's Health Accelerator Plan
- NENC Green Plan Refresh
- Future Arrangements for Provider Oversight Meetings
- Palliative and End of Life Care (PEOL) Proposal

11 November 2025

- Demand Management Plan
- Finance and Performance Operational Planning Submission 2026-27 Update
- Child Protection Information System (CP-IS) Implementation
- ICBP028 – Media Handling Policy
- ICB HR02A - Supporting Attendance Policy
- ICB HR03 - Education Training Learning and Development Policy
- ICB HR10 - Induction Policy
- ICB HR26 - Secondary Employment Policy
- ICB HR07 Recruitment Policy
- Policy Deletion - Volunteers Policy and Health at Work Policy

9 December 2025

- Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance 2025
- ICB HR18a – Sexual Misconduct Policy
- ICBP007 - Complaints Policy

13 January 2026

- Niche Report
- Provider Requested Service Change Proforma
- HR13 – Freedom to Speak Up Policy

10 February 2026

- Digital Update and Ambient Voice Technology (AVT) Overview
- Attention Deficit Hyperactivity Disorder (ADHD) and Autism Task and Finish Group Terms of Reference
- Sexual Safety Update
- NENC Five Year Strategic Commissioning Plan
- ICBP009 Counter Fraud, Bribery and Corruption Policy

10 March 2026

- Specialised Commissioning Delegation Agreement and Memorandum of Understanding Amendments
- Service Reform Workstream Closedown Report
- Women's Health Hub Investment Proposal 26-29
- Implications of National Special Educational Need and Disabilities Reforms
- Research and Evidence Metrics
- Manchester Arena Inquiry Update
- ICBP033 Procurement Policy
- ICB HR018a Sexual Misconduct Policy

Governance and Assurance

The Committee also received assurance reports on the following items:

- Risk management position
- Corporate governance (statutory duties)
- Information governance, including the Data security and Protection
- Programme plan progress
- Policy management (review of policies)

Details of main challenges faced by the Committee during the year

There were several challenges faced by the Committee including:

- Geographical size and interaction with place-based working
- System performance
- Winter pressures
- Financial pressures
- Workforce pressures
- Continuing healthcare packages
- Prescribing pressures
- Discharges
- Procurement timescales
- Management of agendas (number and timescales of items being received) and committee support

The Committee monitored these areas closely and put mitigating actions in place wherever possible (in line with national and internal requirements). The Board was provided with assurance on these via the Committee's minutes, detailed reports, and presentations at formal Board meetings as well as in-depth reviews as part of Board development sessions. Where risks were identified, these were added to the ICB's corporate risk register as appropriate to ensure more detailed monitoring took place to mitigate these risks to the lowest level.

Key issues to highlight to the Board

The Committee has continued to explore improvements to its effectiveness and efficiency of management to ensure that the meetings are productive and committee member time is effectively utilised. New processes have been put in place to support this and ensure all essential business is conducted appropriately and provide assurance to the Board on delivery of its delegated functions.

The annual review has identified the Committee has delivered its responsibilities as set out in its terms of reference.

Proposal to review Terms of Reference?	No - to note that the Executive Committee has been stood down and replaced by the Leadership Committee.
Chair of the Committee	Samantha Allen, Chief Executive
Report Author	Rebecca Herron, Corporate Governance Officer
Date:	4 June 2026

Item: 9.2

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

BOARD	
16 JUNE 2026	
Committee Escalation and Assurance Report	
Committee Name:	Quality and Safety Committee
Committee Chair:	Dr Saira Malik, Primary Medical Services Partner Member
Dates of Committee Meeting/s:	14 May 2026
Alert: <i>Matters that need the Board's attention or action</i>	
Board Assurance Framework Quarter 4 2025/26 The Committee discussed the Board Assurance Framework (BAF) Quarter 4 2025/26 and recognised that there were some key strategic targets for the ICB that were off track. The Committee recommended that the Board provide a view on the plan for a strategy refresh and reframe in light of changes to the ICB's operating model. The strategy refresh to include public involvement and to provide the public with understanding of why a refresh is needed.	
Advise: <i>Matters to inform the Board of</i>	
Parkinson's Outreach Advanced Community Therapy Team The Committee received a presentation from the Parkinson's Outreach Advanced Community Therapy Team (PROACT) based at South Tees Hospitals NHS Foundation Trust (STHFT). The service is a therapy led service for people with Parkinson's Disease, offering access to specialist physiotherapy and occupational therapy to improve self-management. Based in the community, it supports patients in Middlesbrough and Redcar & Cleveland locality who are adjusting to diagnosis, or facing increasing symptoms, with the option to self-refer. Terms of Reference The Committee reviewed the new Terms of Reference and agreed further discussions to review membership, roles and responsibilities. There was agreement to seek to realign the Pharmaceutical Services Regulation Group (PSRG) as a group under the Neighbourhood Subcommittee. It was felt the responsibilities for the PSRG were more aligned. Complaints Report Quarter 4 2025/26 The Committee received the Complaints Report Quarter 4, 2025/26 which highlighted the standardised approach to register all ICB and Primary Care complaints, plans to advance collaborative work across ICB directorates, improvements to the complaints process, risks and issues, performance against key indicators and learning from complaints. Approved Policies The Committee approved the following policies ICBP003 Choice and Equity Policy – The policy was reviewed and updated to align with recent changes in national guidance and legislation. The review did not result in any substantial changes to the policy.	

- ICBP005 Safe and Supportive Observation Policy – The policy was reviewed and updated to reflect change in relevant national guidance and legislation. The review did not result in any substantial changes to the policy.
- ICBP056 Equality Quality Impact Assessment Policy – The policy had undergone a major rewrite as part of a cycle of improvement coinciding with changes in the NHS architecture and the ICB operating model. The refreshed policy was based on user and quality team feedback and includes update to EQIA proforma to support ease of use and application which no incorporates key characteristics of the NHS England QIA framework.

Personal Health Budgets Policy

The Committee received the draft ICBP060 Personal Health Budgets Policy and requested that additional safeguards were considered for inclusion in the policy, which will brought back to the next meeting for approval.

Area Quality and Safety Report

The Committee received the Area Quality and Safety Report which provided an oversight of key themes and highlighted four specific areas of concern; mortality rates, Regulation 28 – prevention of future deaths reports, Never Events and British Pregnancy Advisory Service (BPAS).

SEND Annual Report 2025/26

The Committee received the SEND Annual Report 2025/26 which provided an annual overview of how NENC ICB has discharged its statutory responsibilities for children and young people with SEND during 2025–26. It offered assurance on system performance, inspection readiness, and progress against national SEND reforms, including priorities for 2026–27. The Committee noted the improving but pressured system position, ongoing workforce and capacity risk (particularly Speech and Language Therapy and Occupational Therapy, inspection findings and themes, and the importance of sustained ICB oversight and assurance as SEND reforms move into a delivery phase during 2026–27.

Clinical Effectiveness and Governance Subcommittee Highlight Report

The Committee received the Clinical Effectiveness and Governance Subcommittee Highlight Report which highlighted the following key areas; Equitable access to NICE approved medicines for the NENC population, Clinical audits, Summary Hospital-level Mortality Indicator (SHMI) reporting, Prescription of drugs of low clinical value assurance and NENC Primary Care Rebate Scheme (PCRS).

Assure: Areas of assurance that the Committee has received

NENC ICB Involvement and Engagement Update

The Committee received the NENC ICB Involvement and Engagement Update which highlighted the strength of the ICB's partnership with Healthwatch as demonstrated in the NENC Healthwatch Network quarterly report. The update also included the quarterly dashboard, offering oversight of activity, emerging themes and how involvement work supported delivery of ICB priorities and statutory duties. The Annual Involvement Report 2025/26 was also received.

Mother and Babies Reducing Risk through Audits and Confidential Enquiries (MBBRACE)

The Committee received the Mother and Babies Reducing Risk through Audits and Confidential Enquiries (MBBRACE) 2024 Perinatal Morality Rates NENC Position Paper which provided oversight of the 2024 Perinatal Mortality Rates across the NENC footprint with specific reference to Trusts who were showing over 5% higher mortality compared to their MBBRACE group average. The report highlighted actions taking place to analyse the data and ongoing monitoring of perinatal mortality within the ICB.

North and South Quality and Safety Subcommittee Minutes

The Committee received the following confirmed minutes for assurance

- North Area – Quality and Safety Subcommittee minutes, 17 February 2026
- South Area – Quality and Safety Subcommittee minutes, 17 February 2026

Committee Annual Review 2025/26

The annual review identified the Committee has delivered its responsibilities as set out in its terms of reference.

Supporting Documentation				
- Confirmed minutes Quality and Safety Committee meeting 12 March 2026 (Appendix 1) - Quality and Safety Committee Annual Review 2025/26 (Appendix 2)				
Conflicts of Interest				
Any potential/actual conflicts of interest associated with the paper?	Yes		No	✓
Recommendation / Action Required				
The Board is asked to receive the Quality and Safety Committee Escalation and Assurance Report and ask any questions of the Committee Chair. The Board is asked to receive for information and assurance; - Confirmed minutes Quality and Safety Committee meeting 12 March 2026 (Appendix 1) - Quality and Safety Committee Annual Review 2025/26 (Appendix 2)				
Report author	Jane Smailes, Corporate Governance Officer			
Date of Approval	3 June 2026			

North East and North Cumbria Integrated Care Board

Confirmed QUALITY AND SAFETY COMMITTEE

**Minutes of the meeting held on 12 March 2026 from 9am
Joseph Swan Suite, Pemberton House, Sunderland**

Present:

Sir Pali Hungin (Chair), Independent Non-Executive Member
Christopher Akers-Belcher, Regional Co-Ordinator for Healthwatch
Ken Bremner, Foundation Trust Partner Member
David Gallagher, Chief Procurement and Contracting Officer
Neil Hawkins, Strategic Head of Governance *Deputising for Claire Riley, Chief Corporate Services Officer*
Jen Lappin, LMNS Head of Quality and Safety *deputising for Amanda Kennett – Director of Midwifery*
Ewan Maule, Clinical Director (Medicines and Pharmacy)
Dr Neil O'Brien, Chief Medical Officer
Dr Saira Malik, Primary Medical Services Partner Member
Hilary Lloyd, Chief Nurse and AHP
Richard Scott, Director of Nursing (North)
Kate O'Brien, Director of Nursing (MHLDN)
Ann Fox, Deputy Chief Nurse

In Attendance:

Mary Bewley, Director of Communications
Trina Holcroft, Deputy Director of Nursing (Safeguarding Lead) –
Item 17 Overview assurance report of Safeguarding Children, Adults
and Cared for Children
Rabina Tindale, Director of Nursing and Patient Safety
Ruby Burdis, Corporate Governance Support Officer (Minutes)

QSC/2026/03/1

Welcome and Introductions

The Chair welcomed all those present to the meeting

QSC/2026/03/2

Apologies for Absence

Apologies were received from:

Ben Anderson, Director of Population Health
Kirstie Hesketh, Deputy Director of Quality
Louise Mason-Lodge, Director of Safeguarding
Dr Rajesh Nadkarni, Foundation Trust Partner Member
Vicky Playforth, Interim Director of Nursing (South)
Claire Riley, Chief Corporate Services Officer
Amanda Kennett, Director of Midwifery

QSC/2026/03/3

Declarations of Interest

The Chair reminded members of the Committee of their obligation to declare any interest they may have on any issues arising at the Quality and Safety Committee meeting which might conflict with the business of the ICB.

Declarations made by members are listed on the ICB Register of Interests. The Register is available via the Committee Secretary and an extract included in the meeting papers.

No additional declarations of interest were noted.

QSC/2026/03/4

Quoracy

The Chair confirmed the meeting was quorate.

QSC/2026/03/5

Minutes of the Previous Meeting held on 15 January 2026

RESOLVED

The Quality and Safety Committee **AGREED** that the minutes from the meeting held 15 January 2026 were a true and accurate record.

QSC/2026/03/6

Matters Arising from the Minutes and Action Log

Matters Arising

No additional matters arising were noted

Action Log

QSC/2026/01/17 – An update regarding staffing within the safeguarding team is provided under item 17. Action closed.

QSC/2026/03/7

Notification of Any Other Items of Business

The Chair highlighted two items for consideration under any other business. One relating to pressures in pharmacy concerns and secondly a letter received from a local medical committee concerning the prescription of antipsychotic drugs.

QSC/2026/03/8

Complaints Quarterly Report – Q3

The Strategic Head of Corporate Governance presented the Q3 Complaints report. The report is still being developed, along with a complaint's dashboard, to ensure the suitable amount of detail is

Official

captured. They welcomed any feedback on the report and dashboard.

During Q3 the team received a total of 715 enquiries and concerns, of which 316 were managed as primary care cases and 189 commissioning cases. The remaining 210 cases were complaint cases being led by other organisations.

The themes of the complaints continue to be:

- Commissioning of NHS Dental Care
- All Age Continuing Healthcare arrangements
- Eligibility criteria for Value Based Clinical Commissioning Policy
- Individual Funding Requests
- Shared Care Arrangements and GP appointment availability
- Clinical care
- Prescribing issues
- Staff attitude / behaviours and values

The Complaints team have been working jointly with All Age Continuing Care and ADHD teams within the ICB to ensure good quality responses are completed.

Preparation is underway in advance of ceasing gluten free prescribing for those over 25, the communications team have developed a template letter to support responses to any complainants.

Work is ongoing to develop the reporting output of complaints, including comparison data, the team aim to include this in the Q4 report.

The Chair asked for assurance around the efficiency of the complaints process and if there was a suitable amount of support. The Strategic Head of Governance noted a significant amount of work had been done to standardise the process and work through the backlog of complaints. The complaints team aim to have completed the 2024 complaints backlog by the end of March to start reporting real time completion of complaints. The majority of the team has been retained in the restructure, with the exception of one band 5 post, therefore there should be suitable resource remaining for complaints.

RESOLVED

The Quality and Safety Committee **RECEIVED** the complaints report for Q3 for assurance.

The Chief Nursing and AHP Officer presented the updated Patient Safety Incident Response Framework Oversight Policy for approval.

The revised policy has undergone a full refresh to reflect the current position of the ICB. In the previous policy there was an emphasis on the ICB's oversight role as providers were developing their PSIRF plans and policies. The focus has moved to include the oversight of organisations that have transitioned to PSIRF.

The Deputy Chief Nurse noted the person responsible for the policy, listed on page 48 of the pack, is the Director of Nursing for Quality. They suggested double checking to ensure the correct title is listed.

The Chair asked for assurance that there is sufficient resource to oversee this process and enquired if it would remain the responsibility of the Committee under the new model. The Chief Nursing and AHP Officer confirmed there is sufficient resource within the Quality Team and it remains the remit of the Committee.

RESOLVED

The Quality and Safety Committee **APPROVED** the Patient Safety Incident Response Framework (PSIRF) Oversight Policy

QSC/2026/03/10

Patient Story – Motor and Vocal Tics

The Committee received an account from the mother of an eight-year-old from County Durham, who shared the challenges her and her family experienced in getting the right care for her daughter following the presentation of motor and vocal tics.

The Chair highlighted the difficulty that the family experienced in getting a diagnosis and frustration felt at the process.

The Chief Medical Officer noted for these conditions sometimes the referral routes are unclear, and therefore improved advice and guidance would be beneficial to prevent extending the waiting time for patients and their families.

The Director of Nursing (Mental Health, Learning Disabilities, Autism and Complex Care) noted work has been ongoing for the last 12 months looking at neurological pathways for conditions where there is not a clear pathway. The ICB is aware there is not always a clear pathway for all conditions or clear guidance on where to seek first level interventions for symptoms. Under the revised ICB structure these conditions will likely sit within the Mental Health Commissioning portfolio. The team will need to review what commissioned services are in place and either develop a commissioning intention to deliver a better spread of services or consider if a case should be made for more investment.

ACTION

The Director of Communications and Engagement to organise a response to the patient/family thanking them for the input and informing them work is ongoing to improve pathways.

RESOLVED

The Quality and Safety Committee **ACKNOWLEDGED** the feedback shared through the lived experience example, **RECEIVED** it as a source of reassurance, and **THANKED** those who contributed.

QSC/2026/03/11

NENC ICB's Involvement and Engagement Update

The Director of Communications and Engagement provided the Committee with a summary update on the ICB's involvement and engagement activity.

Mental health and primary care (GP, pharmacy, dental) are the most frequently cited priorities indicating persistent challenges in these areas. Hospital discharge and acute/in hospital care are highlighted as areas needing improvement, particularly regarding smooth transitions and quality of care. Nursing/care homes are a growing focus, reflecting concerns about access and standards in residential care.

In the last quarter the ICB has 59 involvement projects linked to commissioning priorities and service change programmes. Some examples of engagement work included:

- Community engagement with ethnic minority communities around cancer screening and kidney health awareness
- Faith based coproduction to improve cancer screening participation.
- Collaborating with Youth Watch on more inclusive sexual education for LGBTQ young people
- Working with Northumbria Police and other partners to address knife crime

Alongside these larger engagement programmes, the team receive organic feedback from across communities, it is encouraging that the feedback received this way is consistent with the main themes of primary care, mental health, hospital care and care homes.

On behalf of the ICB, Healthwatch carried out engagement relating to primary care, focusing on timely access to GP appointments and continuity of care for patients with long term conditions. This work highlighted that patients want to know how service change will affect them, they want the ICB to ensure the quality and safety of the services and patients are keen to shape services as part of the ten-year plan.

The Regional Co-ordinator Healthwatch Network noted concerns

Official

from patients in the Primary Access Recovery Plan report who had not been offered the extended access appointments. The scale of this issue will be clearer by monitoring the use of extended hours, the NHS app and pharmacy first. The report was received at the Primary Care subcommittee and received positive feedback.

The Regional Co-ordinator Healthwatch Network highlighted the End-of-Life piece of work referenced in the report, noting the amount of engagement was encouraging.

The Chair felt assured by the report and noted the depth of the work provides excellent feedback. The Chair invited the Chief Medical Officer to offer their thoughts on the volume of e-consultation requests and noted it might take time to unpick if e-consultations improve access to primary care or delay it.

The Chief Medical Officer noted e-consultations can be useful, but they do require review to prevent patients making unsafe decisions for example, submitting an e-consult for chest pain.

The Chair asked the Chief Nurse and AHP Officer what the ICB's role would be in furthering the work to improve end of life care that was highlighted in the report. The Chief Nurse and AHP Officer noted the ICB have a McMillan sponsored specialist nurse on a two-year secondment to lead on improvement work for end-of-life care, particularly around choice. She has presented at the Chief Nurse Network and the Chief Nurse and AHP Officer offered to invite her to a Committee meeting if appropriate.

The Chair invited the Foundation Trust partner member for his perspective on end of life care in secondary care services. The Foundation Trust partner member agreed it was a priority area and highlighted that reliance on charitable funding for services results in some long-term viability and sustainability concerns. They noted the importance of working jointly with the ICB and other Trusts to improve access and equity of services.

The Chair noted the quality of end-of-life care has been highlighted as part of parliamentary discussions relating to assisted dying. The Chief Medical Officer noted that end of life care is an area of improvement, identified by the organisation. There is an established end of life network which will help pull together areas of good work in the patch and identify improvements required.

The Chair thanked the Director of Communications and Engagement for the report and noted the importance of Patient Voice. The Director of Communications and Engagement thanked the Regional Co-ordinator Healthwatch Network for the management of the network.

RESOLVED

The Quality and Safety Committee **RECEIVED** the report for information and assurance that the ICB continues to fulfil its statutory involvement and engagement duties.

QSC/2026/13/12

Area Quality Reports

The Director of Nursing (North) presented the Area Quality and Safety Report.

The Care Quality Commissioning (QCQ) inspection report for Cumbria, Northumberland, Tyne and Wear (CNTW)'s CAHMS service was published on 15th January with a rating of Requires Improvement alongside five regulatory breaches. An action plan is in place and it being monitored through the Trust Quality and Performance Committee and the ICB led Rapid Quality Review group.

County Durham Darlington Foundation Trust (CDDFT) received a CQC S29A warning notice on 23rd December 2025, following a well led inspection in response to concerns about the trust's governance systems, the management of identified risks and the processes for learning from incidents and complaints. The report is still awaited, and any actions will be reported into the Integrated Quality Improvement Group.

Newcastle Clinics was rated inadequate 19th January 2026, following a May 2025 inspection. Seven breaches of regulation were identified. However, due to a new leadership team taking over the organisation at that time no enforcement action was initiated. An ICB assurance visit took place on 3rd February, and several actions suggested.

CQC carried out an unannounced inspection to North Cumbria Integrated Care FT, over the 17th-18th February, with a focus on mental health in emergency departments. No regulatory breaches were identified. This spotlight has also led the ICB to pose questions internally around the level of surveillance in place for MH patients attending emergency departments and discussions are ongoing.

Following an unannounced CQC inspection of a GP practice in North Cumbria the ICB were informed that CQC were considering issuing the practice with a Section 31 (immediate suspension) notice. However, the CQC since opted to put in place conditions for non-urgent actions. This is a level 2 incident being led by the ICB. Incident management and communication plans are in place.

CNTW received a Regulation 28 report on 7th December 2026, following the coroner's suggestion that there was significant and widespread concerns with the management and oversight of medications. An action plan is in place to address these concerns.

Official

Spire Hospital Washington is undertaking an internal 5 year look back of upper limb orthopaedic patients following concerns raised about a former consultant's practice. Concerns relate to consent processes, technical standards of surgery, duty of candour and inappropriate follow up with reference to post operative staged imaging. Patients affected have been sent letters and duty of candour is being enacted. The ICB is maintaining oversight of the situation through a fortnightly oversight incident group.

CDDFT Maternity continues to be discussed as part of intensive quality assurance process and has been demonstrating improvements. Meanwhile North Tees Hartlepool Foundation Trust (NTHFT)'s midwifery-led service in Hartlepool, remains suspended. The local maternity and neonatal system is supportive of the temporary closure and engagement with service users is underway to better understand their needs.

In relation to Standardised Hospital Mortality Indicators, CDDFT remains banded higher than expected. ICB formal dialogue is underway regarding data quality and coding issues.

South Tyneside and Sunderland Foundation Trust (STSFT) notified the ICB of an issue where 1795 patients possibly may not have had their DEXA report reviewed by their GP. Risk to patients is judged to be minimal and is under review.

Cora Health, released approximately 20,896 letters to GP practices across South Tyneside, Durham, Darlington, Northumberland and North Tyneside. Most of these letters were "information only" communications, such as general updates to care plans that required no clinical/GP action. Cora Health have reviewed letters and concluded with 95% confidence that the risk of those letters requiring action (when not identified as such) is less than 1%. Internal investigations are ongoing.

STSFT's UKAS laboratory accreditation remains suspended. Centralisation of services, staffing changes, system and supply chain issues have all impacted on the ability to deliver a consistently high-quality service. UKAS plan to revisit the Trust laboratory on 23rd March.

The Regional Co-Ordinator for Healthwatch asked when the Committee would receive an update in relation to the infection, prevention and control work referenced in the report. The Chief Nursing and AHP Officer noted 3 Foundation Trusts have volunteered to be a part of this programme, dates have been identified in March 2026 for visits. An event is planned for 6th June to discuss the output of this report, after which an update will be shared with the Committee.

ACTION

Secretariat to include Infection, Prevention and Control update on

Official
the agenda for July's Quality and Safety Committee.

RESOLVED

The Quality and Safety Committee **RECEIVED** the report for assurance and information.

QSC/2026/03/13

HSSIB Investigation Report – Patient Care in Temporary Environments

The Health Services Safety Investigations Body (HSSIB) report into patient care in temporary care environments (TCE) was published in January 2026. The report focused on exploring the management of patient safety risks associated with using temporary care environments. The report highlighted that these spaces are not originally designed, staffed or equipped for patient care but are being used on a regular basis as a response to patient flow pressures within acute hospitals.

TCEs are often referred to as "corridor care" and "temporary escalation spaces". The use of different language is confusing to both patients and staff.

Findings in the report related to patient and staff experience, normalisation, lack of incident reporting on the use of TCE and managing patient safety risks. One safety observation suggested, to improve patient safety there is a need to enhance the understanding of the use of TCE across all hospital settings. Which may include agreeing definitions of TCE and enhanced information gathering on their use and impact on patient safety.

A number of local-level learning prompts have also been suggested that may help organisations and staff identify and think about how to respond to specific patient safety concerns at the local level. These relate to aspects such as TCE policies, MDT decisions making on TCE, adaptations and patient literature.

Requests have been made to each Acute Trust to discuss the HSSIB report and actions are being taken at their internal Quality Committees. ICB quality representatives attend each Trust Quality Committee.

The Foundation Trust partner member noted all trusts have been written to by Sarah-Jane Marsh to begin a process of more accurate data collection and to clarify a definition of what constitutes "corridor care". They suggested it would be helpful to revisit this item once the definition has been established and data has been collected.

The Chief Medical Officer noted this was discussed on the urgent and emergency care call 12 March 2026, where it was agreed the current definition is open to interpretation. As a network they have agreed to link in with Trust performance leads for consistency across

Official

the patch. They will also engage with NHS region to explain how "corridor care" can be used an effective way to manage care in the system when necessary.

ACTION

Secretariat to include Patient Care in Temporary Environments on the agenda for September's Quality and Safety Committee.

RESOLVED

The Quality and Safety Committee **RECEIVED** the report for information and assurance.

QSC/2026/03/14

Update on Compliance with EQIA Process

The Director of Nursing (North) presented an update on the EQIA process compliance. The process has been in place since March 2025 and assessments are required for decommissioning or redesigning of services and for new policies.

Staff are engaged with the process and there is a SOP and Policy available to support them. The Quality team continue to offer advice and guidance to support teams. 173 assessments have been logged since 1 April 2026.

The Chief Nurse and AHP Officer thanked the Quality team for the robust piece of work and noted it provided excellent assurance to the Committee.

The Regional Co-ordinator for Healthwatch suggested utilising Boost to develop training, given NECS is no longer able to produce the materials. The Deputy Chief Nurse noted the Quality team are providing this at the moment, alongside the SOP and Policy, but it could be considered in the future.

RESOLVED

The Quality and Safety Committee **RECEIVED** the EQIA compliance report for information and assurance.

QSC/2026/03/15

2025 CQC Maternity Survey – NENC Summary Report

The LMNS Head of Quality and Safety presented the summary report of the 2025 CQC Maternity Survey. There were 119 NHS Trusts in England included, with an overall response rate of 29% (16,744 women). The survey reviewed three stages of the maternity journey: Antenatal Care, Labour & Birth and Postnatal care.

Five Trusts in England were categorised as achieving "better than expected results" which included Gateshead Health NHS Foundation Trust and North Cumbria Integrated Care NHS foundation Trust.

Six Trusts in England were categorised as achieving "worse than

expected" results which included County Durham and Darlington Foundation Trust.

The challenges highlighted for Trusts in the region included delays in receiving help on wards and staffing pressure, along with inconsistent care after discharge and variation in infant feeding support. A NENC task and finish group is being set up to focus on postnatal improvement across NENC.

ACTION

Secretariat to include LMNS update on the agenda for May 2027 Quality and Safety Committee.

RESOLVED

The Quality and Safety Committee **RECEIVED** the Maternity Survey NENC summary report for information and assurance.

QSC/2026/03/16

Model ICB Assurance Practice Guides

The ICB have completed 5 self-assessments against Model ICB Good Practice Guidance developed by NHS England.

The Clinical Director (Medicines and Pharmacy) presented the self-assessment for Medicines Optimisation. They noted this self-assessment considered the current functions within the team and the proposed structure and new ways of working. The report highlights areas in which the team are functioning well and where there are some risks.

In relation to Safeguarding, the Chief Nursing and AHP Officer noted a new good practice guidance was shared in January 2026. In the original model blueprint safeguarding was a function listed for transfer out of ICBs which has caused confusion with partners. The Chief Nursing and AHP Officer presented at the Chief Nurses meeting to clarify the ICB's statutory responsibilities relating to safeguarding.

Infection, Prevention and Control was also listed as to transfer in the original model blueprint but will now remain the responsibility of the ICB. The Chief Nurse and AHP Officer noted there is not a dedicated team for IPC and never has been, however there is knowledge of IPC within the Quality Team.

In relation to special education needs and disabilities (SEND) the Deputy Chief Nurse noted there have been no significant changes to the structure as the SEND model was reorganised more recently. The content of the report is accurate against the NHSE guidance however, the Department of Education has since released a white paper which will have implications for SEND. The ICB SEND leads, commissioning and nursing team are working together to create a local area reform plan in response to the white paper.

In relation to All Age Continuing Care the Director of Nursing (MHLDN) noted the self-assessment demonstrates that the ICB broadly aligns with national good practice expectations and has clear plans to address the remaining gaps.

RESOLVED

The Quality and Safety Committee **RECEIVED** the good practice guidance reports for information and assurance.

QSC/2026/03/17

NENC ICB Overview Assurance Report of Safeguarding Children, Adults and Cared for Children

The Deputy Director of Nursing, Safeguarding Lead (North) joined the meeting to present the Overview Assurance Report of Safeguarding Children, Adults and Cared for Children.

Risk assessed operational resilience plans have been developed and shared with safeguarding and NHS partners. Meetings have also been commenced with providers to establish better working across the health system and avoid duplication.

There are vacancies in the Designated Doctor roles however recruitment is in progress to resolve this and the Durham/Darlington post has been filled.

The compliance of initial health assessments for children entering care remains on the risk register. There is often a delay from the local authority in informing the Trusts that children have entered care and the deadline to complete the assessment is 20 days.

In relation to the Medical Advisor role, this has been clarified as not being the responsibility of the ICB, Directors of Children's Services have been notified.

The ICB continue attend, as partners, all statutory boards and partnerships. CNTW have issued a letter stating they will not be attending all subgroup meetings, this is being considered and a joint response coordinated from the adult safeguarding board.

Work continues as part of influencing the model of the Families First Partnership Programme. A joint ministerial letter addressed to safeguarding children partner leads reiterated the request for progress and clarifies that there is an expectation for "safeguarding partnerships to ensure dedicated and expert roles in multi-agency child protection teams". Local Authorities can use grant funding to support safeguarding partners to deliver reforms suited to their local context.

North Cumbria Integrated Care have submitted a notice of intent that they no longer wish to carry out the health function in the Cumbria

Official

Multi-Agency Safeguarding Hub (March 26). They have agreed a three-month extension and the ICB are reviewing potential providers under the urgent contract award process.

All NHS providers are struggling with the safeguarding demand combined with sickness and vacancies within teams, the ICB is supporting where possible.

There is a joint targeted area inspection ongoing in Gateshead in relation to child sexual abuse in the family environment, this will be ongoing for 3 weeks.

RESOLVED

The Quality and Safety Committee **RECEIVED** the Overview Assurance Report of Safeguarding Children, Adults and Cared for Children for information and Assurance.

QSC/2026/03/18

Clinical Effectiveness Highlight Reports (December 2025 and February 2026)

The Chief Medical Officer noted the work of the Clinical Effectiveness Group is currently focused on audits, mortality and prescribing issues. They highlighted that the system is currently non-compliant with NICE, as the decision to add TA1087: *Betula verrucosa* for treating moderate to severe allergic rhinitis or conjunctivitis caused by tree pollen has been deferred due to concerns regarding funding and commissioning of service across the system. An Interface group is being formed to enable the ICB and its providers to meet to resolve the specific barriers occurring in response to the recommended introduction to some NICE approved treatments.

The Clinical Effectiveness Group is reviewing over 100 national audits. These have been scheduled and a process established whereby audits are risk rated and reported to the Group. Five audits have been identified as being an "enhanced risk". The Chief Medical Officer and Chief Nurse and AHP Officer are discussing how actions from the audits will feed into the quality management framework.

The national GIRFT team undertook two diabetes reviews, one specifically into services for children and young adults living with diabetes and a gateway review for adults with diabetes. These audits are demonstrating the variation in access to diabetes care, particularly for young people transitioning to adult services. This will be added to the ICB risk register.

The Group continues to review the hospital mortality data and support improvements. County Durham and Darlington Trust's mortality rate remains "higher than expected" and increasing. The Chief Medical Officer has met with the Trust who are confident this is a coding issue. The Chief Medical Officer requested a Data Quality

Official
Improvement Plan from the Trust within 4 weeks.

RESOLVED

The Quality and Safety Committee **RECEIVED** the highlight report for information and assurance.

QSC/2026/03/19

Chief Nurse Report by Exception

There were no updates to receive by exception.

QSC/2026/03/20

Feedback from Subcommittee Chairs by Exception

There were no updates to receive by exception.

QSC/2026/03/21

**For information / assurance items escalated from
Subcommittees**

QSC/2026/03/21.1

**Antimicrobial Resistance (AMR) and Healthcare Associated
Infections (HCAI) Subcommittee Minutes – 03 December 2025**

RESOLVED

The Quality and Safety Committee **RECEIVED** the Antimicrobial Resistance (AMR), and Healthcare Associated Infections (HCAI) Subcommittee Minutes from 03 December 2025 for assurance.

QSC/2026/03/21.2

System Quality Group Minutes – 11 December 2025

RESOLVED

The Quality and Safety Committee **RECEIVED** the System Quality Group Minutes from 11 December 2025 for assurance.

QSC/2026/03/21.3

**NENC ICS Health Safeguarding Subcommittee Minutes – 08
August 2025**

RESOLVED

The Quality and Safety Committee **RECEIVED** the NENC ICS Health Safeguarding Subcommittee Minutes from 08 August 2025 for assurance.

QSC/2026/03/21.4

**South Area Quality and Safety Subcommittee Minutes –16
December 2025**

RESOLVED

The Quality and Safety Committee **RECEIVED** the South Area Quality and Safety Subcommittee Minutes from 16 December 2025 for assurance.

QSC/2026/03/21.5

**North Area Quality and Safety Subcommittee Minutes – 16
December 2025**

RESOLVED

The Quality and Safety Committee **RECEIVED** the North Area Quality and Safety Subcommittee Minutes from 16 December 2025

for assurance.

QSC/2026/03/21.6 SEND Subcommittee Minutes – 22 October 2025

RESOLVED

The Quality and Safety Committee **RECEIVED** the SEND Subcommittee Minutes from 22 October 2025 for assurance

QSC/2026/03/21.7 North East and North Cumbria (NENC) ICB Integrated Delivery Report – February 2026

RESOLVED

The Quality and Safety Committee **RECEIVED** the Integrated Delivery Report (February 2026) for information and assurance.

QSC/2026/03/22 Any Other Business, New Risks to add to the Risk Register and Items for Escalation to Board

Community Pharmacy Pressures

The Chief Contracting and Procurement Officer presented the report on pressures in community pharmacy outlining the 616 pharmacies across NENC and highlighting the joint working with Health and Wellbeing Boards.

NENC ICB have an established Pharmacy Assurance Group which monitors community pharmacy compliance with the National Community Pharmacy Contractual Framework (CPCF) to ensure all community pharmacies are delivering services in a safe and effective manner.

The Chief Contracting and Procurement Officer noted due to inflation and national changes the costs have increased for pharmacies whilst the national contract rates have not increased at the same rate. They highlighted the risk of pharmacy closures, especially those in retail outlets, and the gaps that would leave in the system.

The Clinical Director (Medicines and Pharmacy) noted that community pharmacies are increasingly sustaining on private services for example, weight loss medication. Furthermore, the business model for pharmacies relies on up front costs for expensive stock and then are reimbursed later when medication is prescribed. Issues with supply chains also have a direct impact on this business model.

RESOLVED

The Quality and Safety Committee **RECEIVED** the community pharmacy update for information and assurance.

Anti-psychotic medication prescribing

The Chair noted they had received a letter from a local medical

Official
committee which stipulated that antipsychotic medication should be prescribed and monitored by the mental health trusts and not GPs.

The Chief Medical Officer has responded to the letter to provide assurance and will share the response with the Chair. This issue has been discussed at the NTAG Group and a pathway has been agreed through the shared care medicines LES.

The Primary Care Services partner member asked if the ICB's guidance is in line with National Guidance, and the Clinical Director (Medicines and Pharmacy) confirmed it was.

RESOLVED

The Quality and Safety Committee **RECEIVED** the update for information and assurance.

QSC/2026/03/23

Meeting Critique

No meeting critique noted.

QSC/2026/03/24

Date and Time of Next Meeting

The next meeting of the Quality and Safety Committee will be held Thursday 14 May 2026.

CLOSE AT 10:43am

Signed



Position

Chair

Date

14 May 2026

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

BOARD	
16 JUNE 2026	
Report Title:	Quality and Safety Committee Annual Review 2025/26
Purpose of report	
In line with its terms of reference, the Committee must undertake an annual review of its performance and provide an account of its work to the Board. The attached report is proposed to be sent to Board in June as a summary of the Committee's work in 2025-26.	
Key points	
As set out in the ICB Constitution, each formal committee of the Board is required to undertake an annual review of its effectiveness against its agreed terms of reference and provide assurance to the Board it has delivered its delegated functions.	
The attached review has been undertaken for the period 1 April 2025 – 31 March 2026 and will be used to inform the accountability report within the ICB annual report for 2025-26. The report includes a review of attendance and any key issues to highlight to the Board.	
The report provides a brief introduction of the scope and remit for the Committee and provides a summary of the main areas of work and achievements throughout 2025-26.	
Risks and issues	
No significant risks or issues to consider for the annual review. The report includes details of how the Committee receives regular risk reports concerning the risks aligned to the Committee within the corporate risk register.	
Assurances and supporting documentation	
- The Committee is required to undertake an annual review of its effectiveness against its terms of reference to ensure delivery of the committees required roles and responsibilities - The Committee has met its terms of reference throughout the year for 2025/26 - The report highlights the various reports presented to the Committee throughout the year providing assurance on services commissioned	
Recommendation/action required	
The Board is asked to receive the 2025/26 annual review of the Quality and Safety Committee for information and assurance.	
Acronyms and abbreviations explained	
As described in the report.	

Sponsor/Approving Executive Director	Professor Sir Pali Hungin, Chair of the Quality and Safety Committee and Independent Non Executive Member					
Date approved by Executive Director	7 June 2026					
Report author	Jane Smailes, Corporate Governance Support Officer					
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						
Note any relevant Acts, regulations, national guidelines etc						
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	Not applicable					
Contracting and Procurement	Not applicable					
Local Delivery Team	Not applicable					
Digital implications	Not applicable					
Clinical involvement	Not applicable					
Health inequalities	Not applicable					
Patient and public involvement	Not applicable					
Partner and/or other stakeholder engagement	Not applicable					
Other resources	Not applicable					

ANNUAL REVIEW OF THE QUALITY AND SAFETY COMMITTEE

In line with its terms of reference, the Committee must undertake an annual review of its performance and provide an account of its work to the Board.

Review period	1 April 2025 to 31 March 2026		
Number of Meetings	6		
Members	Number of meetings eligible to attend:	Number of meetings attended by members:	Number of meetings deputy attended: (*n/a – no deputy)
Independent Non-Executive Director (Chair)	6	6	n/a
Chief Medical Officer	6	4	2
Chief Nurse	6	4	1
Chief Contracting and Procurement Officer	6	5	1
Chief Corporate Services Officer	6	3	2
Foundation Trust Partner Member	6	4	n/a
Foundation Trust Partner Member	6	3	n/a
Primary Medical Care Partner Member (Vice Chair)	6	6	n/a
Director of Allied Health Professions	6	4	n/a
Director of Medicines Optimisation and Pharmacy	6	2	2
Director of Nursing (North)	6	4	n/a
Director of Nursing (South)	6	4	n/a
Director of Nursing – Complex Care	6	2	n/a
Director of Midwifery	6	1	2
Director of Quality	6	2	2
Deputy Chief Nurse	6	2	n/a

Main achievements and assurances

This annual report summarises the activities of the Quality and Safety Committee (the Committee). The Committee was consistent in reporting to the Board, providing highlight reports from April 2025 to March 2026, to demonstrate the extent to which the Committee has met its terms of reference and providing assurance regarding key priorities since the establishment of the North East and North Cumbria Integrated Care Board (the ICB).

The Committee has structured its business around the three core pillars of patient safety, clinical effectiveness, and patient experience.

This report had been informed by a review of the papers presented to the Committee against the responsibilities set out in its terms of reference and priorities outlined in the cycle of business. Some of the key areas of discussion by the Committee are summarised below.

- Area Quality Reports
- Patient Involvement and Experience update
- Complaints
- Board Assurance Framework and Risk Register
- Integrated Quality, Performance and Finance Report
- Patient Stories
- Medicines Optimisation Annual Report
- Pharmacy Shortages and System Coordination
- Financial Pressures from NICE Technology Appraisals
- Regional Maternal Mortality Review Updates
- Infection Prevention and Control
- Complex Care Incident Management
- Special Education Needs and Disabilities (SEND)
- Patient Safety Incident Response Framework
- Subcommittee Minutes
- Inter-agency Disputes Policy approval
- Annual Safeguarding Report
- Never Events (3-year system review)
- Health Services Safety Investigations Body Learning (incl. sepsis report)
- Medicine shortages
- Rising antimicrobial resistance risk
- Breast Service Reviews
- Equality & Quality Impact Assessment Policy
- Clinical Policy Approval

The Committee also received assurance reports on the following items:

- Subcommittee Minutes
- Clinical Effectiveness and Governance Subcommittee Highlight Reports
- Integrated Delivery Report

Details of main challenges faced by the Committee during the year

The Committee has noted that the responsibilities as defined within the Terms of Reference are extensive. The volume of papers associated with agenda items was comprehensive due to the responsibilities of the Committee, though this can make it difficult to read and process all papers ahead of the meeting. The format and content of some of the reports has changed over the past year to improve the readability for members.

The frequency of the meetings was considered to be appropriate with meetings well chaired. Efforts have been over the past year to ensure sufficient time was given to each agenda item.

Key issues to highlight to the Board

The Committee has continued to explore improvements to its effectiveness and efficiency of management to ensure that the meetings are productive and committee member time is effectively utilised. Processes have been put in place to support this and ensure all essential business is conducted appropriately and provide assurance to the Board on delivery of its delegated functions.

The annual review has identified the Committee has delivered its responsibilities as set out in its terms of reference.

Proposal to review Terms of Reference?	The Terms of Reference were amended as part of the wider changes to the ICB's operating model and move to a strategic commissioner. The Committee has subsequently requested some changes, and they will be brought to Board for approval later in the 2026.
Chair of the Committee	Professor Sir Pali Hungin, Independent Non-Executive Member
Report Author	Jane Smailes, Corporate Governance Support Officer
Date:	4 June 2026

Item: 9.3

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

BOARD	
16 JUNE 2026	
Committee Escalation and Assurance Report	
Committee Name:	Finance, Performance and Investment Committee
Committee Chair:	Dr Mike Smith, Primary Medical Services Partner Member
Dates of Committee Meeting/s:	5 March 2026
Alert: <i>Matters that need the Board's attention or action e.g. area of non-compliant, safety issue, new risks identified.</i>	
None	
Advise: <i>Matters to inform the Board of - developments, opportunities or areas subject to ongoing monitoring.</i>	
The Committee met for the final time on 5 March 2026. This meeting marked the end of its role under the existing ICB governance structure. As part of the transition to a strategic commissioning organisation, new governance arrangements were introduced and the functions and duties previously held by the Finance, Performance and Investment (FPI) Committee integrated into the Leadership Committee.	
Assure: <i>Areas of assurance that the Committee has received</i>	
ICB Financial Performance The Committee received an update on the financial performance of NENC ICB and NENC ICS in the financial year 2025/26 for the nine months to 31 December 2025. The Committee supported the approach to apply a 5% overhead contribution on relevant in-year funding allocations. Financial Sustainability Group Highlight Report The Committee received the report and were assured of the robust process in place to provide assurance to NHS England that the Financial Sustainability Group were working collectively to achieve delivery of financial efficiencies for 2025/26. ICB Performance Update The Committee received an overview of quality and performance using data covering December 2025 and January 2026 and concluded it had received the required assurance in relation to performance. Committee Effectiveness Review The Committee reviewed the results from the effectiveness survey.	
Supporting Documentation	
- Confirmed minutes from the meeting held on 5 March 2026 (appendix 1) - Committee annual review report (appendix 2)	

Conflicts of Interest				
Any potential/actual conflicts of interest associated with the paper?	Yes		No	✓
Recommendation / Action Required				
The Board is asked to receive for information and assurance; • Committee escalation and assurance report • Confirmed minutes from the meeting held on 5 March 2026 (appendix 1) • Committee annual review report (appendix 2)				
Report author	Toni Taylor, Corporate Governance Officer			
Date of Approval	11 June 2026			

North East and North Cumbria Integrated Care Board**Finance, Performance and Investment Committee****Minutes of the meeting held on Thursday 5 March at 10:00hrs
Via MS teams**

Present: Ken Bremner, Chief Executive South Tyneside & Sunderland NHS FT
 Levi Buckley, Chief Delivery Officer/ SRO for Mental Health, Learning Disability and Autism
 Richard Henderson, Director of Finance (Corporate)
 Jen Lawson, Head of Corporate Governance
 Jacqueline Myers, Chief Strategy Officer
 Dr Neil O'Brien, Chief Medical Officer
 Dr Mike Smith, Primary Medical Services Partner Member and Chair

In attendance: Ben Anderson, Director of Population Health Management
 Emma Ottignon-Harris, Executive Assistant (minutes)

FPI/2025-26/89 Welcome and introductions

The Chair welcomed all those present to the meeting and it was confirmed that the meeting was quorate.

It was agreed that the meeting would be recorded for the purpose of minutes.

FPI/2025-26/90 Apologies for absence

Apologies for absence were received from David Stout (Independent Non-Executive Director), David Chandler (Chief Finance Officer) and Rajesh Nadkarni (Executive Director, Cumbria Northumberland Tyne and Wear NHS FT).

FPI/2025-26/91 Declarations of interest

There were no declarations of interest raised for this meeting.

FPI/2025-26/092 Minutes of the previous meeting held on 5 February 2026**RESOLVED:**

The Finance, Performance and Investment Committee **AGREED** that the minutes of the meeting held on 5 February 2026 were a true and accurate record. Minutes of the extra-ordinary meetings during the medium term financial planning period held on 15, 22 and 29 January 2026 were also

ratified.

FPI/2025-26/093 Matters arising from the minutes

None received.

FPI/2025-26/094 Action Log

There were no outstanding actions to report.

FPI/2025-26/095 Notification of urgent items of any other business

None received.

FPI/2025-26/096 ICB financial performance update (M10)

The Director of Finance (Corporate) introduced the report which provided the Committee with an update on the financial performance of the North East and North Cumbria Integrated Care Board (ICB) and NENC Integrated Care System (ICS) in the financial year 2025/26 for the nine months to 31 December 2025.

- The ICS were reporting a forecast breakeven position with a year-to-date deficit of £11.9m, which was £7.6m better than planned, this improvement from the previous month largely reflected a movement in the ICB position.
- At month 10, following NHSE forecast change protocol, one organisation Country Durham and Darlington NHS FT (CDDFT) had deteriorated its forecast position by £24m, but had been offset with improvements in other organisations which included NEAS and a £23m improvement to ICB plan.
- A number of non-recurrent benefits had been realised in-year which had enabled the improvement in the ICB position, including receipt of additional non-recurring funding, paused investments through discretionary spend controls, reductions in some independent sector forecasts and demand management actions.
- Main pressures continued to be increased ADHD/ASD assessments with non-NHS providers, continuing care budget challenges, rising prescribing costs and risk of elective activity exceeding funding. However, there was overall confidence that the revised ICB forecast position could be managed.
- Net unmitigated risk for the ICS had reduced to £22m (from £63m previous month) and for the ICB now reduced to nil. It was not anticipated that changes in month would alter the month 11 position.
- A further update was given following publication of the month 10 report that non-recurrent allocations had been received from NHS England (NHSE) to support pressures in the current and following year. These allocations were expected to be transferred largely to providers in month 12 subject to ICB executive committee approval. Assurance was provided that discussions had taken place with each NENC organisation regarding these financial allocations.

In response to concerns raised due to challenging service reform decisions and cost reduction measures which included changes to commissioned services as a £23m improvement to plan had been reported, it was explained that the improved position was materially supported by non-recurrent benefits, including additional NHS England funding and benefits arising within commissioning budgets. It was also clarified that £30m savings requirement in 2026-27 remained, although there would be an expectation of some non-recurrent benefits in year. There was a wider discussion regarding the assurance process and investment panel decisions but to date it was not clear which national requirements would continue to apply.

- Details of the proposal to apply a standard overhead contribution of 5% to support costs incurred by the ICS towards administration of a substantial amount of non-recurring and in-year funding allocations was provided. The Committee supported the proposal to apply a standard overhead charge, however a request was made for finance colleagues to develop a more consistent and standardised overheads approach.

RESOLVED:

The Finance, Performance and Investment Committee:

NOTED the latest year to date and forecast financial position for 2025/26.

NOTED there are a number of financial risks across the system still to be managed.

NOTED the latest ICB underlying position.

SUPPORTED the suggested approach to applying a 5% overhead contribution on relevant in-year funding allocations.

FPI/2025-26/097 Financial sustainability group highlight report

The Director of Finance (Corporate) introduced the financial sustainability group (FSG) efficiency assurance report.

- It was noted that at month 10, the ICB was forecasting delivery of efficiency savings broadly in line with plan, with forecast ICB efficiency of just over £126m. This reflected a £0.9m reduction from month 9. This movement was mainly down to a downgraded forecast with the All Age Continuing Care (AACC) programme and joint package reviews, however were offset by higher than expected savings from Mproved package reviews.
- Prescribing and Medicines optimisation programme performance was reported ahead of plan and had improved by £0.5m since month 9.
- The work programme going forward would focus on planning for 2026/27 rather than the closing position for 2025/26.

RESOLVED:

The Finance, Performance and Investment Committee:

Were **ASSURED** of the robust process in place to provide assurance to NHS England that ICB FSG are working collectively to achieve delivery of financial efficiencies for 2025/26.

FPI/2025-26/98 ICB performance update

The Chief Strategy Officer introduced the shorter version NENC integrated delivery report (IDR) for 2025-26 which provided an overview of quality, performance and finance and aligns to the new 2025-26 operating framework. The report used published performance and quality data covering December 2025 to January 2026, and finance data was for January 2026 (month 10).

A summary of key highlight areas relevant to the FPI Committee was provided:

Urgent and Emergency Care:

- Pressures continued and deterioration was seen across the whole urgent and emergency care system metrics, with the exception of A&E 12-hour performance which had improved since January and was ahead of plan but remained below the national ambition of 10%.
- A&E 4 hour performance had improved to 76.7% in February and there was a strong push to secure an improved year-end position and work towards the national and more ambitious NENC target. At this point in time, it was too early to predict the end of March 2026 position.
- NEAS continued to perform strongly across winter pressures and remained the best performing ambulance trust nationally despite a drop in category 3 performance.
- A steady decline in 45 minute ambulance handover was noted which required further improvement work.

Elective Care Diagnostics and Cancer:

- The headline referral to treatment (RTT) position had seen a modest improvement but remained below plan and would be a challenge to achieve the ambitious medium term requirement for all providers to return to 92%.
- Providers are participating in a number of Q4 2025/26 sprint initiatives with expected improvements in RTT and long waiters but as the sprints had been announced late there had been limited time to mobilise plans for additional activity.
- Although the aggregate system ambition of reducing 52-week waiters to 0.5% of the total waiting list was not expected to be achieved, there had been a steady improvement both in the proportion and the absolute number of patients waiting over 52 weeks.
- The number of patients treated with 62 days of referral for suspected cancer had shown some improvement in December, but caution was aired as some patients choose to defer pathway completion until after Christmas. Performance remained below plan which was expected to recover by March but a challenge was set to avoid a renewed drop in the months to follow.
- Although factors such as movement of breast cancer patients across the system had been accounted for, the 28 faster diagnosis standard (FDF) position was highlighted as a concern to achieve the 80% target. Cancer

improvement sprints had also been launched, albeit even later than the RTT interventions, and had only just begun to take effect.

- NENC had seen a worsening position with diagnostics performance for patients waiting over 6 weeks and that a deeper analysis was required. North Cumbria Integrated Care NHS FT (NCIC) was highlighted as a specific outlier.

There was a further discussion regarding the deterioration in cancer performance, and any other specific underlying reasons. It was explained that there were a combination of factors rather than a single cause. Overall referral rates were rising year on year, creating sustained pressure on pathways where capacity had not grown at the same pace as demand. Skin cancer pathways were a longstanding challenge, and despite a summer peak, the pathway had not subsequently returned to balance. Breast pathways were a major factor, due to the movement of CDDFT breast cancer patients across the system which had affected performance. Neurology remained a challenge and gynaecology was also emerging as a concern. Recovery plans had been shared which would be supported by cancer sprint funding. Further work was also under way on breast services, including process redesign and a longer-term commissioning plan intended to provide greater stability, restore some capacity at CDDFT and support a more sustainable future model of facilities, workforce and safe service delivery.

Mental Health, Learning Disabilities and Autism:

- The increase in the average length of stay and deterioration in discharge rate standards were highlighted. Work was ongoing with an inpatient transformation group to address these issues.
- In contrast the number of people accessing individual placement support services had continued to improve.

Primary Care:

- An improvement in patients who described their overall experience of their GP as good was reported in March 2025 at 78.9% and above the national average of 75.4%.

RESOLVED:

The Finance, Performance and Investment Committee **RECEIVED** the content of the report and concluded it had received the required assurance in relation to performance.

FPI/2025-26/100 Committee effectiveness review

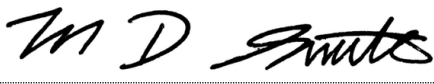
The Head of Corporate Governance advised members that the committee effectiveness report was not complete and therefore would be circulated via email outside of the meeting.

FPI/2025-26/101 AOB

No additional items of business were raised for discussion.

The Chair reminded members that this was the last Finance, Performance and Investment Committee meeting as new governance arrangements would be in place from May 2025 following ICB transition. Members were thanked for their time, commitment and contributions to meetings and formal appreciation and recognition to the Chair was noted.

Signed:

Dr Mike Smith 

Position:

Committee Chair

Date:

5 June 2026

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

BOARD	
16 JUNE 2026	
Report Title:	Finance, Performance and Investment Committee Annual Review 2025/26
Purpose of report	
The attached review outlines the achievements and assurances the Committee has gained throughout the year 2025/26 to demonstrate its roles and responsibilities and includes any risks identified as part of this work.	
Key points	
As set out in the ICB Constitution, each formal Committee of the Board is required to undertake an annual review of its effectiveness against its agreed terms of reference and provide assurance to the Board it has delivered its delegated functions. The Committee met for the final time on 5 March 2026. This meeting marked the end of its role under the existing ICB governance structure. As part of the ongoing transition to a strategic commissioning organisation, new governance arrangements are being introduced. Consequently, the functions and duties previously held by the Finance, Performance and Investment (FPI) Committee were integrated into the Leadership Committee.	
Risks and issues	
The key challenges faced by the Committee are outlined in the attached report.	
Assurances and supporting documentation	
The Committee is required to undertake an annual review of its effectiveness against its terms of reference to ensure delivery of the Committees required roles and responsibilities. The Committee has met its terms of reference throughout the year for 2025/26.	
Recommendation/action required	
The Board is asked to receive the 2025/26 annual review of the Finance, Performance & Investment Committee for information and assurance.	
Committee Chair	Dr Mike Smith
Date approved	May 2026 David Chandler Chief Finance Officer
Report author	Toni Taylor, Corporate Governance Officer

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						
Note any relevant Acts, regulations, national guidelines etc						
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	N/A					
Contracting and Procurement	N/A					
Local Delivery Team	N/A					
Digital implications	N/A					
Clinical involvement	N/A					
Health inequalities	N/A					
Patient and public involvement	N/A					
Partner and/or other stakeholder engagement	N/A					
Other resources	N/A					

Annual Review of Finance, Performance & Investment (FPI) Committee

In line with its terms of reference, the Committee must undertake an annual review of its performance and provide an account of its work to the Board.

Review period	1 April 2025 to 31 March 2026	
Members	Number of meetings eligible to attend:	Number of meetings attended by members:
Jon Rush - Non-Executive Member (Chair) <i>left 22 May 2025</i>	1	1
Eileen Kaner - Non-Executive Member (Vice Chair) <i>left 31 December 2025</i>	5	5
Ken Bremner - Foundation Trust Partner Member	10	9
Levi Buckley - Chief Delivery Officer	10	9
David Chandler - Chief Finance Officer	10	8 1 Deputy
Dr Neil O'Brien - Chief Medical Officer	10	9
Dr Rajesh Nadkarni - Foundation Trust Partner Member	10	6
Jacqueline Myers - Chief Strategy Officer	10	7
Dr Mike Smith – Primary Medical Services Partner Member (Chair from May 2025)	10	9

Role and responsibilities of the Committee

The purpose of the Committee is to provide oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable, system financial plan. The committee reviews and scrutinises the financial performance of both the ICB and NHS organisations within the ICB footprint, as well as having an overview of overall operational performance and investments.

The Committee's responsibilities fall under the following categories within the terms of reference:

- Financial framework
- Resource allocation
- National framework
- Financial monitoring
- Financial performance
- Productivity and efficiencies
- Capital
- Risk management

Details of main work areas

The FPI Committee was a Committee of the ICB Board. It was in operation throughout the twelve-month period from 1 April 2025 to 31 March 2026.

The FPI Committee met ten times in the period 1 April 2025 to 31 March 2026. The main items of business were:

- Monthly ICB financial performance updates
- System Recovery Board assurance and escalation reports

- Integrated Delivery Report
- Risk Management Report and Board Assurance Framework
- Committee Effectiveness Review
- Deep dive: A&E 4-hour waits
- NENC Medium Term Financial Plan – Scenario Planning
- Finance and performance operational planning submission 2025-26
- Specialised Commissioning Delegation ICB risk share agreement
- Infrastructure strategy update
- Learning disability performance update
- Deep dive: Community waiting list metrics
- NENC infrastructure strategy and capital / CDEL
- NHS medium term planning 2026-27 to 2030-31 submission
- Draft NENC ICB five-year strategic commissioning plan

A year end committee effectiveness survey was completed by members and attendees seeking their views on how effective the committee had been this year.

Main achievements and assurances

The annual review report summarises the activities of the Finance, Performance and Investment Committee. The Committee was consistent in reporting to the Board, providing highlight reports from its establishment in 2022 to its final meeting in March 2026, to demonstrate the extent to which the Committee met its terms of reference and providing assurance against key priorities.

The Committee monitored financial and performance issues and provided support and advice to the Executive team.

The Committee has met its terms of reference throughout the year for 2025/26.

Details of main challenges faced by the Committee during the year

Due to prescribed deadlines from NHS England regarding the NHS Medium Term Planning 2026/27 – 2030/31 submission, the Committee had to work flexibly and convened three extraordinary meetings regarding this.

Key issues to highlight to the Board

The FPI Committee was established by the ICB Board on 1 July 2022 and met for the final time on 5 March 2026. As part of the transition to a strategic commissioning organisation, new governance arrangements were introduced and the functions and duties previously held by the Finance, Performance and Investment (FPI) Committee were integrated into the Leadership Committee.

Proposal to review terms of Reference	The Committee met for the final time on 5 March 2026 marking the end of its role.
Chair of the Committee	Dr Mike Smith, Primary Medical Services Partner Member
Report Author	
Date:	June 2026

Item: 9.4

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

BOARD	
16 JUNE 2026	
Committee Escalation and Assurance Report	
Committee Name:	Audit Committee Highlight Report
Committee Chair:	David Stout, Independent Non-Executive Member
Dates of Committee Meeting/s:	Audit Committee meeting held on 09 April 2026 Extraordinary Audit Committee meeting held on 23 April 2026
Agenda Items Covered:	
Audit Committee Meeting held on 09 April 2026 • Board Assurance Framework (BAF) and Risk Management Report • Conflicts of Interest – Compliance Report • ICB Governance Handbook Update 2026/27 • ICB Finance Update • Internal Audit Progress Report • External Audit Progress Report • Counter Fraud Progress Report Extraordinary Audit Committee Meeting held on 23 April 2026 • The Annual Report and Accounts for 2025/26 in preparation for submission to the Board meeting on 16 June 2026. • The annual self-assessment of the Audit Committee's Effectiveness and Process Checklist for 2025-2026. • The review of ICB Seal Annual Report 2025-26. • Information Governance Assurance Report (quarter 4). • Interim Baseline Submission Cyber Assurance Framework (CAF) - aligned to DSP Toolkit 2025-2026. • Internal Audit Plan.	
Alert: <i>Matters that need the Board's attention or action</i>	
A key risk was raised regarding the potential loss of experienced staff and associated organisational knowledge during ongoing structural changes which may affect service quality and business continuity. Concerns around the changes in responsibilities between the ICB and foundation trusts have created uncertainty, particularly in areas such as governance, infection control, and incident reporting. This may impact the Committee's ability to gain assurance on commissioned services. The Committee was assured that these risks are reflected in the corporate risk register and aligned to the emerging ICB operating model, with responsibilities being reassigned as structures are finalised.	

Advise: *Matters to inform the Board of - developments, opportunities or areas subject to ongoing monitoring.*

Annual Report and Accounts for 2025/26

The Committee received progress updates for the ICB Annual Report 2025/26 in preparation for submission to the Board meeting on 16 June 2026, during the extraordinary meetings held on 23 April and 11 June 2026. The report is on track for Board approval on 16 June and submission to NHS England by 22 June 2026.

Conflicts of Interest

The Committee received a Conflicts of Interest Compliance Report for 2025/26 for assurance. The Committee discussed non-responses to declaration requests and assurance was provided that a formal escalation process is in place to address this and ensure effective management of potential conflicts. Future reports should clearly confirm escalation outcomes to avoid the risk of false assurance.

Assure: *Areas of assurance that the Committee has received*

Audit Committee Meeting 09 April 2026

Board Assurance Framework (BAF) and Risk Management Report

The Committee received the latest risk management report, corporate risk register and board assurance framework for review and assurance for quarter 4 of 2025/26. The report included information on the structure of the BAF and the work underway to realign this to the ICB's new operating model.

ICB Governance Handbook Update 2026/27

The Committee received the proposed changes to the ICB's standing financial instructions and the scheme of reservation and delegation. The changes proposed were to reflect the ICB's transition to a strategic commissioning role.

ICB Finance Update

The Committee received an update on the ICB's financial position and essential financial governance matters, covering financial performance, losses and special payments, tender waivers and aged debtors and creditors. An update on the implementation of ISFE2 financial system was noted with assurance provided that some ongoing national issues that were being managed through local mitigations.

Internal Audit Progress Report

AuditOne shared a progress report for information and assurance highlighting the progress and outcomes from internal audit activity. Four reasonable assurance reports had been issued following the issue of the final Head of Internal Audit Opinion for 2024/25. The second draft of the Head of Internal Audit Opinion for 2025/26 would be presented to the Audit on 23 April 2026.

Internal Audit Charter

The annual review and approval of the Internal Audit Charter and protocol evidenced the ICB's conformance with the Global Internal Audit Standards. There was a minor amendment to the Charter for 2026/27 to include the Chief Executive Officer in the escalation protocol.

External Audit Progress Report

The Committee received the External Audit Progress Report and Audit Strategy Memorandum, which set out the planned approach, including assessment of significant risks and the scope of the work to be undertaken. An assessment based on the work completed to date and the current understanding of the organisation confirmed that no significant weaknesses had been identified in the ICB's arrangements for securing value for money.

Counter Fraud Progress Report

The Committee was provided with a progress report providing an update on the work undertaken for the period 20 January 2026 to 20 March 2026. The report also included the proposed Counter Fraud Work Plan for 2026/27. The local proactive exercise, in line with the annual leave investigative work, had been completed and a draft report was currently awaiting management comments. The final report would be shared with Members.

Extraordinary Audit Committee Meeting 23 April 2026

Annual Report and Accounts for 2025/26

The Committee reviewed assurance to the first draft of the Annual Report which included an overview of the Performance Report, Accountability Report and Financial Statements.

- The National Audit Office (NAO) Checklist.
- Summary of Memorandum and draft Accounts

The draft Head of Internal Audit Opinion (HoIAO) report was received by the Committee. The Opinion did not contain an overall assurance at this point however this would be included as part of the final draft report on 11 June 2026. The final draft annual report and accounts will be reviewed and recommended by the Committee for Board approval at the forthcoming meeting on 11 June 2026.

Annual Self-Assessment of Audit Committee's Effectiveness and Process Checklist for 2025-26

The Committee received the annual self-assessment report of its effectiveness and process checklist. No areas of concern or suggestions for improvement were identified, with no required actions. The Committee would continue to explore areas of improvement around succession planning for the Audit Committee Chair along with the integration with other committees to support robust processes.

Review of ICB Seal Annual Report 2025-26.

The Committee received the ICB Seal Annual Report for 2025/26 which provided robust assurance on the use of the ICB seal in the execution of documents during 2025/26.

Information Governance Assurance Report (quarter 4)

The Committee received the Information Governance Assurance Report for Quarter 4 2025–26, which included a summary of information governance activity, including Freedom of Information and Subject Access Requests, and Data Protection Impact Assessments. No concerns were noted and the Committee received positive assurance that the ICB had not breached any statutory requirements.

Interim Baseline Submission Cyber Assurance Framework (CAF) - aligned to DSP Toolkit

The interim Baseline Submission (CAF) for 2026/27 report was presented, outlining the initial audit had been completed identifying some areas for refinement prior to the final audit in May 2026 with no areas of concern, the ICB remained on track to publish the final submission of the toolkit on 30 June 2026.

Internal Audit Plan

The Committee received assurance on progress towards finalising the Internal Audit Plan for 2026/27. A list of potential audits was being refined into a risk based short list for executive director review. A reserve list would be developed, using a risk-based approach, to provide appropriate substitute audits if any changes to the audit plan required this.

Supporting Documentation

- Confirmed Audit Committee minutes 05 February 2026 – Appendix 1
- Audit Committee Annual Effectiveness Report 2025-26 – Appendix 2

Conflicts of Interest

Any potential/actual conflicts of interest associated with the paper?

Yes

No

✓

Recommendation / Action Required

The Board is asked to receive the Committee Escalation and Assurance Report and ask any questions of the Committee Chair.

The Board is asked to receive for information and assurance;

- Confirmed Audit Committee minutes from the meeting held on 05 February 2026 (appendix 1)
- Audit Committee Annual Effectiveness Report 2025-26 (appendix 2)

Report author

Lynda Hutchinson, Head of Complaints and Patient Experience

Date of Approval

08 June 2026

**North East and North Cumbria Integrated Care Board
Audit Committee**

Minutes of the meeting held on Thursday 5 February 2026 at 14:00 p.m. via MS Teams

Present: David Stout, (Chair), Non-Executive Director, ICB
Pali Hungin, Non-Executive Director, ICB

In Attendance: David Chandler, Chief Finance Officer, ICB
Mark Kirkham, Partner, Forvis Mazars
April Coulson, Associate Director of Internal Audit, AuditOne
Sharon Fatkin, Senior Internal Audit Manager, AuditOne
Richard Henderson, Director of Finance (Corporate), ICB
Gareth Davies, Counter Fraud Specialist, AuditOne
Deborah Cornell, Director of Corporate Governance and Board Secretary, ICB
Emma Clayton, Freedom to Speak Up Guardian, ICB (for items 9 and 10)
Lynda Hutchinson, Head of Corporate Governance, ICB
Cath Andrew, Audit Manager, Forvis Mazars (from 14:40 p.m.)
Nicola Hearn, Principal Auditor, AuditOne
Joanne Leadbitter, Executive Assistant, ICB (minutes)

AC/2025-26/103 Welcome and Introductions

The Chair welcomed colleagues to the Audit Committee meeting of North East and North Cumbria (NENC) Integrated Care Board (ICB).

AC/2025-26/104 Apologies for Absence

Apologies for absence were received from Claire Riley, Chief Corporate Services Officer, ICB.

AC/2025-26/105 Confirmation of Quoracy

For the meeting to be quorate, a minimum of two independent non-executive members were required, including either the Chair or Vice-Chair.

It was agreed the meeting was quorate.

AC/2025-26/106 Declarations of Interest

External and Internal Audit colleagues had a conflict of interest in relation to item 18.1, Review of Internal Audit Report – Feedback to the Effectiveness of AuditOne (Annual Review). It was agreed that the Chair would request the relevant colleagues to leave the meeting at the appropriate point.

The Chair confirmed that if any further interests were raised during the meeting, they would be acted on accordingly.

AC/2025-26/107 Minutes of the Previous Meeting

RESOLVED:

The Committee **AGREED** that the minutes from the Audit Committee on 9 October 2025 were a true and accurate record of the meeting.

AC/2025-26/108 Minutes by Exception for Approval at ICB Private Board

RESOLVED:

The Committee **AGREED** there were no confidential areas within the minutes of 9 October 2025 and the minutes in their entirety should be presented to the Public Board meeting.

AC/2025-26/109 Matters Arising from Minutes

There were no matters arising from the minutes of the meeting on 9 October 2025.

AC/2025-26/110 Action Log Updates

The action log was reviewed by the Committee with updates revised accordingly.

AC/2025-26/111 ICB Freedom to Speak Up Update Report

The Freedom to Speak Up (FTSU) Guardian presented an update on freedom to speak up activity, including emerging themes and key developments. It was reported that twelve confidential cases were reported since taking up the role in October, all of which have now been resolved. It was noted that although a QR code had been introduced to facilitate anonymous reporting, no anonymous cases had been submitted to date. Continued challenges with the dispersed locations of ICB offices are making in-person interactions more difficult. Despite this, positive feedback was reported from staff and increasing contact from individuals wishing to raise concerns.

The FTSU Guardian raised concern that senior-manager training compliance stood at 11.1%, which would be addressed with OD colleagues. There had been a successful release of a promotional video with the Communications Team, which had led to increased interest from individuals wishing to become FTSU Champions. The Committee was updated on work relating to psychological safety workshops and the planned refresh of the organisational reflection tool.

The Committee was informed of national changes whereby the National Guardian's Office (NGO) would close in June 2026, with FTSU oversight moving to the Department of Health and Social Care and NHSE, supported by CQC. The FTSU Guardian viewed this change as beneficial, expecting to enhance regulation and offer improved support.

The non-executive director queried why such a high proportion of concerns originated from nursing midwifery. It was explained that leadership and

management challenges had been identified and that targeted training programmes were being introduced under the Chief Nursing Officer's direction.

The Chief Finance Officer added that executive team members had been actively engaging with frontline staff across All Age Continuing Care, which had been well received. The FTSU Guardian further confirmed their intention to report openly back to staff on themes, lessons learned and organisational action.

A new national reporting system introduced by the NGO required certain types of concerns to be logged under "inappropriate behaviour". Although the FTSU Guardian thought the wording did not always align with the nature of the concerns, it was confirmed that the ICB would apply the necessary categories.

The FTSU Guardian clarified boundaries in supporting primary care, focusing on guidance and network development rather than direct involvement in HR issues, to avoid being overwhelmed given their role was part-time.

RESOLVED:

The Committee **NOTED** the report and emerging themes from Q3 2025/26; **CONSIDERED** the strategic and operational implications of the National Guardians Office closure on speaking-up culture and governance; **ENDORSED** the development of a regional Primary Care FTSU Guardian support group and ongoing staff engagement activities and **NOTED** training compliance and continued focus on senior manager engagement.

AC/2025-26/112 ICB Freedom to Speak Up Policy

The FTSU Guardian presented the Freedom to Speak Up Policy (Version 3) and advised the Committee that the policy had been updated in line with the national policy framework, ensuring all new requirements were accurately incorporated. Local adjustments were also made to ensure the policy aligns with the requirements of the ICB.

RESOLVED:

The Committee **APPROVED** NENC ICB HR13 – Freedom to Speak Up Policy (Version 3) for implementation across the organisation; **NOTED** the completed Equality Impact Assessment and supporting consultation processes and **SUPPORTED** dissemination and awareness of the policy across all workforce groups.

AC/2025-26/113 Comments in relation to risk from committee chairs (by exception)

The Chair invited members to raise any comments, by exception, regarding the risk management from individual committees that may be relevant to the Audit Committee.

The Chair of the Quality and Safety Committee and Remuneration Committee reflected on the broader context of organisational pressures arising from the need to reduce costs, restructure teams and redefine the ICB's future role. The importance of maintaining organisational memory, continuity and realism about staff capacity was stressed, highlighting a risk that the organisation might inadvertently assume more capability than would remain after restructuring.

The Chief Finance Officer and Director of Corporate Governance and Board Secretary confirmed that these concerns were being incorporated into both the Board agenda and an upcoming Board development session focused on strategic commissioning. The Committee noted the importance of monitoring risk throughout the transition.

AC/2025-26/114 ICB Board Assurance Framework and Risk Management Report

The Director of Corporate Governance and Board Secretary presented the quarterly Board Assurance Framework (BAF) and Risk Management Report. There had been movement in several risk scores, and one risk, NEC0031, had increased this quarter. It was explained that the BAF structure would remain in its current form until approval of the ICB operating model, and background work was underway to prepare for future updates.

The Chair identified a typographical error in the risk section on the cover sheet of the report, where a score of 20 had been labelled “amber high” instead of “red”, and asked that the correction be completed ahead of Board submission.

The Chief Finance Officer noted the importance on keeping the BAF understandable and accessible to public readers, highlighting examples of controls and the lack of clarity for non-specialists. It was acknowledged that a thorough review involving executives would be beneficial.

The Chair questioned whether it remained appropriate for the overall goal rating to default to the highest associated risk, particularly where other risks were materially lower. The Director of Corporate Governance and Board Secretary acknowledged the longstanding debate and reiterated that current practice was in line with national best practice, although agreed the issue could be revisited during future BAF development.

Following a question from the Chair, the Director of Corporate Governance and Board Secretary assured the Committee that the risk management system remained sound and responsive, with risks being identified, updated, and managed appropriately, despite organisational challenges

ACTION: The Director of Corporate Governance and Board Secretary to amend point number 2 in the risks and issues section of the cover sheet to reflect the score of 20 "amber high" prior to submission of the report to the Board.

RESOLVED:

The Committee **SATISFIED** itself that the ICB has a sound system of internal control concerning the management of risk; **SATISFIED** itself that the BAF accurately reflects the principal risks to achieving our objectives as well as their current mitigations; **RECOMMENDED** the approval of the BAF for quarter 3 2025/26 by the Board; **RECEIVED** and **REVIEWED** the corporate risk register for assurance and **NOTED** the place risks with a residual rating of 12 and above.

AC/2025-26/115 Information Governance Assurance Report Quarter 3 and Data Security and Protection Toolkit (DSPT) Compliance

The Director of Corporate Governance and Board Secretary introduced the Information Governance report for Quarter 3. It was confirmed that all Freedom of Information (FOI) requests had been responded to within statutory timeframes and year-on-year trends indicated no strong themes noted due to the varied nature of FOI requests. An update was issued on Subject Access Requests, highlighting that recent changes to classification had impacted comparative volume metrics.

The Committee was informed that the baseline submission for the Cyber Assurance Framework had been completed in December 2025 and that an interim assessment had been undertaken with AuditOne in January 2026. The outcome of the assessment was awaited and would be fed into the next report, and the team remained on track for the June 2026 submission.

The report flagged increased delivery risks due to staff capacity and specialist requirements in light of organisational changes, with ongoing monitoring and mitigation in place.

RESOLVED:

The Committee **NOTED** the content and status of the report; **NOTED** the increased risk to delivery; **NOTED** the Interim Audit assessment will take place in January 2026; **RECEIVED** the Q3 Information Governance Report for assurance and **NOTED** the next cycle for CAF publication will be final submission in June 2026.

14:40 p.m. Cath Andrew, Audit Manager, Forvis Mazars, joined the meeting at this point

AC/2025-26/116 Audit Committee Terms of Reference: Annual Review

The Director of Corporate Governance and Board Secretary summarised the updates to the wording of the Audit Committee Terms of Reference which have been aligned across all ICB committee Terms of Reference.

The Chair observed that the current composition did not meet the requirement for four independent members and stated that this needed to be addressed within the future governance structure. The Chair also sought clarification on quorum arrangements where a conflict of interest arose among the two existing non-executive members. The Director of Corporate Governance and Board Secretary confirmed that the revised wording permitted quoracy to be maintained using a two-thirds calculation, ensuring the Committee could continue to operate.

The Chief Finance Officer recommended the inclusion of references under section 6.12 Auditor Panel with the inclusion of procurement and finance expertise when forming the Auditor Panel, suggesting the addition of "Utilise the appropriate expertise within the ICB to support the Panel in its role and responsibilities.

RESOLVED:

The Committee **REVIEWED** and **APPROVED** the proposed amendments to the Audit Committee Terms of Reference and **RECOMMENDED** submission of the

terms of reference to the Board for formal ratification; subject to the inclusion of references to procurement and finance expertise as described above.

AC/2025-26/117 ICB Finance Update Report

The Chief Finance Officer reported that the ICB was forecasting achievement of its financial target, with an underspend contributing to the mitigation of pressures across the system. It was noted that the ICS was expected to deliver an overall balanced position, despite County Durham and Darlington NHS FT forecasting a £24m deficit. Members were reassured that risk-management mechanisms were in place to reconcile this variance by year-end.

A summary of key cost pressures was provided, including a projected £28m overspend in ADHD services, ongoing challenges in prescribing due to international price fluctuations, and scrutiny from NHS England regarding All Age Continuing Care financial efficiency. It was noted that elective activity had been effectively managed and that the ICB had received additional funding related to strike action and elective recovery.

It was reported that in relation to losses, special payments and waivers, one Parliamentary Health Service Ombudsman-related special payment of £875 had been approved, linked to a personal health budget. The report included a summary of all waivers agreed since the last report, two of which linked to £7m in Health and Growth Accelerator funding.

The Committee was updated on the position of debtors and creditors. It was reported that the overall debtor position had improved slightly since the previous period, with balances reducing following the settlement of a large invoice relating to Lancashire and South Cumbria ICB. An outstanding debtor balance of approximately £1.8m remained in respect of business rates rebates due from NHS England; this was being actively followed up and was not considered high risk.

A significant proportion of the remaining debtor balance related to local authorities, with appropriate recovery and escalation processes in place. Continuing Healthcare debt was identified as the main underlying recovery risk; however, this was largely provided for and did not present a material financial risk. The creditor position had improved notably, particularly in relation to NHS Property Services, where sustained work had resulted in a significant reduction in balances aged over 90 days. The Chair commended the Director of Finance, Corporate, and all staff involved, on the progress of reducing aged NHS Property Services creditor balances.

The Director of Finance, Corporate, provided an update on ISFE2, the new national financial ledger system. It was confirmed that while the system was functioning, some control risks and operational inefficiencies had emerged, leading to significant additional workload across finance teams nationally. NHS England was holding frequent meetings to resolve issues, but progress remained slow.

A Non-Executive Director questioned whether external auditors of CDDFT should have anticipated the Trust's significant financial deterioration. Both the

Chief Finance Officer and the Partner, Forvis Mazars, explained that external auditors were responsible for assessing value for money arrangements and the accuracy of annual accounts, but not for providing real-time financial oversight.

RESOLVED:

The Committee **RECEIVED** the report for information and were **ASSURED** around the content; **NOTED** the special payment recorded in the current financial year which has been approved in line with ICB Financial Delegations; **NOTED** the tender and quotation waivers that have been approved in line with ICB Financial Delegations and **NOTED** the issues presenting with ISFE2 and mitigations being taken to manage potential control risks.

AC/2025-26/118 Annual Accounts and Annual Report Timetable

The Head of Corporate Governance presented the timetable for the 2025/26 Annual Report and Accounts and confirmed alignment with national submission deadlines. It was highlighted that an Audit Committee meeting was scheduled prior to the submission deadline, and that an internal timeline would be maintained to track Committee and Board dates for sign-off.

RESOLVED:

The Committee **NOTED** the annual report key dates timeline for 2026.

AC/2025-26/119 Internal Audit Progress Report

The Senior Internal Audit Manager, AuditOne, updated the Committee on progress against the Internal Audit Plan and reported that all 2024/25 work had been completed. Three final reports had been issued since the last meeting, two with good assurance and one with reasonable assurance related to safeguarding checks. Four audits from the 2025/26 plan had also been completed with substantial or good assurance ratings, and ten further audits were in progress.

There were six audits behind schedule, where a draft report was planned to be issued. However, for four of these audits, fieldwork was either complete or would be completed in the next couple of weeks. It was planned that all audits in the 2025/26 internal audit plan would be at draft reporting stage by the end of June 2026. It was emphasised that, for the first time in some time, there were no overdue audit actions.

The report included information on a proposal to combine two planned CHC audits into a single governance-focused audit for all age continuing healthcare. It was confirmed that planning for the 2026/27 audit year was underway.

The Committee's attention was drawn to assurance levels below "good" in the internal audit end of year opinion. It was noted that to date, four reasonable assurance reports had been issued following the issue of the final Head of Internal Audit Opinion for 2024/25.

The Chair highlighted potential risks arising from staff reductions as part of organisational change in the ICB. The Director of Corporate Governance and Board Secretary and the Chief Finance Officer outlined transition-planning work

and reassured the Committee that critical skills risks were being managed as part of the ICB's voluntary redundancy process.

RESOLVED:

The Committee **RECEIVED** the progress reports as a form of assurance and **APPROVED** the proposed amendments to the internal audit plan for 2025/26.

AC/2025-26/120 External Audit Progress Report and External Audit Plan

The Partner, Forvis Mazars, reported that it was a relatively quiet period for external audit. It was noted due to sickness absence in the engagement team, this had delayed some preparatory work however, an experienced Audit Manager has now been appointed to address this. Kath Andrew was introduced to the Committee and confirmed they were looking forward to working with the team.

RESOLVED:

The Committee **NOTED** the external audit progress report and external audit plan.

AC/2025-26/121 Counter Fraud Progress Report

The Counter Fraud Specialist, AuditOne presented the Counter Fraud Progress Report which provided an update on counter fraud work undertaken between 19 September 2025 and 19 January 2026.

It was confirmed that 57 tasks had been completed and 40 were in progress. Three overdue tasks related to an annual leave Local Proactive Exercise (LPE) and Counter Fraud Policy updates and were close to completion. The Counter Fraud Policy was updated to include new legislation and was pending Executive Committee approval. Overdue recommendations are now implemented and systems in place to combat fraud.

There had been eight new referrals, several of which related to Personal Health Budgets (PHBs) concerns. It was noted that increased PHB reporting was expected following recent awareness-raising exercises.

The Committee received an update on a number of historical counter fraud cases that had been previously reported and were continuing to be monitored or investigated.

A1CF/23/0188 - Personal Health Budget (PHB) case that had been the subject of a previous investigation report presented to the Audit Committee. This case had already been concluded and therefore required no further update.

A1CF/23/0240 - related to a travel-claim investigation that had been referred to the NHS Counter Fraud Authority (CFA). This case remained active and that the CFA was awaiting advice from the Crown Prosecution Service (CPS). Despite the ongoing nature of the investigation, the ICB had started to recover some of the identified financial losses, which was considered a positive development as legal processes continued.

A1CF/24/0226 - allegation of procurement fraud against a former employee. This had been investigated and no fraud had been identified, resulting in the case being closed with no further action required.

A1CF/25/0003 - case involving intelligence gathering, which continued to be monitored. Intelligence reports had continued to be received during the reporting period. These reports had not yet met the threshold for a formal investigation but were being retained and assessed in line with counter fraud procedures.

A1CF/25/0101 - allegation that an employee had been working elsewhere during contracted hours. Both counter fraud and internal management reviews had been undertaken and there was insufficient evidence to substantiate the allegation. As a result, no fraud action was taken.

A1CF/25/0127 - allegation concerning medical practices submitting false claims. Enquiries into this matter were still ongoing in order to determine whether the issue represented deliberate fraud or administrative error. The ICB started recovery processes to reclaim any incorrect payments, regardless of the outcome.

The Counter Fraud Specialist highlighted the outcomes of two Local Proactive Exercises (LPEs). The first related to Personal Health Budgets and focused on raising awareness, strengthening fraud-proofing arrangements and supporting staff understanding of fraud risks. It was reported that over 100 members of the Continuing Healthcare team had received targeted engagement and that PHB policies and procedures had since been fraud-reviewed and approved. It was noted that the increase in PHB-related referrals was likely a direct consequence of this awareness-raising work, which was described as a positive outcome.

The second LPE related to pre-employment checks along with the reviewed implementation of previous recommendations. It was confirmed that no cases of fraud had been identified. It was reported that new starters were now being processed through a revised provider arrangement, with evidence showing compliance with NHS employment standards. There were some documentation gaps within transferred staff files, but work was underway to ensure records were complete and consistent going forward.

RESOLVED:

The Committee **RECEIVED** the progress report and remaining appendices for Information.

AC/2025-26/122 Audit Committee Cycle of Business 2026-27

The Audit Committee Cycle of Business 2026-27 was presented for information.

RESOLVED:

The Committee **RECEIVED** the Audit Committee Cycle of Business 2026-27.

AC/2025-26/123 Any Other Business

There were no items of any other business.

15:25 p.m. Mark Kirkham, Partner, Forvis Mazars, Cath Andrew, Audit Manager, Forvis Mazars, April Coulson, Associate Director of Internal Audit, AuditOne, Sharon Fatkin, Senior Internal Audit Manager, AuditOne, Gareth Davies, Counter Fraud Specialist, AuditOne and Nicola Hearn, Principal Auditor, AuditOne left the meeting at this point.

AC/2025-26/124 Review of Internal Audit Report – Feedback to the Effectiveness of AuditOne (Annual Review)

The Committee reviewed feedback received from staff who had recently participated in internal audits. It was highlighted that feedback was more positive than the previous year, particularly regarding communication, efficiency and clarity of approach.

The Committee discussed one area of learning relating to the way key financial controls were split across multiple audits, which had created inefficiencies. It was agreed that this should be revised for the next audit cycle.

Members also considered comparative cost-per-day rates and agreed to undertake a benchmarking of audit costs exercise with other ICBs to assess value for money and quality of internal audit.

ACTION: The Audit Committee Chair and the Chief Finance Officer to contact counterparts from North East and Yorkshire ICBs to gather feedback on cost and quality of their internal audit service for benchmarking purposes.

It was agreed that a formal feedback letter would be drafted by the Head of Corporate Governance and shared with the Chair to review and approve before being sent to Internal Audit.

ACTION: The Head of Corporate Governance to draft a formal correspondence to AuditOne to provide feedback on the review of internal audit effectiveness, to share with the Chair for approval prior to sending to internal audit.

RESOLVED:

The Committee **REVIEWED** and **APPROVED** the annual Internal Audit Effectiveness Survey results 2025 for AuditOne and **RECOMMENDED** the feedback and outcome of the survey data to be relayed to Internal Audit AuditOne to support future improvements and ways of working.

AC/2025-26/125 Review of the Meeting

The Chair requested feedback and learning points following the meeting. Participants reflected that the meeting had been well-structured and comprehensive. It was felt that the meeting had run smoothly and there were no significant issues or lessons to be learned.

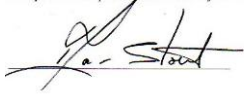
This was the first Audit Committee meeting for the Non-Executive Director, and the suggestion was made to provide a copy of the HFMA's Audit Committee Handbook.

ACTION: The Head of Corporate Governance to provide the Non-Executive Director with a hard copy of the HFMA's Audit Committee Handbook and the link to the on-line version.

AC/2025-26/126 Date and Time of Next Meeting

The next meeting of the Audit Committee was scheduled to take place on Thursday 9 April 2026, 10:00 a.m. to 12:00 noon, via MS Teams.

Meeting closed: 15:40 p.m.



Signed:

Position: Audit Committee Chair

Date: 9 April 2026

AUDIT COMMITTEE ANNUAL REPORT 2025/26	
<i>In line with its terms of reference, the Committee must undertake an annual review of its performance and provide an account of its work to the Board.</i>	
Review period	01 April 2025 to 31 March 2026
Number of Meetings	Four (plus 2 extraordinary meetings)
Membership and terms of reference	The Committee has continued to refine its terms of reference to reflect the scope of the responsibilities within the Committee's remit and to ensure it has the appropriate representation to provide assurance to the Board.
Role and responsibilities of the Committee	
The Audit Committee has been established to contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.	
Details of main work areas and assurances	
Integrated Governance, Risk Management, and Internal Control Throughout the year, the Committee has consistently received reports pertaining to the review and assurance of the corporate risk register and Board Assurance Framework. This process ensures comprehensive oversight of all significant risks associated with the delivery of ICB operational plans and confirms that mitigation strategies have been implemented as effectively as possible. The Committee is assured that the Board Assurance Framework remains suitable for its intended purpose, undergoes regular review and updates, and that robust risk management practices are well-established across the organisation, in accordance with the Board-approved risk management strategy. The Committee reviewed and recommended changes to the Scheme of Reservation and Delegation (SoRD), as well as financial delegations and limits, in accordance with its terms of reference throughout the year. In addition, the Committee also received assurance reports concerning: the appropriateness of the process for considering compliance reporting for conflicts of interest within the ICB	

- annual review of the use of the ICB seal
- progress of the annual ICB Fit and Proper Persons Test submission report to NHS England

Internal audit

The Committee regularly reviewed reports from internal audit and discussed key findings, including the head of internal audit's opinion and management's response. It ensured effective coordination between internal and external auditors to make the best use of audit resources. The Committee also assessed the effectiveness of the internal audit service during the annual review process.

External audit

The Committee maintained an effective and collaborative relationship with our external audit providers during the financial year.

External auditors have provided regular updates to coordinate and track a work plan, focusing on tasks related to the annual report, accounts, and audit opinion during the yearly review process.

Counter Fraud

During the year, the Committee was provided with regular updates from designated counter fraud specialists. These reports assured the Committee that the ICB maintains robust measures for addressing fraud, bribery, and corruption (including cyber security), in accordance with NHS Counter Fraud Authority (NHSCFA) standards.

The Committee examined and tracked counter fraud work plans, regularly received updates on fraud prevention activities, and monitored the progress on any action plans put in place.

Information governance

The Committee was provided with regular updates throughout the year regarding information governance structures and assurance measures. These reports encompassed assurance related to the annual submission of the Cyber Assurance Framework (CAF) aligned to the Data Security and Protection Toolkit (DSPT).

Freedom to speak up

The Freedom to Speak Up (FTSU) Guardian provided an update on FTSU processes, progress, and an overview of activity including emerging themes and key developments for 2025-26 through regular reporting throughout the year.

Financial reporting

The Committee received consistent reports from the Chief Financial Officer, which offered assurance regarding the fulfilment of the ICB's statutory obligations and adherence to applicable financial governance frameworks.

In accordance with the financial delegations approved by Board, certain matters must be presented to the audit committee for information, including:

- authorisation of debt write-offs and losses
- special payments
- authorisation of a single tender/single quote waiver

The quarterly report presented to the Committee also provides a summary of all such items.

Annual Report and Accounts

Throughout the year, the Committee was provided with regular progress reports regarding the production of the ICB annual report and accounts. Both internal and external audit offered assurance during this period, (including audit opinions prior) to the final approval of the annual report and accounts. The Committee also received assurances concerning the effectiveness of outsourced services and systems managed by external providers as part of the annual reports and accounts assurance process.

Committee effectiveness review process and findings

The HFMA checklist focuses on processes through various themes and questions, which are completed by the Chair and Board Secretary to provide assurance to the Board regarding the delivery of its delegated functions. Given the tenure of two non-executive directors during 2025, it was determined that the comprehensive checklist would be replaced with an annual effectiveness survey for 2025-2026, consistent with the approach adopted by other parent Committees.

There were two main areas of concern around non-executive members capacity and the Committee's independence. These issues were being addressed regarding the Board's changing composition and new governance arrangements.

The survey results indicated that no areas of concern or suggestions for improvement were identified, with no required action.

The Committee will continue to explore any areas of improvement around succession planning for the Audit Committee Chair along with previous discussions around the integration with other committees to support robust processes.

Proposal to review terms of Reference?	Audit Committee terms of Reference were reviewed and revised for approval on 05 February 2026
Chair of the Committee	David Stout, Non-Executive Member
Report Author	Lynda Hutchinson, Head of Corporate Governance
Date:	11 June 2026

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

BOARD

16 JUNE 2026

Report Title:

**NENC ICB Annual Report & Accounts
01 April 2025 to 31 March 2026**

Purpose of report

To present the Board with the North East and North Cumbria Integrated Care Board (ICB's) Annual Report and Annual Accounts for period 01 April 2025 to 31 March 2026.

Key points

This report has been drafted and developed in line with the direction and guidance from NHS England in accordance with the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM) and is structured as follows:

- Performance Report
- Accountability Report
- Financial Statements

The performance reports include several key areas which include:

- Chair's Foreword
- Statement from the Chief Executive
- Performance overview, analysis (including key performance measures, the organisation's development and performance, performance on other matters including sustainability on environmental matters and reducing health inequalities)
- Statement of Activities. The ICB's main areas of work and highlights of our workstream priorities and key achievements from April 2025 to March 2026 have included the healthier and fairer programme, housing, health and care programme and women's health and programme aims.

The detailed accountability report describes how the organisation meets its key accountability requirements and incorporates best practice to comply with statutory duties and regulations of corporate governance. The three areas in this section detail:

- The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April 2025 to 31 March 2026, including membership and organisation of our governance structures and how they supported the achievement of our objectives.
- The **Remuneration and Staff Report** describes our remuneration policies for executive and non-executive directors, including salary and pension liability information. It will also provide further information on our workforce, remuneration and staff policies.

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

The ICB Audit Committee met on 11 June 2026 and reviewed the reports with internal and external auditors.

Key ICB milestones and activities

The key dates/milestones for the ICB annual report process are detailed below:

Due Date	Report Submissions
11/06/2026	• Audit Committee reviewed and approved the final ICB reports for submission for Board review and approval
16/06/2026	• Board to receive and review the annual report and accounts for approval to submission to NHS England
22/06/2026	Information to be submitted to NHS England • Fully audited and signed annual report and accounts 01 April 2025 – 31 March 2026 • Final ICB Head of Internal Audit Opinion • Final NAO disclosure checklist 2025/2026
01/07/2026	• ICB annual report and accounts (unsigned version) to be published on NENC ICB website
01/07/2026	• Final version of ICB annual report and accounts to be emailed to HWBB Chairs
28/07/2026	• AGM Meeting to be held in public at Board to present the ICB annual reports and accounts 2025/2026

Areas and issues to note

The latest draft of the Head of Internal Audit Opinion (HoIAO) has provided an overall rating of good assurance that the ICB has a sound system of internal control, governance and risk management designed to meet the organisation's objectives. Whilst the overall assurance level will not change in the final version to be submitted to NHS England, the status of the ongoing audit work will be updated to provide the most up to date position prior to submission.

The draft HoIAO brings to the attention of the Accountable Officer a high priority action from the safeguarding arrangements audit undertaken in October 2025 for consideration for inclusion in the annual governance statement (AGS) relating to improvements with regards to record keeping. This action has been implemented and improvements put in place to mitigate any associated risk. The evidence has been reviewed by the Chief Executive (as Accountable Officer) and Audit Chair and considered against the criteria in the NHS England guidance and agreed that this did not meet the criteria for inclusion in the AGS.

Financial Statements

The accounts were reviewed by Audit Committee on 11 June 2026 and recommended for approval by the Board.

The Board is asked to approve the annual report and accounts for 2025/26. Please note a final check of formatting will be undertaken prior to final publication.

The ICB accounts were reviewed separately by the Audit Committee at its meeting on 11 June 2026 and have now been merged with the annual report for final submission.

An accounts briefing note has been included as item 10.2 for information and is intended to give a basic understanding of the ICB accounts for the year, including explanation of significant balances. It is recommended this document is read alongside the accounts.

The accounts themselves are based on a standard national template and the format and layout is unchanged from the prior year. There are four 'primary statements' within the accounts together with a number of supporting notes which provide further analysis of income and expenditure during the year, along with asset and liability balances held at the end of the year. This is all explained in further detail in the briefing note at item 10.2.

Risks and issues

The key risks are highlighted in the attached report.

Assurances and supporting documentation

- The ICB annual report 2025/26 has been developed in accordance with the direction and guidance issued from NHS England in accordance with the Department of Health and Social Care Manual for Accounts (DHSC).
- The detailed information included within the report has been prepared by the relevant subject matter experts.
- The annual report has been shared with the Audit Committee for approval on 11 June 2026
- The annual report has been shared with the Leadership Committee for approval on 09 June 2026
- In preparing the annual report and accounts for the ICB is demonstrating how as an organisation their functions were discharged during the period 01 April 2025 – 31 March 2026 and the ICB has provided assurance to consulting with the relevant Health and Wellbeing Boards (HWBBs).

Recommendation/action required

The Board is asked to:

- Receive and review the ICB annual report and accounts for 2025/2026
- Approve the ICB annual report and accounts for submission to NHS England by 9am on 22 June 2026
- Approve signatories to be incorporated within the annual report from the ICB Chief Executive and the External Auditor Forvis Mazars, LLP

Acronyms and abbreviations explained

NENC ICB – North East and North Cumbria Integrated Care Board
 DHSC – Department of Health and Social Care
 NAO – National Audit Opinion
 HoIAO - Head of Internal Audit Opinion
 HWWB – Health and Wellbeing Board
 KLOEs – Key Line of Enquiry

Executive Committee Approval	09 June 2026
Sponsor/Approving Executive Director	D Cornell, Director of Corporate Governance, Communications and Involvement (Board Secretary)
Date approved by Executive Director	01 June 2026
Report author	M Rice, Senior Corporate Governance Manager R Henderson, Director of Finance

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						
Note any relevant Acts, regulations, national guidelines etc						
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	Finance teams involved in creation of annual report and accounts					
Contracting and Procurement	Not Applicable					
Local Delivery Team	Not Applicable					
Digital implications	Not Applicable					
Clinical involvement	Not Applicable					
Health inequalities	Not Applicable					
Patient and public involvement	Not Applicable					
Partner and/or other stakeholder engagement	Engagement on the first draft of the ICB Annual Report has taken place with the Health and Wellbeing Board Chair's					
Other resources	Not Applicable					

Better health and wellbeing for all...

Annual report and accounts

1 April 2025 – 31 March 2026



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Chair's Foreword

Professor Sir Liam Donaldson

This year has been an important period of change for our Integrated Care Board. As a result of organisational changes in the NHS, we will have a more focused role in assessing and meeting the health needs of the 3.2 million people we serve.

The technical term for this new role is *strategic commissioning*.

It means we can look at the landscape of health and care across the North East and North Cumbria and do so with a clear line of sight to determine what services are available, where they are and, over time, get a much clearer view of the quality of care they can deliver.

It also means we can develop a much deeper understanding of what members of our population need and want from the care they receive. To do this we will be looking at the best data that we can assemble. It will be used not just to supply background information, but to provide real insights into how services are performing.

In achieving these benefits for our population, we have a powerful lever: ensuring that the money allocated to us is used to get the best possible services for patients and the public.

Compared to many other parts of the country, our area has a poorer health record. More people fall ill from preventable causes. More people die earlier than they should. More people spend long periods of their lives with chronic ill health or disability.

Some statistics are a stark challenge to both health and local authorities. The North East continues to have the highest rates in the country for deaths related to drug poisoning and drug misuse. Suicide rates are among the highest in England.

The North East has the highest rate of alcohol-related deaths, more than twice as high as the east of England. A recent fall is encouraging, but alcohol-specific deaths are still 30% higher than in 2019 before the pandemic.

Working together, we are addressing the wider determinants of health. A strong example is our WorkWell programme, which supports people to remain in or return to work through a combination of health and employment support.

This includes investment in health and work coaches, targeted support for musculoskeletal and mental health conditions, and new digital approaches. Additional funding secured for 2026/27 will bring total investment to £30 million over two years, enabling us to embed and expand this work.

In a part of England with persistently higher levels of economic inactivity and ill health, this work is critical. Through close collaboration with combined authorities, local authorities and the voluntary and community sector, we are helping to tackle longstanding challenges around unemployment, health inequality and economic inclusion.

We have also seen significant progress through our Housing, Health and Care programme. Our shared memorandum of understanding represents a major step forward, showing a collective recognition of the fundamental role that good housing plays in health and wellbeing. This level of collaboration is in itself a notable achievement and provides a strong foundation for the future.

We are actively targeting alcohol, tobacco and obesity among the key causes of ill health, with alcohol care teams in every trust, and smoking rates now down to 10%, though they are higher in some of our most deprived communities.

Our commitment to mental health remains strong, and working with partners in the voluntary, community and social enterprise sector we have seen an expansion in crisis support services and safe havens. I am delighted to see our investment in ambulance services coming to fruition as they achieve the best response times in England.

Alongside this progress, it is important to be open about the challenges we have faced.

This year brought serious concerns about quality and safety of care in some services, most notably highlighted through the Royal College of Surgeons review which the ICB commissioned into breast surgery services at County Durham and Darlington NHS Foundation Trust.

When the NHS falls short of the standards people have a right to expect, the impact is profound. Ensuring action is taken and outcomes shared openly and transparently is fundamental to the culture we want to shape across our local NHS services.

We continue to work closely with the Foundation Trust and our partners to ensure that improvements are made and sustained, and the learning shared across other trusts in the region.

Such events are not common, but they underline the importance of constant vigilance – not just in responding to specific incidents but ensuring the quality and safety of everyday care in our healthcare system.

We will continue to strengthen our oversight of quality and safety, recognising that public confidence depends on us acting decisively, transparently and with compassion if things go wrong.

Strengthening our workforce remains a key priority. This year, staff have continued to deliver high-quality care in the face of sustained pressure, including the impact of national industrial action.

The development of new medical training opportunities will play an important role in attracting and retaining the best talent in the North East and North Cumbria. The partnership between Imperial College London, the University of Cumbria and the NHS to establish the Pears Cumbria School of Medicine is a significant step forward, adding to the strong and growing range of medical training at Newcastle, Sunderland, Teesside and Northumbria universities.

Together, these institutions will help us grow a skilled and sustainable medical workforce for the future, rooted in and committed to the communities we serve. This is, of course, part of a much wider workforce, and we remain equally committed to supporting all those who work across health and care.

As we look ahead, our direction is clear. We will continue to strengthen our role as a strategic commissioner – focusing on better outcomes for our communities. Delivery of healthcare will increasingly be led through our partners at place and neighbourhood level, supported by strong collaboration with NHS, local authorities and the voluntary sector.

I would like to place on record my sincere thanks to our staff for their professionalism, resilience and continued commitment to patients and communities through what has been a demanding year of change. For those colleagues who have taken the opportunity to retire or explore new roles and left the NHS, I offer my thanks for your service and the lasting contribution you have made.

I also want to thank all our partners for their continued collaboration. Working together, our ambition remains strong and consistent: a determination to improve health outcomes, reduce inequalities, and provide safe, high-quality care for all our communities.

Professor Sir Liam Donaldson

Chair, North East and North Cumbria Integrated Care Board

Statement from the Chief Executive

Samantha Allen

This year has been a story of change – and a time of achievement. Our transition to a new strategic commissioning role saw us reduce running costs and adapt the way the ICB operates, while still making progress in our aim to improve health and wellbeing and ensure people receive high quality care.

It's a tribute to the professionalism and determination of our staff, Board members, partner organisations and communities that so much has been achieved against a backdrop of uncertainty and change. My sincere thanks go to those staff who have left the organisation, often after long and dedicated careers in our region's NHS.

As our transition plans took shape, the drive and commitment of staff and partners to improve health and wellbeing never wavered. Major achievements in winter planning, urgent and emergency care, dental services, health and work, primary care and mental health – to name just a few – are testament to this.

We start our next chapter with renewed focus and confidence for the future. Our [five-year strategic commissioning plan](#) sets out how we will work with partners to plan and commission services for the 3.2 million people we serve, building on our shared ambition of [better health and wellbeing for all](#).

We continue to be guided by clear principles: being evidence-led, focused on value and outcomes, and centred on improving people's lives. In line with national guidance and the [model ICB blueprint](#), we are investing in priority areas such as insight and population health, to ensure we have a strong evidence base on which to plan services for our communities.

Importantly, we remain committed to listening and working with patients, carers and communities in the decisions we make. The progress we have made reflects the strength of our system and the shared commitment of many partners.

One great example is the careful planning that takes place before winter. Every springtime, colleagues from NHS bodies, councils and other partners come together to make detailed plans so that services can continue to provide high quality care no matter what weather, bugs and problems the season throws at us.

With initiatives like acute respiratory infection hubs, proactive frailty care and improvements to patient flow, we approached winter 2025-26 well prepared.

Between October and March, the region's NHS received 18,000 more 111 contacts and 15,000 more 999 calls, with 7,000 more ambulances arriving at hospitals, compared to the previous year.

At the same time, category two ambulance response times - for conditions like stroke, chest pain or major burns - improved by almost five minutes. Ambulance handover times reduced by 18%, with 7,000 fewer ambulances having to wait over 45 minutes to hand over at A&Es.

Performance against the 4-hour target - the number of patients admitted, transferred, or discharged within four hours - improved by 1.3% for adults and 1.4% for children. The region's GP practices provided more than 9 million appointments between October and February.

In March, our A&Es faced their busiest month ever - but continued to improve their performance. We are not yet where we want to be but improving performance while helping record numbers of patients is an achievement worth marking.

The latest data also shows a steady improvement in waiting times for elective procedures. There is still much to do but waiting lists in the North East and North Cumbria are down to 343,000 – their lowest level since the pandemic.

The proportion of people waiting less than 18 weeks for treatment has improved, while the number waiting over a year has almost halved in the past 12 months. I'd like to thank the many colleagues and partners who are working so hard to make these improvements.

Another key step is our Oral Health and Dental Strategy, which aims to provide fairer access to dental care, prevent dental disease, and make it easier to get care from an NHS dentist.

We launched a £9.5 million urgent dental access centre (UDAC) network to provide 109,000 appointments every year to help people manage urgent dental problems safely.

Patients can book their own appointments via our website, giving them more choice about where and when to access urgent care and alleviating pressure on NHS 111 to triage urgent dental issues. Almost 60,000 patients have been treated at our 23 UDACs already.

We invested £2 million in initiatives to prevent poor oral health from an early age. This includes fluoride varnish schemes to make teeth stronger, and supervised toothbrushing to give almost 32,000 children the equipment, skills and knowledge to care for their teeth and gums.

To stabilise NHS dentistry, we increased the minimum rate paid to dentists to deliver NHS care, paid loyalty bonuses to experienced dentists, supported practices in our most deprived communities, and replaced capacity in areas where NHS services have been lost.

We have also delivered support to grow and upskill the dental workforce, so we have a strong pipeline of NHS dentists for the future.

As a commissioning organisation, we know that excellent services are not enough on their own. We were one of the first regions to develop [a WorkWell service](#), to help people with health conditions stay in or return to work.

Our WorkWell advisors have already helped hundreds of people – from a Sunderland resident helped to take control of a chronic back problem with sports massage, pain management strategies and a phased return-to-work plan agreed with their employer, to a Cumbrian patient who benefited from one-to-one support, talking therapy and improved work-life balance before returning to their job.

The programme also offers extra support for musculoskeletal problems, gynaecological conditions and obesity – all common reasons for having to leave the workforce. With one person in 18 in our region working in health and care, the programme is extending mental health, menopause and counselling support for these staff, which also helps our services run better by reducing sickness absences.

In addition, the programme unveiled a range of digital innovations focused on mental health and wellbeing, musculoskeletal and women's health, helping people access the right support earlier and stay well.

As commissioners, we can make a big impact by listening, identifying areas for improvement and trying new approaches. With patient feedback and evidence showing the need for a wider range of mental health services, we commissioned mental health safe havens in Ashington, Wallsend, Newcastle, Gateshead, Redcar and Whitehaven – with our first young people's haven now getting established on Newcastle's Westgate Road.

Our GP practices are delivering more patient care than ever, often working with higher levels of acuity at the same time as providing more than 85,000 appointments per working day.

This achievement comes despite very real workforce and sustainability challenges for practices. Our Primary Care Access Recovery Plan is helping to improve resilience, support more integrated neighbourhood working, address workforce issues and improve infrastructure.

Our community pharmacists continue to enhance their role, with 60,000 Pharmacy First consultations taking place every month for common conditions like sore throats and uncomplicated urinary tract infections. More than 50 per cent of Covid vaccinations in our region take place in community pharmacies.

Women in our region face some of the worst health inequalities in the country. We are strongly committed to listening to women and girls, so we can provide inclusive services that meet their distinctive needs.

A little over two years ago, we opened our region's first women's health hubs in Sunderland and Gateshead as part of our ambitious women's health programme. The hubs have made a real impact and will now continue for another year, with a view to using their experience and extending services across the region in the coming years.

We have seen that for every pound invested, the hubs generate £8 in benefits, reducing waiting times, improving access to care and helping women stay in work.

Across our region, there is a real determination to tackle the many inequalities that women face. As the year came to an end, we were delighted to host Dame Lesley Regan, Women's Health Ambassador for England, who challenged and inspired our Board to build on this progress and tackle issues ranging from cervical cancer, contraception, and violence against women and girls to heavy bleeding, menopause and osteoporosis.

Another key initiative is the SPOT CKD programme. An innovative partnership of the ICB, Health Innovation North East and North Cumbria and Boehringer Ingelheim, the programme is working with practices in Sunderland, South Tyneside and South Tees to identify Chronic Kidney Disease (CKD) earlier and strengthen care.

The project is supporting clinical pharmacists to take a leading role in CKD care within GP practices, helping to identify patients earlier, review medications and ensure people receive the right treatment at the right time.

Smoking and alcohol are still among the biggest causes of ill health and early death in our region, as well as adding pressure to health and care services.

As a region, we have made amazing progress in the past 20 years, with adult smoking rates in the North East falling from 29% in 2005 to 10% last year. Much of this is down to the tireless work of many partners, including [Fresh and Balance](#), as well as thousands of people who have made the personal commitment to quit smoking.

As the year came to an end, we were looking forward to the Tobacco and Vapes Act becoming law and taking us another step closer towards our [vision for a smokefree future](#), backed by a strong range of services to help people quit.

We continue to lead system-wide action to reduce alcohol-related harm, including specialist alcohol care teams which have supported more than 10,000 patients in our region's foundation trusts.

A key focus in the coming year will be developing neighbourhood health services to bring care closer to home, help people stay well and reduce the need for hospital visits. You can get involved through our People's Hub, the [Boost](#) learning and improvement community, and our Communities of Practice.

We are now testing this approach in Stockton and Sunderland, where GPs, nurses, social care, pharmacists and other professionals work as a single team to provide joined-up care in one place.

Over time, we will extend this approach across the region, using detailed data, digital tools and new ways of funding and organising services.

Looking ahead, we can expect further change in the NHS as we embrace our new mission as a strategic commissioning organisation. With our new operating model taking shape as the year came to an end, we are well placed to make a real difference in the coming years, never losing sight of our mission: to improve health and wellbeing and ensure people receive high quality care.

Samantha Allen

Chief Executive, North East and North Cumbria Integrated Care Board

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PERFORMANCE REPORT

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Samantha Allen

Chief Executive

North East and North Cumbria Integrated Care Board

XX June 2026

Performance Overview 2025/26

The NHS North East and North Cumbria Integrated Care Board (ICB) is the statutory decision-making body of the North East and North Cumbria Integrated Care System (ICS). The ICB is responsible for the commissioning of most health services and the effective stewardship of NHS spending for all people who live in the North East and North Cumbria.

The performance overview summarises the purpose of the ICB including its business model and structure as well as its objectives and strategy. The section gives an overview of how the ICB has performed against its key objectives in 2025/26 to date and highlights its main risks to achievement and how it mitigates against these risks.

About our Integrated Care Board

The ICB is part of a system of statutory NHS organisations which formed on 1 July 2022 and is responsible for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of health services. The ICB also works locally with health and wellbeing boards in each of the 14 local authority areas. The ICB's place-based teams work alongside our 64 primary care networks (PCNs) which are groups of local GP practices, social care teams and other community-based care providers.

NENC ICB has the general statutory function of arranging health services for its population and is responsible for the performance and oversight of NHS services within its ICS. The NENC ICB Oversight Framework is integrated into the wider ICB cycle of business, and this ensures that it is a powerful tool for the achievement of the ICB's strategic and operational aims as articulated in its strategy and operational plan. Following extensive engagement and co-production with a wide range of partners, the Better Health and Wellbeing for All strategy has been created to improve the health and care for people who live in the North-East and North Cumbria. The ICB, working with partner organisations as part of the Integrated Care Partnership (ICP) has developed its Integrated Care Strategy, in line with national guidance. The ICB has operated its oversight arrangements with regard to its statutory duties, its agreed priorities and the requirements set out in its 2025/26 Operating Plan which addresses the NHS England Operating Plan Guidance for this year.

The ICB, along with 14 local authorities, forms the statutory committee of the ICP. The ICP is responsible for setting and developing our strategy for health and care in the region. It is an equal partnership between local government and the NHS with a key purpose to align the ambition and strategies of partners across the area to improve the health of our communities.

Our vision, goals and ambition

Within the ICB, our vision is better, fairer, health and wellbeing for everyone. This is intended to be an inclusive vision, capturing the need to improve health and broader wellbeing for everyone across the North East North Cumbria (NENC). The North East and North Cumbria ICP is a statutory committee of fourteen local authorities and the Integrated Care Board (ICB).

The ICP published the North East and North Cumbria integrated care strategy, Better Health and Wellbeing for All, in December 2022. It is an ambitious strategy organised around four key goals:

Longer, healthier lives: reducing the gap between how long people live in the North East and North Cumbria compared to the rest of England.

Fairer outcomes: we know that everyone does not have the same opportunities for good health, because of where they live, their income, education, and employment.

Better health and care services: high quality services no matter where you live and who you are.

Giving our children the best start in life: enabling them to thrive, have great futures and improve lives for generations to come.

Delivering our ambitious goals and ambitions set out in the ICS strategy requires a continued commitment by all partners across NENC. Given the changing NHS landscape and continued financial challenges facing the NHS, strong collaboration is required to deliver the three shifts and the outcomes set out in this plan and the ICS strategy.

As the ICB transitions to being a strategic commissioner, in-line with the Model ICB Blueprint and best practice guides, the ICB will be setting out the care models and outcomes that are aligned to local and national priorities and underpinned by robust population health needs assessments. These will be evidence-based, patient centred, co-produced and are focused on effectiveness, productivity and financial sustainable.

Using our ICS partnership arrangements, organised through networks and programme workstreams, the ICB will set the strategic direction to improve health and wellbeing across NENC and secure the desired outcomes via commissioned contracts with Providers.



Key issues and risks that could affect delivery of objectives and future performance and plans relate to capacity and workforce challenges, and services which have been adversely impacted by Industrial Action in recent years. The ICB continues to support its providers in managing these pressures and improvements have been seen during 2025/26, in particular achieving a significant reduction in patients waiting over 52 weeks. Whilst the focus in 2025/26 has been to deliver a continued reduction in long waiting patients, the proportion of patients on the waiting list who have been waiting for less than 18 weeks has remained a focus for NENC ICS. In 2025/26 we have consistently been the best or second-best performing ICS (out of 42) against this long-standing NHS Constitutional target.

In 2025/26 we continue our focus to improve our performance for our patients with cancer. Additional resources and continued work with our providers are focussing on recovery.

Specific pressures are noted below which could impact delivery of our objectives and future performance:

- Access to Primary Care, across General Practice and community Dentistry, Pharmacy and Optometry.
- Urgent and Emergency Care (UEC) capacity.
- Ambulance Handover delays.
- High level of hospital attendances leading to high bed occupancy.
- Pressures within social care together with health service capacity resulting in patients who no longer meet the criteria to reside having had their discharge delayed.
- Increase in need for mental health, learning disability and neurodiversity pathways and very long waits in some pathways.
- Workforce pressures have placed additional pressure on existing staff.

Performance analysis

The performance analysis section provides a detailed performance summary of how the ICB measures its performance; what it sees as its key performance measures; how it checks performance against those measures; and the link between key performance indicators (KPIs), risk and uncertainty.

The section builds on the performance overview giving a more detailed integrated performance analysis and long-term expenditure trend analysis where appropriate and informed by our use of statistical process control. The section also describes how risks have affected the organisation achieving its objectives; how risks have been mitigated; and likelihood of their impact, including how existing and new risks could affect performance and delivery of plans in future years.

The ICB has a duty to improve its quality of services, and this section gives an overarching summary of ICB performance, followed by more detailed analysis in relation to mental health and safeguarding, as well as a review of the steps the ICB has taken to implement its joint local health and wellbeing strategy.

The ICB measures performance utilising a range of performance metrics which are aligned to NHS England's operational planning metrics and encompass a wide range of recovery objectives as well as some NHS Long Term Plan (LTP), NHS People Plan commitments, quality and safety, and health inequality measures. This is underpinned using a statistical process control (SPC) approach which is considered best practice to enable boards and systems to understand where there is significant variation and most risk and therefore focus attention on those areas that require improvement support.

The ICB routine performance assessment encompasses key elements of the 2025/26 operational planning priorities, NHS Oversight framework (NHS OF) metrics, and the targets as set out in the NHS Constitution. The Finance, Performance and Investment Committee, Executive Committee and Quality and Safety Committees consider the element of risk to achievement of the operational planning priorities within the organisational risk register so that the impact on the quality of care to our patients is minimised.

During 2025/26, NHS England continued a process by which trusts are allocated to tiers in relation to their elective, cancer and diagnostics performance, Tier 1 NHSE led, Tier 2 ICB led with support from NHSE. Informal performance support is also in place for UEC in 2025/26. At the end of 2025/26 all trusts continue to see improvements through this process, and one trust remains under tier one escalation for both elective care and cancer at the end of March 2026, one trust remains in tier 2 escalation for elective and two remain under tier 2 escalation

for cancer at the end of quarter 4 2024/25. NHSE will review Tiering and Segmentation in early Quarter 1 of 2026/27.

In 2023/24 NHSE introduced a tiering system for Urgent and Emergency Care (UEC) similar to the existing system for elective care. However, for UEC ICBs were allocated to tiers, rather than trusts. NENC ICB was not assessed as needing Tier 1 or Tier 2 support in 2025/26 for UEC.

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Table: NHS Oversight Framework (NOF) & CQC Summary

Appendix 1 - NHS Oversight Framework (NOF) & CQC Summary

Provider	NOF Segment	CQC Rating	Oversight Arrangements	Additional Escalation/Support	CQC Additional Comments/Other Reviews
North Tees and Hartlepool NHSFT	1	Requires improvement (2022)	ICB led	Range of support including NECS support for incident reporting. Tier 2 for Cancer.	
Northumbria Healthcare NHSFT	1	Outstanding (2019)	ICB led	Elective recovery meetings have been ad-hoc reflecting their performance delivery.	Maternity services – good overall (safe domain also good)
Newcastle Upon Tyne Hospitals NHSFT	2	Requires improvement (2024)	ICB led	Removed from Tier 2 (Aug 25) for Cancer. GIRFT support in place. Fortnightly Tier 3 elective recovery meetings	Warning notice Dec 22 re healthcare provided to patients with a mental health need, learning disability or autism. Maternity services rated as requires improvement (May 23).
South Tyneside and Sunderland NHSFT	2	Requires improvement (2023)	ICB led	National maternity Safety Support Programme. Elective recovery meetings have been ad-hoc reflecting their performance delivery	Maternity services – Requires Improvement (2022)
County Durham and Darlington NHSFT	3	Good (2019)	NHS E/ICB led	Removed from Tier 2 Elective (12.4.23). Regular Tier 3 elective recovery meetings.	Maternity services at UHND and DMH rated as Requires Improvement (Apr 24). Warning notice issued re improvements to managing each maternity service.
Gateshead Health NHSFT	3	Good (2019)	ICB led	Enhanced finance oversight/ support led by NHS E. Regular Tier 2 elective recovery meetings with Gateshead with move to fortnight planned.	Maternity services – Good overall (2023)
North East Ambulance Service NHSFT	3	Requires improvement (2023)	ICB led	Progress against CQC action plan provided through the Quality Review Group. National maternity Safety Support Programme. Regular Tier 3 elective recovery meetings	Maternity services – Requires Improvement (2023)
South Tees NHSFT	3	Good (2023)	NHSE/ICB finance	Quality - supported by ICB/NHSE. Enhanced finance oversight. Tier 2 for both Elective and Cancer.	Maternity (Jan 24): James Cook requires improvement overall, and for being safe and well-led; Friarage Hospital requires improvement overall and for being well-led, and good for being safe (Jan 24)
Tees, Esk and Wear Valleys NHSFT	3		NHSE Quality Board	Support and additional capacity from the wider NHS to progress programme of improvement work across services.	
Cumbria, Northumberland, Tyne and Wear NHSFT	4		NHSE/ICB finance	Action plan monitored via the Quality Review Group.	Learning disability and autism services - requires improvement Aug 2022
North Cumbria Integrated Care NHSFT	4	Requires improvement (2023)	ICB led	NCIC Tier 1 for both Elective and Cancer. Enhanced finance support from NHSE.	Maternity services – good overall (Safe domain – requires improvement)

Further Information on Trust Segmentation and Methodology can be accessed via this link: <https://www.england.nhs.uk/long-read/acute-trust-league>

General Practice CQC Ratings

Local Authority	Outstanding	Good	Requires Improvement	Inadequate
County Durham	6	53	2	1
Cumbria	7	24	1	0
Darlington	1	10	0	0
Gateshead	1	22	2	0
Hartlepool	0	11	0	0
Middlesbrough	0	18	1	0
Newcastle upon Tyne	3	24	1	0
North Tyneside	4	15	1	0
Northumberland	3	32	0	0
Redcar and Cleveland	0	14	0	0
South Tyneside	1	19	0	0
Stockton-on-Tees	0	20	1	0
Sunderland	4	35	0	0
Total	30	297	9	1

Residential Social Care CQC Ratings

Local Authority	Outstanding	Good	Requires Improvement	Inadequate
County Durham	11	116	8	1
Cumbria	4	70	10	0
Darlington	2	21	3	1
Gateshead	2	42	2	1
Hartlepool	0	25	2	0
Middlesbrough	2	38	2	0
Newcastle upon Tyne	7	51	9	0
North Tyneside	0	32	6	0
Northumberland	4	80	9	0
Redcar and Cleveland	0	34	6	0
South Tyneside	1	27	1	0
Stockton-on-Tees	3	44	3	0
Sunderland	6	75	4	0
Total	42	655	65	3

Community Social Care CQC Ratings

Local Authority	Outstanding	Good	Requires Improvement	Inadequate
County Durham	4	47	2	0
Cumbria	0	36	6	0
Darlington	2	16	1	0
Gateshead	0	38	2	0
Hartlepool	0	12	0	0
Middlesbrough	1	17	2	0
Newcastle upon Tyne	4	37	0	1
North Tyneside	3	24	4	1
Northumberland	7	34	2	0
Redcar and Cleveland	1	14	1	0
South Tyneside	2	16	0	0
Stockton-on-Tees	1	25	0	0
Sunderland	2	39	0	0
Total	27	355	20	2

Performance summary and mitigations 2025/26

Urgent and Emergency Care

The NENC Urgent and Emergency Care Network identified three UEC System Priorities for 2025/26. These were:

- Enhancing the Respiratory Pathway
- Maximising Preventative and Home Facing Offer
- Improve Hospital Flow and Discharge

There has been an extensive programme of work to deliver improvements across urgent and emergency care. Key programmes of work include:

- Alternatives to Emergency Department (A-tED) to offer increased offer in the Community
- Implementation of Care Co-ordination hubs and Single Point of Access (SPoA).
- Maximisation of the use of Virtual Wards and Urgent Crisis Response (UCR)
- System Co-ordination Centre deployment – 8am-8pm, 7 days per week
- Facilitated system approach to develop targeted action plans to support improvement in Ambulance Handover Delays
- Maximising the use of and access to Same Day Emergency Care (SDEC)

2025/26 Performance summary and mitigations

Key

	Metric	Period	Value	Plan	+/- Plan	Target
▲						
A&E 4 Hour Performance % (National Sitrep)		Feb 2026	76.8%	80.0%	-3.2%	82.1%
C2 Average Response Time		Feb 2026	20:41	23:26	-02:45	24:24
% of Attendances in A&E over 12 Hours		Feb 2026	6.9%	4.7%	+2.1%	4.3%
% of Handovers to take over 45 Minutes		Feb 2026	5.6%	0.0%	+5.6%	0.0%

Performance Highlights

A&E 4-hour response time measures the percentage of patients arriving at an A&E department who are admitted to hospital, transferred to a more appropriate care setting, or discharged home within 4 hours.

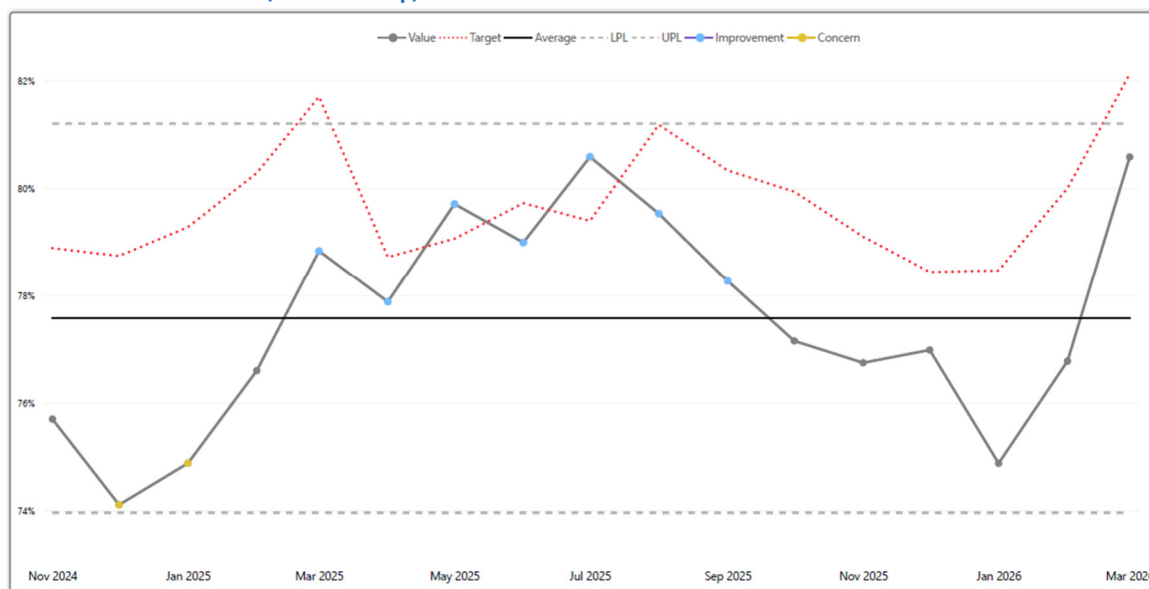
There has been a specific focus nationally on the delivery of the 78% standard for 4 hour waiting time in A&E throughout 2025/26. A&E performance has improved during 2025/26 across NENC, continuing to perform favourably when compared to the national position. A&E 4-hour performance achieved 80.6% in Mar26, below plan, however above national ambition of 78% and achieving 78.2% at YTD position.

Despite sustained winter pressures and increased activity in 999/111 calls and ambulance arrivals, performance improved across several key areas over a 6-month winter comparison between Oct 2025–Mar 2026 vs same period in 2024/25.

Notable improvements included:

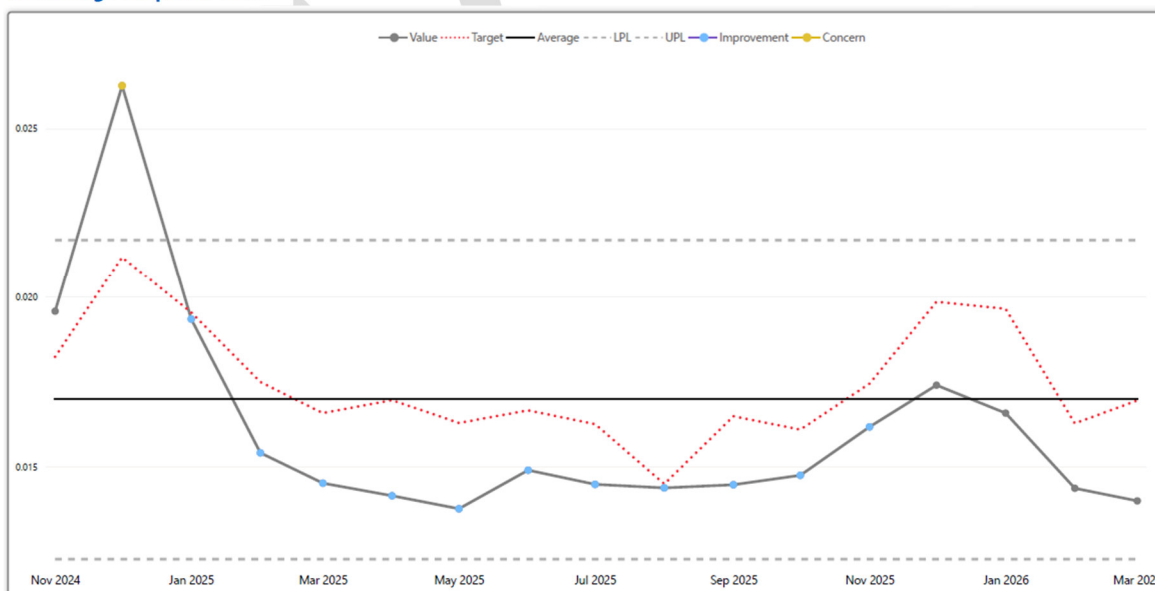
- A&E 4-hour and 12-hour performance improving by 1.3% and 15.6% respectively
- A 5-minute improvement in Category 2 response times
- A 5-minute reduction in average handover times
- A 5.1% reduction in handovers exceeding 45 minutes

Urgent and Emergency Care -
A&E 4 Hour Performance % (National Sitrep)



Category 2 mean ambulance response - calls are those that are classed as an emergency or a potentially serious condition that may require rapid assessment, urgent on-scene intervention and/or urgent transport. Performance for the North East Ambulance Service (NEAS) has continued to improve throughout 2025/26 and at Mar26 Cat 2 response was reported at 20 minutes: 09 seconds, meeting the national ambition of 30:00 mins for 2025/26. YTD position to Mar26 reports NEAS have maintained their position as top performing ambulance trust for all 4 response time metrics, including the priority metric of Cat2.

Urgent and Emergency Care -
C2 Average Response Time



Ambulance Handover time exceeding 45 minutes

In line with the Urgent and Emergency Care Plan 2025/26 (published 6 June 2025) and in response to last winter's prolonged ambulance handover delays, a national directive was issued to eliminate handovers exceeding 45 minutes. Building on this, our Trusts continue to make strong progress through targeted initiatives to improve patient flow and internal processes. Collaborative work between Trusts and NEAS such as call-before-convey approaches and the use of Care Coordination Hubs has strengthened our ability to direct patients to appropriate services.

Although fully eliminating >45-minute handover delays remain challenging, the system has delivered notable improvement. Across NENC ICB, despite an increase in activity, average handover times have reduced by 4.19 minutes in winter 2025/26, compared to winter 2024/25. Mar 26 position reported 2.5% >45-minute handovers, the lowest number reported to date. This position reflects the positive impact of sustained efforts across the system.

Delivery and risk into 2026/27

Work continues to expand and join up new models of care outside of hospital settings to provide a safe and efficient alternative to in-patient care. This work will support patients who would otherwise be in a hospital setting to receive care and treatment in their own home, to prevent avoidable admissions into hospitals and enable early supported discharge out of hospital.

Primary and Community Care

A general practice action plan was developed in Jun25, setting out 1) tackling unwarranted variation, 2) improving contract oversight, 3) improving commissioning and transformation for general practice. The ICB has finalised a framework which sets out the ICBs expectation of practices regarding contract compliance on all new GP contract changes.

2025/26 Performance summary and mitigations

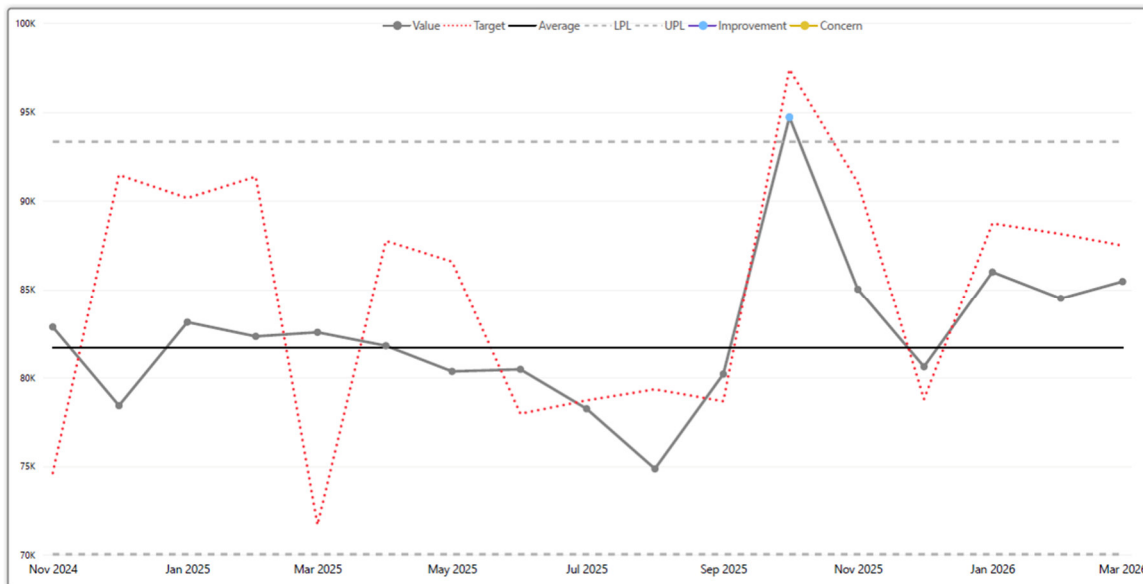
Metric	Period	Value	Plan	+ / - Plan	Target
Primary Care Appointments per Working Day	Jan 2026	85,980	88,732	-2,751.9	87,482
Number of Urgent Dental Appointments Delivered	Jan 2026	23,172	27,034	-3,862.0	26,510
Percentage of unique patients seen by NHS dentist (adult) - rolling 24m	Feb 2026	40.4%	42.0%	-1.6%	42.0%
Percentage of unique patients seen by NHS dentist (child) - rolling 12m	Feb 2026	63.1%	61.0%	+2.1%	61.0%

Key Performance Highlights

General Practice appointments - across NENC have remained broadly static throughout 2025/26, peaking in Q3. Actual appointment volumes are below plan between Apr25 – Mar26 (latest available data) but plans in place to maximise capacity moving into 2026/27.

Urgent Dental Appointments – The Government are moving towards implementation of new dental reforms from 1st April and as a result have ceased data provision, of the Urgent Appointments data publication from NHSE. It is not yet understood what data provision will be provided from either NHSE or BSA.

Primary Care -
Primary Care Appointments per Working Day



Dementia diagnosis rate – The NHS England target for the dementia diagnosis rate has historically been to diagnose 66.7% of people estimated to be living with the condition. While this target was previously set to be achieved by March 2025, it was formally removed from the 2025/26 operational planning guidance, however performance is still being considered against this. For NENC ICB, we have reported a consistently good performance rate against this metric and have a year-end position of 68.9% which exceed the national ambition.

Annual health check and plan for people on the learning disability register - Improvement against target continues across NENC month on month with a further acceleration expected at year-end in line with historical trends as patients are invited in for their annual recall.

Delivery and risk into 2026/27

- The delivery of GP Services to patients is impacted by GP collective action, limiting the number of GP consultations per session.
- A Primary Care Access Recovery Plan has been implemented across our system. There are significant delivery gains to this plan including:
 - Continued roll out of Modern General Practice Access
 - Utilising digital tools to improve access
 - Using outcomes/data to inform planning and future priorities
 - Sharing good practice/lessons learnt
- The ICB is continuing to work with GP practices to verify compliance positions and develop action plans with Practices to gain compliance where needed, including the outcomes of any electronic Declaration of Compliance (eDEC) returns.
- Urgent Community Response (UCR) data quality work continues. Focus remains on increasing UCR referrals, including 999/111, TEC responders and care homes. Co-ordinated focus at ICB level within Urgent Responsive Care group.
- The ICB has had some success in re-commissioning dental activity from contract hand-backs. In addition, a network of urgent dental access centres with on-line booking capacity for patients has been implemented across NENC which will supplement the mandated minimum capacity of unscheduled care appointments that every high street practice will need to deliver from April 2026.

Elective Care, Cancer & Diagnostics

During 2025/26 the Operational Planning ambitions for elective care were to:

- Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement
- Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement
- Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026
- Improve performance against the headline 62-day cancer standard to 75% by March 2026
- Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026

The ICB and Provider Collaborative have maintained their strong working relationships throughout 25/26 and continue to support trusts helping to navigate pressures focussing on key improvements to deliver the Operational Planning ambitions.

2025/26 Performance summary and mitigations

Key	Metric	Period	Value	Plan	+ / - Plan	Target
	Number of patients on waiting list (RTT incomplete)	Jan 2026	346,353	332,122	+14,231.0	329,799
	% patients waiting for initial treatment on incomplete pathways within 18 weeks	Jan 2026	69.7%	72.7%	-3.0%	74.0%
	% patients waiting more than 52 weeks for treatment (Incomplete pathways only)	Jan 2026	1.1%	0.6%	+0.5%	0.5%
	% Patients waiting more than 6 weeks from referral for a diagnostic test (9 core tests)	Jan 2026	14.5%	5.4%	+9.1%	5.1%
	% of patients FDS within 28 days	Jan 2026	66.7%	81.4%	-14.7%	82.9%
	% of patients treated within 62 days of referral for suspected cancer	Jan 2026	68.1%	74.4%	-6.3%	76.8%
	Proportion of cancer diagnosed at stages 1 or 2 - Rolling 12 Months	Nov 2025	60.1%	75.0%	-14.9%	75.0%

Key Performance Highlights

Significant progress on elective recovery across NENC has been achieved in 2025/26 with many more patients seen because of increased capacity. Quarter four of 2025/26 has been particularly productive leading to the best reported annual position for many headline elective metrics.

Improving the **proportion of patients on the waiting list who have been waiting for less than 18 weeks** has been a key focus for NENC ICS. In 2025/26 we have consistently ranked first or second (out of 42 ICBs) best performing ICS against this long-standing NHS Constitutional target. Performance of 72.3% (Mar26) falls short of our very ambitious plan but significantly exceeds the national ambition of 65.0%.

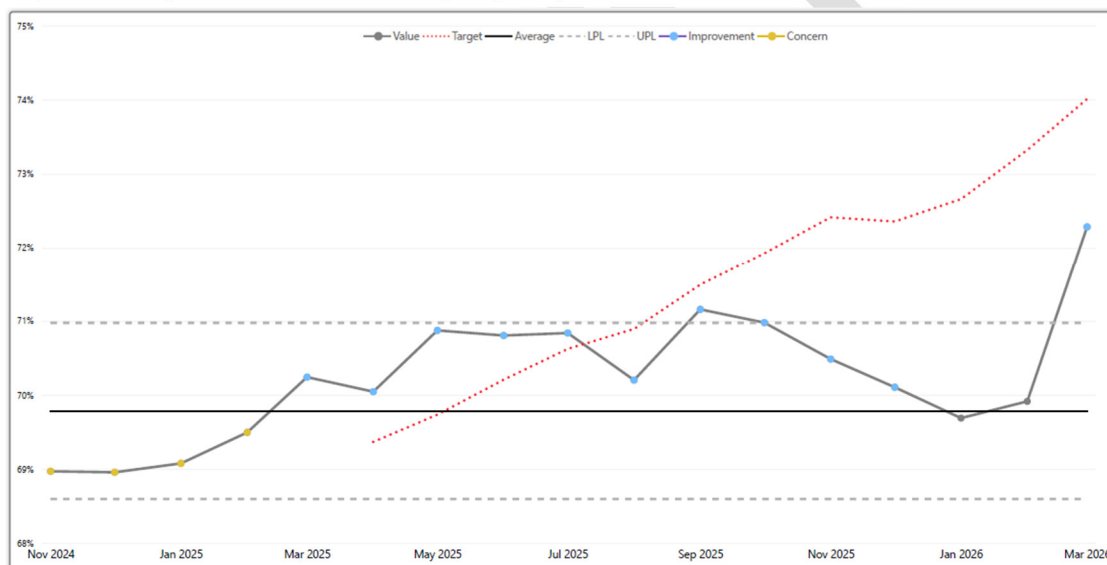
There has been a determined effort in 2025/26 to reduce the number of **long waiting patients** across NENC and as of March 2026 the number of patients waiting >52 weeks has reduced from a high of 6,977 (2024/25) to 2,379 in 2025/26. This represents 0.7% of the total waiting list against a national ambition of 1.0%

Waiting list size for non-urgent, consultant led treatments for physical health conditions has experienced sustained and relentless growth following the COVID pandemic. Maintaining the reducing trend established in 24/25 has been a challenge in 25/26. Whilst the rate of reduction hasn't met our ambitious plan, we are still reporting a substantially lower position of 343,121 (Mar26) compared to the all-time high of 367,480 recorded in August 2023.

Elective delivery continues to be a top priority over the next three years with the ICB and hospitals now focussed on delivery of 2026/27 Operational Planning trajectories. 2025/26 has seen further development and experience within the Elective Care infrastructure across NENC ICS. We have a comprehensive governance structure embedded across the system. Whilst not an exhaustive list the following groups have gained in both maturity and impact during 2025/26 and will continue to play a pivotal role covering the elective reform agenda in 2026/27 and beyond

- Planned Care Board
- Mutual support coordination group
- Outpatient Leads group
- GIRFT Coordination group
- Theatres group
- Specific pathways/alliances
- Bespoke task and finish groups

Elective Care Diagnostics and Cancer -
% patients waiting for initial treatment on incomplete pathways within 18 weeks



Cancer and Diagnostics

NENC ICB and The Northern Cancer Alliance (NCA) aims to speed up cancer pathways, increase diagnostics capacity, reduce waiting times and improve operational performance. Early diagnosis is key to increasing survival rates and reducing variation in treatment for our cancer patients. This in turn will improve patient experience and quality of life, hence reducing health inequalities in cancer services.

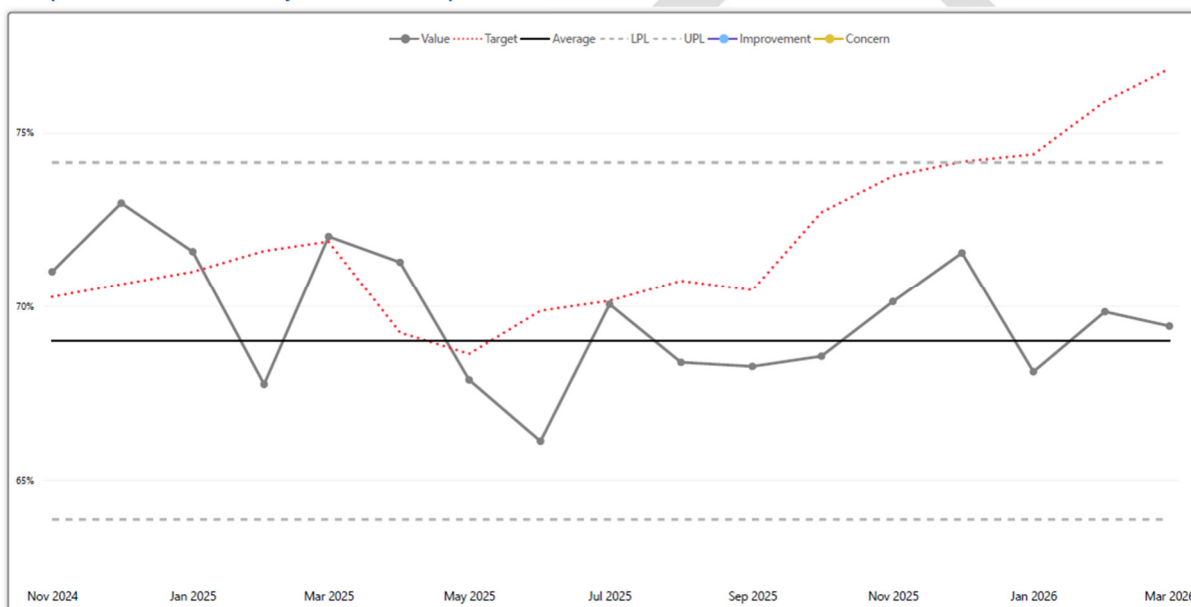
During 2025/26 the Operational Planning ambitions for cancer were to:

- Improve performance against the headline 62-day cancer standard to 75% by March 2026
- Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026

Most providers across NENC submitted an Operational Planning trajectory to deliver the **headline 62-day standard** to 75% by March 2026. Achieving a 25/26 high of 71.5% falls short of this ambition with a collection of notable challenges significantly hampering performance improvement. Additional resources and continued tiering work are focussing on recovery including system wide redesign of pressured pathways in breast and skin.

Faster Diagnosis Standard (FDS) – measures the percentage of patients that are diagnosed or have a cancer diagnosis ruled out within 28 days. Performance across 25/26 has been well below plan with performance ranging 66.6% - 76.7%; the impact of a very challenging year. Recovery and significant performance improvement is a key focus for 26/27 as we work towards a national ambition of maintaining 80%.

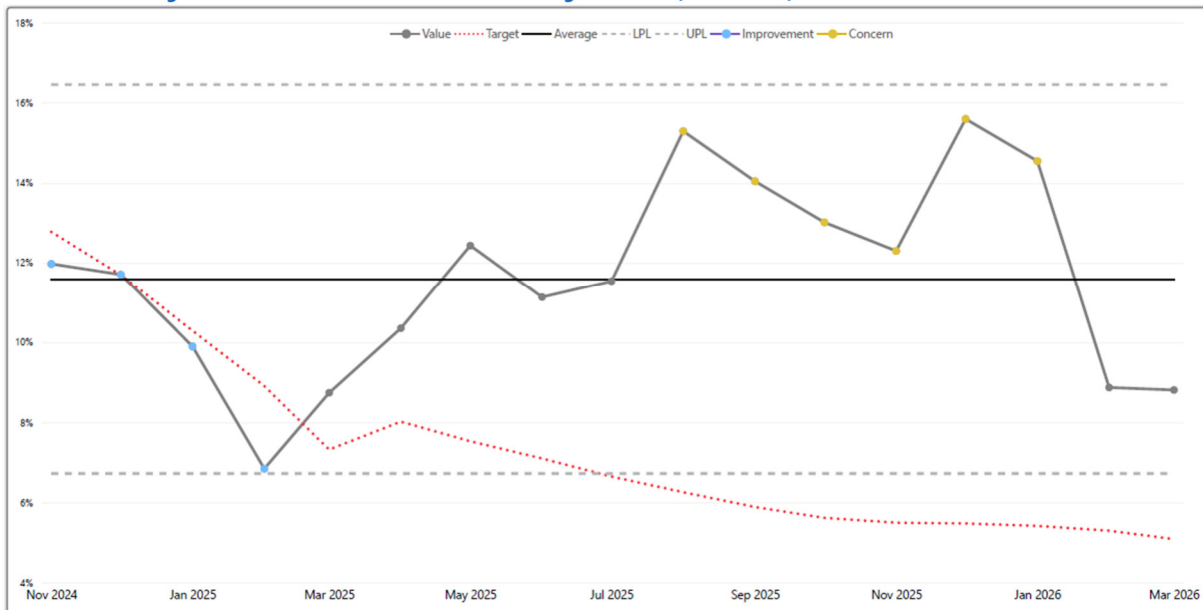
Elective Care Diagnostics and Cancer -
% of patients treated within 62 days of referral for suspected cancer



The diagnostic performance standard - measures the percentage of patients that receive a diagnostic test within six weeks. 2025/26 has proven immensely challenging with performance largely deteriorating over the year. We have significant variation across our providers requiring focussed and targeted recovery actions. Dedicated improvement plans for providers and underutilised community diagnostic centres are a key focus for 26/27.

Elective Care Diagnostics and Cancer -

% Patients waiting more than 6 weeks from referral for a diagnostic test (9 core tests)



Elective - Delivery and risk into 2026/27

Elective recovery continues to be a significant focus in 2026/27 and with the continued success of reducing the number of long waiters we are working towards the following key ambitions:

- Improve the percentage of patients waiting no longer than 18 weeks to deliver a national performance target of 70% with every trust expected to deliver a minimum 7%-point improvement
- Ensuring the proportion of people waiting over 52 weeks for treatment is no more than 1% of the total waiting list

NENC ICS are committed to delivering the elective care ambitions in 2026/27 though financial constraints and notable transformation objectives mean this will be another challenging year.

Cancer & Diagnostics - Delivery and risk into 2026/27

Cancer and diagnostic performance standards continue to be a high priority for NENC ICS. In terms of 2026/27 the following key ambitions feature in the latest NHS Operational Planning Guidance:

- Improve performance against the headline 62-day cancer standard to 80% by March 2027
- Maintain performance against the 28-day cancer Faster Diagnosis Standard of 80%
- Improve performance against the 31-day cancer standard to 94% by March 2027
- Improve performance against the diagnostics 6-week wait standard to achieve national performance of no more than 14% of patients waiting over 6 weeks for a test

Three of our eight acute providers have been escalated into formal Tiering arrangements during 25/26 reflecting the ongoing complex challenges faced to deliver the required performance. Whilst we have demonstrated periods of delivery, improvement and sustainability are key priorities in 26/27 at both organisational and tumour level.

NENC ICS are committed to delivering further improvement and achieving the 2026/27 ambitions but are mindful of the pressures from workforce, financial resource and fragility of some services.

Mental Health

As a region we are committed to reducing health inequalities of people with mental health problems and for people with a Learning Disability and Autistic people. Improving waiting times for adults and young people for mental health services is key as well as ensuring there is more support to meet emotional and mental health and wellbeing needs through improved access to psychological therapies. Reducing the reliance on inpatient settings and beds for Adults and Children and Young People with a Learning Disability is a key aim.

2025/26 Performance summary and mitigations

Metric	Period	Value	Plan	+/- Plan	Target
Talking Therapies Reliable Recovery Rate	Jan 2026	48.0%	49.0%	-1.0%	49.5%
Talking Therapies Reliable Improvement Rate	Jan 2026	68.5%	68.5%	+0.0%	68.8%
Rate per 100k Population of MH Bed Days for Discharges from adult acute, older adult acute and PICU beds	Jan 2026	1,889	2,022	-133.1	1,914
Average length of stay for adult acute mental health inpatient services	Jan 2026	56.7	52.8	+3.9	52.5
Number of people accessing Individual Placement Support services	Jan 2026	2,290	2,264	+26.0	2,429
Total number of inappropriate Out of Area (OOA) Placements	Jan 2026	1	0	+1.0	0
No of CYP accessing support by NHS funded community services (rolling 12 months)	Jan 2026	59,185	60,528	-1,343.0	60,897
Number of women accessing specialist community perinatal mental health services (rolling 12 months)	Jan 2026	2,395	2,375	+20.0	2,355

Key Performance Highlights

NHS Talking Therapies for Anxiety and Depression (TTAD) – In 2025/26, there were two key metrics (described below) for talking therapies.

Reliable recovery - This indicator shows the proportion of people completing treatment who have shown significant improvement and recovered. NENC ICB set a local target of 49.5% against this metric for 2025/26. Performance has fluctuated throughout the year and a final year-end position of 48.1% has been noted, which is a variance of 1.4%.

Reliable improvement - A person is defined as showing a reliable improvement if there is a significant improvement in their condition following a course of treatment, measured by the difference between their first and last scores on questionnaires which are tailored to their specific condition. The target we set for NENC ICB was agreed at 68.8% Performance has remained consistent and has generally been achieved month on month. Unfortunately, the year-end position is under target by 0.8% and is reported as 68%.

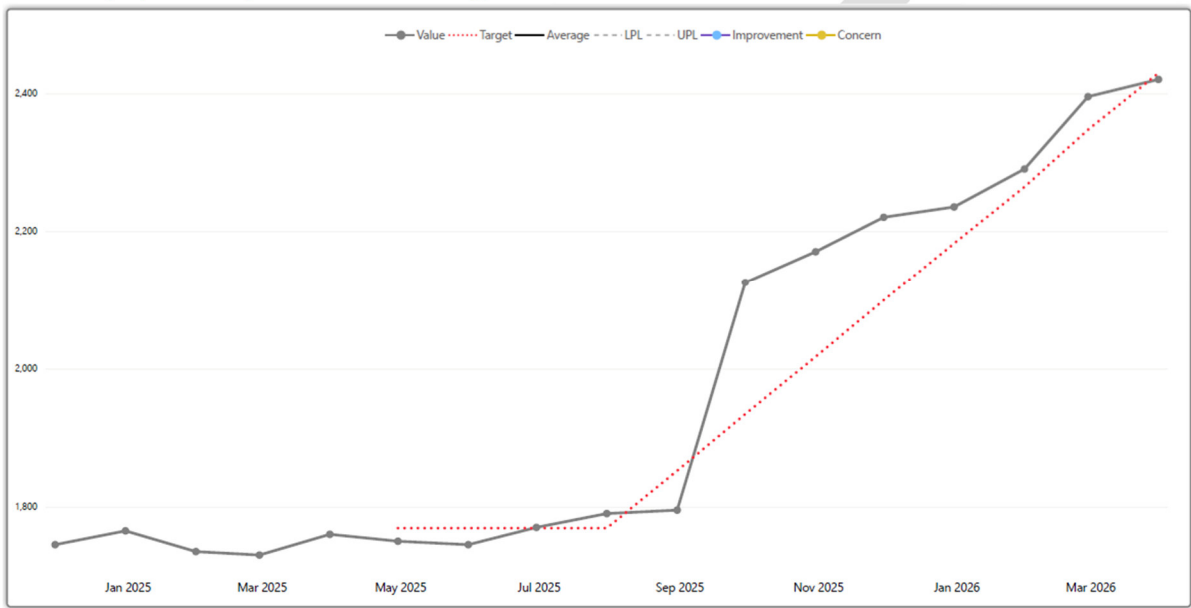
Out of area (OOA) placements (bed days) – Despite being one of the higher performers against this metric in the region, NENC reported 1 out of area placement in January 2025. Contributing factors include system pressures with high bed occupancy rates and an increase in delayed discharges due to social care and housing.

Access to children and young people's mental health services - Whilst performance began well in 2025/26, there was a marked deterioration in performance over the summer and autumn period. An element of this can be attributed to data quality issues with one provider where not all activity has been captured following a migration of systems. At this time, it is unknown as to

whether NHSE will permit a historical refresh of the data submission. Whilst performance has increased more recently, the year-end target of 60,897 has not been reached, the Mar26 position is noted as 59,790. Going forward, activity captured via the Mental Health Support Teams will also contribute to delivery of this metric.

Individual placement support (IPS): IPS is an evidence-based approach that helps individuals with mental health conditions find and maintain employment. It focuses on integrating employment support with mental health treatment and provides personalised, intensive support to help individuals find suitable employment. IPS is a new performance metric for 2025/26. Access has continued to increase month on month but the year-end target of 2,429 was not met by 9, with a reported position of 2,420.

Mental Health Care -
Number of people accessing Individual Placement Support services



Women accessing specialist community perinatal mental health (PMH) services: Specialist PMH services provide care and treatment for women with complex mental health needs and support the developing relationship between the parent and baby. We have continued to see a month-on-month increase in access and as such the year-end target has been exceeded with a position of 2,44 recorded.

Learning Disabilities and Autism

2025/26 Performance summary and mitigations

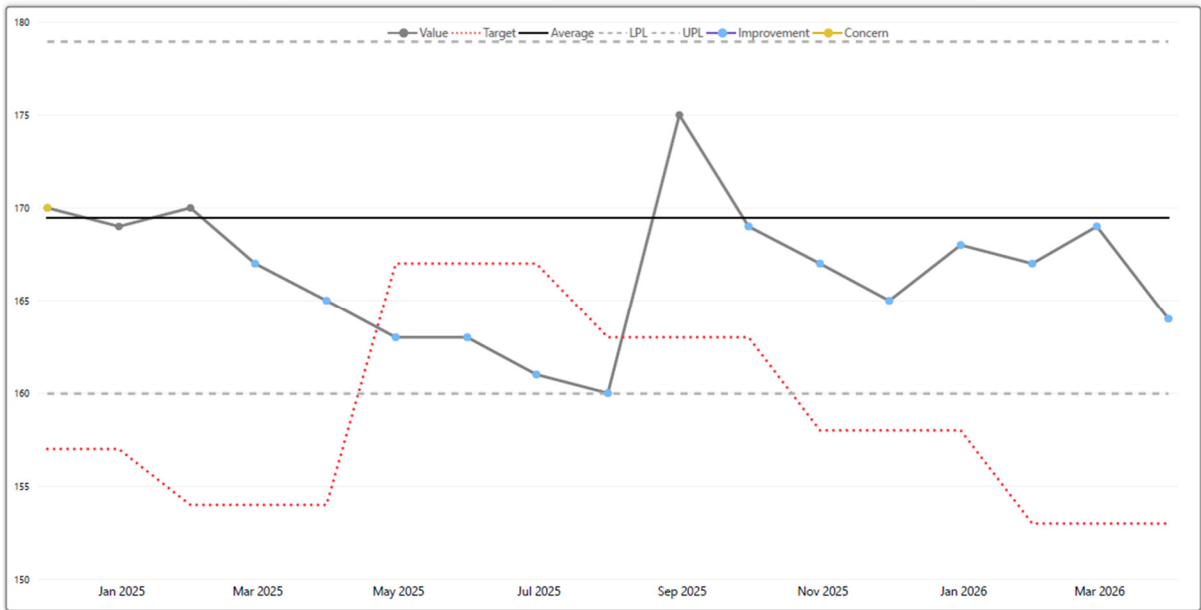
Metric	Period	Value	Plan	+/- Plan	Target
LDA Inpatient Beds Occupied by Adults & Older Adults (from the AT database)	Feb 2026	169	153	+16.0	153

Key Performance Highlights

Reducing reliance on inpatient care (IP) – achievement of this target has been a risk throughout the year. Whilst there was strong performance in the first half of the year, there has been a steady decline from Aug25 onwards. The year-end position is noted as being 11 over plan,

with a value of 164. However there have been several discharges of individuals with significantly extended lengths of stay spanning multiple years which is extremely positive.

People with a Learning Disability and/or who are Autistic -
LDA Inpatient Beds Occupied by Adults & Older Adults (from the AT database)



Delivery and risk into 2026/27

Challenges have remained in the delivery of some key ambitions in 2025/26 for mental health and for people with Learning Disabilities and Autism. The ICB is working to improve mental health pathways for our patients, with a focus on key areas including Neurodevelopmental pathways as well as investing in extra support to meet emotional, mental health and wellbeing needs.

Safety

The NHS Patient Safety Strategy describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems. NENC will continue to support staff and providers to share safety insight to improve safety including patient safety culture, patient safety systems and the strategic aims of insight, involvement and improvement. Oversight continues across NENC through local Quality Review Groups. The Quality & Safety Committee monitors data relating to mortality, and the regional mortality network supports quality improvements.

2025/26 Performance summary and mitigations

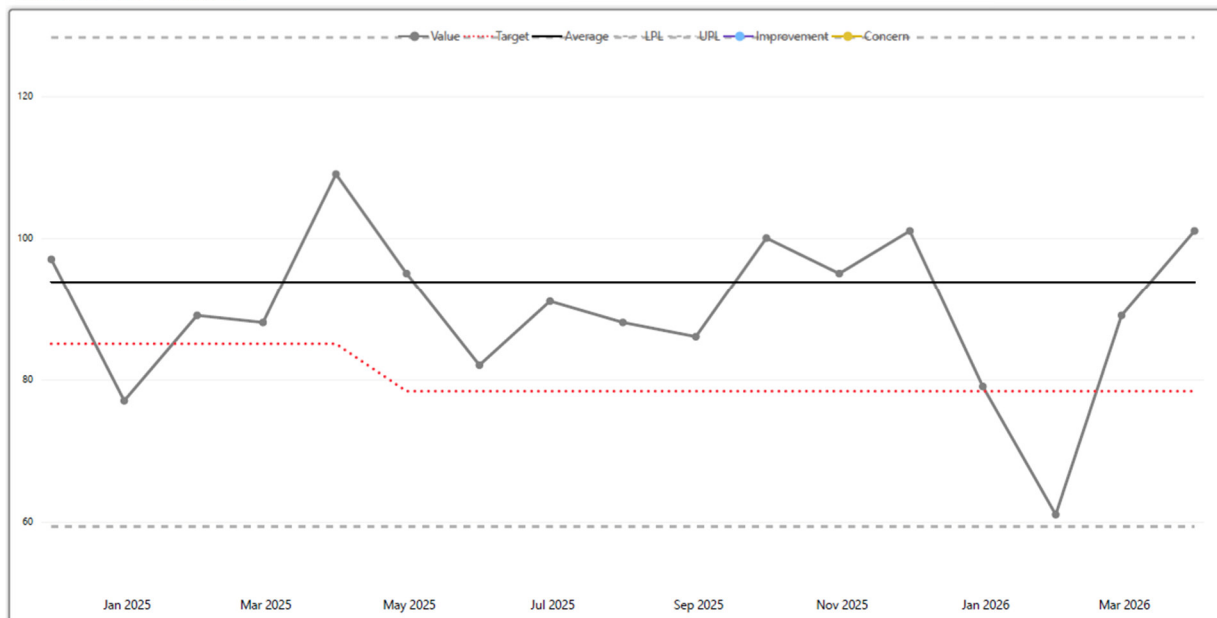
Metric	Period	Value	Plan	+ / - Plan	Target
Incidence of C Difficile	Jan 2026	61	78	-17.3	78
Incidence of E Coli	Jan 2026	283	219	+64.5	219
Incidence of MRSA	Jan 2026	3	0	+3.0	0

Key Performance Highlights

The Infection Prevention and Control (IPC) Patient Safety Incident response framework (PSIRF) matrix and framework has been developed. Regular updates are taken to the Quality and Safety Committee.

Pressures continue with key Healthcare Acquired Infections (HCAI) across NENC ICB and the e-coli and MRSA infections remain over target year to date. An ICB wide plan has been reviewed regularly at the Health Care Acquired Infection (HCAI) subcommittee.

Patient Safety - Incidence of C Difficile



Delivery and risk into 2026/27

The ICB is looking to establish a learning platform to support learning across the region. Sound risk assessments have been developed by our Trusts for management of HCAI. Regular updates are provided to the Quality and Safety Committee.

NENC oversight

The ICB works in partnership with NHS England regional team in relation to oversight of trusts including the tiering introduced for elective, cancer and diagnostics. These meetings are focussed on identifying and deploying high-quality support to aid rapid performance improvement.

In addition, the ICB works with trusts within the key strategic programmes to drive performance improvement via service improvement and the deployment of programme investment, for example via the Urgent and Emergency Care Programme, the Cancer Alliance, and the Strategic Elective Board.

Delivery and risk into 2026/27

Work continues to expand and join up new types of care outside of hospital to provide a safe and efficient alternative to in-patient care. This work will support patients who would otherwise be in a hospital to receive acute care and treatment in their own home, to prevent avoidable admissions into hospitals and enable early supported discharge out of hospital.

NENC Provider Collaborative Elective Programme

To support delivery of the national constitutional standards, an Elective Care Recovery and Improvement Programme supported by the NENC Provider Collaborative is established to restore and transform elective services. The programme aims to eliminate long waits, reduce overall waiting times, and address health inequalities through effective demand management and maximised system capacity.

Over the past year, providers across the NENC acute Foundation Trust community have made significant progress by working collectively to reduce both the size of waiting lists and the time patients wait for planned care. This collaborative, system first approach has strengthened resilience, enabled smarter use of available capacity, and ensured patients receive timely, high-quality treatment closer to home.

Our performance against the national 18-week Referral to Treatment (RTT) standard continues to rank among the strongest in England, demonstrating the impact of shared leadership, coordinated delivery and a commitment to equitable, sustainable improvement across the system.

In May 2025, we held the first combined Elective and Urgent & Emergency Care Spring Conference. Centred around the theme Learning Together, Delivering Together, this brought the system together to unite priorities and shape the shared agenda for the year ahead. The conference provided a valuable platform to reflect on progress, strengthen collaborative working, spread good practice, and accelerate improvement. Using getting it right first time (GIRFT) methodology to inform future reform, the event created a supportive environment for shared learning, capability building and the identification of opportunities to improve patient experience, outcomes and overall performance.

Key Achievements 2025/26

Mutual Support

Throughout the year, our shared values of transparency and mutual respect have been central to strengthening mutual support across the system. This inclusive approach has enabled greater sharing of best practice and innovation.

While the Mutual Support Coordination Group continued to facilitate discussions relating to more than 600 patients across 12 specialties, we know this is an underestimate due to manual tracking limitations. Several trusts have also provided indirect support by taking on increased volumes of out of area referrals driven by patient choice, particularly within Breast services.

Statement of activities

Strategic Commissioning and Medium-Term Planning

As a result of the 10-year NHS plan and the Medium-Term Planning Framework [Link to Medium-Term planning framework](#) which was published in October 2025, the ICB developed a five-year Strategic Commissioning Plan for 2026/27 to 2030/31 [Link to five-year strategic commissioning plan](#). This commissioning plan is complimentary to the ICS Strategy: Better health and wellbeing for all and has a 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.

The ICB's commissioning strategy is congruent to the 10 Year Plan and focuses on the three left shifts:

- **From Hospital to Community:** Shifting care delivery out of hospitals and into local communities, homes, and primary care settings (general practice, community pharmacy and community optometry) to make healthcare more accessible and convenient, reducing hospital reliance.
- **From Analogue to Digital:** Accelerating digital transformation to free up staff from admin, empower patients to manage their health online, and create a more efficient system.
- **From Sickness to Prevention:** Proactively focusing on preventing illness and promoting healthy choices, rather than just treating diseases once they develop, to improve long-term public health.

Our strategic commissioning approach will be informed by the ICB Blueprint, best practice guides and to promote integration:

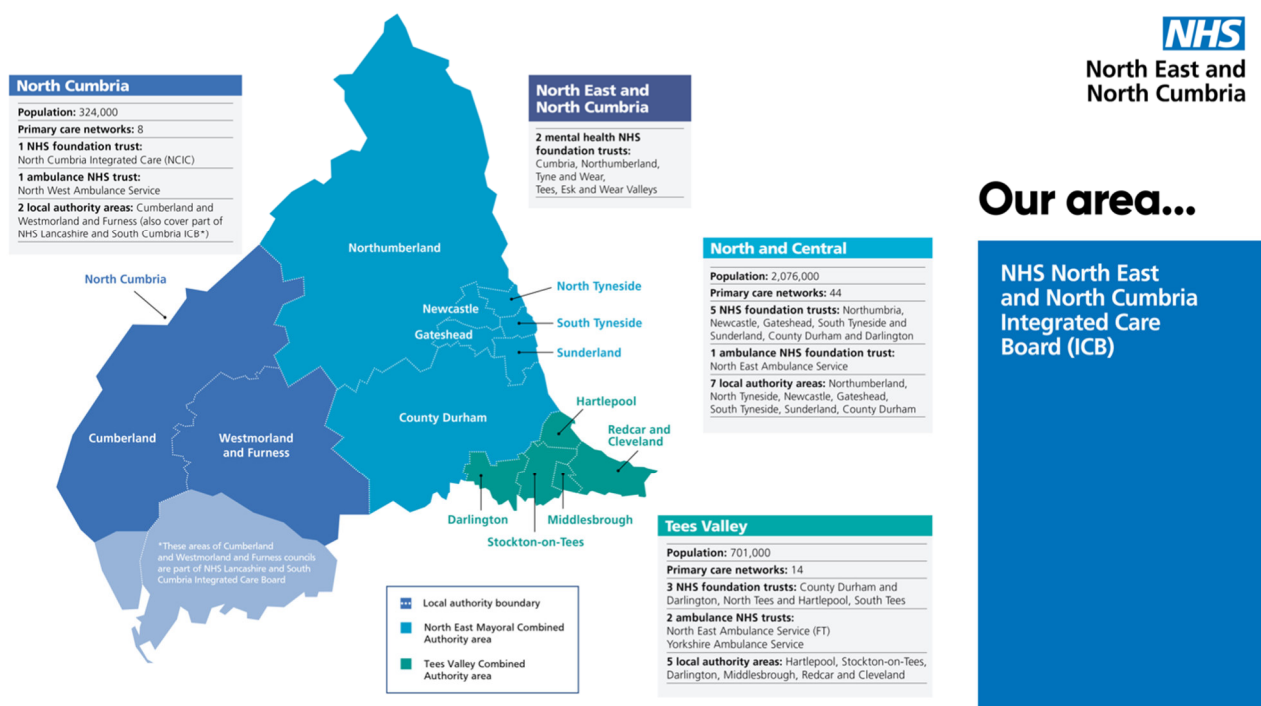
- **Integrated Neighbourhood Health:** Commissioning focuses on developing "neighbourhood health services" that join up primary care, community health, and social care.
- **Joint Commissioning:** The strategy utilises Section 75 agreements between the NHS and local authorities to pool budgets for integrated care, such as the Better Care Fund (to be replaced by the Neighbourhood health and integrated care funding (ICFF)).
- **Social Value and Anchor Institutions:** The ICB uses its commissioning power to support local economic development, recognising that employment is a key driver of health.

The ICS Strategy is now in its 4th year and although our strategic outcomes and goals remain the same, the publication of key national guidance requires the health and care system to change. In the summer of 2026, we will embark on a process to refresh our ICS strategy and undertake an annual refresh of our plans in accordance with national planning guidance. This will include engagement with our partners across the health and care system.

Partnership Working

The ICB continues to work closely with our partners to ensure our governance and partnership arrangements are fit for purpose to improve health and care outcomes for our population. We have engaged with our partners throughout our development journey, regularly briefing and working with Health and Wellbeing Boards, Overview and Scrutiny Committees, Healthwatch organisations and patients' groups, and our Voluntary Community Social Enterprise (VCSE) partnership programme. The ICB is responsible for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services. As well as its strategic functions, the ICB works locally with health and wellbeing boards in each of

our 14 local authority areas. The ICB's place-based teams also work alongside our 64 primary care networks (PCNs) which are groups of local GP practices, social care teams and other community-based care providers.



The North East and North Cumbria Integrated Care Partnership (ICP) is statutory committee of the fourteen local authorities and the NHS Integrated Care Board (ICB).

The ICP is responsible for setting and developing our strategy for health and care in the region. It is an equal partnership between local government and the NHS, with a key purpose to align the ambition and strategies of partners across the area to improve the health of our communities.

The ICP is made up of our four partnerships based around our main centres of population. These are:

- North Cumbria
- Central (County Durham, Sunderland and South Tyneside)
- North (Gateshead, Newcastle, North Tyneside, Northumberland)
- Tees Valley (Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-on-Tees)

We have committed to working together through a single overarching ICP alongside four local ICP arrangements. These local ICPs will develop a strategic picture of health and care needs from their constituent local authority places working with partners including existing health and wellbeing boards. The NHS 10-Year Health Plan has provided a clear national direction for improving health and care outcomes. Its implications for the North East and North Cumbria system have helped the Integrated Care Partnership (ICP) to refine regional priorities and shape a coherent set of strategic ambitions.

In 2025, the Integrated Care Board (ICB), working closely with partners across the Integrated Care Partnership, published a 10-Year Plan for Longer and Healthier Lives for All. This plan sets out a shared vision for transforming health and care services across the region and responding to the needs of our population over the next decade.

To deliver this ambition, the ICB and system partners have aligned around three fundamental shifts:

Making better use of technology

Digital innovation will be central to transforming care, enabling faster access, improved quality, and more connected services. Better use of technology will support patients and professionals alike, improving efficiency, integration, and outcomes across the system.

Moving more care from hospitals to communities

Care will increasingly be delivered closer to where people live, including in community settings and in people's own homes. This shift will help reduce unnecessary hospital activity, support independence, and provide care that is more personalised and accessible.

Preventing sickness, not just treating it

A stronger focus on prevention will help people stay healthier for longer. By addressing the wider determinants of health and intervening earlier, the system aims to reduce avoidable illness and narrow health inequalities across the region.

Better Health and Wellbeing for all

The 'Better health and wellbeing for all' plan sets out how our integrated care system will work together to reduce inequalities, improve experiences of our health and care services and improve the health and wellbeing of people living and working in the North East and North Cumbria by 2030 and beyond.

The system is led by the Integrated Care Board (ICB) and the Integrated Care Partnership (ICP). The ICP includes 14 local authorities and works with the ICB to improve health across the region.

Together, we created a ten-year plan called 'Better health and wellbeing for all.' This plan tackles major health problems, improves services, and reduces inequality. [Link to integrated care strategy better health and wellbeing](#)

Our four key goals...



Longer & healthier lives

Reducing the gap between how long people live in the North East and North Cumbria compared to the rest of England



Fairer outcomes for all

As not everyone has the same opportunities to be healthy because of where they live, their income, education and employment



Better health & care services

Not just high-quality services but the same quality no matter where you live and who you are



Giving children and young people the best start in life

Enabling them to thrive, have great futures and improve lives for generations to come

Emergency Preparedness, Resilience and Response

As part of the NHS, the ICB needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather events to infectious disease outbreaks or a major transport accident. This is referred to as emergency preparedness, resilience, and response (EPRR).

The Civil Contingencies Act (2004) requires NHS organisations and providers of NHS funded services to show that they can deal with such incidents while maintaining services.

The 2022 Health and Care Bill amended the 2004 Civil Contingencies Act (CCA) to designate ICBs as “Category 1 responders”. This means that the ICB, with other key agencies, are at the core of an emergency response and therefore subject to the full set of civil protection duties under the CCA which includes coordinating the activities of all providers of NHS funded healthcare to plan for and respond to emergencies.

As a Category 1 responder, the ICB must:

- Assess the risk of emergencies occurring and use this to inform the ICB and consider system contingency planning.
- Have in place a single incident response plan that sets out how the ICB will respond to any significant, critical, or major incident in and out of hours
- Have a risk-based single business continuity plan that sets out how the ICB will continue to provide its core and critical functions in response to a disruption to service provision
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance co-ordination
- Cooperate with other local responders to enhance co-ordination and efficiency

In addition to meeting legislative duties, the ICB is required to comply with guidance and framework documents, including but not limited to:

- NHS England Emergency Preparedness, Response and Resilience framework
- NHS England Core Standards for Emergency Preparedness, Response and Resilience

- NHS England Business Continuity Framework

The ICB is committed to developing and maintaining planned and resilient services by taking a proactive approach to EPRR.

Since inception of the ICB in July 2022 the ICB System Resilience team have worked to ensure that the ICB is able to deliver its core statutory functions as a Category 1 responder.

The ICB System Resilience team have developed ways of working to ensure an integrated resilience function able to respond to any emergency across the NENC Integrated Care System.

The ICB work collaboratively across the system with all NHS Accountable Emergency Officers (AEOs) their EPRR leads and with a range of multi-agency partners including representing the NHS at the Northumbria, Cumbria, Cleveland and County Durham and Darlington multi-agency Local Resilience Forums (LRFs).

The ICB System Resilience team continue to work with NHSE and system providers to ensure appropriate training and exercising is in place as a critical component of delivering the ICB's statutory responsibilities, ensuring that all staff who would support any escalation or incident are trained, competent and qualified to effectively undertake that role. Furthermore, all staff who have a role within the planning for and / or response to a business continuity, critical or major incident all undertake continuous professional development and maintain a personal development portfolio (NHS Commander portfolio) in accordance with the NHS core standards for EPRR to demonstrate competence against the required National Occupational Standards (NOS) for Civil Contingencies every three years as a minimum which is facilitated by the ICB System Resilience Team.

Throughout 2025/2026, North East and North Cumbria ICB EPRR team have participated in or led on numerous "Live" and "Table-top" multi-agency training events with partners ensuring that the ICB is ready to respond and provide system leadership to any mass fatality, mass casualty, high consequence infectious disease (HCID) or chemical, biological, radiological and nuclear (CBRNe) incidents as well as participating in Exercise Pegasus, the three phase National Tier 1 Pandemic Preparedness Exercise.

These exercises were designed to maximise organisational learning and so that staff could test incident response roles in a safe environment, enabling any feedback gained via a robust debriefing process to enhance and improve the ICB's operational readiness.

NENC ICB System Resilience team have also been pivotal in managing and providing system co-ordination, oversight and leadership to a number of significant operational pressures throughout the year including outbreaks of infectious disease, business continuity and critical incidents. The ICB successfully ensured that key partners and stakeholders were able to provide safe and effective patient care and treatment during these incidents.

These have ranged from:

- Extreme weather events (Storm Claudia)
- Major Incidents declared by wider system partners (Newcastle West End explosion, Cumbria West Coast Main Line Train Derailment and M6 closure)
- Critical incidents (Gateshead Health NHS Trust Picture Archiving and Communication System [PACS])
- Supply chain issues
- Failure of utilities or IT systems including cyber-attacks which have affected service delivery

- GP Collective Action
- Resident Doctors Industrial Action
- Communicable disease outbreaks (measles, avian influenza, scabies, meningococcal, seasonal influenza, norovirus, group A streptococcus and RSV) which has resulted in the need to provide diagnostic testing, manage clinical assessment, prescribe medication and/or the facilitation and mobilisation of vaccination campaigns at multiple sites, premises or geographical locations.
- Multiple instances where organisations have lost the ability to deliver services which have affected healthcare delivery or where specific care has needed to be provided to a defined cohort of affected patients above and beyond core service delivery such as during surge/periods of escalation.

Each of these Level 1 and Level 2 incidents (as defined by the NHS Incident Response Level framework) have required a dedicated ICB command and control structure to be implemented (provided by the ICBs System Coordination Centre) in order to direct the actions of commissioned organisations and personnel and maintain patient safety.

These challenges are expected to remain, especially with future changes in the NHS operating model and an evolving threat landscape. However, NHS North East and North Cumbria is committed to strengthening NHS preparedness through its work plan, which includes providing guidance and frameworks, building response capability, running training and exercises, and collaborating with partners to ensure whole system planning. The ICB System Resilience team will continue to further develop rigorous and robust systems, processes and flexible arrangements so that the ICB is able to effectively lead the NHS response during any significant incident or emergency which can be scalable and adapted to work in a wide range of specific scenarios. This includes regularly assessing the risks to the local population as well as considering community and national risk registers and/or using lessons identified and learned from previous incidents to update plans and embed good practice ensuring that the organisation is able to continue to meet the statutory and mandatory duties as set out in the Civil Contingencies Act 2004 and the NHS England EPRR Framework.

Medicines Optimisation

Medicines Optimisation focus during 2025/26 has been delivering safer, more effective and more sustainable use of medicines across our system, against a backdrop of continued operational pressure, financial challenge and increasing complexity within the national medicines landscape. Despite these challenges, we have maintained a strong focus on improving patient outcomes, reducing unwarranted variation and strengthening system-wide governance.

During the year, we have made significant progress in developing a more consistent and outcomes-focused approach to medicines optimisation. This includes the introduction of system-wide prescribing pathways, strengthened shared care arrangements, and the development of the Medicines Local Enhanced Services and Prescribing Outcomes Scheme, with high levels of engagement from general practice. Targeted clinical programmes have delivered measurable improvements in areas such as antimicrobial stewardship, respiratory care and the safer use of high-risk medicines, supported by effective collaboration across primary care, secondary care, community pharmacy and patient groups. However, there remain significant challenges. Demand continues to increase, workforce and organisational change impacts delivery, and medicines supply issues persist across key areas. National developments, including movement towards a single formulary, will require further adaptation of our approach. As we move into 2026/27, our focus will be on strengthening

governance, embedding consistent commissioning approaches, and continuing to deliver improvements in quality, safety, and value for our population.

Medicines Governance

NENC reviewed and approved key prescribing pathways and guidelines, including the Oral Antipsychotics safe prescribing pathway and attention deficit hyperactivity disorder (ADHD) shared care guidance. A new primary care rebate scheme process was also introduced, improving governance, consistency and transparency while supporting financial benefit to the ICB. Work on amber medicines continues to ensure appropriate shared care guidance is in place, clarifying responsibilities across care settings and supporting safe, consistent prescribing practice.

A key priority for 2026/27 is to strengthen governance by embedding representation from the ICB and partner organisations, addressing the impact of vacancies and organisational change, and reviewing terms of reference to ensure arrangements remain fit for purpose as the ICB develops its strategic commissioning role.

National work to develop a single formulary will present further challenges, requiring adaptation of current governance processes to incorporate future national outputs.

Development of the Medicines Local Enhanced Services (LES)

The ICB addressed longstanding inconsistencies in shared care arrangements across the region. This was achieved through the development of a consistent, locally commissioned GP service for medicines, alongside a programme of work to align shared care clinical agreements across NENC with all system partners. Over 97% of practices are participating in the scheme with alternative providers commissioned for those practices that have declined. This has ensured safer, more equitable care for patients, with clear accountability, reduced variation in clinical practice, and more reliable ongoing management across primary and specialist service.

Medicines Quality, Innovation, Productivity and Prevention

Significant cost efficiencies of over £21 million in medicines were achieved across the year through close collaboration with primary and secondary care colleagues, helping to manage demand and prescribing growth while delivering high-value care for patients. This ensured the ICB maximised value from available resources and made strong progress towards planned savings targets, with a clear focus on improving outcomes and optimising the safe and effective use of medicines.

Priorities included adopting cost-effective safety needles and lancets (including promoting a shift from FP10 prescribing to procurement by employers) and switching from Edoxaban to better-value, direct oral anticoagulants (DOACs) generating savings. Prescribing trends show a reduction in non-preferred DOACs.

Gluten free

NENC ICB progressed a programme to reduce routine prescribing of gluten-free foods, supporting financial sustainability and addressing variation across the region.

An engagement exercise was carried out with over 1,400 responses from patients, carers and stakeholders to inform decision-making. Please see 'Engaging people and communities' for more information. Following this, a decision was made to restrict prescribing to patients aged under 25, alongside plans to standardise provision and decommission legacy schemes.

Deprescribing activity commences from 2026/27, ensuring a consistent and targeted approach to support those most in need.

Prescribing Outcomes Scheme

An independent NECS review found wide variation in local prescribing schemes, creating complexity, inequity, and administrative burden without clear evidence of improved outcomes or value. In response, a single Prescribing Outcomes Scheme (POS) has been developed for 2026/27, aligned to the ICB Medicines Strategy and focused on key areas such as respiratory disease, diabetes, and mental health. The scheme introduces mandatory outcome targets, including cost-effective prescribing and deprescribing, while allowing flexibility for local delivery. Uptake has been strong, with almost all practices participating. A review is planned during 2026/27, and the scheme includes a community pharmacy component to support whole-system engagement.

Medicines Safety

The ICB strengthened its system-wide approach to medicines safety and shortages through the Medicines Safety Group, improving oversight, intelligence sharing, and prioritisation. Key achievements included translating learning from toxicity incidents and valproate-related risks into coordinated action, alongside increased focus on high-risk medicines such as opioids, propranolol, and gabapentinoids. National safety priorities progressed, including correcting allergy records and improving medicines safety in pregnancy. Ongoing supply challenges, particularly for ADHD, gastrointestinal medicines, and insulin detemir, were managed through coordinated triage, guidance, and partnership working, ensuring safer medicines use across NENC.

Public and Practice Engagement

Public Involvement and Engagement

The ICB delivered two major patient engagement campaigns to improve medicines use. The 'Only Order What You Need' campaign, concluding in September, aimed to reduce medicine waste, highlighting annual losses of over £20 million. It achieved strong engagement, with over two million impressions and high levels of understanding among the public. Prescribing growth slowed, although wider system pressures such as access and supply continued to influence over-ordering.

The 'Little Bug Busters' campaign, launched in November, focused on reducing unnecessary antibiotic use in children and promoting self-care. Using a multi-channel approach, it increased awareness of antimicrobial resistance and appropriate medicine use, alongside a 41% rise in Healthier Together app registrations.

Both campaigns demonstrated effective communication and improved patient awareness, though further work is needed to expand reach and address ongoing behavioural and system challenges.

Practice Engagement



GP Team net is a key communication channel supporting consistent prescribing information across General Practice. The Medicines Optimisation team reviewed and updated legacy guidelines, improving accuracy, relevance, and usability through streamlined navigation. A dedicated Medicines Optimisation (MO) page was developed as a central hub for POS 2026/27 resources, including webinars and supporting materials, enhancing accessibility and delivery. Plans for 2026/27 include reviewing the MO Bulletin to improve clarity and visibility, with increased links to GP Team net to provide concise messaging while maintaining access to detailed guidance.

Medicines Strategy

Overprescribing

A key focus was system-wide collaboration through the overprescribing steering group, bringing together primary, secondary, mental health, and academic partners to share learning and raise the agenda. Incentive schemes and the “Only Order What You Need” campaign supported reductions in oversupply, achieving a 5.4% decrease across targeted medicines and £816,000 savings. Reducing high Anticholinergic Burden (ACB) was also prioritised, with rates now below the national average. Engagement was strengthened through well-attended Primary Care Network (PCN) events and shared learning, alongside HINENC masterclasses on overprescribing, supported by cross-sector expertise including geriatric input. Key measures will continue within the 2026/27 POS.

Antimicrobials

Antimicrobial resistance (AMR) remains a significant public health threat and a key priority within the NENC Medicines Strategy 2025–2030. The strategy aims to reduce antibiotic prescribing by 5% by 2030, increase five-day prescribing, expand use of access category antibiotics, and reduce prescribing in children through education and behaviour change. Throughout 2025/26, strong progress was achieved. Overall antibiotic prescribing in general practice fell by approximately 6%, surpassing the national baseline reduction target. Five-day prescribing improved across key antibiotics, with amoxicillin exceeding national targets, and notable gains in doxycycline and flucloxacillin. Access category prescribing reached 64%, progressing towards the 70% national ambition, while prescribing in children also declined. These improvements reflect sustained clinical engagement and a system-wide focus on antimicrobial stewardship across primary and secondary care.

Analgesia

The ICB coordinated system-wide work to improve pain management, focusing on optimising analgesia, particularly opioids and gabapentinoids, due to high prescribing levels and associated risks. A clear clinical position aligned to national guidance was established to support safe use. Quality improvement initiatives in general practice included data-led identification of high-risk patients, audits, and pharmacist-led deprescribing. Education resources supported structured reviews, tapering, and shared decision making. Work with Trusts improved discharge prescribing practices and follow-up, with some introducing pre-operative pathways and dedicated clinics. Targeted actions on gabapentinoids included high-risk patient reviews and deprescribing support. Emphasis on personalised care and self-management contributed to safer prescribing, with opioid use reducing by 5.6% and gabapentinoids by 3.5% by December 2025. These priorities will continue in 2026/27 schemes and plans.

Cardiovascular Disease (including Diabetes)

The Medicines Optimisation team contributed to key system groups, providing expertise on medicines across cardiovascular disease and diabetes. We have reduced deaths and hospital admissions from cardiovascular disease through the consistent application of evidence-based management and optimisation of medicines, delivered in collaboration with primary and secondary care colleagues. This has included a strong focus on preventative treatment, with the proportion of patients at risk of cardiovascular disease prescribed lipid-lowering therapy increasing to over 60% - significantly above the national average. This improvement demonstrates the impact of targeted clinical interventions and coordinated system working in both improving patient outcomes and reducing future demand on acute services.

Ongoing horizon scanning and preparing for new guidance, such as updated NICE type 2 diabetes guidelines (Feb 2026) and a forthcoming Semaglutide appraisal for cardiovascular disease in May 2026.

Respiratory

New asthma guidance introduced the Anti-Inflammatory Reliever (AIR) approach and expanded Maintenance and Reliever Therapy (MART) use and clinicians across NENC worked together to implement updated age-specific respiratory guidance - improving diagnosis, prescribing and patient outcomes. This led to a 6% annual reduction in the Short Acting Beta Agonist (SABA) - to- Inhaled Corticosteroid (ICS) / Long-Acting Beta Agonist (LABA) ratio, indicating improved preventer prescribing. Chronic Obstructive Pulmonary Disease (COPD) guidance was also updated, alongside new primary care pathways and the OPTIMISE enhanced service to improve inhaler use, reduce exacerbations and admissions. Implementation was supported through webinars and online resources. A key innovation was new deprescribing guidance for theophylline in adult asthma, supporting safer practice, with NENC among the first systems nationally to develop such guidance.

Depression

NENC continues to have the highest weighted antidepressant prescribing in England. However, in 2025/26 there has been early evidence of improvement. Growth in the number of patients prescribed an antidepressant was 1.3%, below the England average of 1.74% and the lowest in the North East and Yorkshire region. There was also a small reduction in long-term prescribing, with the proportion of patients receiving antidepressants for more than one year reducing from 43.8% to 43.6%.

In 2026/27, further improvement will be supported through the POS, which now includes a target to reduce inappropriate antidepressant prescribing. This will be enhanced by access to the Specialist Pharmacy Service (SPS) antidepressant deprescribing toolkit and teaching webinars from Mark Horowitz, lead author of *The Maudsley Deprescribing Guidelines: Antidepressants, Benzodiazepines, Gabapentinoids and Z-drugs*, and will continue in partnership with primary care and mental health trusts.

Secondary Care Medicines Value

The Medicines Value Programme, launched in March 2025, brought together acute providers and the ICB into a collaborative, data-driven model to address rising secondary care medicines costs and variation. Through shared decision-making, benchmarking, and peer learning, it supported consistent adoption of best-value treatments such as biosimilars and generics. In its first year, the programme delivered over £18m in value, reduced spend growth to 1.6% (vs 4%

nationally), and generated additional savings. It also strengthened collaboration and secured research funding to explore patient experience. Future priorities include improving access, outcomes, productivity, and reducing variation in high-cost medicines pathways.

Healthier and Fairer Programme

The Healthier and Fairer Programme is the Integrated Care System's system-wide transformation vehicle for prevention and the reduction of health and healthcare inequalities. It brings together senior clinical and executive leadership from the ICB, Directors of Public Health, NHS providers, the Office for Health Improvement and Disparities (OHID), and the voluntary and community sector to deliver coordinated, evidence-based action at scale.

Established in 2022/23, the programme has evolved into a mature, assurance-led delivery model, characterised by robust governance, data-driven prioritisation, and a strong emphasis on evaluation and learning. It supports delivery of the Integrated Care Partnership Strategy Better Health and Wellbeing for All, contributing directly to all four system goals and to the national strategic shifts from sickness to prevention, hospital to community, and analogue to digital.

The programme currently operates through three workstreams:

- Prevention
- Healthcare Inequalities
- Health and Growth Accelerator (subject to separate governance)

The 2024/25 Quality Committee report focuses on the first two workstreams, which together address the main modifiable drivers of premature mortality and years lived in ill health in the region.

Governance is provided through the Healthier and Fairer Advisory Sub-Committee, co-chaired by the Chief Medical Officer and the Chair of the Association of North East Directors of Public Health. Delivery is supported through the ICB Programme Management Office, with formal highlight reporting, risk management, and financial assurance.

Prevention

Prevention is a cornerstone of the ICB's long-term strategy and is central to reducing avoidable illness, demand on acute services, and health inequalities. The Prevention Workstream is structured around three priority programmes that reflect the main modifiable contributors to premature mortality in the region:

- Alcohol
- Tobacco
- Healthy Weight and Treating Obesity (HWTO)

These programmes operate across the full prevention spectrum: primary (population-level risk reduction), secondary (early identification and brief intervention), and tertiary (harm reduction and improved care pathways).

All three programmes are aligned to:

- The ICP strategy,

- The NENC Clinical Conditions Strategic Plan,
- CORE20Plus5,
- The national 10-Year Health Plan.

Tobacco

The Smokefree NHS programme continues to deliver a comprehensive, system-wide response to tobacco dependency across 10 NHS Foundation Trusts and 18 clinical pathways. Tobacco Dependency Treatment Services are now embedded across all acute, maternity, mental health and community pathways, enabling systematic identification, referral and treatment.

- The programme has supported the identification of over 112,400 smokers, with more than 82,890 referred to in-house services.
- NENC is now ranked first nationally for hospital tobacco identification and referral and remains in the top quartile for quit outcomes.
- Smoking at time of delivery has reduced by 40% since 2021, contributing to improved maternal and neonatal outcomes and significant cost savings. The programme has led the roll out of digital cessation pathways, transition to national pregnancy incentives from NENC scheme, implementation of Swap2Stop and vape pilot schemes during 2025/26.
- The programme has hosted several regional best practice events and contributed to regional, national and international dissemination of learning via webinars and conferences.
- Delivering on community mental health tobacco dependency services as well as Lung cancer screening enhanced smoking cessation services

The ICB also commissions and funds Fresh- the comprehensive tobacco control programme which has now been delivering an eight key strands approach for 21 years.

Tobacco remains the single largest contributor to years of life lost in the North East and North Cumbria. The SFNHS programme and Fresh work very closely together (the team is based together) and alongside local authorities, NHS providers, community services, regional and national partners to deliver a whole-system approach to tobacco control and reducing smoking prevalence

The programme includes:

- Expert support and leadership for effective Tobacco Dependency Treatment services
- Workforce training and referral pathways and proactive approach to CQI
- Targeted interventions in high-prevalence communities,
- Insight led communications and year-round media to motivate quitting
- Delivery of comprehensive approaches to tobacco control areas including tackling illicit tobacco, and second-hand smoke
- Proactive national role around policy developments including preparation and planning for multiple policies from Tobacco and Vapes Bill of direct NHS relevance
- Effective influencing for national policies to support NHS

This partnership approach has contributed to the region achieving the second lowest adult smoking prevalence in England, now below the national average, representing a sustained improvement from the highest rates nationally in 2005. In 2024 smoking rates had declined by 65% since 2005- the largest decline of any region in England.

- Strengthened stop smoking systems and access, launching and embedding the regional varenicline PGD and pharmacy supply service (282 pharmacies, 1500+ patients, 120

already smoke free), mapping system interventions, and gaining national recognition for NHS pharmacotherapy work

- Strengthened regional strategy and leadership, including extensive LA/ICB engagement in shaping the 2025–2028 Strategic Delivery Plan and sustained expert guidance on vaping, tobacco control and system development.
- Delivered wide ranging local support, from local alliance planning (NHS and LA partnership) and workplace smokefree tools to targeted locality advice, presentations, and high value partnership working with the ICB's Healthier Together Programme.
- Expanded regional coordination and networks, hosting multiple forums (Local TC Network, Stop Smoking COI, Tobacco Crime & Regulation, Quarterly Lunchtime Learning) with hundreds attending and securing new strategic influence via the NE Chamber of Commerce.
- Led impactful advocacy and national influence, coordinating regional mobilisation around the Tobacco & Vapes Bill, supporting ASH, and providing national leadership on illicit tobacco, including bi annual surveys and WHO representation.
- Achieved major communications and behaviour change impact, with high performing "Smoking Survivors", Stoptober and New Year campaigns, with record level of PR coverage, and strong evidence of quit attempts and engagement and continued majority support of NE public for policies tracked by opinion surveys.

Alcohol

Alcohol-related harm remains higher in NENC than the England average, with alcohol-related deaths still significantly higher than pre-pandemic levels. There is an ICP ambition to reduce alcohol-related hospital admissions by 20% by 2030. Latest data does however show a positive trend with a 17.9% fall in the alcohol specific death rate in the North East between 2023-24.

In 2025/26 the Alcohol Programme has led system-wide action to reduce alcohol related harm through:

- Specialist Alcohol Care Teams (ACT) have delivered services within all acute Foundation Trusts across NENC, seeing 10,939 patients from April 2024 - March 2025. Local analysis has demonstrated a return on investment of **£5.06 for every £1 invested** in ACTs.
- The Programme for Alcohol Studies, a comprehensive NENC alcohol training platform available to the health, social care and voluntary sector workforce available via the Boost Learning Academy has delivered training to over 3000 staff.
- The programme continues to use a population health management approach to support and develop pathways between NHS and other services and has developed a Toolkit for primary care to support this approach.
- Local Stigma Kills campaign resources have been developed to highlight the damaging impact stigma within primary care can have to people accessing the care they need to reduce alcohol related harm

Healthier weight and treating obesity (HWTO)

Obesity has a significant impact on population health leading to diabetes, metabolic diseases, liver disease, heart disease, and stroke. The NENC Healthcare Needs Assessment estimates 725,000 individuals have a BMI>30, with 280,000 living with severe obesity and over 80,000 individuals classified as obese have 4+ long term conditions. An estimated 136,000 children are living with overweight or obesity, with

21,000 of those living with severe obesity. Obesity is highly correlated with deprivation as those residing within the most disadvantaged areas of NENC are twice as likely to be obese as those within affluent areas for both CYP and adults. A 10% reduction in obesity prevalence could lead to significant cost savings for the NHS & workplace productivity. This social gain could be equivalent to almost £6 billion per year. The HWTO programme delivers a system-wide, life-course approach combining prevention, treatment, and long-term behaviour change. The programme aligns to the ICP ambition to increase the number of people at a healthy weight by 10% and supports the national priority to move from sickness to prevention.

The Healthy Weight and Treating Obesity Programme leads system-wide action through.

- Theme 1 – Whole System Approach to Obesity including the development of ICB wide Healthy Weight Declaration
- Theme 2 – Food Environment and Commercial Determinants of Health which will include the development of an advocacy framework, associated with unhealthy food and non-alcoholic drinks, to support ICB healthy weight declaration in NENC.
- Theme 3 – Service Provision
- Theme 4 – Workforce
- Adult and CYP HWTO Healthcare Needs Assessments.
- Healthy Weight Dashboard launched on RAIDR.
- Comms and Engagement

In 2025/26:

Governance & structure

- Revised HWTO governance and PMO established for 2025/26 that included primary, secondary and tertiary prevention

Theme 1

- Commissioned Food Active to co-design a **Whole System Obesity Strategy**.
- Regional stakeholder engagement and logic model development.
- Annual action plan built using Lead / Collaborate / Advocate framework.

Theme 2

- Commissioned Blue Grass Research to gather knowledge, perceptions and insight associated with the food environment from adults living within the most deprived communities to support the development of an advocacy framework, associated with unhealthy food and non-alcoholic drinks, to support ICB healthy weight declaration in NENC.

Theme 3

- **Primary Prevention** – Webpage developed and covers key topics of advice/guidance, service provision, bariatric surgery, and obesity medications.
- **Secondary prevention** – Webinars held to support primary care with RAIDR patient finding, behavioural insights and support packs for practices target patients effectively and increase uptake of NHSE digital weight management programme. Attended by 165 HCP rated as extremely useful for understanding the programme, referral process and

patient finding. The workstream/ICB are heading towards achieving 3% of eligible population (BMI>30 with diabetes and/or hypertension) accessing the programme.

Implemented NHSE interim commissioning guidance for NICE TA guidance of Tirzepatide for Overweight and Obesity using primary care delivery model via a locally enhanced service specification. The services went live in June 2025 and 265 of 338 practices, 1415 prior approval tickets have been issued and 1207 referrals to behavioural support for obesity programme.

- **Tertiary prevention** – Development and implementation of Complications of Excess Weight Clinics delivered by South Tees NHS Foundation Trust and Newcastle Upon Tyne NHS Foundation Trust. Provided service provision to over 200 children with funding provided for both services to maintain provision for 2025/26 and into 2026/27.

The Health Inequalities funded services provided access to additional 1000 patients per year with Funding approved to be recurrent from 2026/27 onwards.

ICB-approved investment to support trusts in prescribing anti-obesity medications within Tier 3 SWMS underpinned by HWTO patient prioritisation policy for the prescribing of all anti-obesity medications in line with the primary care model. Over 200 patients have been given access to anti-obesity medications.

Theme 4

- Programme of Healthy Weight and Treating Obesity Studies: has 30 live modules that are a mix of national and local modules developed by subject matter experts from across NENC. Over 500 registered participants, 1000 modules completed, with an average feedback score of 4 out of 5.

Healthcare Inequalities

The Healthcare Inequalities Workstream targets unwarranted variation in access, experience and outcomes. It focuses on those who experience the poorest health and the greatest barriers to care, particularly the one million people living in the most deprived 20% of neighbourhoods (the CORE20).

The workstream includes seven programmes:

- Deep End Network
- CORE20Plus5
- Inclusion Health
- Poverty Proofing
- Health Literacy
- Digital Inclusion
- Healthy Communities and Social Prescribing

The workstream is co-led by senior NHS and local authority public health leaders and is aligned to the statutory NHS Legal Statement on Health Inequalities.

Deep End

Delivery of Deep End Network projects within general practices based in the most socio-economically disadvantaged populations of NENC ICB; including

- The successful delivery of an opioids and gabapentinoids deprescribing pilot in the North ICP resulting in increased referrals to Ways to Wellness and reduction in opioid/gabapentinoid use prior to surgery. This has subsequently been rolled out in Durham, South Tyneside & Sunderland, and Tees.
- Improved childhood vaccination rates, including opportunistic vaccination of other household members also overdue vaccination
- Embedding clinical psychology in primary care that included working to improve talking therapy completion rates, increasing opportunities for people with mood disorders, and supporting lower-intensity interventions using mental health practitioners
- The provision of a link worker in practice to address the social determinants of health needs at neighbourhood level
- Investing in and supporting Deep End practices to become training practices to improve recruitment and retention rates
- Network engagement with member practices to foster the Deep End community in NENC, identify challenges, generate ideas and inform future initiatives •
- Established five GP Fellowships in to enable GPs to develop and implement a healthcare inequalities improvement project within their practice
- Public Involvement and Engagement (PIE) training and learning opportunities through Newcastle University
- Research undertaken by Newcastle University as Deep End Network partner

Core20PLUS5

CORE20Plus5 is the national framework for reducing health inequalities at both national and system level. Locally, the programme focuses on:

- The most deprived 20% of the population,
- Plus inclusion groups,
- Across ten clinical areas linked to premature mortality and/or health inequalities
- Adults – maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, and hypertension
- Children & Young People – asthma, diabetes, epilepsy, oral health, mental health

The programme uses population health management, waterfall analysis and equity metrics to track progress and prioritise action.

During 25/26 there have been several projects focused on the 'plus' part of the framework. The 'plus' is defined as communities that experience poor access, uptake, experience and outcomes of healthcare due to multiple factors, including stigma, marginalisation, and discrimination.

These include:

The Childhood Immunisation project - which supports the principles of co-design and engagement with communities with low uptake and aims to reduce health inequality in childhood immunisation.

The Blood Borne Virus (BBV) Peer Support project - supports the NHS England programme Blood Borne Virus (BBV) opt Out scheme where blood tests for HIV are routinely taken at the Emergency department, unless someone attending chooses to opt out. This

project is focused on support for people who are subsequently diagnosed with HIV through peer support.

The Neighbourhood Health Hub & Probation project - is based in Middlesbrough, Redcar & Cleveland. This is a fast-moving collaborative project which aims to address the significant, often unmet health needs of people on probation.

Inclusion Health

The Inclusion Health programme focuses on people experiencing extreme exclusion, including homelessness, substance dependency, contact with the criminal justice system, and multiple complex needs. It works to improve access, continuity, and experience of care through trauma-informed pathways and cross-sector collaboration.

In 2025/26 the ICB developed the Approach to Inclusion Health which was co-produced with Voluntary and Community Sector partners that work with inclusion health groups, academics who undertake research into health inequalities experienced by stigmatised and marginalised communities, and with NHS clinicians. This framework identified 6 principles, which if considered will support better commissioning and health service provision for people from inclusion health groups. These principles are

- Trauma Informed
- Research Led & Evidence Informed
- Data Driven
- With People of Lived Experience
- Family and Support Network Focused
- Parity of Esteem

The **Multiple and Complex Needs** allocation to Local Authority Public Health Teams supports improving community engagement and access to health services for locally identified marginalised and stigmatised communities.

Poverty Proofing

Poverty proofing delivered by Children North East ensures that health services do not inadvertently exclude or disadvantage people experiencing poverty. A Poverty Proofing audit in healthcare settings helps reduce health inequalities by systematically identifying financial, social, and practical barriers that prevent patients from accessing and engaging with care. Through staff interviews, patient voice engagement, and service scoping, the audit identifies and reports on how poverty affects attendance, treatment adherence, communication, and overall experience. It explores stigma, unconscious bias, and staff confidence in discussing poverty, while addressing service-specific challenges, such as those in maternity, paediatrics, and long-term condition pathways.

In 2025/26 Poverty Proofing Audits have been completed in

- Child and Adolescent Mental Health Services
- Community Mental Health Services
- Alcohol Services
- 10 GP Surgeries
- Paediatric hospital services
- Obesity services

- Outpatients
- Maternity services
- Sexual health
- Dentistry
- Social Prescribing services

Health Literacy

Health literacy is about people being able to access, understand and use information to make decisions about their health. The information we tell patients is often complicated. So, is the information we write for them. This can make it hard for patients to understand their health.

The Regional Health Literacy Team, hosted by Health Innovation North East and North Cumbria (HI NENC) have supported the health and care system in addressing health literacy requirements in 2025/26 through

- The development of validated health literacy standards that enable NHS organisations to understand what they need to do
- The development of a health literacy toolkit that provides practical approaches in support of meeting the standards
- Undertaken service reviews that make full patient journeys health literate that support access and positive experiences of healthcare, including reviewing and updating literature to a reading age of between 9 and 11 years
- Overseen funded projects across multiple organisations so partners can develop their own health literate capacity and capability
- Provided workforce training via the Boost Learning Academy and in-person "train the trainer" learning
- Supported the national community of practice on behalf of NHS England

Digital Inclusion

Digital inclusion remains a critical challenge in the North East and North Cumbria, with only 81% of adults reporting foundational digital skills, the lowest in England. The Digital Inclusion programme ensures that as health and care services shift online, no one is left behind.

Over the past year, the programme has:

- Boosted skills and confidence for just under 1000 individuals through drop-in sessions, home visits, and community events.
- Captured measurable efficiency savings via the Great North Care Record, with 7,400 accesses saving £8,308 of staff time.
- Exceeded workforce training targets, with Digital Inclusion packages piloted in Gateshead and Newcastle, engaging 167 participants in two months, with 96% recommending the training to colleagues.
- Doubled the NENC ICS Digital Inclusion Steering Group membership to over 60, strengthening regional collaboration and motivation.
- Awareness boosted to thousands through the NHS App campaign at Sunderland Football Stadium and the foundation, Beacon of Light.
- Distributed nearly 500 repurposed devices, increasing access to technology and capturing learning through the programme playbook.
- Updated the Digital Exclusion Heatmap for targeted approach and contributed to the National Digital Exclusion Risk Atlas.

- Delivered inclusive practice initiatives, including deaf awareness training and eLearning.
- Published an interactive Digital Inclusion Awareness video and eLearning for Boost users across the North East and Yorkshire, with potential for national adoption.

Through coordinated projects, partnerships, and system-wide engagement, the programme is embedding digital inclusion across workforce practice, community support, and service design ensuring digital services are accessible to all and bridging the region's digital skills gap.

Healthy Communities & Social Prescribing

Social prescribing enables all primary care professionals to refer people to a range of local, non-clinical services. It seeks to address people's needs in a holistic way and supports individuals to take greater control of their own health.

In 2025/26 the Voluntary Organisations' Network North East (VONNE) has supported sustainable and effective approaches to social prescribing across the North East and North Cumbria. Work undertaken includes

Capacity building through the Infrastructure Investment Programme that supported

- Reading for Wellbeing projects with Local Authority library services
- Improving access for inclusion health groups with Darlington Association on Disability
- Developing awareness and skills through collaboration between PCNs and the VCSE facilitated by Durham Community Action
- Reducing isolation and support for children with special educational needs with Hartlepool Community Trust
- Investing in Local Authority Health Champions Projects that align with the CORE20Plus5 objectives
- System development, collaboration and integration with Cumbria CVS, in Newcastle with Connected Voice, with Inspire South Tyneside, Sunderland Voluntary Sector Alliance, Northumberland Thriving Together, and Teesside Mind.

Women's Health

Strategic highlights

- The National Women's Health Strategy, first published in 2022, was refreshed and republished in March 2026.
- NENC ICB published a five-year Women's Health Plan to inform strategic commissioning intentions over the next three years.
- Building on learning from the Women's Health Hub (WHH) pilot phase (2023–25), we committed a further 12 months of investment in the Sunderland and Gateshead WHHs as exemplars of best practice.
- We refreshed the NENC Women's Health BI dashboard to support strategic decision-making and improve outcomes for women and girls.
- We co-designed a Contraception Strategic Plan and Strategic Commissioning Framework.
- We developed a Learning Disability Menopause Passport to support equal, equitable and reasonably adjusted access to menopause care.

- We co-designed an audit tool for primary and secondary care to assess how violence against women and girls (VAWG) is being addressed across our healthcare organisations.

Refreshed National Women's Health Strategy

NENC ICB will continue working with national partners and regional system leads to align our five-year plan with the refreshed National Women's Health Strategy. The refresh reflects the need to:

- Respond to clear evidence that women's health outcomes and experiences have worsened, including declining healthy life expectancy, long waits for key services, and persistent failures in diagnosis, treatment and care.
- Recognise that women are too often not listened to, with symptoms dismissed, pain undertreated, and care shaped by a paternalistic, one-size-fits-all model.
- Address stark inequalities, particularly for women in deprived communities and women from ethnic minority backgrounds, whose outcomes remain significantly worse.
- Reflect the view that the 2022 strategy identified the right issues but lacked the delivery model and pace needed for meaningful change.
- Drive faster reform by aligning women's health with the 10 Year NHS Health Plan's focus on prevention, community-based care, digital access, and patient voice, choice and empowerment.

NENC ICB Women's Health Plan

During 2025–26, we published a five-year NENC ICB Women's Health Plan, informed by:

- Continued strategic engagement with system stakeholders across the North East and North Cumbria.
- Our Women's Health Needs Assessment, published in July 2024.
- The Big Conversation, a survey developed with Healthwatch and supported by focus groups, reaching 4,500 respondents across the region.
- The Explain Market Research report, capturing the experiences, views and priorities of young women across NENC.

Evaluation findings from our pilot Women's Health Hubs (WHHs) in Sunderland, Gateshead and North Cumbria.

Our five-year Women's Health Plan (2025–30) aims to improve access to healthcare services for women and girls across the region through the following priorities:

1. **Menstrual health and gynaecological conditions:** We will improve access to timely information, diagnosis and treatment closer to home wherever possible.
2. **Fertility, pregnancy and postnatal support:** We will reduce variation in access to fertility services, postnatal care and bereavement support. All women in NENC will receive timely information on contraception and be offered their preferred choice wherever they live.
3. **Menopause:** All women in NENC will have access to well-trained professionals who provide personalised menopause support. The NENC ICB Menopause Policy will also be rolled out with a focus on workplace support.
4. **Mental health and wellbeing:** We will improve prevention, identification and management of mental illness affecting women, especially those who have experienced abuse and adversity.

5. **Cancers:** We will address identified gaps in services and deliver improvements in cancer prevention, early detection and treatment for women.
6. **Health impacts of abuse and violence against women and girls:** We will embed evidence-based, in-house advocacy services to sensitively identify, support and refer women and girls experiencing abuse and violence.
7. **Healthy ageing and long-term conditions (LTCs):** Our clinical pathways, particularly for cardiovascular and musculoskeletal conditions, will help women understand modifiable risk factors and support them to live long, healthy lives.
8. **The development of Women's Health Hubs:** WHHs will deliver holistic, high-quality care that is locally accessible in the community.

Impact of NENC Women's Health Hubs

Building on learning from the pilot and proof-of-concept phase, further ICB investment was secured for Sunderland and Gateshead WHHs in 2025/26, enabling both hubs to continue developing as exemplars of integrated neighbourhood care.

Sunderland

The WHH at Pallion Health Centre, launched in September 2023, continued to provide cervical screening, menopause care, contraceptive services, pessary fitting and ultrasound scan services for women across the whole of the city.

An independent pilot evaluation demonstrated strong value for money, with a benefit–cost ratio of **8:1** and an estimated **£37.6m** in benefits over 10 years, including improved quality of life, fewer unwanted pregnancies, reduced workplace absence, secondary care savings and earlier detection of cervical cancer.

Early evaluation findings from the 2025–26 investment show the hub is reaching women facing multiple disadvantages, including low income, homelessness, domestic violence, alcohol use, and women from ethnically minoritised, migrant and asylum-seeking communities, supporting national and local ambitions to reduce health inequalities.

Preliminary findings identified four main factors affecting women's access to healthcare:

- **Community & Place**
 - Significant variation in service availability across local areas.
 - Proximity and affordable transport improved attendance.
 - Stigma around women's health limited engagement.
 - Trusted relationships encouraged open discussion.
- **Healthcare Environment**
 - Past negative experiences (feeling judged or dismissed) reduced trust.
 - Fragmented services created barriers.
 - Need for greater cultural sensitivity and awareness of socioeconomic realities.
 - Positive experiences occurred where staff provided relational, trauma-informed care.
- **Social Connections**
 - Peer and community support enabled access.
 - Negative influences (e.g., discouraging partners) sometimes led to disengagement.
 - Trusted community organisations played a vital role in providing practical and emotional support.
- **Individual Circumstances**

- Competing priorities, childcare and complex personal situations often led to deprioritising care.
- Emotional barriers included fear of judgement or unintended involvement from authorities.
- Health empowerment, service awareness and confidence to self-advocate were strong enablers.

Gateshead

The Gateshead Women's Health Gateway was established in response to local gynaecology waits of around 37 weeks and consistent feedback that women needed faster access and clearer routes into care.

The evaluation highlighted two findings: women wanted quicker access and fewer handoffs between services, and primary care skills were not being used systematically. This includes non-contraceptive LARC for heavy menstrual bleeding and painful periods, and community pessary services for pelvic prolapse, both now delivered through ICB-commissioned enhanced services.

The Gateway is a clinical routing and pathway qualification function, bringing together professionals from primary care, secondary care gynaecology, sexual health, nursing, pharmacy and allied professions to review referrals and direct women to the right setting first time.

In the first phase, linked to the ICB's 2025/26 investment, referrals from two PCNs were clinically reviewed through the Gateway model and stratified so that:

- women who clearly need surgical or specialist secondary care input go directly to the appropriate pathway.
- women who can be managed safely in enhanced primary care or intermediate clinics are redirected to these appropriate settings.
- women suitable for specific specialist services are routed straight into those services, rather than waiting in a general list such as the Chronic pelvic pain clinic.

This approach makes better use of primary care capability and creates a structured feedback loop between secondary and primary care, helping build confidence, skills and shared understanding of what can safely be delivered outside hospital settings.

ICB investment has also established a Gateshead Women's Health clinical network across PCNs to strengthen the intermediate community offer and expand capacity for conditions that do not always require hospital-based care. **The aim is to support a safe left shift, where appropriate, and reduce unnecessary delays.**

As a result of this investment, the Gateway model is strengthening the following service areas:

- non-contraceptive LARC for menstrual conditions
- community pessary assessment and fitting
- enhanced menopause support
- PCOS and metabolic women's health models under development
- consideration of newer oral treatments for endometriosis where clinically appropriate
- urogynaecology activity that can lend itself to community delivery and is under consideration

Gateway pathway qualification also supports earlier access to a newly commissioned multidisciplinary chronic pelvic pain service in secondary care, including pain specialists, pelvic physiotherapy, psychology and nursing support. This helps suitable patients enter the pathway sooner rather than remaining on a general waiting list.

2025/26 Developments

Following the NENC ICB transition programme during 2025–26, the new ICB leadership team will:

- Review Women's Health programme leadership and governance to ensure arrangements remain fit for purpose and support delivery of the priority outcomes in our five-year plan.
- Ensure Women's Health priorities are aligned with emerging strategic commissioning intentions set out in the refreshed NENC ICB Strategy.
- Develop a scalable model for further WHH roll-out across the region, building on continued investment in Gateshead and Sunderland during 2025–26.
- Subject to a successful expression of interest to NHS England, deliver a three-year Steps to Safety programme: a referral pathway from general practice into independent specialist services for domestic abuse and sexual violence. The programme aims to improve identification, increase referrals into specialist support, improve safety, and reduce the health impacts of violence and abuse, with the ambition that by 2029 any victim or survivor in England can access this support wherever they live.

Housing, Health and Care Programme

In the North East and North Cumbria, we have set up a Housing, Health, and Care Programme to build on the collaborative work already underway to improve housing, care, and support so people can stay healthy and live independently.

The programme is led by the North East branch of the Association of Directors of Adult Social Services (ADASS), the NHS North East and North Cumbria Integrated Care Board, the Northern Housing Consortium, and the TEC Services Association (TSA), with support from many other partners.

We have partnered with the Housing Learning and Improvement Network (LIN) to develop a baseline review of housing needs in the region. This, along with feedback from events, and discussions, and our community of practice has shaped our plans for the next five-years.

Some of the ambitions in this plan include:

- A significant reduction in cold and damp homes.
- Better quality housing that allows older people to age well, with a 10% decrease in older people needing residential care.
- 525 new units of extra care for older people.
- 1,750 additional homes tailored for people with complex needs.

This is underpinned by 3 priorities as set out in our 5-year roadmap

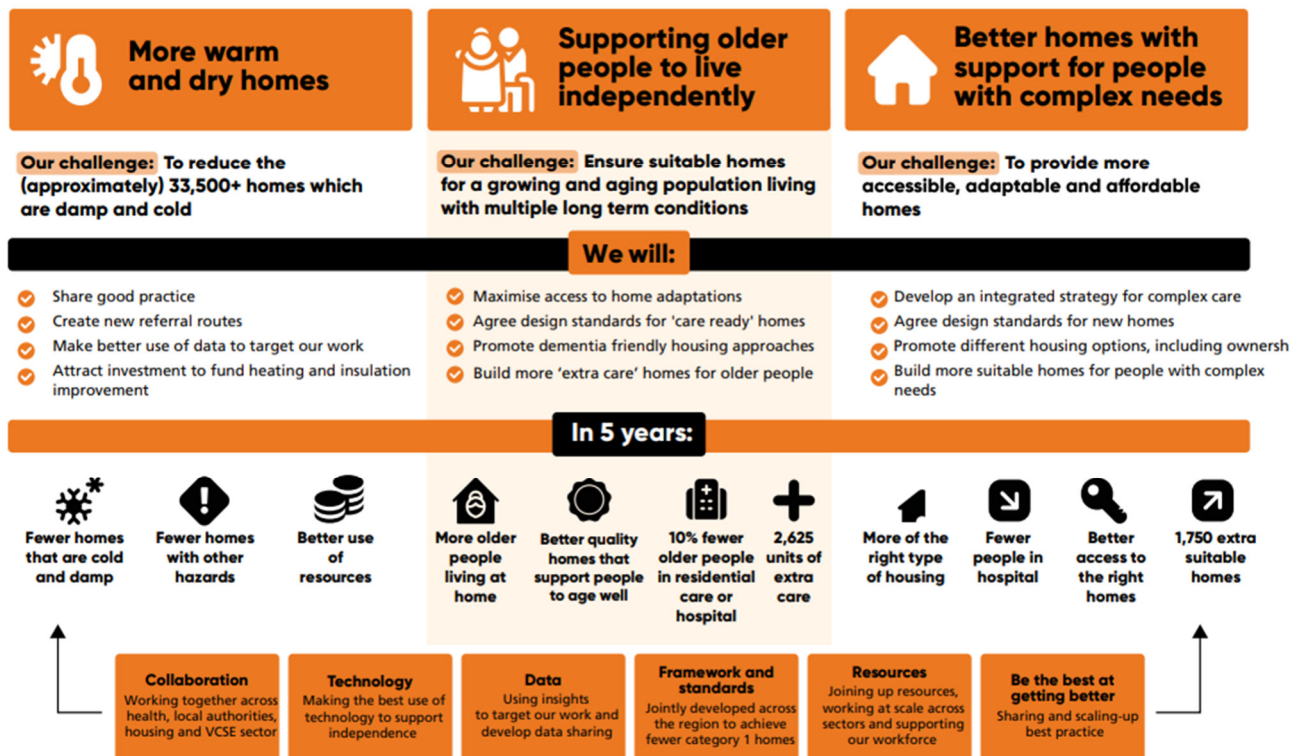
1. More Warm and dry homes- Everyone needs a home that is safe, warm and dry. Damp, mould, fall or electrical risks affect our health.
2. Supporting older people to live independently - We need more choices such as bungalows and supported living with care, for people with dementia, frailty or complex needs.
3. Better homes with support for people with complex needs - We need safe, supported homes for people with learning disabilities, autism, or mental health needs. Good quality homes with the right support can help people stay out of institutional care.

Housing, health and care programme



Better homes and healthier lives

Our roadmap 2024 – 2029



Primary Care

Primary Care is the foundation of NHS services. However, we know that there is major pressure across community dentistry, general practices, community pharmacy and optometry. There is a very real workforce and sustainability crisis across many primary care services, and many people experience poor access to primary care.

General Practice

General Practice is delivering more patient care than ever, often working with patients with higher levels of acuity and dependence than ever before. This is against a backdrop of a very real workforce and sustainability challenge. During the 2023/24 financial year we developed a Primary Care Forward Plan. For general practice the key focus is on:

- Implement the Primary Care Access Recovery Plan
- Improving the stability and resilience of general practice

- The opportunities to integrate general practice and system partners through integrated neighbourhood working, and through stronger primary care networks
- Structural solutions to workforce sufficiency
- Strengthen the enablers infrastructure including estates and digital

Our short-term focus is to ensure the stability of general practice. There is a need to stabilise provision and build resilience in general practice providers. This needs to recognise the diversity in size, delivery models and challenges that individual practices face. The current natural direction of travel is towards developing relationships with wider stakeholders to create resilience.

Community Pharmacy

Community pharmacies in the North East and North Cumbria have continued to play a critical role in improving access to care and supporting the delivery of the Primary Care Access Recovery Plan during 2025/26. Building on strong initial engagement in the national Pharmacy First initiative, the service has become embedded across the system, providing direct access to a range of clinical services for seven conditions, including sore throat, sinusitis, shingles and uncomplicated urinary tract infections. This continues to make effective use of pharmacists' clinical expertise, reducing the need for GP appointments and supporting wider system flow. Across NENC, 98% of pharmacies are registered to provide the service, with over 60,000 consultations per month undertaken across the region. Ongoing support from locally funded ICB coaches has enabled continued optimisation of service delivery, including resolution of IT challenges, strengthening referral pathways, and improving integration with general practice.

The oral contraception service has continued to expand during 2025/26, with further consolidation of workforce capability following the delivery of advanced clinical skills training across each Local Pharmaceutical Committee (LPC) area. The service is now firmly established as part of the wider women's health offer, improving access, reducing inequality, and supporting demand management within specialist sexual health services. With over 8,000 consultations delivered per month, the service continues to demonstrate its potential to increase patient choice and enable greater capacity for more complex cases to be supported within secondary care.

The Community Pharmacy Primary Care Network (PCN) lead model has matured further over the course of the year, strengthening collaboration between community pharmacy, general practice and wider system partners. With 66 out of 67 posts filled, PCN pharmacy leads have been instrumental in embedding Pharmacy First pathways, improving communication, and supporting integrated neighbourhood working. Emerging best practice across a number of localities has been captured and shared across networks to support consistent delivery and drive continuous improvement.

Community pharmacies have also maintained a significant contribution to the system's vaccination programme, delivering over 50% of COVID-19 vaccinations across NENC. This reflects the continued trust placed in community pharmacy as an accessible and convenient setting for preventative healthcare, and its essential role in supporting population health management and reducing health inequalities.

During 2025/26, community pharmacy has increasingly been positioned as a key enabler of the ICB's strategic shift from hospital to community-based care, supporting prevention, early intervention, and improved patient experience through accessible, high-quality local services.

Optometry

Primary Care Opticians have delivered enhanced minor eye care services in Co Durham and North Cumbria, taking pressure off acute trusts.

Optometry practices have been engaged with piloting an EyeV digital referral platform to accelerate the patient pathway to secondary care.

Optometry contractors across NENC are involved in a pilot (sponsored by the Primary Care Collaborative) to access the National Shared Record system.

Local Optical Committees have been engaged in developing a primary care workforce strategy, and some firm foundations have been put in place to transform eye care service delivery across NENC, including the development of a single point of access. A commissioning approach is developing to deliver wider eye care services, over and above General Optical Services (GOS) eye sight tests and the engagement of primary care optometry in Community Diagnostic developments

Dentistry

The ICB continued to develop and deploy its dental recovery plan to stabilise local NHS dentistry and improve access to mitigate some of the national challenges to the service through:

- Additional urgent care appointments, out of hours treatment and minor oral surgery capacity
- A network of Urgent Dental Access Centres to treat urgent and emergency dental needs
- New contracts to provide more routine and general dental services
- Reviewing payment rates to dentists that deliver NHS care and direct support to practices that are at risk of handing back their NHS contracts
- Working with the deanery to support initiatives to stabilise and grow the dental workforce

Elective Care

NENC Provider Collaborative Elective Programme

To support delivery of the national constitutional standards, an Elective Care Recovery and Improvement Programme supported by the NENC Provider Collaborative is established to restore and transform elective services. The programme aims to eliminate long waits, reduce overall waiting times, and address health inequalities through effective demand management and maximised system capacity.

Over the past year, providers across the NENC acute Foundation Trust community have made significant progress by working collectively to reduce both the size of waiting lists and the time patients wait for planned care. This collaborative, system first approach has strengthened resilience, enabled smarter use of available capacity, and ensured patients receive timely, high-quality treatment closer to home.

Our performance against the national 18-week Referral to Treatment (RTT) standard continues to rank among the strongest in England, demonstrating the impact of shared leadership,

coordinated delivery and a commitment to equitable, sustainable improvement across the system.

In May 2025, we held the first combined Elective and Urgent & Emergency Care Spring Conference. Centred around the theme *Learning Together, Delivering Together*, this brought the system together to unite priorities and shape the shared agenda for the year ahead. The conference provided a valuable platform to reflect on progress, strengthen collaborative working, spread good practice, and accelerate improvement. Using GIRFT methodology to inform future reform, the event created a supportive environment for shared learning, capability building and the identification of opportunities to improve patient experience, outcomes and overall performance.

Key Achievements 2025/26

Mutual Support

Throughout the year, our shared values of transparency and mutual respect have been central to strengthening mutual support across the system. This inclusive approach has enabled greater sharing of best practice and innovation.

While the Mutual Support Coordination Group continued to facilitate discussions relating to more than 600 patients across 12 specialties, we know this is an underestimate due to manual tracking limitations. Several trusts have also provided indirect support by taking on increased volumes of out of area referrals driven by patient choice, particularly within Breast services.

In December 2025, the Provider Leadership Board approved the development of principles for a more proactive mutual aid model to reduce variation and enable more consistent access to elective care. The system has also agreed to implement a NENC wide Visible Patient Tracking List (PTL) via the Federated Data Platform providing a single, consistent view of elective demand, improving transparency and supporting more proactive, equitable pathway management.

Getting It Right First Time (GIRFT)

In August 2025, the Strategic Elective Care Board endorsed a GIRFT baseline assessment across all eight acute trusts. This systemwide analysis enabled the identification of common challenges, variation and opportunities to strengthen elective and planned care delivery. In October 2025, a full set of GIRFT informed recommendations was approved by the Planned Care Board, providing a clear, evidence-based roadmap for improvement.

During the year, the NENC system also secured national accreditation for two further Surgical Hubs, at the Friarage, Northallerton and West Cumberland Hospital, Whitehaven, further strengthening elective capacity and resilience with 6 surgical hubs now accredited and one awaiting accreditation across North East and North Cumbria.

Outpatient Transformation Group

Reset in October 2025, the Outpatient Transformation Group has focused on RTT challenged specialties such as ENT and Gynaecology, with the aim of reducing waits and improving patient flow. The group has driven improvement by optimising existing digital technologies, deploying new digital solutions, and redesigning outpatient pathways to shorten time to treatment. This work supports national changes to eRS and the development of a Single Point of Access for referrals and Advice & Guidance.

At the request of the NENC ICB, provider Chief Executives and Chairs (October 2025), the group developed a set of follow up recommendations aligned to GIRFT best practice to reduce outpatient follow-up activity. These were shared with all providers to support a consistent, high impact approach to maximising outpatient capacity. Additional key outputs include:

- **Missed Appointments & PIFU Task & Finish Group (April 2025):** was established to improve Missed Appointment and Patient Initiated Follow-Up (PIFU) performance, drawing on best practice from providers that had achieved positive results in these areas. The outputs from this work were used to produce a 'quick wins' guide, which was circulated to all NENC providers

Mental Health, Learning Disabilities, Neurodiversity and Wider Determinants

The North East and North Cumbria (NENC) Integrated Care Board (ICB) is committed to improving mental health, learning disability, autism and neurodiversity services across the region. In a context of increasing demand and system pressures, collaboration across NHS trusts, local authorities, voluntary and community sector organisations, and people with lived experience remains essential to delivering sustainable and high-quality services.

Our shared ambition is to ensure people receive the right care, at the right time, and in the right place. By working collectively across the system, we aim to improve outcomes, reduce health inequalities, and make the most effective use of available resources.

This work is led by the ICB's Mental Health, Learning Disability, Neurodiversity and Wider Determinants transformation team, working in a matrix model alongside place-based delivery teams. Place teams play a crucial role in shaping and delivering change locally, ensuring transformation is responsive to the needs of communities and neighbourhoods while maintaining a consistent strategic direction across the region.

This section highlights key achievements during 2025/26 and priorities for 2026/27, demonstrating our continued commitment to improving access, quality and outcomes for people across the North East and North Cumbria.

Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme (IPQT)

The Inpatient Quality Transformation (IPQT) programme focuses on transforming mental health, learning disability, and autism inpatient care across NENC. The programme aims to reimagine inpatient care models, drive cultural change, and improve the quality, safety and experience of care for individuals receiving inpatient support.

Key Deliverables

Drive cultural change and reimagine inpatient care models across all NHS-funded mental health, learning disability, and autism inpatient settings.

Achievements during 2025/26

- Published the NENC bed census and alternatives to crisis report, providing improved system insight into inpatient demand and community-based alternatives.
- Conclude the work of the established task and finish groups covering:
 - Acute inpatient services for adults
 - Inpatient services for older adults
 - Inpatient services for autistic adults and adults with a learning disability
 - Acute mental health rehabilitation services
- Launched Version 1 of the NENC Mental Health Inpatient Dashboard to strengthen system oversight and support data-driven improvement.
- Continued delivery of the Culture of Care Programme to support improvements in therapeutic environments and staff culture.
- Strengthened the involvement of people with lived experience and carers in programme development and oversight.
- Progressed work to reduce length of stay in adult acute mental health inpatient services.
- Continued work to reduce reliance on inpatient care for people with a learning disability and autistic people.
- Progressed system work to reduce the number of patients who are clinically ready for discharge and those experiencing the longest lengths of stay.
- Developed a long-term implementation plan for the IPQT programme aligned with national commissioning guidance.

Priorities for 2026/27

- Continue work to reduce length of stay in adult acute mental health inpatient services.
- Further reduce reliance on inpatient care for people with a learning disability and autistic people.
- Reduce the number of patients who are clinically ready for discharge and those experiencing extended lengths of stay.
- Reduce the number of individuals placed in long-term out of area placements.
- Launch Version 2 of the IPQT Mental Health Dashboard to enhance system oversight and performance monitoring.
- Finalise outputs from the Programme Operational Groups covering:
 - People with a learning disability and autistic people
 - Aging adults
 - Rehabilitation
 - Acute services
- Collate and support capital funding applications including Learning Disability and Autism crisis accommodation, 24/7 neighbourhood mental health centres and mental health emergency departments.
- Develop an evaluation framework to measure programme impact and inform future priorities.
- Monitor and provide assurance regarding Service Delivery

Mental Health expenditure

The Mental Health Investment Standard (MHIS), set by NHS England, requires all ICBs to increase their planned spending on mental health services by a greater proportion than their overall increase in budget allocation each year.

The ICB reports compliance against the MHIS monthly throughout the year. For 2025/26, the ICB has reported achievement of the MHIS and details of compliance can be found in note 7 of the financial statements.

Leading the way on Work and Health

Early in 2025, NHS North East and North Cumbria ICB was designated as one of three 'Health and Growth Accelerators' in England, alongside West Yorkshire and South Yorkshire ICBs. This meant that NENC ICB received a £19.46m funding package to develop an innovative programme of work to help tackle the unmet health needs that can often lead to absence from work and then longer-term economic inactivity.

This is a significant and growing challenge in the North East and North Cumbria, where up to one in three working age adults in many parts of our region are economically inactive due to poor health.

Since then, we have been working closely with our partners to develop a programme of work that aims to help more of those local people who struggle to stay in work to get the help they need. This is centred on accessible WorkWell services, person-centred 'bio-psychosocial' support, accessible via GP referral, for those in work but struggling with their health.

As well as this, we have invested in additional clinical services to enhance the WorkWell offer, including support for common MSK and mental health conditions, as well as investing in our Staff Mental Health and Wellbeing Hub to ensure that our colleagues in health and care can access the mental health support they need to thrive in work.

As the 2025 Healthcare Professionals' Consensus Statement for action on health and work concluded, good work is essential to good health, so with future years' WorkWell funding confirmed for the North East and North Cumbria the ICB remains committed – with our partners in local and combined authorities – to investing in the services that can best support local people to access and stay in work.

Local maternity and neonatal system

The ambition is for maternity and neonatal services across the NENC to become safer, more personalised, kinder, professional, and more family friendly. The ICB and its partners have been required to deliver the Three-Year Delivery Plan for Maternity and Neonatal Services which comes to an end in March 2026. The plan focuses on four key strategic priorities which includes:

- Listening to and working with women and families with compassion
- Growing, retaining and supporting our workforce
- Developing and sustaining a culture of safety, learning, and support
- Standards and structures that underpin safer, more personalised, and more equitable care.

Below are some examples of key projects that have been delivered over the last 12 months which contribute to these strategic priorities:

NENC Maternity and Neonatal Voices Partnerships (MNVP) Bench Marking Assessment

The NENC LMNS utilised the MNVP Collaborative Assessment Tool (2025) to gather evidence around current MNVP provision and challenges within our area. Produced by NHS England, the National Maternity Self- Assessment Tool was developed to help trusts and local systems self-assess their maternity services against national standards and best practice. The LMNS have undertaken the benchmarking exercise with each of the NENC MNVP's which will inform next steps and actions required to enable MNVPs to operate in line with the National Guidance (2023).

Perinatal Quality Oversight

Perinatal Quality Oversight Provider meetings take place on a quarterly basis between the ICB and 8 Provider Trusts that deliver perinatal care. These meeting review the trust quarterly perinatal quality surveillance provider reporting submissions which include a range of quality and safety considerations.

Perinatal Quality Oversight Annual Assurance Peer Review Visits took place between November 2025 and February 2026. The aim of the 2025/2026 LMNS visits to the 8 Provider Trusts was to obtain assurance that providers are compliant in all areas of the Three-Year Delivery Plan for Maternity and Neonatal Services.

Maximising Student Placement Capacity

System working with the ICB, 8 provider trusts and Higher Education Institutions to maximise student placement capacity whilst ensuring high quality clinical placements across NENC and to improve both staff and student experience.

Delivery of the LMNS Equity and Equality Plan

The NENC LMNS Equity & Equality Steering Group continues to oversee the development and implementation of the Equity & Equality Action Plan and its associated project which include:

- Delivery of a train the trainer model across 8 NENC provider trusts which has resulted in 40 trainers being able to deliver cultural curiosity training as part of the NENC training faculty.
- Development of the migrant pathway to support pregnant migrants who may move into or out of the NENC so that health professionals have access to the patient record.
- Launch of the LMNS Personalised Care Toolkit which aims to support expectant mothers and birthing people to feel more confident, informed, and involved in decisions about their care.
- Delivery of Human Rights in Maternity Care training to staff working in perinatal services across NENC. There has also been specific training delivered to cohorts of student midwives in collaboration with Higher Education Institutes.
- Hosting of the first Cancer in Pregnancy Study Day attended by Multi-Disciplinary Teams across NENC.

Great North Care Record and Electronic Maternity Records

The Great North Care Record (GNCR) and the NENC LMNS have delivered the country's first shared care record integration of BadgerNet, the maternity services electronic patient record. Digital sharing of maternity data provides access to up-to-date information, including risk

factors, care plans and birth details, at the point of care. All 8 maternity provider trusts are connected to the Great North Care Record.

Children and Young People

This year has seen sustained and highly effective partnership working across the ICB, local authorities, education settings and NHS providers, underpinned by a shared commitment to improving outcomes for children and young people. Together, we have continued to deliver an ambitious and collaborative programme of work that strengthens statutory delivery, builds inclusive practice and responds to the needs of families across our system. The breadth of this work has generated many significant achievements; a selection of these key highlights is set out below.

- Expanded integrated support through Family Hubs in Durham, using local data to target health and social care services—including speech and language therapy, occupational therapy, bowel and bladder nurses, CAMHS drop-ins and enhanced sleep support—directly into Best Start Family Hubs. A co-produced “neuro roadshow” created a one-stop offer for families seeking advice on supporting neurodiverse children, while a review of the Health Inequalities midwife role showed positive impact on breastfeeding and smoking in pregnancy. The team also completed a full review of commissioned Family Hub services to inform future commissioning strategy.
- Launched and embedded a new neighbourhood MDT model in Northumberland, enabling GPs, paediatrics, mental health, therapies, early help, family hubs, local authority teams and VCSE partners to jointly assess and support children closer to home. Over 80 children benefitted from earlier identification and coordinated intervention through monthly MDTs, with strong early evidence of improved outcomes, streamlined pathways and better family experience. A blueprint is now being developed to support wider rollout across the ICB.
- Improved early speech and language support in Sunderland and South Tyneside through a new cross-system initiative that trained more than 400 education staff in specialist Talk Boost approaches. This programme—part of Sunderland Communicates Together—is enabling earlier identification and support for children with speech, language and communication needs in mainstream settings, reducing waits and improving confidence, communication and early learning outcomes.
- Partnerships for Inclusion of Neurodiversity in Schools (PINS) has been delivered to 70 schools across North Cumbria, Gateshead, Hartlepool, Redcar and Newcastle which has strengthened whole school neuroinclusive practice, including workforce training for school staff on neurodivergence and communication needs. Participation in national PINS showcases, webinars and delivery groups reflects the ICB’s commitment to early, school level support for neurodivergent pupils and partnership working with education and parent carers.
- New intelligence and data dashboards: The development of the CYP Assurance Dashboard and Best Start in Life Dashboard brought together children’s data for the first time, enabling proactive identification of pressures including neurodevelopmental waits, mental health demand, SEND related health provision and inequalities in early years outcomes.
- Youth voice shaping decisions: The Know Our Impact Youth Board influenced governance agendas, pledges, communication standards and policy discussions. Their insights were incorporated into Strategic Oversight Group papers and escalations, and young people took active roles in system events and professional forums.
- Evidence based initiatives delivering impact: The region expanded the Eyes on the Baby multi agency training programme, reaching thousands of frontline staff, and progressed

the Northumberland neighbourhood MDT pilot to improve integrated care for children with complex needs.

- Improved risk management and escalation: Regular review of system risks reduced several long-standing issues and created clearer routes for raising CYP concerns—including mental health, SEND health duties, and financial pressures—into the Executive Committee

Our PHM strategy and delivery framework supports the ICB's ambition to move towards 'thriving' status on the PHM maturity matrix. We want to create the knowledge, skills, and culture to support embedding PHM as a way of working across NENC, working across the three core capabilities for PHM (intelligence, infrastructure, interventions, and incentives)

Digital and Technology

There have been a significant number of digital and technology developments over the past year, including approval and publication of the first NENC ICS Digital Inclusion Strategy, progression of Digital Modern General Practice, NENC Network Refresh Programme and strengthening of regional cyber resilience capabilities.

NENC ICS Digital Inclusion Strategy

Digital inclusion means offering all interested people the option to use digital technologies and services. We recognise that new digital tools can also create barriers for those not yet connected.

In 2024/25 we agreed our regional digital inclusion strategic vision: "To ensure that all people and employees have equitable access and understanding of digital technologies, allowing for a more accessible, efficient, and effective health and care system".

Driven by this vision and working together with regional partners across health, social care, and the VCSE sector, the first NENC ICS Digital Inclusion Strategy was developed, formally approved, and published in June 2025: [Link to ICS digital inclusion strategy 2024-26](#)

This strategy is informed by research, data, and the NHS England framework for digital inclusion, including its five domains for action. It sets out a defined strategic approach for the NENC ICS, aiming to pinpoint digital inclusion requirements and build upon the positive initiatives already underway.

Tackling the '8am rush' through optimising Digital Modern General Practice

The Digital Modern General Practice (MGP) Programme works with GP practices to enhance and optimise use of digital tools.

The Programme aims to simplify everyday tasks, improve patient care and reduce administration workload through streamlining processes, freeing up more time for patient care. It also empowers patients by enabling better access to their health information, improving communication, and making services more efficient and responsive to their needs.

Over the past year, the ICB has continued to work closely with NECS and NCIC to enhance the provision and use of digital tools within General Practices, in line with the objectives originally set out in the Primary Care Access Recovery Plan (PCARP).

We have overseen the continued delivery of the Programme, supporting Practices in their transition to a Modern General Practice (MGP) Model, tailored to meet their unique requirements.

Collaborative projects and initiatives have provided targeted support to GPs and Primary Care Networks (PCNs), enabling the adoption of digital technologies that fulfil PCARP priorities: empowering patients, addressing the 8am rush, modernising general practice, reducing bureaucracy and increasing capacity.

This work has been structured to take a holistic approach, assisting GP Practices in identifying their needs and improving both efficiency and access.

The programme uses the following schemes to help support Practices:

- Prospective Records Access
- Online Services (Directly Bookable Appointments/Repeat Medication)
- NHS App Support
- Advanced Telephony
- Online Consultations enhancements
- Website Improvement/Accessibility
- Triage/Care Navigation

Strengthening Cyber Resilience Across NENC ICS

During 2025/26, NENC ICS made significant progress in strengthening cyber security across the system.

The ICS initially secured and deployed £1.386 million of approved Cyber Risk Reduction capital and revenue funding, contributing to the final system investment of circa £2 million following a second round of bids, helping to protect patient data, support staff and ensure the resilience of digital services that underpin care delivery.

This investment reflects a strong system wide commitment to keeping services safe, reliable and trusted in the face of an increasingly challenging cyber threat landscape.

Funding was targeted at the areas of greatest risk and opportunity, focusing on practical improvements that deliver real benefits for our public and workforce, including:

- Reduced the likelihood and potential impact of major cyber incidents
- Improved protection of sensitive patient and staff information
- Strengthened the resilience of digital services that support care delivery
- Increased consistency of cyber controls across Trusts, reducing system wide risk.

Investment strengthened how access to systems and data is protected, including improvements to access controls and management, helping reduce the risk of cyber-attacks that rely on compromised accounts.

Trusts have strengthened cyber threat detection with enhanced monitoring, simulations, and advanced data-loss prevention tools targeting new risks like generative AI.

Improved funding has also boosted resilience and recovery, enabling faster and safer service restoration after disruptions.

Funding enabled technical improvements and enhanced cyber governance, such as updated risk dashboards and security strategies, which improved oversight and assurance. These improvements ensure consistent, active management of cyber risks across NENC.

NENC Network Refresh Programme

Refresh of the Community of Interest Network (CoIN) and replacing this with a modern network infrastructure known as a software-defined wide area network (SD-WAN) has continued to progress over the past year.

Primary aims of the Programme are to provide 'Gigabit capability' across the General Practice estate, increasing network bandwidth, allowing for modern applications to run more efficiently.

Additional anticipated benefits include potentially increasing productivity of staff across General Practice and enhancing network resilience. In addition, the Starlink equipment being installed in rural sites will increase connectivity speeds in a more cost-effective way than traditional circuits.

The NENC Network Refresh programme continues to progress across surveys, circuit installations, SD WAN deployment and site migrations. As of March 2026, 160 sites have been fully migrated.

A full migration schedule is in place, with the projected programme completion expected during June 2026.

Benefits realisation work conducted to date demonstrate significant bandwidth improvements at migrated sites (average uplift 212%). Starlink deployments are progressing, with a number of sites installed and pilot testing underway before wider rollout.

Key next steps include maintaining installation pace, ensuring Starlink integration, increasing daily migrations and embedding lessons learned.

Secure Data Environments

Significant progress has continued across the NENC ICS Secure Data Environment (SDE) programme, with several key programmes now fully established and operational. Notably, new governance arrangements are in place, including the launch of the Data Access Committee (DAC) and the Public Engagement Group (PEG). These structures are strengthened further with additional ICB-level governance and reporting.

As the SDE data controller, the ICB completed and submitted Section 251 applications to the Confidentiality Advisory Group (CAG) for both research and non-research purposes. Reviews and further approvals for both applications was granted during the year.

Onboarding of Primary and Secondary Care data has continued throughout 2025/26, with live data now successfully flowing into the SDE.

NENC ICS Digital Inclusion Strategy

Digital inclusion is about providing everyone who is able and interested, with the choice to access and interact with digital technologies and services. We acknowledge introducing new digital technologies can create barriers and inequalities to those not digitally connected. We are

working to ensuring no one is 'left behind' as we introduce new digital services, putting people at the heart of everything we do.

In 2024/25 we have agreed our regional digital inclusion strategic vision:

"To ensure that all people and employees have equitable access and understanding of digital technologies, allowing for a more accessible, efficient, and effective health and care system".

Guided by this vision and in collaboration with regional partners from health, social care, and VCSE, we have developed our first draft NENC ICS Digital Inclusion Strategy. This strategy builds on research, data and the NHS England framework for action on digital inclusion and the five domains for action. Our strategy outlines a clear strategic plan for the NENC ICS, to identify digital inclusion needs and enhance the ongoing positive initiatives.

Artificial Intelligence

During the past year a significant focus has been to consider the potential opportunities in relation to Intelligent Automation (IA) and specifically the adoption and use of Artificial Intelligence (AI) within the NENC healthcare system.

Working with the NENC Chief Clinical Information Officers (CCIO) network, we have created an AI Advisory Group that includes a range of stakeholders and subject matter experts from within the NENC system and beyond. Our intention is to continually improve and strengthen our AI governance arrangements, whilst our knowledge and understanding develops.

Our initial approach has been to establish "AI leadership" arrangements, and to develop appropriate AI frameworks and guidance, that can then be scaled and adopted across the NENC healthcare system.

Furthermore, we are considering opportunities for the development of AI learning materials to ensure, staff have a fundamental understanding of AI, its opportunities and potential risks prior to large scale implementation and deployment.

Specialised Commissioning

Following the signing of a delegation agreement between NHS England and NENC ICB, significant specialised commissioning responsibilities were delegated to the ICB in 2025/26. A dedicated subcommittee of Executive Committee was established in April 2025 to manage the specialised commissioning agenda. The subcommittee brings together expertise from within the ICB but also colleagues from the NHS England commissioning hub who have responsibility for specialised commissioning within the North East and Yorkshire area. In line with other areas of commissioning, specialised commissioning plans, budgets and contracts are approved at the start of the year via Executive Committee and ICB Board as appropriate, and then the specialised commissioning subcommittee meets to monitor in-year delivery and make decisions in line with delegated limits. The subcommittee has continued to meet throughout the year to discharge required business.

Task force on climate-related financial disclosures (TCFD)

The DHSC GAM follows a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies,

in line with [HM Treasury's TCFD aligned disclosure guidance for public sector annual reports](#). These TCFD disclosures, as interpreted and adapted for the public sector by the HM Treasury, will be gradually implemented in sustainability reporting until the 2025-26 financial year.

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

The GAM has also adapted the requirements for scenario analysis in the strategy section of the TCFD disclosures to better fit the needs of the public sector. Disclosures are cross-referenced to the Performance Report, Governance Statement and Green Plan.

The management of any risks are incorporated into the ICBs risk management approach. The ICB risk management approach is outlined within the risk management arrangements and effectiveness section of this report.

The ICB refreshed Green Plan is a comprehensive document which outlines the risks and actions to ensure the delivery of the ICS Green Plan targets. You can find out more in the following document [here](#).

Sustainability/NetZero

The Integrated Care Board (ICB) North East and North Cumbria Sustainability Programme will use its role to influence the regional healthcare community in reducing the NHS's impact on the factors that influence climate change. Highlighting the importance of including environmental considerations in moving from cure to prevention, hospital to home, and analogue to digital.

Our objectives include:

- Objective 1: Improved engagement and education.
- Objective 2: Baseline data collation - establishment of regional guidance frameworks.
- Objective 3: Influence plans and policy - work with the regions health care system to influence regional and trust green plans and policy.

The North East and North Cumbria Integrated Care System (NENC ICS) cover a population of 2.9 million people across Northern England. The Initial Green Plan was approved July 2022 following extensive regional collaboration. The plan was refreshed in 2025 informed by several workshops with regional sustainability leads which identified key priorities ('Golden Threads')

The organisations covered by the Green Plan includes:

- North Cumbria Integrated Care NHS Foundation Trust
- County Durham and Darlington NHS Foundation Trust
- Gateshead Health NHS Foundation Trust
- South Tees Hospitals NHS Foundation Trust
- North Tees and Hartlepool NHS Foundation Trust
- Northumbria Healthcare NHS Foundation Trust
- The Newcastle Upon Tyne Hospitals NHS Foundation Trust
- South Tyneside and Sunderland NHS Foundation Trust
- Cumbria, Northumberland Tyne and Wear NHS Foundation Trust

- Tees, Esk and Wear Valleys NHS Foundation Trust
- North East Ambulance Service NHS Foundation Trust
- North West Ambulance Service (aligned with North West regional area)
- North East and North Cumbria ICB

Governance Pillar

- Greener NHS Delivery Board - lead Chris Gormley Chief Sustainability Officer
- NEY Greener Regional Steering Group - Caroline Wood Sustainability Lead
 - Regional Oversight: Provider Collaborative leads and Sustainability Sub Groups, ICS Infrastructure Board, ICB Executive Steering Boards.
- NENC ICB Infrastructure Board
- ICB Sustainability leadership Group
 - Working Groups: Clinical, Medicines, Travel and Transport (including Clean Air), Adaptation Biodiversity, Digital, Waste and Procurement.
- Provider Collaborative Sustainability Leads meeting
 - Board-level Sustainability /Net Zero leads at each Trust.

Board oversight occurs through:

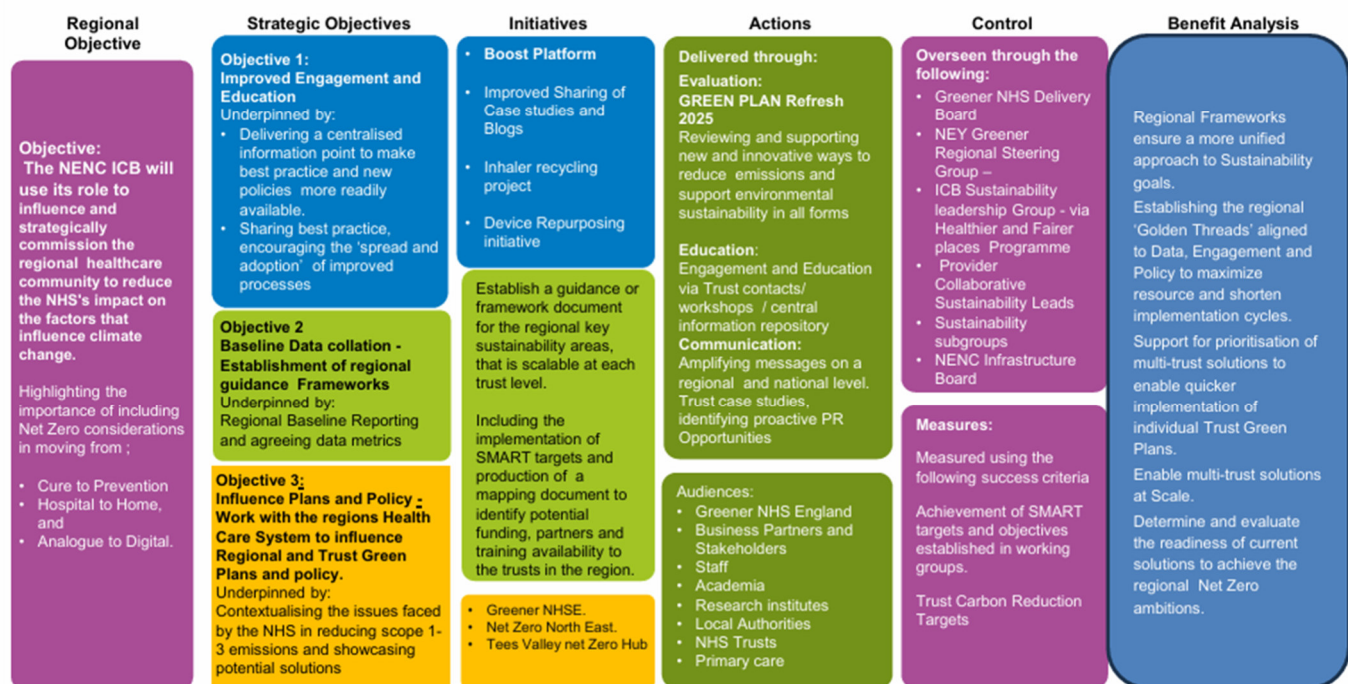
- Board and committees reviewing strategy, performance and risks (including environmental)
- Oversight of Green Plan delivery
- Monitoring performance via annual reporting cycle

Management Role:

- Sustainability programme leads across Energy, Waste, Biodiversity, Travel and Transport, Procurement, Adaptation, Sustainable Health Care and Medicines optimisation
 - ICS Green Plan governance
 - Reporting into governance/risk processes

Strategy Pillar

ICB NENC Green Plan Refresh 2025 - Plan on a Page



Risk Management Pillar

Climate risks are not standalone but integrated into corporate risk framework and risk registers. Risks are mitigated through existing risk mitigation processes and via Green Plan Actions.

Metrics and Target Pillar

The NENC ICB Refreshed Green Plan supports and promotes the standards for sustainable healthcare leadership by embedding sustainability into every facet of healthcare delivery, the NENC ICB will pave the way for a future that is healthier, greener, and more resilient.

Individual Trust are accountable for achieving their Green Plan target and work is underway to develop dashboards and regional reporting.

Examples of successes to date

- Going Green in Laparoscopic Surgery - Members of the surgical team at Darlington Memorial Hospital initiated a project to reduce the environmental impact and cost of the frequently performed laparoscopic cholecystectomy. By switching to reusable kit, over 12 months a cost reduction of £80,650 was achieved equating to a reduction of 58% in procurement costs
- Green Kidney Care -Multi-partner project aiming to produce a benchmarking framework to track and measure progress, whilst also encouraging implementation of more sustainable kidney care.
- CSH estimate that the widespread replication of 20 green innovations in UK kidney units could result in savings of £7 million, 11,000 tonnes CO2e and 470 million litres water per year

- Newcastle Hospitals commissions a bus service to transport staff between the Royal Victoria Infirmary and the Freeman Hospital. Go North East to switch from a vehicle powered by fossil fuels to an electric vehicle, saving 144 tonnes of CO₂e per annum.
- By 2026, NHS providers need to achieve the new clinical waste segregation targets of 20:20:60. This means:
 - 20% HTI (High-Temperature Incineration); 20% AT (Alternative Treatment);
 - 60% OW (Offensive Waste)
- The acute hospitals across the region have met the key targets for the 20: 20: 60 clinical waste segregation according to the 2023-24 ERIC data.
- South Tees Trust – James Cook Pop up ecco shops helping reduce food waste and promote sustainability. The pop-up shop is taking high quality, good to eat surplus food and making it available to staff for a small donation.
- ICB Sustainability page developed on the Boost platform to share regional information and best practice [ICB Sustainability Programme | Boost](#)
- Northumbria Healthcare NHS Foundation Trust's replacing old steam systems with energy-efficient heat pumps, saving 4,465 tonnes of CO₂ each year—equivalent to 15,000+ trips from Land's End to John O'Groats!

Energy

Buildings and estates represent 10% of the NHS's carbon footprint. Hospitals in particular are large consumers of energy due to their size, amount of equipment and the need to maintain patient comfort levels.

The Integrated Care System (ICS) Sustainability Group appointed an energy subgroup to lead on this issue and agreed to strive to achieve energy emissions of net zero by 2030.

This will be achieved by pursuing all options for energy efficiency and adopting renewable energy across existing sites.

Waste and the circular economy

The healthcare sector consumes sizeable amounts of single use plastics, for example Personal Protective Equipment (PPE) and single use medical devices, and due to the nature of healthcare, has to deal with hazardous and clinical waste. It should be noted that waste is usually a product of procurement or operations decisions, for example the choice of purchasing single use plastic cutlery for cafeterias will inevitably lead to plastic waste. Therefore, it is important to trace waste arisings back to source.

The Integrated Care System (ICS) Sustainability Group already has a waste subgroup to lead on this area and has set an overall target for 2030. This target needs to be shared through member organisations.

Target:

Achieve zero waste to landfill across the ICS by 2030.

Non-clinical waste

The priority will be to develop circular economy solutions where raw materials originate from recycled sources and are fed-back into the loop after they have been used (emulating natural cycles such as the carbon cycle).

While waste and water together represent 5% of the NHS's carbon footprint, the carbon benefits of shifting to a circular economy will be most felt in the supply chain by replacing virgin materials with recycled materials.

Supply chains for circular economy opportunities can be weak but may be strengthened by joint procurement exercises and the use of forward commitment procurement.

Where circular economy solutions are not available, the waste hierarchy will be followed, i.e. promoting minimisation, reuse, and recycling of waste. Where these options are not available, energy recovery will be prioritised over landfill.

Target:

All food waste segregated and sent for anaerobic digestion by 2030.

Biodiversity

Biodiversity and green spaces are of high importance to all trusts within the North East and North Cumbria (NENC) region, and progress in this area is varied across trusts. The biodiversity group are therefore able to share best practice, advice, contacts, and knowledge to support progression and foster opportunities for all trusts to expand on their current work.

The group work collaboratively; identifying opportunities to take work forward as a region and have recently worked together to develop a regional communications approach to No Mow May, ensuring consistent messaging to staff, patients and visitors. This has been important in engaging our communities with this work and the many benefits of taking action in several small areas can have to support wildlife populations and habitats overall.

Improving quality and quantity of biodiversity and green spaces broadly within the region and on our vast NHS estate and land provides many benefits both environmentally and to health and wellbeing, and so we have a duty to ensure we do this. This ranges from environmental benefits such as increasing essential ecosystem services such as those from pollinators, improving air quality, reducing negative impacts from heatwaves and urban heat islands from cooling abilities of trees and vegetation, reducing flood risk and impacts and carbon sequestration. This in turn can reduce the impacts to health from the climate crisis, and furthermore provides health benefits, providing opportunities for communities to spend time in green spaces being active, supports stress reduction and mental wellbeing improvements - aiding generally in illness prevention and recovery.

Travel and transport (including clean air)

The North East and North Cumbria Integrated Care System (NENC ICS) travel and transport group bring together a wealth of knowledge and experience in the sustainability sector and addresses transport related issues faced by NHS trusts in our region.

The group is focused on developing and delivering collaborative solutions to reduce the environmental impact of transport related activities across the region.

This includes logistics of NHS fleet decarbonisation, identifying and implementing sustainable modes of transport to and between NHS facilities for staff and patients, improving health and wellbeing of staff and patients, and improving air quality at NHS sites.

Currently, the group are working on development of a regional sustainable travel framework to support trusts in delivering the targets set out in the national travel and transport strategy. This collaborative approach is essential in understanding the importance and interdependencies of the local transport system in delivering NHS services in the region.

Procurement

Supply chain and procurement

The NHS supply chain accounts for 62% of its carbon footprint. One of the two key carbon targets for the NHS is to achieve net zero status of its supply chain by 2045. The aspirational target in this plan is for Integrated Care System (ICS) members to bring this target forward to 2040.

The benchmarking exercise flagged up procurement as an area requiring improvement, with only four Trusts having a green procurement plan, and a further two Trusts and one former Clinical Commissioning Group (CCG) working on such a plan. This is a key area for ICS members to address.

Embedding best practice

The ICS currently deals with supply chain sustainability via its general procurement group. The option of a specific sustainable procurement working group will be kept open as the strategy progresses.

Adaptation

Even if the best-case Paris Agreement target of keeping average global temperature rises to 1.5°C above pre-industrial levels is met, significant climate-related impacts are to be expected. This includes rising sea levels, flooding and increased incidents of extreme temperature.

All public bodies are required to have an adaptation plan, but the benchmarking survey suggested that only a third of Trusts and no former Clinical Commissioning Groups (CCGs) had a plan in place.

Adaptation to climate impacts also includes ensuring the medical services provided evolve to meet emerging needs, including the health impacts of extreme weather, eco-anxiety etc.

There are potential synergies between climate adaptation measures and providing therapeutic green space on NHS sites, for example planting trees to provide shade or gardens designed to absorb excess stormwater.

Primary Care

With up to 90% of healthcare appointments delivered in primary care settings, it is essential that we adopt environmentally friendly and sustainable practices. Specific areas of focus are staff and patient travel, energy use and prescribing.

Our region has a strong community of healthcare professionals who are engaged in encouraging action on sustainability in primary care. We are keen to showcase areas of 'good

practice' across the North East and North Cumbria; if something works well in a Primary Care Network (PCN) in Carlisle it could potentially be replicated in a GP surgery in Middlesbrough.

We encourage as many primary care staff as possible to become involved in the Greener Practice North East meetings - a great forum for sharing ideas relating to sustainability in primary care.

Workforce Programme

During 2025–26, the North East and North Cumbria Integrated Care Board continued to strengthen its system-wide approach to workforce, culture and staff experience, delivering a coordinated portfolio of programmes designed to support recovery, improve wellbeing and build a sustainable future workforce. Working in partnership with providers, local authorities, VCSE organisations and education partners, the ICB has focused on strengthening workforce insight and planning, enhancing staff mental health and wellbeing support, widening participation and inclusion, and improving staff experience across primary, secondary and social care. The following section highlights key achievements and impacts across these programmes, demonstrating the system's collective commitment to supporting, developing and retaining the health and care workforce.

System Recovery Workforce Programme

The System Recovery Workforce Programme has strengthened the North East and North Cumbria Integrated Care System's approach to workforce oversight, improving both the quality and consistency of information used to inform system decision making. During 2025–26, the programme embedded integrated monthly monitoring of key workforce metrics, including whole time equivalent (WTE), sickness absence and premium rate expenditure. Closer collaboration between ICB workforce and finance teams, the provider collaborative and individual trusts has created a more aligned and transparent approach to planning, enabling the system to better link workforce requirements, financial sustainability and service recovery needs.

Health & Wellbeing System Offer

As part of the NENC Health & Growth Accelerator programme, the system has strengthened its support offer for the health and care workforce through investment in the North East and North Cumbria Staff Wellbeing Hub and the development of a comprehensive wellbeing offer hosted on the Boost platform. Engagement with both the Hub and the wider wellbeing resources continues to increase month on month, supported by positive user feedback and the introduction of enhanced services including twice weekly Menopause Clinics, expanded specialist psychiatric support for alcohol and substance use, and increased uptake of Drink Coach's online Alcohol Test and coaching following targeted promotion. Accelerator funding is enabling the Hub's expansion to further improve staff mental health, wellbeing and retention across the region.

Fertility Policy

Partnership working revealed that fertility treatment was inconsistently managed across NHS employers, often misclassified under sick leave or maternity. A lack of awareness and policy clarity left many employees unsupported at a vulnerable time.

A subgroup formed to develop a clinically informed system-wide fertility policy offering up to five days of paid leave per cycle, for up to three cycles in a 12-month period for any member of staff

going through fertility treatment including provisions for partners. By providing protected leave for treatment, the policy supports emotional wellbeing, improves workforce retention, and crucially, helps reduce unnecessary use sickness absence. Education to support line managers was also provided. The policy, training and supporting educational sessions will be hosted on the “Boost” platform, ensuring visibility and ease of access across all partner organisations.

One staff member shared:

“Being so open and honest about it when there is stigma around it – is so hard and sometimes it feels like the wrong thing, so seeing it written down about removing the stigma and trying to create this open environment feels so huge and meaningful.”

Mini Scrubs – Primary School Careers

To help children have the best start in life and think about their future careers, the ICB has made resources to bring NHS jobs into classrooms. There are six activity packs, using approved BBC material, which make learning about NHS careers fun and interactive. These packs go along with the Mini Scrubs uniforms, which were given out previously, so children can role-play different NHS jobs. Children will learn about NHS chefs, doctors and radiologists, and how these professionals help keep people healthy. Studies show that children decide early which jobs they think are possible for them, so the Mini Scrubs programme aims to help them aim high, break stereotypes, and encourage their ambitions. All materials are available to download from the ICB website.

T Levels – Helping Young People Explore NHS Careers.

The ICB was awarded three years of funding from the Department for Education to set up a T Levels Industry Placement Coordinator in the North East and North Cumbria. T Levels are qualifications similar to A Levels, but they let young people spend time working in real jobs, learning practical skills and applying what they learn in class. This helps them discover the wide variety of jobs in the NHS. The coordinator is based at Northumbria Health Care NHS Foundation Trust. The ICB and the Trust worked with other partners to win the funding and are continuing to develop the T Level programme for young people now and in the future.

Supporting People with Care Experience

Following being one of 10 national trailblazers when the NHS Universal Family Programme first launched, the ICB and partners have continued to challenge ways of working to reduce barriers for people with care experience, especially young people. Having care experience means being in the care of the local authority as a child, and evidence tells us that people who have been in care experience greater health inequalities than peers who have not. They can also face additional barriers to education, training and employment.

We have:

- enhanced our recruitment policy to include a guaranteed interview for people with care experience
- coordinated a careers event bringing together 17 employers to offer young people access to careers advice, working professionals and opportunity to gain new qualifications
- commissioned an innovative pre-employment programme with a focus on developing confidence, self-esteem nurturing self-belief and connections with employers and professionals

GP & Social Care People Promise pilot

The North East and North Cumbria ICB delivered a structured People Promise Pilot to improve staff experience, retention, wellbeing and culture across Primary Care and Social Care. The pilot responded to high sickness, turnover and workforce pressures, with feedback from the system retention network highlighting challenges in sustainability, psychological safety and staff voice.

The ICB implemented a standardised model including a baseline survey, reflective practice, self-assessment, targeted interventions, monthly reporting, a post pilot survey and accreditation. Eleven pilot sites used this approach to embed the seven People Promise elements, drawing on an evidence-based intervention bundle covering flexible working, recognition, wellbeing, compassionate leadership, team collaboration and staff voice. Support included deep dive learning for managers, access to the NENC Retention Repository, wellbeing resources, tailored analysis and ongoing coaching.

Health equity and inclusion

We have seen a significant increase in users on our Boost Learning Academy, which now has over 26000 users. The Learning Academy is hosted by the ICB for our Healthier and Fairer Inequalities programme, to both upskill our workforce and population, to reduce Health Inequalities.

As part of this we host the Oliver McGowan Mandatory Training on Learning Disability and Autism, to support the rolling out of the mandatory training for all NHS staff within NENC. The ICB has funded the training provided by colleagues in the charitable and voluntary sector, who facilitate the training which is delivered in collaboration with lived experience trainers. To date we have trained several thousand NHS staff within our region, and this training will be refreshed on a rolling basis.

The ICB has also led the North East and Yorkshire region, four ICBs and NHS England, in creating an Antiracist approach, which has been agreed by four CEO and regional Director for NHSE. The ICB also hosts an Anti-Racism hub, which provided a range of learning opportunities, and toolkits to tackle Racism and other forms of religious Hatred, with a focus on antisemitism and Islamophobia.

As part of our Public Sector Equality Duty, the ICB has created a new Equality Impact Assessment (EIA) assurance and approval process, including a STAR chamber for the most high-profile changes to our commissioned services.

We continue to report on our Workforce Pay Gaps, Gender Pay Gap, and the Disability and Ethnicity Pay Gap and have seen some small improvements in some of the pay gaps, but more work contained with our Pay Gap action plan.

We have also seen increases in our workforce declaring their protected characteristics, which is a positive sign that our people feel more confident in reporting and feel support. A particular improvement has been seen in People with Disabilities declaring their data.

Boost Learning and Improvement Community

Boost is the North-East and North Cumbria's system wide learning and improvement community, supporting people across health, care, local government, VCSE and communities

to learn together, connect and improve. Over the past year, Boost has continued to grow in reach and impact, now supporting nearly 25,000 active members across the region. Through the Boost Learning Academy, thousands of colleagues have accessed free, practical learning in improvement, system leadership, health equity and inclusion. Boost has also convened large scale improvement events and communities of practice, including system conferences showcasing improvement work and targeted communities focused on priority areas such as healthy weight and obesity.

During a period of significant organisational change, Boost has supported ICB and system transition and consultation programmes, using facilitated learning and change workshops to help teams make sense of change and develop shared ways of working. In parallel, the development of the Boost People's Hub has strengthened the involvement of citizens and people with lived experience. Together, these activities position Boost as a key system asset, creating the conditions for collaboration, shared learning and continuous improvement across North East and North Cumbria.

Population health management

Our Population Health Management (PHM) approach builds on a data-driven methodology to help plan and deliver care that maximises our impact in achieving health outcomes and reducing health inequalities. It includes looking at wider determinants of health and collaborating with partners to make best use of collective resources.

Our aim is to embed PHM approaches across the ICB, provider collaborative, local and PCN levels to support a fundamental shift from reactive to proactive care for our communities, supporting delivery of the ICB vision as well as the ambitions set out in the NHS Long Term Plan and NHSE Operational Planning Guidance.

Research

Research & Evidence team transferred from NECS to ICB 1/4/25 to support the ICBs statutory duties and requirements as a strategic commissioner. They work strategically and operationally, nationally and regionally, internally and with collaborators in the research ecosystem to align R&E with ICB NENC priorities and population needs.

Strategic work

- Strategically working with senior leaders in NHSE, DHSC on policy with regards placement and responsibilities of research across the evolving NHS system structure
- Applied Research Collaborative (ARC) is integral to R, E and E working and support within the ICB, with their priorities areas of research closely aligned to ICB priorities. Outputs to support ICB decisions available <https://arc-nenc.nihr.ac.uk/evidence> and ICB learning platform BOOST
- Newcastle Health Research Partners Research Oversight Committee to bring wider NENC system voice and priorities for research, shifting conversation and thinking away from acute services research and how partnership strengths of research system can align and be additive to the priorities and 3 shifts
- Aligned with 4 NENC funded Health Determinant Research Centres, (HDRCs) based in Local Authorities to support national push for more community and out-of-hospital research.

Research inclusion

Following work demonstrating the gap in research activity in deprived areas compared with more affluent areas and understanding the reasons, (NECS now ICB) R&E working with RRDN published [Link to: how can we make research more equitable?](#) In addition, RRDN have prioritised resources to support Deep End practice with now seven of the 52 Deep End practices recruiting patients

Research Engagement Network, NHSE funding, has continued and extended so the use of the coproduced materials, from young people with MH conditions, Community Engagement Toolkit. [Link to community engagement toolkit](#) is available to researchers and more generalisable to other communities underserved by research. This is cross- sector initiative with VONNE, voluntary sector, ARC, RRDN, both Mental health trusts and young people.

Capacity building

Training

Building capacity and capability across ICS to provide relevant skills, resources and confidence for finding and using evidence from research and evaluating impact in strategic commissioning. Online training schedule, supported by BOOST, has been developed and eLearning modules available.

Evidence Maturity Matrix

As ICB transitions into Strategic Commissioning understanding the competency skills and gaps is essential. A Maturity index was deployed for a baseline assessment response received and analysed. The overall evidence maturity score was 2.33 / 4, and gaps and training needs identified

Knowledge mobilisation

To ensure the right evidence gets to the right person in the right way and in the right time for decision making, the team undertake various tasks from communication channels, targeted information and conversations to mobilise knowledge from research. This is enhanced by ARC funded Knowledge Mobilisation fellow who has undertaken evidence summaries

1. Hybrid working to influence estates strategy
2. Flu vaccination uptake for frontline healthcare workers for winter plan
3. Integration of cardiac and pulmonary rehabilitation services for new service planning

Research Governance

The R&E team ensures the Research Governance framework is applied with policies and procedures to follow national guidelines. This provides staff outside NHS wishing to undertake research in primary care a Letter of Access (LOA). Also any research, in primary care settings that does not meet the NIHR portfolio criteria must undergo Capacity & Capability assessment to ensure it is deliverable.

Activity April 2025 to February 2026

- LOAs: 26 issued
- Research projects, including two confirmations of Capacity and Capability :23

Priority areas in ICB

- Commissioning intentions: Working alongside to support & advise on evidence needed for planning cycle and work with 2 key commissioning intentions / priorities of tele dermatology and neurodevelopmental pathways
- WorkWell: R&E are embedded and leading the multi method evaluation of this nationally funded Health & Growth Accelerator NHSE pilot for health & economic inactivity. This includes working with data analytics team regionally and nationally, supporting the NIHR national research programme, and commissioning and managing external evaluations locally
- Mental Health: Co-chair Mental Health Evidence & Evaluation group to embed and share with representatives from ICB, practitioners, VCSE, academia and lived experience covering MH, LD and autism,
- Women's Health: synthesis evidence from the current Women's health hubs, research, and support evaluation plans to produce evidence for future sustainable integrated neighbourhood approach.
- Deep End: Support Research pillar of Deep End, promoting new research opportunities, building research capacity, sharing new evidence and co-applicant on NIHR funded Co-Developing a Care Pathway Between Community Pharmacies and General Practices in the Deep End
- Primary and community care Research capacity building with the shift of services from hospital into community and the increase in primary care staff getting involved in research, a virtual centre of academic primary & community care is supported by ICB (Research capability funding) and Newcastle University

Research grant hosting

ICB is now a recognised host of national research grants for out - of - hospital research. NIHR Research for Patient Benefit grants on

- Shared medical appointment for COPD,
- Social care provision for South Asian communities
- Others planned or submitted awaiting outcome

Research delivery network

Regional activity of recruitment into research studies is 35999, across all settings .27 % of GP practices are research active with 14 studies now recruiting in community-based settings. 19.4% are commercial studies

Secure Data Environment

Providing strategic leadership and operational ongoing support, promotion, research governance and ethics advice in the set-up, feasibility and early mobilisation of the NENC ICB SDE, policy & processes.

All Age Continuing Care (AACC)

The Integrated Care Board (ICB) remains committed to ensuring that individuals with complex health needs receive safe, effective, person-centred continuing care services across all age groups. During 2025/26, the All Age Continuing Care (AACC) service continued to support

adults and children with assessed ongoing healthcare needs through a coordinated approach spanning assessment, commissioning, quality assurance, safeguarding, and market engagement.

The service worked in accordance with the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, alongside statutory responsibilities for Children and Young People's Continuing Care. AACC teams collaborated closely with provider organisations, local authorities, acute trusts, community services, mental health services, primary care, and the voluntary sector to improve outcomes and experience for patients and carers.

Service Activity and Performance

During the reporting period, the AACC service managed a sustained level of demand across both adult and children's pathways. Key areas of activity included:

- Completion of NHS Continuing Healthcare (CHC) assessments and reviews;
- Delivery of Children and Young People's Continuing Care assessments;
- Fast Track pathways for individuals requiring urgent packages of care;
- Management and review of jointly funded care arrangements;
- Oversight of Personal Health Budgets (PHBs);
- Quality assurance and safeguarding oversight across commissioned placements.

The ICB continued to monitor performance against national and local indicators, including timeliness of assessments, review compliance, and package sustainability. Improvements were made in reducing delays between referral and decision-making through strengthened triage processes and enhanced multidisciplinary working.

The service also maintained focus on ensuring that care packages remained clinically appropriate, proportionate, and reflective of individuals' changing needs. Routine review processes supported effective stewardship of resources while prioritising patient safety and quality of care.

Person-Centred Care and Experience

A key priority throughout the year was strengthening the voice of patients, families, and carers within continuing care processes. The service continued to promote person-centred planning and sought to ensure individuals were actively involved in decisions regarding their care and support arrangements.

Feedback received from patients and families highlighted the value of:

- Improved communication from case management teams;
- Greater continuity of care coordination;
- Increased flexibility through Personal Health Budgets;
- Collaborative working between health and social care partners.

The ICB recognises that continuing care pathways can be complex and emotionally challenging for families. Work therefore continued to improve the accessibility of information, consistency of communication, and transparency of decision-making processes.

Quality, Safety and Safeguarding

The AACC service maintained robust governance arrangements to support quality and patient safety. Clinical quality reviews, provider assurance processes, safeguarding oversight, and contract monitoring arrangements were undertaken throughout the year.

Where concerns regarding quality or safety were identified, the ICB worked proactively with providers and partner agencies to implement improvement actions. Safeguarding remained a core priority, with AACC staff contributing to multi-agency safeguarding processes and ensuring that vulnerable individuals were appropriately protected.

The service also strengthened quality surveillance arrangements for high-cost and complex placements, including enhanced oversight of out-of-area placements where appropriate.

Workforce and Service Development

During 2025/26, the ICB continued to invest in workforce development across the AACC service. Training and professional development activity focused on

- Application of the National Framework;
- Decision Support Tool (DST) consistency;
- Mental Capacity Act and Deprivation of Liberty Safeguards;
- Safeguarding responsibilities;
- Trauma-informed and person-centred practice.

The service also undertook work to improve recruitment and retention within specialist nursing and case management roles, recognising the importance of maintaining a skilled and resilient workforce.

In response to increasing complexity and demand, the ICB reviewed elements of the operating model to strengthen integration across children's and adults' continuing care pathways and improve transition arrangements for young people moving into adult services.

Priorities for 2026/27

Key priorities for the coming year include:

- Further reducing assessment and review waiting times;
- Improving transition pathways between children's and adult continuing care services;
- Enhancing digital systems and data quality;
- Strengthening co-production with patients and carers;
- Continuing to develop the provider market to improve capacity and sustainability;
- Embedding quality improvement and assurance processes across all commissioned services.

The ICB remains committed to delivering equitable, high-quality continuing care services that support people with complex needs to achieve the best possible outcomes and quality of life

Learning from Lives and Deaths – LeDeR

The Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR) programme remains a key component of the ICB's commitment to improving the quality, safety, and equity of care for people with a learning disability and autistic people. The

programme supports the identification of themes, learning, and opportunities for improvement arising from reviews of deaths, with the aim of reducing health inequalities and preventable mortality.

During the year, the ICB continued to strengthen local LeDeR processes in partnership with provider organisations, local authorities, primary care, and voluntary sector partners. Reviews were undertaken in line with national guidance, with a continued focus on ensuring that the voices and experiences of families and carers were central to the review process. Findings from reviews highlighted recurring themes including delays in diagnosis or treatment, challenges in care coordination, barriers to accessing services, and the need for improved recognition of deteriorating health. In response, the ICB and system partners have continued to implement targeted actions to improve the quality of care and patient experience. These included:

- strengthening awareness and uptake of reasonable adjustments across services
- improving identification of people with a learning disability and autistic people within healthcare systems
- promoting the use of annual health checks and health action plans
- enhancing workforce training in learning disability, autism, and communication needs; and
- improving multi-agency working and information sharing to support more joined-up care.

The ICB has also continued to support the development of compassionate and inclusive approaches to end-of-life care, ensuring that people with a learning disability and autistic people receive equitable access to high-quality palliative and bereavement support. Learning from LeDeR reviews is routinely shared through governance structures, provider forums, safeguarding arrangements, and quality improvement programmes to ensure that learning translates into measurable improvements in practice. The ICB remains committed to embedding the principles of co-production and involving people with lived experience and family carers in shaping future improvements.

While progress has been made, the ICB recognises that significant inequalities in health outcomes persist for people with a learning disability and autistic people. Reducing avoidable deaths and improving life expectancy will remain a core priority for the system in the coming year.

Transforming Care

The ICB has continued to support the ambitions of the Transforming Care programme by working collaboratively with partners to reduce reliance on long-term inpatient care for people with a learning disability and autistic people. Throughout the year, there has been a continued focus on ensuring that individuals are supported to live as independently as possible within their local communities, with care that is person-centred, least restrictive, and tailored to individual needs.

Through close partnership working with local authorities, housing providers, community teams, providers, individuals, and families, the ICB has supported timely discharge planning and the development of appropriate community-based support packages. This has included investment in enhanced community support, crisis prevention and response services, supported living arrangements, and personalised care planning to help prevent unnecessary hospital admissions and reduce delayed discharges.

The ICB recognises that successful discharge from hospital requires sustainable community provision and strong multi-agency collaboration. As a result, work has continued to strengthen community infrastructure, improve transitions of care, and ensure that people and their families are actively involved in decisions about future support arrangements. The programme remains focused on improving quality of life, promoting independence, and ensuring that people receive care in the right place, at the right time, and as close to home as possible.

Quality Governance

The ICB published its Quality Strategy in October 2024, recognising that by working together across our system, there are opportunities to make care safer and set the highest ambition for quality and safety standards for our communities. The strategy sets out standards across key overarching themes of culture and climate, positive experiences, patient safety, clinical and multi-professional leadership, and clinical effectiveness. The ICB continues to progress the development of a patient safety centre, with a key focus on infection prevention and control, pressure ulcers, and sepsis.

The ICB has established quality structures to support oversight from place-to-board, based on National Quality Board guidance. Learning and areas for escalation feed into the area Quality subcommittees, chaired by a Director of Nursing which focus on patient experience, patient safety, and clinical effectiveness. Key learning from these and areas for escalation are discussed at the ICB Non-Executive Director (NED) chaired sub-board Quality and Safety Committee.

The ICB has implemented an EQIA policy and established a robust EQIA process to support service change, de-commissioning, commissioning, and procurement. This process aligns with NQB requirements and ensures any proposed changes that might impact quality, equality, and sustainability in services, is central to any decision making.

In preparation for the ICB's transition to a strategic commissioning organisation in April 2026, we have reviewed our quality governance arrangements to ensure they are suitable and appropriate to support the ICB through the development of our new Quality Management Framework (QMF). The QMF will support the ICB in its statutory role to monitor and assess the quality of commissioned services.

The ICB System Quality Group (SQG) remains in place. Based on best practice guidance from the National Quality Board, this group retains a wider than health-focused review of quality across the system. The meetings include representatives from regulators and colleagues from Health Education England (HEE) and reviews quality concerns across all health and social care providers. Items for learning or onward escalation are discussed at the Regional Quality Group (RQG), chaired by NHS England (NHSE).

All Age Safeguarding, cared for and Care Experienced Children and Young People

Statutory Responsibilities

NHS North East and North Cumbria ICB have continued to discharge its statutory safeguarding duties throughout 2025/26 in relation to its all-age safeguarding responsibilities and for cared

for and care experienced children and young people. The ICB was able to maintain assurance and oversight of its duties as outlined in the NHSE Safeguarding and Accountability and Assurance Framework (SAAF) 2024.

The Executive Chief Nurse and AHP Officer who holds the statutory accountability for safeguarding was supported by the Directors of Nursing who held delegated statutory safeguarding responsibilities covering each of the ICB local delivery team (LDT) areas working with local delivery team directors.

Each LDT had in place designated professional teams delivering against the statutory ICB functions and providing safeguarding leadership, expertise and specialist advice within the ICB, to commissioned providers and across partner agencies.

Processes were in place to monitor the safeguarding arrangements of our commissioned health services and to provide assurance that children and adults at risk of abuse were safeguarded in all NHS settings as well as individual homes, independent hospitals, and in care sector provision. The Designated Teams took account of national and local guidance, directives and learning from reviews in order to focus on the improvement and development of our services.

The ICB worked closely with NHSE to provide assurance that the ICB was fulfilling its safeguarding statutory functions, duties, roles, and responsibilities. NHSE regional leads attended the NENC ICS Executive Health Safeguarding subcommittee and provided feedback to the ICB and, where required, further information and clarification on specified areas of monitoring in order to provide the required assurance and data requested. NENC ICS Health Safeguarding Executive subcommittee reports to the ICB Quality and Safety Committee, which in turn is a subcommittee of the ICB Board.

The ICB was able to demonstrate that appropriate safeguarding governance systems (see diagram below) were in place for discharging their statutory safeguarding duties and functions in line with the following key legislation:

- Care Act 2014
- Children Act 1989 and 2004
- Children and Social Work Act 2017
- Working together to Safeguard Children 2018 (updated December 2023)
- Child Deaths - The Child Death Review Statutory Guidance (2018)
- Looked After Children - Promoting the health and wellbeing of Looked after Children (DfE 2015)
- Prevent - Counter Terrorism and Security Act, 2015 (Prevent Duty)
- Mental Capacity - Mental Capacity Act (MCA, 2005)

The safeguarding team has continued to fulfil its statutory functions by attending and contributing to meetings where the ICB is a statutory partner and or has a duty to cooperate. These have included adult boards and children's partnerships, corporate parenting boards, community safety partnerships, Prevent, domestic abuse local partnership boards (DALPBs) and violence reduction boards. The team has worked closely with providers on rolling out phase 2 of the child protection information sharing (CP-IS) which is now part of the NHS standard contract, data collection of both the providers and ICBs safeguarding commissioner assurance tool (P-SCAT and SCAT) and the children in care data, have been fundamental in raising awareness of and supporting the use of mental capacity act assessments with providers and maintaining links with LMNS and participating in various regional and national work.

Learning reviews continue with domestic homicide reviews, child safeguarding practice reviews and safeguarding adult reviews. The safeguarding team participates in these reviews sharing their expertise and forming recommendations from the findings, then disseminating the learning across the health system, seeking assurance the learning is embedded.

Work has been undertaken with the relevant Lead Safeguarding Partners (LSPs), Executives and Child Safeguarding Partnerships (CSPs) across the ICB footprint to reinforce and embed the ICBs full commitment to meeting the required updated guidance in Working Together to safeguard children 2023, 2024 and 2026.

The ICB continued its leadership and/or membership of the Child Death Overview panels (CDOP) which meet regularly to review child death cases. Modifiable factors identified during these reviews mirrored the national picture including obesity, parental smoking, parental drug and alcohol misuse, domestic abuse, mental ill health and co-sleeping and unsafe sleeping practices. CDOP chairs are formal members of the NENC ICS Health Safeguarding Executive subcommittee.

Work has commenced with partner agencies relating to the children's social care reforms which requires a revision of children's multi-agency safeguarding hubs and the introduction of Multi-Agency Child Protection Teams (MACPT). This work will continue over future years and will consider the integration with neighbourhood health teams.

	Safeguarding Children's Partnership Annual Reports	Safeguarding Adult's Board Annual Report
North	• Cumbria Safeguarding Children Partnership Annual Report 2024/25 • North Tyneside Safeguarding Children Partnership Annual Report 2024/25 • Newcastle Safeguarding Children Partnership Annual Report 2024/25 • Gateshead Safeguarding Children Annual Report 2024/25	• Cumbria Safeguarding Adults Annual Report 2024/25 • North Tyneside Safeguarding Adults Annual Report 2024/25 • Newcastle Safeguarding Adults Annual Report 2024/25 • Gateshead Safeguarding Adults Annual Report 2024/25
South	• Durham Safeguarding Children Partnership Annual Report 2024/25 • South Tyneside Safeguarding Children Partnership Annual Report 2024/25 • Sunderland Safeguarding Children Partnership Annual Report 2024/25 • Darlington Safeguarding Partnership Annual Report 2024/25 • South Tees Safeguarding Children Partnership Annual Report 2024/25	• Durham Safeguarding Adults Partnership Annual Report 2024/25 • South Tyneside Safeguarding Adults Board Annual Report 2024/25 • Sunderland Safeguarding Adults Board Annual Report 2024/25 • Darlington Safeguarding Partnership Annual Report 2024/25 • South Tees Safeguarding Adults Annual Report 2024/25

Learning from Lives and Deaths of People with Learning Disability and Autistic People (LeDeR)

Learning from Lives and Deaths of People with Learning Disability and Autistic People (LeDeR) NENC ICB has robust strategic arrangements in place to ensure the delivery of LeDeR.

Learning from LeDeR continues to be a crucial service improvement programme to influence commissioning and service provision to reduce premature mortality and health inequalities of people with learning disability and autistic people. Each LeDeR review is not just a statistic, but a story that helps the system understand what is working well and where improvements are needed.

Main deliverables for the workstream

Across 2024, the North East and North Cumbria Integrated Care Board strengthened its LeDeR programme by completing 195 high quality reviews, improving consistency, governance, and system wide learning, while embedding lived experience voices at every stage. Significant achievements included major improvements in respiratory, dysphagia, diabetes and cancer pathways; the establishment of specialist Communities of Practice; refreshed Acute Learning Disability and Autism Diamond Standards adopted across all trusts; expanded accessible resources such as health passports, hospital packs, STOP and WATCH tools, and national easy read materials; and co-produced awareness campaigns including Reasonable Adjustments, All Behaviour Happens for a Reason, and new communication guidance. Workforce transformation progressed through extensive training for GPs, ambulance staff, family carers, and the rollout of Oliver McGowan mandatory training, alongside the continued expansion of Positive Behavioural Support programmes. Population health management was strengthened through improved dashboards and insights, supporting targeted interventions that address the leading causes of premature mortality such as pneumonia, aspiration pneumonia, heart disease and cancer. Together, these achievements demonstrate a coordinated, evidence driven approach that is reducing health inequalities, improving care quality, and embedding learning into commissioning and service improvement across the region.

As well as feeding into the Quality and Safety Committee, learning from LeDeR is cascaded for local authorities via Health and Well Being Boards ensuring learning from LeDeR is widely shared and implemented locally.

The ICB is responsible for ensuring:

- LeDeR reviews are completed for the deaths of all people with learning disability and autistic people from NENC
- Learning is extracted from reviews; SMART actions are developed and implemented to improve the quality of all health and care services for people with learning disability and autistic people to reduce health inequalities and premature mortality
- Local Delivery Teams with their local authority partners ensure local action is embedded to address issues identified from reviews
- Recurrent themes and significant issues are identified and addressed at a more systematic level

Achievements during 2025/26

Key accomplishments during the report period include:

- Publication of LeDeR Annual Report 2024 a copy of which can be found here
- Publication of LeDeR Annual Report 2024 Easy Read Summary which can be found here
- Publication of Learning into Action Report 2024 which can be found [Link to learning into action report](#).

Special education needs and disabilities (SEND)

In 2025/26, the ICB Integrated Care Board continued to strengthen the delivery of its statutory responsibilities for Special Educational Needs and Disabilities (SEND), aligned to the NHS England Model ICB Best Practice Framework. As part of the national change programme, the ICB focused on embedding consistent quality assurance, improving governance, and supporting local partnerships to meet the expectations of the SEND and AP (Alternative Provision) reforms.

The programme of work drew directly on the High Impact Actions for ICBs, the annual refresh of the SEND Quality Assurance Framework (QAF), and preparation for Local Area SEND Reform Plans. All five High Impact Actions were completed during the reporting year. Routine audits of EHCP statutory health advice and quality assurance processes have been undertaken, with agreed actions now in place across providers.

The ICB continues to work closely with local authority partners to support ongoing preparation for inspections, reflecting the regional inspection profile in which nine NENC areas have been inspected. During the last year, Cumberland and Sunderland SEND Partnerships underwent inspection by CQC and Ofsted and both received Outcome 2 (The local area partnership's arrangements lead to inconsistent experiences and outcomes for children and young people with SEND). Partnership action plans are in place, with six monthly monitoring by NHSE and DfE and show evidence of positive progress within local SEND arrangements. The results of Northumberland's SEND inspection, carried out in February 2026, has not yet been published.

Engaging people and communities

The ICB is committed to listening to the views of patients, carers, the public and stakeholders across North East and North Cumbria. This includes actively seeking feedback from people with protected characteristics and communities experiencing health inequalities. We use a range of involvement, engagement and communication approaches to ensure community voices shape the services we commission. Our methods continue to evolve, informed by learning about what works well and by maintaining a balanced mix of digital, face-to-face and community-based approaches.

How we support involvement - The ICB has a dedicated involvement team that supports commissioners to assess when and how involvement is required. The team provides practical advice, planning support, project management and, where appropriate, commissions independent engagement activity. Each programme of work is supported by a bespoke involvement plan setting out clear objectives, methods and required resources. We have robust processes to ensure patients' and communities' views inform service design, evaluation and change. This includes a service change toolkit, guidance on engagement approaches, and access to specialist advice from regional involvement leads.

Building partnerships and networks - We build and facilitate strong networks with local communities, public sector partners and voluntary, community and social enterprise (VCSE)

organisations. These relationships support coordinated engagement, shared learning and consistent messaging across the region. Importantly, these partnerships create opportunities for continuous listening outside of formal consultation processes. This enables relationship-based engagement rather than purely project-driven activity.

Governance and assurance - Involvement activity is reported through formal governance structures, including the quality and safety committee and the ICB board. Regular updates provide assurance that statutory duties to involve are being met and demonstrate how feedback informs decision-making.

Overview of our approach

Shaping services through listening - We work with system partners, patients, carers and the public to improve patient safety, experience and outcomes, supporting people to optimise their health and wellbeing. Our annual involvement and engagement report provides detailed examples of how this work has influenced decisions.

Collaborative listening across the system - As part of an integrated care system, we work closely with partner organisations. In some cases, partners may discharge involvement duties on our behalf. We maintain oversight and assurance through established governance arrangements.

Working with our communities - We work closely with Healthwatch and VCSE partners across local areas. Feedback is shared across NHS and partner organisations to support service improvement. We remain committed to strengthening these relationships and developing new ways of working with communities.

Supporting high-quality involvement - The ICB has developed a comprehensive suite of materials to support meaningful engagement, including our involvement strategy, toolkits, guidance documents, training materials and proformas for staff.

Shaping services through listening

We work with system partners, patients, carers and the public to improve safety, experience and outcomes, supporting people to optimise their health and wellbeing.

Our vision reflects our commitment to making the best use of public resources while ensuring decisions that affect patients are made in partnership with local people. Sustainable, person-centred services depend on meaningful public influence in service development and change.

We undertake demographic monitoring aligned to the nine protected characteristics of the Equality Act 2010, and beyond where appropriate. This helps us understand who is participating, identify under-represented groups and undertake targeted engagement where needed. Where data allows, we analyse responses by demographic group to support our duties relating to equality and health inequalities.

In an increasingly complex health landscape, capturing community insight is essential to identifying and addressing inequalities. Strengthened partnerships with Healthwatch and the voluntary sector have improved consistency in listening, messaging and feedback-sharing across the region.

Annual involvement and engagement report

Our annual involvement and engagement report provides a comprehensive overview of engagement activity during 2025/26 and demonstrates how patient, carer and community insight has shaped ICB decisions. The report outlines:

- Major service change programmes and how statutory duties to involve were met
- Targeted engagement with communities experiencing health inequalities
- Partnership work with Healthwatch and VCSE organisations
- Examples of co-design and lived experience shaping service models
- How demographic monitoring informed inclusive approaches
- Lessons learned and improvements made because of feedback

It highlights not only the breadth of engagement activity, but the tangible impact of listening, including changes to service specifications, communication approaches, access routes and outcome measures. The report also sets out areas for development, including strengthening inclusive engagement, improving feedback loops and embedding co-production principles more consistently across commissioning.

By publishing the report annually, we provide transparency and assurance to our communities, partners and the Board that involvement is meaningful, proportionate and directly influences decisions.

Working with our communities

Working with Healthwatch

The ICB is committed to listening to local communities and working with trusted community-based organisations to support meaningful two-way conversations.

A key partner in this work is Healthwatch. Healthwatch organisations play an important role in representing the views of patients and communities and are active across a wide range of local forums and networks. We work closely with the Healthwatch Network across North East and North Cumbria to coordinate engagement activity, share intelligence and ensure feedback is acted upon.

Dedicated funding supports this partnership, helping to embed engagement and involvement across commissioning programmes and service change. This collaborative approach enables consistent messaging, wider reach and timely insight into people's experiences of health and care services.

You can read more about [how we work with Healthwatch](#).

Working with the voluntary, community and social enterprise (VCSE) sector

We work with a broad range of voluntary, community and social enterprise (VCSE) organisations across the region. These organisations have strong relationships within local communities and are often best placed to reach people who may not traditionally engage with statutory services.

Through these partnerships, we can involve diverse populations in shaping local health services and ensure that the voices of communities experiencing health inequalities are heard.

VCSE partners also support us to design inclusive engagement approaches, deliver community-based conversations and share information in accessible and trusted ways.

You can read more about [how we work with the Voluntary, Community and Social Enterprise sector \(VCSE\)](#).

Working with Haref Network

We work closely with the Haref Network in Newcastle to strengthen engagement with ethnically marginalised communities.

Through this partnership, we share health information, surveys and engagement opportunities with a wide range of community organisations led by and supporting ethnically marginalised groups, including asylum seekers and refugees. The network also enables ongoing dialogue about emerging health issues, barriers to access and community priorities.

Regular meetings throughout the year help ensure that health messaging is accessible, culturally appropriate and responsive to community need.

Listening forums and community conversations

Across North East and North Cumbria, we continue to strengthen our involvement approach by working alongside community groups, lived experience networks, VCSE partners and patient forums.

These relationships allow us not only to share information about current programmes of work, but to listen carefully to what matters most to people. Community conversations provide valuable insight into lived experience, local concerns and emerging issues.

ICB colleagues regularly attend community meetings across the region. Sessions are shaped around the interests and priorities of attendees, creating flexible spaces where people can ask questions, raise concerns and influence local health discussions.

This ongoing, relationship-based approach ensures listening is continuous rather than limited to formal consultations, helping us respond more effectively to community insight and improve services accordingly.

Example of how we work with communities to listen, learn and improve

Transforming Together Network: power sharing and radical inclusion

The Transforming Together Network was created in response to the Dismantling Disadvantage report. It has become a strong example of community led partnership working that shifts power. Supported by Agenda Alliance and funded by the Smallwood Trust, the network has demonstrated shared power, collaboration and inclusion since 2024.

Its success has been built on recognising every voice and every form of expertise, building resilient relationships, and properly resourcing meaningful participation. Work progressed through three subgroups:

- Data, evidence and information
- Commissioning, funding and power sharing

- Collaborating and convening

These groups developed practical recommendations and demonstrated the importance of sustained structural support. As funding concludes, partners are working to secure the long-term legacy of the network.

Engaging diverse ethnic communities through the Sunderland International Bangladesh Centre
The Sunderland International Bangladesh Centre has hosted a range of activity that shows how culturally competent engagement can lead to measurable impact. Examples include:

- A local GP using the Mela to connect with communities about basic health screening and demonstrate how digital tools can free up time for proactive care.
- Academic research identifying barriers to cancer screening for Muslim women, followed by a faith aligned and co-produced health promotion approach that led to significant improvements in screening uptake.
- A kidney specialist working with ethnic minority communities to address myths around transplantation and improve consent rates. This work is now expanding into a chronic kidney disease trailblazer programme using digital and multilingual engagement tools.
- Participatory action research exploring cultural barriers to care home use, highlighting the importance of community ambassadors and long-term trust building.
- Macmillan supported, co designed faith-based work that increased cancer screening uptake and improved awareness of end-of-life services.

These examples show that listening to lived experience, particularly from communities facing structural inequalities, leads to better interventions and more trusted care.

Working with the Deaf community across the region

In County Durham, the patient experience team at County Durham and Darlington NHS Foundation Trust partnered with the ICB to hold a dedicated session with members of the Deaf community. Participants shared examples of communication support not being available at critical moments in both primary and acute care. These insights have informed improvement work, and further sessions are planned to ensure continued learning.

In Tees Valley, new relationships have been established with central Deaf community groups. This has included attending coffee mornings to build trust, promote involvement opportunities, and support longer term co production.

In Cumberland, the Lived Experience Network is helping to improve interpreting services and contributing to the development of a patient passport that better reflects communication needs.

Further detail is available in the full [annual involvement and engagement report](#). A summary of a few of our projects has been included below:

WorkWell: helping people stay healthy and in work

During 2025, the ICB worked with people across the North East and North Cumbria to shape WorkWell, a government-funded programme that supports people with long-term health conditions to stay in work or return to employment. We know that good work can improve health and wellbeing, but when people become unwell, they often need the right support to remain in or re-enter work. That is why lived experience was placed at the heart of the design.

More than 500 people helped shape the service, including members of the public, employers, health and employment professionals, voluntary and community organisations, WorkWell coaches and PAS (Patient Advisory Service) advisors. Engagement included focus groups, stakeholder interviews, surveys, lived experience workshops and testing of draft communication materials. We worked closely with Healthwatch and voluntary, community and social enterprise organisations to ensure we reached people who may not usually engage through NHS routes.

Strong and consistent themes emerged. Participants highlighted the importance of trust, clear information about data use, and reassurance that participation is voluntary. Relationship-based support was seen as essential, with continuity from a named WorkWell coach making a significant difference. People described non-linear health journeys and emphasised the need for flexible support that allows pauses and re-entry without stigma. Self-referral routes were widely supported, alongside community-based promotion.

Feedback helped shaped the final service model, including consent processes, self-referral pathways, flexible appointment options, clearer communications, and a broader definition of success that values confidence, wellbeing and stability alongside sustained employment.

By embedding lived experience throughout, WorkWell has been developed as a trusted, accessible service designed around the real experiences of the people it aims to support.

Stopping gluten-Free prescriptions

During 2025, the ICB considered whether to stop prescribing gluten-free bread, rolls and flour. These items were prescribed to people with coeliac disease or dermatitis herpetiformis, who must follow a strict gluten-free diet to stay healthy. The review was prompted by wider availability of gluten-free food in shops, clearer labelling, significant cost differences between NHS and retail prices, and the need to use NHS resources fairly and sustainably.

Before making any decision, we carried out extensive public engagement to understand the potential impact. A total of 1,414 people responded to a public survey. We also held four focus groups with people living with coeliac disease, parents and professionals, alongside two community discussions. Written responses were received from members of the public, an MP, Coeliac UK and an online support group. Effort was made to hear from groups who may be disproportionately affected, including people on low incomes, families with children, older adults, rural residents, pregnant women, new mothers and South Asian communities.

Clear and consistent themes emerged. Many participants said prescriptions are vital in helping them afford gluten-free food, which is often significantly more expensive than standard products. Concerns were raised that removing prescriptions could lead to financial hardship, reduced dietary adherence and increased health risks. People also described the emotional impact of managing a lifelong condition, with prescriptions providing reassurance, dignity and confidence. Access challenges were highlighted, particularly in rural areas and for those with limited mobility.

While most respondents favoured retaining prescriptions, particularly for those most in need, many suggested alternative approaches such as voucher schemes, subsidies or improved procurement arrangements to reduce NHS costs.

This engagement ensured that decision-makers understood both the financial considerations and the real-life impact on people's health and wellbeing before reaching any conclusions. The

responses directly informed the final decision, resulting in gluten-free prescriptions being retained for children and young people up to the age of 25, while discontinuing routine prescriptions for adults, balancing clinical need with the responsible use of NHS resources.

End-of life care health needs assessment (HNA)

The ICB is updating its end-of-life care health needs assessment (HNA) to better understand current and future need for palliative and end-of-life care across the North East and North Cumbria. Palliative and end-of-life care supports people with serious or life-limiting illness to live as well as possible, while also supporting families, carers and those close to them.

While service data tells us about demand and activity, it does not explain how care feels. For that reason, lived experience was central to the assessment.

We gathered insight through a region-wide public survey, community conversations delivered with Healthwatch and voluntary sector partners, and targeted inclusion work to reach people less likely to complete surveys. This included carers, bereaved families, people with learning disabilities, minority ethnic communities, faith groups, rural and coastal residents, and health and care professionals. We also reviewed lived experience letters, focus group feedback, and video and podcast discussions to ensure a broad range of voices were heard.

Clear and consistent themes emerged. Compassionate, honest communication was described as the single most important factor shaping experience. People valued clear explanations, time to ask questions, and being listened to without feeling rushed. Continuity of care and strong relationships with professionals were seen as essential to building trust and reducing anxiety. Many families described challenges navigating a complex system, particularly when services felt fragmented or poorly coordinated.

Participants highlighted the importance of dignity, effective symptom control, cultural understanding and the option to die in a preferred place, often at home. People with learning disabilities emphasised the need for reasonable adjustments, including easy read materials and trusted support.

This engagement has directly shaped the updated HNA, strengthening its focus on communication, coordination, cultural competence, reducing inequalities, and recognising that quality end-of-life care is defined not only by clinical standards, but by dignity, trust and emotional safety.

Involving families in shaping respite services

During 2024, following Tees, Esk and Wear Valleys NHS Foundation Trust's (TEWV) decision to close respite provision at Aysgarth and Bankfields, the ICB began commissioning a new respite model for the Tees Valley area. Respite services provide essential short breaks for people with learning disabilities and autistic people, while offering vital support for families and carers. Given the importance of these services, it was crucial that the future model was safe, sustainable and co-designed with those who use it.

Engagement began early and continued throughout the planning process. ICB colleagues met families face-to-face across Middlesbrough, Stockton and Redcar to hear directly about their experiences and priorities. Families told us that trusted, skilled staff and continuity of care must be preserved, while the physical environment needed improvement to feel more homely and better support people with complex health needs.

To ensure independent and inclusive engagement, Skills for People and Inclusion North led a wider listening exercise. This included 12 structured listening sessions (online and in person), a detailed survey, one-to-one conversations, and ongoing discussion through a monthly partnership group. This flexible approach enabled families with different schedules and communication needs to participate.

Clear themes emerged: preserve relationship-based care and nursing support; create a modern, welcoming environment; and maintain transparent communication and genuine partnership throughout decision-making.

Family feedback directly influenced the identification of Levick Court as the preferred new location. Families supported this option due to its more homely setting, suitability for complex needs, and ability to maintain nursing provision. The ICB announced its intention to commission Levick Court in September 2025, with the new service expected to open in early 2026.

This programme demonstrates the ICB's commitment to co-design and ensuring families play a central role in shaping the services they rely on.

Listening to people about GP access, the NHS App and Pharmacy First

During 2025/26, we worked in partnership with the Healthwatch North East and North Cumbria Network to understand how people are experiencing changes to general practice under the new Modern General Practice Access (MGPA) framework. This region-wide engagement covered all 14 local authority areas and aimed to gather timely feedback to inform improvements.

Healthwatch distributed 15,000 information leaflets and carried out extensive face-to-face outreach in GP practices, pharmacies, hospitals, libraries, community hubs, faith venues, job centres and foodbanks, ensuring rural, coastal and urban communities were included. Accessible formats such as Easy Read, large print, translated materials and BSL support were used. Effort was made to hear from older people, carers, people with learning disabilities, Deaf people, people from ethnic minority backgrounds and those who are digitally excluded. Alongside this, a regional survey gathered over 360 responses.

The strongest and most consistent theme was difficulty accessing GP appointments. People described busy phone lines, the "8am rush", confusing online forms and inconsistent experiences across practices. While some reported positive access, experiences varied significantly.

Awareness of extended access appointments was low, with many people saying they had not been offered this option. Digital tools such as the NHS App were valued by those confident using them, particularly for ordering prescriptions and viewing test results. However, barriers including identity verification, older devices and low digital confidence meant these routes are not suitable for everyone.

Pharmacy First was often described as convenient, but awareness and understanding varied. Some groups, including disabled people, carers and those with limited English, reported compounded barriers.

Findings have informed recommendations to improve communication, routinely promote extended access, reduce pressure at peak times, strengthen telephone access, support those

who struggle with digital tools and address inequalities. Engagement remains ongoing to ensure people's experiences continue to shape primary care improvement.

Collaborative listening

Although the ICB retains statutory responsibility for involvement, we adopt a distributed leadership model across the integrated care system. Partners may, in some cases, discharge involvement duties on our behalf. We maintain oversight and assurance through established governance arrangements and system reporting. Involvement is embedded across several system programmes, including:

Secure Data Environment (SDE) - The North East and North Cumbria Secure Data Environment is part of a national NHS programme that allows health and care data to be used safely for research and service planning. Public involvement is built into the programme. Public members are embedded in governance structures, shaping decisions, communications and data access processes. Surveys and ongoing engagement ensure public views guide how data is used.

Northern Cancer Alliance - The Northern Cancer Alliance brings together NHS trusts and partners to plan and improve cancer services across the region. Public involvement informs cancer service reviews, including targeted engagement with under-represented communities to address barriers such as language and access.

Maternity Voices - Through the Local Maternity and Neonatal System (LMNS), women and families co-design improvements to maternity and neonatal services. They ensure that women and families are involved in shaping safer, more personalised and kinder services.

Child Health and Wellbeing Network - This network brings together organisations from different sectors to work with children, young people and families. It provides a forum for listening to children, young people and families in shaping priorities.

Learning Disability Network - The North East and North Cumbria Learning Disability Network includes people with learning disabilities, families, and professionals from health, social care, education and the voluntary sector. The network ensures people with learning disabilities are actively involved in service development and decision-making

Stroke Network - The Stroke Network connects people with lived experience of stroke to regional service development. Regular meetings and newsletters provide updates and opportunities for stroke survivors and carers to influence improvements in stroke care.

Financial review

The following funding streams are provided to ICBs:

- Programme Budget Allocation – this funding relates to direct health care expenditure. This includes delegated primary care and specialised commissioning budgets.
- Running Cost Allowance – this funding is to cover the administrative costs of running the ICB.

The funding resources available to the ICB during the year were as follows:

	Programme allocation £'000	Running Cost allowance £'000	Total funding allocation £'000
Total initial ICB Funding allocation	8,998,211	48,637	9,046,848
Additional in-year allocation adjustments	374,186	10,350	384,536
Total ICB funding for the year	9,372,397	58,987	9,431,384

A balanced financial plan was agreed for the ICS overall for 2025/26, after receipt of deficit support funding from NHS England of £33.3m. This included a planned surplus of £11.8m in the ICB which offset planned deficits across provider trusts.

Further details on the ICB's financial position, together with the wider ICS position, can be found in the finance reports presented to Board, which are published as part of Board papers on the ICB's website.

Financial targets and performance for the period

The ICB has several financial duties under the NHS Act 2006 (as amended). Performance against these duties is reported in note 20 of the annual accounts and is summarised in the table below.

Unlike commercial companies which make a profit or loss, ICBs are set resource limits within which they must contain net expenditure for the year. There are separate resource limits set for revenue and capital expenditure, with revenue expenditure limits further split between programme spend and running costs ('administration').

The ICB financial performance is reported on an in-year basis. As can be seen from the table below, all relevant financial duties were met for 2025/26:

Target	Target Met?
Revenue resource use does not exceed the amount specified in Directions ICBs are required to manage overall revenue expenditure within the revenue resource limit (the 'break-even duty'). For 2025/26, the ICB delivered an overall surplus of £34.86m.	✓
Revenue administration resource use does not exceed the amount specific in Directions A separate running cost allowance is provided to all ICBs to cover the administrative costs of running the ICB. There is a requirement to manage administrative costs within this allowance. Total running costs for the year amounted to £51.10m, which was within the running cost allowance of £58.99m.	✓
Capital resource use does not exceed the amount specified in Directions The ICB is required to manage capital spending within the capital resource limit. For 2025/26, the ICB incurred £957k of direct capital expenditure which was in line with capital resource received.	✓

Target	Target Met?

An underspend has been delivered in administrative spend during the period which has allowed additional funding to be spent on frontline healthcare services. This reflects plans implemented by the ICB to reduce running costs in response to the requirement from NHS England to reduce the cost of commissioning to within £19 per head of population.

The overall ICB surplus of £34.86m was agreed in order to offset deficits in NHS provider trusts within the system. The original planned ICB surplus was £11.8m. In January 2026, the ICB Board approved an increase to the ICB surplus of £23m to offset a deterioration in the overall provider financial position within the system, ensuring no net impact on the overall ICS position.

Efficiencies totaling £131.5m (compared to a plan of £126.1m) were delivered by the ICB during the year, which has supported delivery of the overall financial position. This has included in particular efficiencies in medicines optimisation and in the delivery of individual packages of care.

Other financial targets

The ICB, along with other system partners, also had a shared responsibility for achievement of financial balance at an ICS level in 2025/26. The ICB has collaborated collectively with partners to manage financial risks across the system in line with the agreed approach to system financial management. This has included monthly review of the financial position and potential financial risks, with targeted actions agreed during the year to successfully mitigate and manage risks.

For 2025/26, a balanced financial plan overall for the ICS was agreed with NHS England at the start of the year. A deterioration in the financial position of one provider trust during the year was mitigated by improvements elsewhere within the ICS, including the ICB position. The final outturn position for the ICS overall is a surplus of £1.1m in total, excluding additional non-recurrent deficit support funding received in March 2026.

The ICB agreed a joint capital resource use plan for the year along with partner NHS Foundation Trusts. The overall capital expenditure across the ICS for 2025/26 was managed within the agreed ICS capital allocation.

Compliance with Better Payment Practice Code

In addition to the above statutory duties, ICBs have similar responsibilities to other NHS organisations in respect of the Better Payment Practice Code (BPPC). The BPPC requires the payment of all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

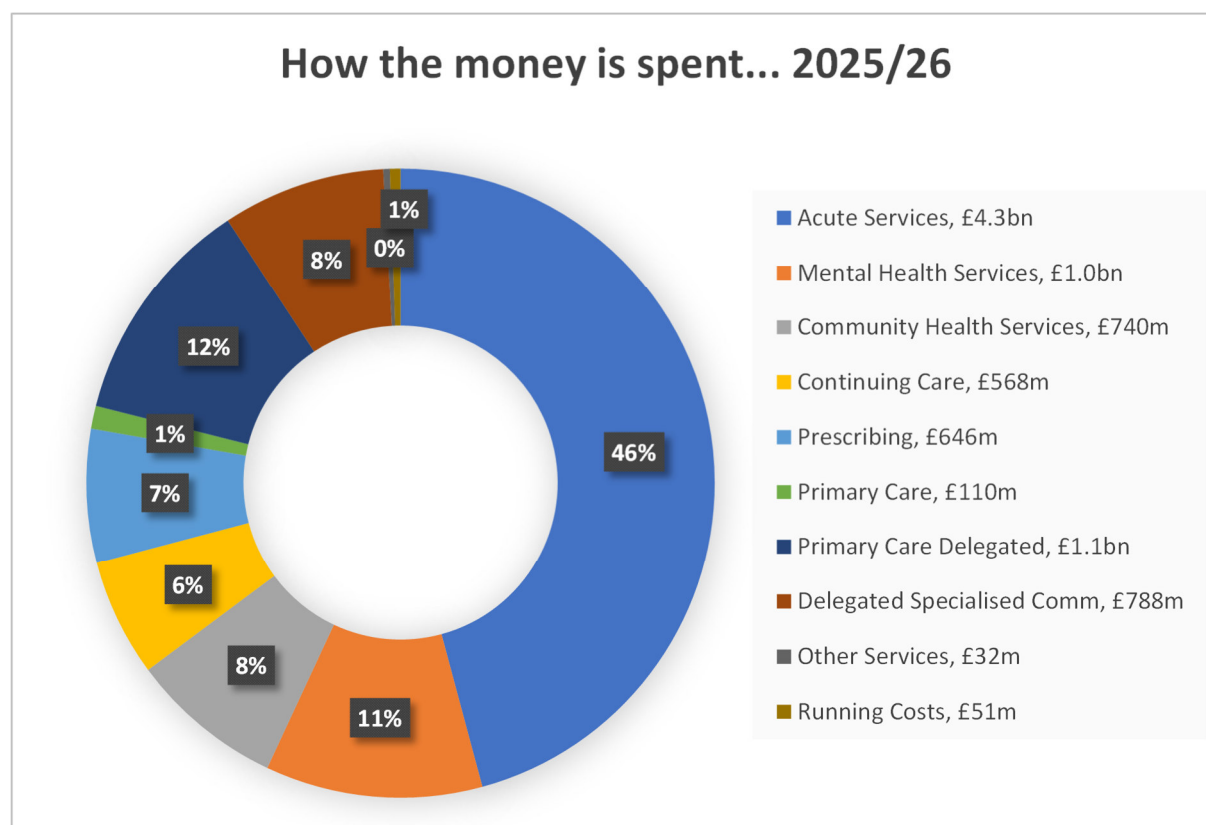
The ICB is deemed to be compliant if it pays at least 95% of invoices within 30 days of receipt, or within agreed contract terms. Details of compliance with the code are given in note 5 to the annual accounts.

Performance against the target is monitored by the ICB monthly with performance maintained

at over 95% of invoices paid within 30 days of receipt, measured against both total invoice value and overall volume of invoices.

How was the money spent?

The ICB works hard to ensure that the revenue allocation it receives is spent wisely, and that it supports the aim of commissioning high quality healthcare whilst ensuring effectiveness and value for money. The chart below shows how the ICB funding allocation was utilised in 2025/26:



Looking ahead

2025/26 was a hugely challenging year financially, both for the ICB and wider ICS, and this will continue to be the case in 2026/27. Although the financial position in 2025/26 was delivered overall across the ICS, this included a significant level of non-recurring benefits, and an under-delivery of recurrent efficiency plans will increase the challenge for 2026/27 with continued high levels of efficiency required.

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. As such, the focus going forward will be on management of the ICB financial position as a strategic commissioner.

A balanced financial plan for the ICB has been agreed for the three years from 2026/27. This requires similar levels of efficiency to be delivered in each year and will require careful management of financial risks, with total net risk for the ICB of over £30m remaining in 2026/27 plans at this point.

The plan does include investment within primary and community services over the three years 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.

DRAFT

ACCOUNTABILITY REPORT

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that North East and North Cumbria Integrated Care Board's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

[Insert signature]

Samantha Allen

Chief Executive

North East and North Cumbria Integrated Care Board

XX June 2026

Introduction to Accountability Report

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

The Corporate Governance Report sets out how we have governed the organisation during the period 1 April 2025 to 31 March 2026 including membership and organisation of our governance structures and how they supported the achievement of our objectives.

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

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

Corporate Governance Report

Membership of the ICB Board is summarised in table 1 below. Profiles of members are given on the [ICB website](#).

Composition of Integrated Care Board

The membership of NHS North East and North Cumbria Integrated Care Board (the ICB) is set out in the ICB's Constitution. The composition of the ICB Board from 1 April 2025 to 31 March 2026 is shown in table 1 below.

Table 1 - Membership of NHS the ICB's Board.

All members were in post on 1 April 2025 until 31 March 2026, unless shown.

Position	Name	Gender	Status
Chair	Professor Sir Liam Donaldson	Male	Voting
Chief Executive	Mrs Sam Allen	Female	Voting
Chief People Officer	Mrs Kelly Angus Secondment 01/11/2025 – 31/03/2026	Female	Voting
Chief Delivery Officer	Mr Levi Buckley	Male	Voting
Chief Finance Officer	Mr David Chandler	Male	Voting
Chief Digital and Infrastructure Officer	Professor Graham Evans Until 30 June 2025	Male	Voting
Chief Procurement and Contracting Officer	Mr Dave Gallagher	Male	Voting

Position	Name	Gender	Status
Chief Nurse and AHP Officer	Dr Hilary Lloyd	Female	Voting
Chief Strategy Officer	Ms Jacqueline Myers	Female	Voting
Chief Medical Director	Dr Neil O'Brien	Male	Voting
Chief Corporate Services Officer	Mrs Claire Riley	Female	Voting
Foundation Trust Partner Member	Mr Ken Bremner	Male	Voting
Foundation Trust Partner Member	Dr Rajesh Nadkarni	Male	Voting
Independent Non-Executive Member	Professor Eileen Kaner Until 31 December 2025	Female	Voting
Independent Non-Executive Member	Mr Jon Rush Until 22 May 2025	Male	Voting
Independent Non-Executive Member (Audit)	Mr David Stout	Male	Voting
Independent Non-Executive Member	Professor Sir Pali Hungin	Male	Voting
Local Authority Partner Member	Mr John Pearce until 31 December 2025	Male	Voting
Local Authority Partner Member	Mr Tom Hall	Male	Voting
Primary Medical Services Partner Member	Dr Saira Malik	Female	Voting
Primary Medical Services Partner Member	Dr Mike Smith	Male	Voting
North East and North Cumbria Voluntary Organisations Network North East (VONNE) Representative	Ms Lisa Taylor	Female	Non-Voting
North East and North Cumbria Healthwatch Representative	Mr Christopher Akers-Belcher	Male	Non-Voting

Committee(s), including Audit Committee

Membership of the ICB Audit Committee

The Audit Committee is a committee of the ICB. It was in operation throughout the twelve-month period from 1 April 2025 to March 2026.

The Committee was established on 1 July 2022 and remains in place. The roles and

responsibilities of the Committee are set out in its terms of reference available at this Insert correct link once approved by Board.

The Committee is comprised of three independent non-executive directors:

Table 2: Membership of the ICB Audit Committee

Position	Name	Gender
Independent Non-Executive Director (Chair)	Mr David Stout	Male
Independent Non-Executive Director (Vice Chair)	Professor Eileen Kaner (position ended 31 December 2025)	Female
Independent Non-Executive Director	Professor Pali Hungin	Male
Independent Non-Executive Director	Mr Jon Rush (position ended on 22 May 2025)	Male

Membership of the Executive Committee

The Executive Committee reports directly to the ICB Board and assists the Board in its duties by overseeing the day-to-day operational management and performance of the ICB, in support of the Chief Executive in the delivery of his/her duties and responsibilities to the Board; provides a forum to inform ICB strategies and plans and in particular the Committee undertakes any commissioning and planning activity on behalf of the Board, helping to secure continuous improvement of the quality of services; and implementation of the approved ICB strategies and plans.

Table 3: Membership of the ICB Executive Committee

Position	Name	Gender
Chief Executive (Chair)	Mrs Sam Allen	Female
Chief People Officer	Mrs Kelly Angus Secondment 01/11/2025 – 31/03/2026	Female
Chief Delivery Officer	Mr Levi Buckley	Male
Chief Finance Officer	Mr David Chandler	Male
Chief Digital and Infrastructure Officer	Professor Graham Evans Until 30 June 2025	Male
Chief Contracting and Procurement Officer	Mr Dave Gallagher	Male
Chief Nurse and AHP Officer	Dr Hilary Lloyd	Female
Chief Strategy Officer	Ms Jacqueline Myers	Female

Position	Name	Gender
Chief Medical Director (Vice Chair)	Dr Neil O'Brien	Male
Chief Corporate Services Officer	Mrs Claire Riley	Female

Membership of the Remuneration Committee

The Remuneration Committee reports directly to the ICB Board and assists the Board by confirming the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including Board members) but excluding non-executive Board member and excluding the Chair.

Table 4: Membership of the ICB Remuneration Committee

Position	Name	Gender
Chair	Sir Liam Donaldson (member from December 2025)	Male
Independent Non-Executive Member	Professor Pali Hungin (Chair of committee from December 2025)	Male
Independent Non-Executive Member	Professor Eileen Kaner (Chair of committee up to leaving ICB December 2025)	Female
Independent Non-Executive Member	Mr Jon Rush (Left ICB May 2025)	Male

Membership of the Finance, Performance, and Investment Committee (FPIC)

The Finance, Performance, and Investment Committee reports directly to the ICB Board and contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan.

All members were in post on 1 April 2025 until 31 March 2026, unless shown.

Table 5: Membership of the ICB Finance, Performance, and Investment Committee

Position	Name	Gender
Foundation Trust Partner Member	Ken Bremner	Male
Chief Delivery Officer	Levi Buckley	Male
Chief Finance Officer	David Chandler	Male
Director of Finance – Corporate	Richard Henderson	Male

Position	Name	Gender
Independent Non-Executive Member (Chair)	Prof Eileen Kaner (Left post 31 st December)	Female
Head of Corporate Governance	Jen Lawson	Female
Chief Strategy Officer	Jacqueline Myers	Female
Foundation Trust Partner Member	Rajesh Nadkarni	Male
Chief Medical Officer	Dr Neil O'Brien	Male
Independent Non-Executive Member (Chair)	Jon Rush (Left post 22 nd May 2025)	Male
Primary Medical Services Partner Member	Dr Mike Smith	Male

Membership of the Quality and Safety Committee

The Quality and Safety Committee reports directly to the ICB Board and assists the Board by providing assurance that is delivering its functions in a way that delivers high quality safe patient care in commissioned services and secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care.

The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care.

Table 6: Membership of the ICB Quality and Safety Committee

Position	Name	Gender
Independent Non-Executive Director (Chair)	Professor Sir Pali Hungin	Male
Chief Medical Officer	Dr Neil O'Brien	Male
Chief Nurse and AHP Officer	Dr Hilary Lloyd	Female
Chief Contracting and Procurement Officer	Mr Dave Gallagher	Male
Foundation Trust Partner Member	Mr Ken Bremner	Male
Primary Medical Care Partner Member (Vice Chair)	Dr Saira Malik	Female
Local Authority Director of Public Health or Partner Member	Mr Tom Hall	Male
Director of Allied Health Professions	Ms Maria Avantageggiato-Quinn	Female

Position	Name	Gender
Clinical Director of Medicines Optimisation and Pharmacy	Professor Ewan Maule	Male
Director of Nursing (North)	Mr Richard Scott	Male
Interim Director of Nursing (South)	Mrs Vicky Playforth	Female
Director of Safeguarding	Ms Louise Mason-Lodge	Female
Deputy Chief Nurse	Mrs Ann Fox	Female
Director of Quality	TBC	
Director of Nursing - Complex Care and Mental Health	Mrs Kate O'Brien	Female
Director of Midwifery	TBC	

Register of Interests

The ICB has arrangements in place for the effective management of conflicts of interest. Details of company directorships and other significant interests held by members of the Board and committees are recorded in the register of interests. The ICB's guidance on managing conflicts of interest and register of interests for Board members is publicly available [here](#). The ICB knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken "all the steps that he or she ought to have taken" to make himself/herself aware of any such information and to establish that the auditors are aware of it.

Personal data related incidents

There were no personal data related incidents reported to the Information Commissioner's Office in the period 1 April 2025 to 31 March 2026.

Modern Slavery Act

The Modern Slavery Act 2015 introduced changes in UK law focused on increasing transparency in supply chains, to ensure our supply chains are free from modern slavery (that is, slavery, servitude, forced and compulsory labour and human trafficking). As both a local leader in commissioning health care services for the population of the ICB and as an employer, the ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking and has produced a statement in respect of its commitment to, and efforts in, preventing slavery and human trafficking practices in the supply chain and employment practice.

The statement was approved by the ICB's Quality and Safety Committee on 14 March 2024 and is available [here](#).

Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the North East and North Cumbria ICB and of its income and expenditure, Statement of Financial Position, and cash flows for the financial year.

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

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced, and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced, and understandable.

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

NHS England has appointed the Chief Executive to be the Accountable Officer of the North East and North Cumbria Integrated Care Board. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the North East and North Cumbria Integrated Care Board's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I should have taken to make myself aware of any relevant audit information and to establish that the North East and North Cumbria Integrated Care Board's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Governance Statement

Introduction and context

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

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

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

Between 1 April 2025 and 31 March 2026, the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the National Health Service Act 2006 (as amended).

Scope of responsibility

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

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

Governance arrangements and effectiveness

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

ICB Constitution

The ICB's Constitution describes how the ICB is organised to provide the best health and care, ensuring that decisions are always taken in the interest of the patients and public we serve. The Constitution is underpinned by the duty that requires NHS bodies to consider the effects of their decisions on the health and wellbeing of the people of England, the quality of services and the sustainable and efficient use of resources.

The ICB Constitution, which incorporates the ICB's Standing Orders and has been assessed as compliant by NHS England, is available [here](#).

ICB Governance Handbook/Structure

The ICB's Governance Handbook combines all the ICB's governance documents and includes:

- The Scheme of Reservation and Delegation which sets out key functions reserved to the Board of the ICB, and functions delegated to committees and individuals
- Functions and Decisions Map
- Financial Delegation

- Financial Limits
- Standing Financial Orders
- Terms of reference for all committees of the Board that exercise ICB functions
- Standard of Business Code of Conduct
- Communities and People Involvement and Engagement Strategy
- Register of Interests
- North East and North Cumbria Integrated Care Partnership (ICP) Terms of Reference
- ICB Overall Governance Map
- List of eligible providers of primary medical services
- Subcommittee Terms of Reference
- North East and North Cumbria ICB Remuneration Guidance

The ICB's Governance Handbook/Structure is available [here](#).

ICB Board

The Board met six times in the period 1 April 2025 to 31 March 2026. The main items of business were:

- Chief Executive Report
- Integrated Delivery
- Finance reports
- Board Assurance Framework
- Committee Highlight Reports and Minutes
- ICB Annual Report and Accounts 2024/25
- Fit and Proper Person Compliance
- Approval of ICB Constitution
- Approval of Governance Handbook
- County Durham and Darlington NHS Foundation Trust Breast Services
- Intensive and Assertive Community Mental Health Care
- Winter Plan 2025/26
- Transition to a Strategic Commissioning Organisation
- Model ICB
- NHS Medium Term Plan 2026/27 – 2030/31
- Strategic Commissioning Intentions 2026/27
- All Age Continuing Care
- Dental Access Recovery Plan
- Digital Inclusion Strategy
- Medicine Optimisation Strategy
- Integrated Neighbourhood Health
- Oral Health and Dental Strategy
- Procurement Strategy
- Standards of Business Conduct and Declarations of Interest Policy
- Primary Care Access Recovery Programme
- General Practice Engagement
- WorkWell Programme
- Learning Disabilities Mortality Review (LeDeR) Annual Report
- NENC ICB Safeguarding Annual Report
- NENC ICB Complaints Annual Report
- Women's Health

Additionally, between 1 April 2025 and 31 March 2026, the Board convened five extraordinary meetings to discuss and make decisions regarding the transition to a strategic commissioner. These meetings covered topics such as staff consultation, estate reviews, and the creation of a new operating model.

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

We have reported on our corporate governance arrangements by drawing upon best practice available. During the year, the Board has continuously considered and reviewed the effectiveness of each of its meetings to seek evidence of constructive challenge, contributions beyond member disciplines, behavior, pace, and enthusiasm.

We continuously monitor our process for managing conflicts of interest to ensure any actual or potential interests are managed effectively and robustly. The ICB has robust processes in place to manage conflicts of interest and has not had any breaches at the time of writing this statement. The declarations of interest register is publicly available on the ICB's website.

The ICB has appointed David Stout Independent Non-Executive Member as Conflicts of Interest Guardian to act as a conduit for anyone with concerns relating to conflicts of interest; to be a safe point of contact for concerns to be raised; to support the application of the principles and policies for managing conflicts, and to provide impartial and unconflicted advice and judgement in cases where it is not obvious whether a material conflict exists or how best to manage.

The annual appraisal process and future development of all board members support the ongoing assessment of board member skills, knowledge and experience and forms part of the NHS England Fit and Proper Person Test Framework for all board members.

The Board has held regular development sessions throughout the year to continuously review, develop and enhance its continuous learning and effectiveness.

The Board met three times for development sessions times in the period 1 April 2025 to 31 March 2026. The main items of business were:

- Transition to a strategic commissioning organisation
- NHS 10-year plan
- Complex care – children and young people
- Families first
- Maternity and neonatal
- Integrated neighbourhood health
- Transitional governance

Having reviewed the effectiveness of the Board's governance framework and associated guidance, I consider that the organisation has followed and applied the principles and standards of best practice.

Attendance list for the Board and its Committees has been combined and can be found in Table 7.

Executive Committee

The Executive Committee is a committee of the ICB. It was in operation throughout the twelve-month period from 1 April 2025 to 31 March 2026.

The Committee was established on 1 July 2022 and remains in place. The membership, purpose, roles and responsibilities of the Committee are set out in its terms of reference.

The Committee reviewed its effectiveness during the last twelve months of operation and concluded that the organisation has followed and applied the principles and standards of best practice. The Committee will continue to explore improvements to its effectiveness and efficiency of management to ensure that the meetings are productive and committee member time is effectively utilised. Processes have been put in place to support this and ensure all essential business is conducted appropriately and provide assurance to the Board on delivery of its delegated functions.

The annual review has identified the Committee has delivered its responsibilities as set out in its terms of reference.

The Executive Committee met twelve times in the period 1 April 2025 to 31 March 2026.

The main items of business were:

- Terms of Reference including:
 - Winter Delivery and Assurance Group
 - Strategic Commissioning Transition Programme Steering Group
 - Attention Deficit Hyperactivity Disorder and Autism Task and Finish Group
 - Integrated Delivery Reports
 - Financial Sustainability
 - Medium Term Financial Plan
- Policy Reviews including:
 - Corporate Policies
 - HR Policies
 - Health and Safety Policies
 - Use of Artificial Intelligence (AI) and Approval Policy
 - Sexual Misconduct Policy
- Priority Areas
- Placed Based Delivery
- Business Cases
- Procurement Exercises and Strategies
- Risk Management and Corporate Risk Register
- Board Assurance Framework 2025/26
- Northern Cancer Alliance Workplan 2025/26
- Winter Planning
- Planning Framework and Business Cycle 2026/27
- Five Year Strategic Commissioning Plan
- Niche Review
- Limited Liability Partnerships
- Healthy Heart Checks
- Women's Health Development
- Primary Care Access Recovery Plan
- Acute Respiratory Infection Hub Funding
- Emergency Preparedness Resilience Response Self-Assessment

- Health and Growth Accelerator Delivery Plan
- Primary Care Priority Pathways
- Learning Disability Network
- Manchester Arena Inquiry
- Contract Mandates

Remuneration Committee

The Remuneration Committee is a committee of the ICB. It was in operation throughout the twelve-month period from 1 April 2025 to 31 March 2026.

The Committee was established on 1 July 2022 and remains in place. The membership, purpose, roles and responsibilities of the Committee are set out in its terms of reference available at this [link](#).

The Committee reviewed its effectiveness during the last twelve months of operation and concluded that the Committee has followed and applied the principles and standards of best practice.

The Committee will continue to explore improvements to its effectiveness and efficiency of management to ensure that the meetings are productive and committee member time is effectively utilised. It was recognised that due to the nature of the Committee's business some urgent and sensitive items could not be planned for however, a comprehensive cycle of business for 2025/26 would be developed.

Processes are in place to ensure all essential business is conducted appropriately and provide assurance to the Board on delivery of its delegated functions.

The Remuneration Committee met eleven times in the period 1 April 2025 to 31 March 2026. The main items of business were:

- Severance schemes
- Pay assurance framework
- Bank workers annual leave arrangements
- Committee effectiveness survey
- ICB Employment tribunal claims
- National very senior manager pay framework
- Redundancy repayment
- Honorarium payment
- Fit Proper Person Test (FPPT) compliance
- Reckonable service
- Very senior manager and Clinical lead pay award
- Compulsory redundancies
- Voluntary redundancies
- Deputy Chief Officer arrangements
- Secondment arrangement
- Retire and return application
- Workforce pay gap annual report
- Civil court claim
- Executives' pay benchmarking report
- Strategic commissioning transition – voluntary redundancy appeals

- Remuneration Committee revised terms of reference
- Very senior manager salaries report

Finance, Performance, and Investment Committee (FPI)

The FPI Committee is a Committee of the ICB Board. It was in operation throughout the twelve-month period from 1 April 2025 to 31 March 2026.

The Committee was established on 1 July 2022 and remains in place. The membership, purpose, roles and responsibilities of the Committee are set out in its terms of reference available at this [link](#).

The Committee has met seven times during 2025/26. Additionally, between 1 April 2025 and 31 March 2026, the Committee convened three extraordinary meetings to discuss and make decisions regarding the NHS Medium Term Planning 2026/27 – 2030/31 submission.

The main items of business were:

- Monthly ICB financial performance updates
- System Recovery Board assurance and escalation reports
- Integrated Delivery Report
- Risk Management Report and Board Assurance Framework
- Committee Effectiveness Review
- Deep dive: A&E 4-hour waits
- NENC Medium Term Financial Plan – Scenario Planning
- Finance and performance operational planning submission 2025-26
- Specialised Commissioning Delegation ICB risk share agreement
- Infrastructure strategy update
- Learning disability performance update
- Deep dive: Community waiting list metrics
- NENC infrastructure strategy and capital / CDEL
- NHS medium term planning 2026-27 – 2030-31 submission
- Draft NENC ICB five-year strategic commissioning plan

Attendance list for the Board and its Committees has been combined and can be found in Table 7.

Audit Committee

The HFMA checklist focuses on processes through various themes and questions, which are completed by the Chair and Board Secretary to provide assurance to the Board regarding the delivery of its delegated functions. Given the tenure of two non-executive directors during 2025, it was determined that the comprehensive checklist would be replaced with an annual effectiveness survey for 2025-2026, consistent with the approach adopted by other parent Committees.

The Committee will continue to explore any areas of improvement around succession planning for the Audit Committee Chair along with previous discussions around the integration with other committees to support robust processes.

This annual review has identified the Committee has delivered its responsibilities as set out in its terms of reference.

The Audit Committee met four times (plus 2 extraordinary meetings) during the period 1 April 2025 to 31 March 2026. The main terms of business were:

- Annual Report and Accounts
- Board Assurance Framework and Risk Management Report
- Conflicts of Interest Compliance Report
- Data Security and Protection Toolkit
- Information Governance Assurance Report
- Annual Review of ICB Seal Report
- ICB Finance Update Report
- Internal Audit Progress Report
- Internal Audit Strategic / Annual Plan and Detailed Programme of Work
- Internal Audit Charter
- Head of Internal Audit Opinion
- External Audit Strategy Memorandum – year ending 31 March 2025
- Counter Fraud Progress Report
- Counter Fraud, Bribery and Corruption policy
- Counter Fraud Annual Report and Self-Review Assessment
- External Audit Completion Report
- External Audit Annual Report
- Audit Committee Effectiveness Survey Checklist
- Fit and Proper Person Test
- Freedom to Speak Up (FTSU)
- External Audit Progress Report
- Review of External and Internal Annual Review of Effectiveness
- Annual Review of Audit Committee Terms of Reference
- Interim Baseline Submission Cyber Assurance Framework (CAF) – Aligned DSP Toolkit 2025-26 Report
- Annual Report 2025/26: Provisional Timeline

All three non-executive directors have served as members of the Audit Committee since its formation on 1 July 2022, with two members concluding their tenure during 2025.

Following the organisational restructure of the ICB, a temporary independent non-executive director has been appointed to support the Audit Committee. This arrangement will remain in place until the new non-executive directors are appointed, and their roles are appropriately aligned with the ICB Committees.

The Audit Committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.

The duties of the Committee are driven by the organisation's objectives and the associated risks. The Committee agrees an annual programme of business; however, this is flexible to new and emerging priorities and risks.

The ICB's external auditors, internal auditors and counter fraud attend the Audit Committee as does the ICB Chief Finance Officer, Director of Finance (Corporate), and the Chief Corporate Services Officer (or her deputy).

The Audit Committee meets quarterly and on each occasion the Audit Committee Chair extends an invitation to the internal and external auditors to meet with him privately prior to the ICB officers joining the meetings. The Chair was present at all meetings.

Quality and Safety Committee

The Quality and Safety Committee is a committee of the ICB. It was in operation throughout the twelve-month period from 1 April 2025 July to 31 March 2026.

The Committee was established on 1 July 2022 and remains in place. The roles and responsibilities of the Committee are set out in its terms of reference available at this [link](#).

The Committee is responsible for ensuring the appropriate governance systems and processes are in place to commission, monitor and ensure delivery of high quality, safe patient care in services commissioned by the ICB. It provides assurance to the Board about the quality of the services being commissioned, and the overall risks to the organisation's strategic and operational plans.

Members of the Committee were asked to complete a short survey and provide their reflections on the Committee's work. Members agreed that the terms of reference were appropriate, noting that the responsibilities within scope of the Committee were vast. Members agreed that the meeting frequency seemed appropriate, and meetings are well chaired but there are challenges with such a full agenda and being able to give sufficient time to each agenda item.

Members did note the volume of papers presented to the Committee was very comprehensive, which could make it difficult to read and process all of the papers in advance of the meeting. Members also noted the work that had been carried out throughout the year to refine the quality exception reports which had improved.

The Quality and Safety Committee met six times in the period 1 April 2025 to 31 March 2026. The main items of business were:

- Area Quality Reports
- Patient Involvement and Experience update
- Complaints
- Board Assurance Framework and Risk Register
- Integrated Quality, Performance and Finance Report
- Patient Stories
- Medicines Optimisation Annual Report
- Pharmacy Shortages and System Coordination
- Financial Pressures from NICE Technology Appraisals
- Regional Maternal Mortality Review Updates
- Infection Prevention and Control
- Complex Care Incident Management
- Special Education Needs and Disabilities (SEND)
- Patient Safety Incident Response Framework
- Subcommittee Minutes
- Inter-agency Disputes Policy approval
- Annual Safeguarding Report
- Never Events (3-year system review)
- Health Services Safety Investigations Body Learning (incl. sepsis report)

- Medicine shortages
- Rising antimicrobial resistance risk
- Breast Service Reviews
- Equality & Quality Impact Assessment Policy
- Clinical Policy Approval

Subcommittees

The Subcommittees are established by their parent committees, and their terms of reference are detailed within the ICB's Governance Handbook which is available [here](#).

The Subcommittees established under the Executive Committee are:

Clinical Effectiveness and Governance Subcommittee

The purpose of the Subcommittee is to support the Quality and Safety Committee to review data and intelligence, implementing continuous service improvement, making informed decisions (based on the data), and ensuring the delivery of high-quality care. The Subcommittee will develop an audit plan for the year ahead, based on priorities identified through the measurement of compliance with national standards including NICE, mortality reviews and Getting It Right First Time. The Subcommittee will identify, manage, and escalate risks to the Quality and Safety Committee.

Contracting Subcommittee

The purpose of the subcommittee is to support the Executive Committee to discharge its duties relating to the delivery of the annual contracting and procurement work programme.

The Subcommittee will provide assurance and oversight of the contracting and procurement function.

Healthier and Fairer Advisory Group Subcommittee

The purpose of the North East North Cumbria (NENC) Healthier and Fairer Advisory Group Subcommittee is to provide strategic advice across the Integrated Care System (ICS) to ensure that action on population health, prevention and health inequalities is embedded into our planning and decision-making arrangements.

Individual Funding Request (IFR) Panel Subcommittee

The main function of IFR Panel is to consider Individual Funding Requests and make decisions to either support or not support the requests based on the information provided to the IFR Panel. Requests will be assessed for access to treatments within the commissioning authority of the ICB.

Investment Oversight and Vacancy Control Panel Subcommittee

The purpose of the Panel is to support the Executive Committee with the application of additional financial controls within the ICB. This will satisfy the requirements of the standard financial controls and associated conditions required by NHS England, in line with the approach agreed across the ICS, and support delivery of the financial plan for 2025/26.

The Panel will review and consider approval of any new discretionary non-pay spend between £10k and £250k, in line with the process agreed by Executive Committee.

The Panel will consider both recurrent items (e.g., between £10k and £250k on a recurrent basis) and non-recurrent one-off items within the same limits. All proposals should have an agreed funding source per NHSE expectations.

Investments over £250k will be considered by either the Executive Committee or the Board as appropriate (following where relevant consideration and recommendation at a Place Committee or similar). A record of decisions and relevant papers will be shared with NHSE Regional Team.

The Panel will review and consider approval of all vacancies within the ICB, following sign off by the responsible executive director.

Mental Health, Learning Disabilities and Autism Subcommittee

The Mental Health, Learning Disabilities and Autism Subcommittee is responsible for providing leadership and direction in relation to the delivery and commissioning of all NHS mental health and learning disability services across the life course, including Young People, Adults and Older adults across the North East and North Cumbria.

Pharmaceutical Services Regulations (PSRC) Subcommittee

The PSRC has been established to receive and determine, on behalf of the ICB, applications submitted under the NHS (Pharmaceutical Services) Regulations 2013 as amended ('the Regulations').

Primary Care Subcommittee

The purpose of the Subcommittee is to support the Executive Committee to discharge its duties relating to primary care including Primary Medical Services, Pharmacy, Optometry and Dentistry.

Place Subcommittees:

- County Durham Place Subcommittee
- Darlington Place Subcommittee
- Gateshead Place Subcommittee
- Hartlepool Place Subcommittee
- Newcastle Place Subcommittee
- North Cumbria Place Subcommittee
- North Tyneside Place Subcommittee
- Northumberland Place Subcommittee
- South Tees Place Subcommittee
- South Tyneside Place Subcommittee
- Stockton Place Subcommittee
- Sunderland Place Subcommittee

The purpose of the ICB Place Subcommittees is to discharge, on behalf of the ICB Executive Committee, the statutory commissioning responsibilities of the ICB which have been delegated

to Place and to carry out responsibility for executive actions and decisions on behalf of the ICB Executive Committee.

People and Organisational Development (OD) Subcommittee

The People and OD Subcommittee has been established to provide assurance to the Executive Committee that adequate and appropriate governance structures, processes and controls are in place in respect of the ICB workforce and organisation development.

The Subcommittee is responsible for ensuring that effective People and OD programmes are developed and deliver continuous improvement in organisational effectiveness, within the context of system transformation and organisational change.

Specialised Commissioning Subcommittee

The purpose of the subcommittee is to support the Executive Committee to discharge its duties relating to the specialised commissioning services as delegated to the ICB from NHS England as described in the agreed Delegation Agreement agreed between both parties.

The Subcommittees established under the Quality and Safety Committee are:

Antimicrobial Resistance (AMR) and Healthcare Associated Infections (HCAI) Subcommittee

The purpose of the Subcommittee is to support the Quality and Safety Committee to discharge its duties relating to bringing together key stakeholders across health and social care from the North East and North Cumbria (NENC) Integrated Care System (ICS) to deliver the national strategy tackling antimicrobial resistance 2019-2024, HCAI reduction objectives, information sharing and best practice and system level (ICB) assurance.

The Subcommittee will be primarily concerned with AMR and HCAI, particularly Gram-negative blood stream infections, Clostridium difficile and Methicillin-resistant Staphylococcus Resistant bacteraemia reduction in services commissioned by health and social care across NENC but will be reactive to new and emerging pathogens.

Quality and Safety Area Subcommittees

- North Area Quality and Safety Subcommittee
- South Area Quality and Safety Subcommittee

The Subcommittees have been established to provide the Quality and Safety Committee with assurance that is delivering its functions in a way that delivers high quality safe patient care in commissioned services and secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the 'Shared Commitment to Quality' and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care.

The Subcommittee's sought to gain and provide assurance to the Quality and Safety Committee, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care.

Safeguarding Health Executive Group; Children, Adults and Cared for Children Subcommittee

The purpose of the Subcommittee is to support the Quality and Safety Committee to discharge its duties relating to safeguarding and care for children.

Special Educational Needs and Disabilities (SEND) Subcommittee

The SEND Subcommittee provides a single oversight of compliance of the health responsibilities relating to the statutory duties for SEND across the ICB.

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Attendance records for the ICB's Board and Committees

Table 7 Attendance records for NENC ICB and Committees 1 April 2025 – 31 March 2026

			BOARD		EXECUTIVE COMMITTEE		REMUNERATION COMMITTEE		FINANCE, PERFORMANCE and INVESTMENT COMMITTEE		AUDIT COMMITTEE		QUALITY AND SAFETY COMMITTEE		TRANSITION COMMITTEE	
Surname	Forename	Post Held	No. of Meetings Held	No. of Actual Attendance	No. of Meetings Held	No. of Actual Attendance	No. of Meetings Held	No. of Actual Attendance	No. of Meetings Held	No. of Actual Attendance	No. of Meetings Held	No. of Actual Attendance	No. of Meetings Held	No. of Actual Attendance	No. of Meetings Held	No. of Actual Attendance
Donaldson	Sir Liam	Chair	11	11			4	4								
Allen	Sam	Chief Executive	11	9	12	10 2x deputy									8	6
Avantaggiato-Quinn	Maria	Director of Allied Health Professionals											6	2		
Angus	Kelly	Interim Chief People Officer Secondment 01/11/2025 – 31/03/2026	11	7	12	3 5x deputy									8	2 6x deputy
Buckley	Levi	Chief Delivery Officer	11	10 1 deputy	12	11 1 x deputy			10	8					8	6
Bremner	Ken	Foundation Trust Partner Member	11	8					10	6			6	4		
Chandler	David	Chief Finance Officer	11	11	12	10 2 x deputy			10	8					8	6 2 x deputy
Dronsfield	Sarah	Director of Quality											6	2 1 X deputy		
Evans	Professor Graham	Chief Digital and Infrastructure Officer Left 30 June 2025	11	4	12	3										
Fox	Ann	Deputy Chief Nurse											6	2		
Gallagher	Dave	Chief Contracting and	11	8	12	10 2 x deputy							6	5 1 x deputy		

			BOARD		EXECUTIVE COMMITTEE		REMUNERATION COMMITTEE		FINANCE, PERFORMANCE and INVESTMENT COMMITTEE		AUDIT COMMITTEE		QUALITY AND SAFETY COMMITTEE		TRANSITION COMMITTEE	
Surname	Forename	Post Held	No. of Meetings Held	No. of Actual Attendance	No. of Meetings Held	No. of Actual Attendance	No. of Meetings Held	No. of Actual Attendance	No. of Meetings Held	No. of Actual Attendance	No. of Meetings Held	No. of Actual Attendance	No. of Meetings Held	No. of Actual Attendance	No. of Meetings Held	No. of Actual Attendance
		Procurement Officer														
Hall	Tom	Local Authority Partner Member	11	11											8	5
Hungin	Professor Pali	Independent Non-Executive Member Rem Com Member from Sept 24	11	11			11	11			6	1	6	6		
Kaner	Professor Eileen	Independent Non-Executive Member Left 31 Dec 2025	11	8			8	7	10	5	6	5			8	6
Lloyd	Hilary	Chief Nurse	11	10	12	9 2 x deputy							6	4 1x deputy	8	5 1 x deputy
Malik	Dr Saira	Primary Medical Services Partner Member	11	10									6	6	8	6
Mason-Lodge	Louise	Director of Nursing											6	1		
Maule	Ewan	Director of Medicines											6	2 3 x deputy		
Myers	Jacqueline	Chief Strategy Officer	11	10 1 x deputy	12	7 5 x deputy			10	6					8	7
Nadkarni	Rajesh	Foundation Trust Partner Member	11	9					10	6			6	3	8	1
O'Brien	Dr Neil	Chief Medical Officer	11	9	12	11 1 x deputy			10	8			6	4 2 x deputy	8	6
Pearce	John	Local Authority Partner Member Left 31 Dec 2025	11	8												
Riley	Claire	Chief Corporate	11	9 1 x deputy	12	12							6	3 2 x deputy	8	7

			BOARD		EXECUTIVE COMMITTEE		REMUNERATION COMMITTEE		FINANCE, PERFORMANCE and INVESTMENT COMMITTEE		AUDIT COMMITTEE		QUALITY AND SAFETY COMMITTEE		TRANSITION COMMITTEE	
Surname	Forename	Post Held	No. of Meetings Held	No. of Actual Attendance	No. of Meetings Held	No. of Actual Attendance	No. of Meetings Held	No. of Actual Attendance	No. of Meetings Held	No. of Actual Attendance	No. of Meetings Held	No. of Actual Attendance	No. of Meetings Held	No. of Actual Attendance	No. of Meetings Held	No. of Actual Attendance
		Services Officer														
Rush	Jon	Independent Non-Executive Member Left 22 May 2025	11	1			2	1	10	1	6	2			8	1
Scott	Richard	Director of Nursing											6	4		
Smith	Dr Mike	Primary Medical Services Partner Member	11	9					10	8					8	6
Stout	David	Independent Non-Executive Member (Audit)	11	10							6	6				

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, we have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the ICB and best practice.

Discharge of Statutory Functions

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

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

Risk management arrangements and effectiveness

Effective risk management is an integral part of the work of the ICB in delivering against its aims, objectives, and strategic priorities in the stewardship of public funds. The ICB's risk management strategy sets out the organisation's approach to risk and the management of risk in fulfilment of its overall objectives. The principles are consistent with those within the NHS England's (NHSE) risk management framework and NHSE's risk management strategy. The ICB acknowledges that risks will arise during the commissioning of health services and tackling health inequalities in an innovative and effective way, but that taking risks can bring benefits and opportunities when managed appropriately. The ICB does not aim to create a risk-free environment, but rather one in which risk is appropriately identified and routinely managed via embedded structures and processes, to enable it and partner organisations to provide safe, high quality, and value for money services for the ICB.

Key elements of the strategy include:

- Clear statements on the responsibilities of the Board and its committees/subcommittees as well as individual accountability for delivery of the strategy.
- Clear principles, aims and objectives of the risk management process.
- Clear processes for the management of risk in commissioned services, partnership working and delivery of the quality, innovation, productivity, and prevention programme.
- A clearly defined process for assessing and managing risks, including implementation and dissemination of the framework for all staff.
- Details of the approach to be undertaken to assess and report risks, including incident reporting, serious incidents, and safeguarding.
- Confirmation of the arrangements for reporting and managing risks through the risk register process.
- A documented process for escalating risks identified at Place to the corporate risk register.
- Arrangements for monitoring and review of the framework.
- The process for embedding risk management in the ICB's activities includes:

- Ongoing review of the risk management framework with a supporting strategy and procedures.
- A Board Assurance Framework, regularly updated and presented to the Board and supporting committees.
- A committee structure with clear accountabilities for risk management.
- A robust incident reporting system through staff are actively encouraged to report incidents to help identify risks.
- A clear policy and process for staff to raise concerns in relation to potential fraud risk.

Capacity to Handle Risk

Responsibility for risk management is identified at all levels across the ICB from Board members, Chief Officers and all managers and staff. The risk management strategy sets out the duties and responsibilities for risk management across the organisation.

Understanding, monitoring, and mitigating risks are fundamental tasks in a successful organisation, as well as basic aspect of good governance. As such, it is the responsibility of the Board to determine the best place for risk management to be positioned ensuring effective management and assurance processes are in place. The overall risk management approach ensures that the strategy is coordinated across the whole organisation.

Resources available for managing risk are finite. The ICB will aim to achieve a prioritised and effective response to risk, whilst striking a balance between cost and benefit. The ICB will therefore take action to manage risk to a level which the ICB can justify as being tolerable. This will be achieved by the Board agreeing and reviewing the ICB's 'risk appetite' regularly.

As a formal committee of the Board, the Audit Committee provides assurance to the Board that systems are in place and operating effectively for the identification, assessment, and prioritisation of risks, potential and actual, and to report on any major strategic issues to the Board and other external agencies as appropriate.

The Committee's specific responsibilities relating to risk management are to:

- Oversee the risk management system and obtain assurances that there is an effective system operating across the ICB.
- Report to the Board on any significant risk management issues.

Audit Committee also reviews the Board Assurance Framework (BAF) quarterly to ensure the Board receives assurances that effective controls are in place to manage all strategic risks. The BAF provides assurance regarding risks relating to services being commissioned as well as risks to the organisation's strategic and operational plans and considers any extreme (red) or high (amber) risks (scored 12 and above) that have been identified at Place.

The Executive Committee receives a quarterly report to review the corporate risk register and the place-based risk register (risks scored 12 and above) and reviews the BAF each quarter ahead of consideration at the Board.

The Quality and Safety Committee and Finance, Performance and Investment Committee review and manage any strategic or operational risks relating to the committees' area of focus. Quality and Safety Committee and Finance, Performance and Investment Committee also review the BAF each quarter ahead of consideration at the Board.

All members of the executive team are responsible for:

- Maintaining awareness of the main risks facing the organisation.
- Taking or delegating ownership of relevant risks that pose a threat to the achievement of objectives or the business of the organisation and ensuring appropriate action is taken to mitigate and manage risks, ensuring regular updates are added to the risk register.
- Ensuring the processes for managing risk within the ICB are clearly understood, appropriately delegated and effective.

All senior leaders have a responsibility to incorporate risk management within all aspects of their work and are responsible for ensuring the implementation of this strategy.

Throughout 2025/26, the ICB had a service line agreement in place with the North of England Commissioning Support Unit (NECS) to provide specialist risk management support, including training in conjunction with the ICB's governance staff. The support included the use of the electronic system used to record and analyse all identified risks.

Risk Assessment

The risk management strategy is supported by a standard operating procedure that sets out a clearly defined process for:

- Risk identification,
- Risk assessment,
- Managing risks through the risk register process.

The risk management strategy defines levels of control or influence over risks depending on the source and type of risk acknowledging that there are risks that are fully or partially within its sphere of control (financial, operational regulatory, compliance), there are occasions where the source of a risk event may be external (for example a change in government policy). While the ICB is unable to prevent such external events, it will focus management efforts on the identification and mitigation of the impact, for example by putting contingency plans in place.

The ICB uses a standard matrix methodology in the application of a risk rating to ensure a consistent approach to the prioritisation of risks and effective targeting of resources. Risks are assessed using the consequence and likelihood of risk occurring, giving an overall rating of extreme, high, moderate, or low. The rating is recorded against the risk and managed via a series of controls and actions with progress monitored via the ICB's governance processes.

The ICB recognises the risk that fraud, bribery, and corruption pose to its resources. This risk is included in the corporate risk register with an appropriate internal risk owner identified. Operational management and recording of detailed fraud, bribery and corruption risks will be conducted by the ICB's counter fraud provider and as agreed in the counter fraud workplan and using a bespoke fraud, bribery, and corruption risk planning toolkit. Regular reports will be provided to the Audit Committee to ensure effective executive and non-executive level monitoring of fraud, bribery, and corruption risks.

Key risks managed from 1 April 2025 to 31 March 2026:

- Risk that both the ICB and wider ICS are unable to agree a robust, and credible, medium term financial plan which delivers a balanced financial position.

- System resilience, escalation planning and management and business continuity arrangements could lead to communities not receiving level of care needed during an incident, increased pressure across the system and inability to delivery core services.
- Commissioned services that fall below the required standards, putting patient health, safety and welfare at risk.
- That delayed ambulance handovers impact negatively on patient safety and patient flow.
- Widespread clinical and social care workforce challenges could impact on delivery of safe services, drive up waiting times and lead to poorer outcomes for patients.
- Choice accreditation – risk that the ICB is required to contract unaffordable levels of Independent Sector (IS) provider capacity.
- General Practice (GPs) intention to take industrial action.
- Weight loss injections and Right to Choose providers.
- Risk that children and young people are unable to access mental health services they need in a timely manner.
- Risk of availability of and poor access to adult mental health services.
- Continuing Care - variation in practice and compliance within the ICB/ICS could result in reputational damage, non-compliance with statutory duties, adverse financial impact, negative patient/family experience and adverse impact on the market and workforce.

The ICB has risk mitigations and (where appropriate) actions in place to reduce risks and these are documented within each risk and assured by the relevant parent committee and Audit Committee.

The ICB has effectively managed its risks in 2025/26. Its systems have been in place for the year under review and up to the date of approval of the annual report and accounts. At 31 March 2026 the ICB carried four high (amber) risks and no extreme (red) risks.

ICB's risk profile

All risks are assessed in terms of their potential impact to the achievement of the goals of the ICS strategy *Better Health and Wellbeing for All* and each risk is aligned to an appropriate directorate and lead director, and individual risk owners have been identified to manage the risks.

As a statutory body it is essential that the ICB demonstrates compliance with regulation and statute. In recognition of these duties, risks have been created to acknowledge that managing these risks is of critical importance to a well-run organisation:

Risk Focus	Controls
ICB public accountability duties	Risk management strategy Annual audit plan ICB policy review and approval framework ICB Constitution and governance structure
Conflict of interest	Signed declarations of interest. Register of interests Gifts and Hospitality Register Minutes of meetings (showing declared interests, exclusions etc.) Conflicts of Interest training

Risk Focus	Controls
Economy, efficiency, probity	Financial Plan Financial reporting and monitoring process Financial governance arrangements, policies, and schemes of delegation
Delivery of NHS constitutional standards	Contract management processes Performance management processes
Safeguarding duties	Quality and Safety Committee Designated and named professionals in place Partnership arrangements with Local Safeguarding Children Boards and Local Safeguarding Adults Boards
Effective patient and public involvement	People and communities' strategy Protocols in place to work with Healthwatch on delivery of involvement activities
System resilience and escalation planning	System-wide surge and escalation plan ICB business continuity plan Emergency planning, resilience, and response (EPRR) compliance Place-based delivery urgent and emergency care groups

Other risk management processes

Equality and quality impact assessment processes have been established. Authors of reports to formal committees must complete an assessment setting out any risks and issues and provide assurances on these; state any conflicts of interest and indicate whether an equality impact assessment has been undertaken where required.

Key stakeholders and the public are involved in the management of risks through board meetings held in public. The risk register is included on the public agenda with an opportunity for questions to be asked about the register as a whole or about individual risks.

The ICB's involvement and engagement strategies, patient feedback, complaints, and staff feedback are all used as an integral part of the approach to risk management.

Risk appetite

Risk appetite is the organisation's attitude to risk as the amount of risk that the organisation is prepared to accept, tolerate or to be exposed to. Risks are considered in terms of both opportunities and threats and the consequent impact on the capability of the ICB, its performance, and its reputation.

The ICB tries to reduce risks to the lowest level reasonably practicable however where risks cannot reasonably be avoided, every effort is made to mitigate the remaining risk. A clear risk appetite statement was approved by the Board for 2025/26 and will be reviewed annually.

The risk appetite statement defines the appetite levels for ten categories of risk: financial risk; patient safety; information sharing; information security; legal and regulatory compliance;

partnership working; people and workforce; reputational; innovation; and health and safety. The agreed appetite levels help owners set target risks in line with the Board's agreed level within each category.

Other sources of assurance

Internal Control Framework

The North East and North Cumbria Integrated Care Board has in place a robust internal control framework which is built up on a set of procedures and processes to ensure we deliver our policies, statutory duties and aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively, and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

Control mechanisms are embedded within all aspects of the ICB's governance, with the oversight of risk management within the organisation being one of them. The ICB's system of internal controls include:

- A Board and governance reporting framework that ensures the ICB has appropriate arrangements in place to exercise its functions effectively, efficiently, and economically and in accordance with the principles of good governance
- A committee structure, where each committee has a vital role in contributing to the establishment of an effective governance infrastructure and reporting mechanisms to raise and escalate risks or decisions
- An approved ICB Constitution, incorporating Standing Orders which is underpinned by the duty that requires NHS bodies to consider the effects of their decisions on the health and wellbeing of the people we serve
- A Governance Handbook which includes key documents that underpin our governance framework, including (but not exhaustive) the Scheme of Reservation and Delegation (SoRD), Prime Financial Policies, Financial Limits, Standards of Business Conduct and ICB committee structures to ensure the Board is fully informed and sighted on its statutory decision making and effective stewardship of NHS spending for all the residents of the ICB
- Robust processes are in place for managing conflicts of interest in line with NHS England's guidance on conflicts of interest for ICBs. This includes producing a register of interest, annual training for staff and submission of declarations of interest. In addition, declarations are required from all Board, Committee and Subcommittee members
- An appointed Accountable Officer (the ICB Chief Executive) who is responsible for (amongst other duties) ensuring that the ICB fulfils its duties to exercise its functions effectively, efficiently, and economically thus ensuring improvement in the quality of services and the health of the local population while maintaining value for money
- The Accountable Officer, working closely with the chair of the ICB, ensures that proper constitutional, governance, and development arrangements are put in place to assure the Board of the organisation's ongoing capability and capacity to meet its duties and responsibilities

- An appointed Chief Finance Officer who is responsible for (amongst other duties) overseeing robust audit and governance arrangements leading to propriety in the use of the ICB's resources
- Staff members who are responsible for reporting problems of operations, monitoring and improving their performance, and monitoring non-compliance with the corporate policies and various professional codes, or violations of policies, standards, practices, and procedures
- There is a clear process for reporting, management, investigation and learning from incidents. The ICB has a Senior Information Risk Owner (SIRO) to support the arrangements for managing and controlling risks relating to information/ data security. The Chief Medical Officer is the Caldicott Guardian, who works with ICB colleagues to ensure that patient confidentiality is protected

Internal audit service

One important feature of the system of internal control is the work of the internal audit service. Through a systematic programme of work, internal audit provide assurance on key systems of control.

The Head of Internal Audit reports to the Audit Committee and has direct access to the Audit Committee Chair as required.

Policies

Another key feature of the system of internal control is the application of a range of policies and procedures.

The ICB has a suite of policies in place, including corporate policies, HR policies, and Information Governance policies. Each policy has a named executive director's lead and staff are advised and reminded of the ICB's policies. Policies are scheduled for review at their due date and approved by the Executive Committee and staff are informed of updates/changes. The ICB also has a number of Standard Operating Procedures to ensure staff understand the procedures that must be followed in certain areas e.g., to establish the ICB's Subcommittees and Groups; how to obtain legal services.

The terms of reference for the ICB Executive Committee ensures that the Committee receives assurance reports relating to statutory and mandatory training, compliance with health and safety, fire safety and first aid at work, information governance, equalities and diversity, and business continuity planning. There is commitment to continuing professional development, with robust processes in place for staff supervision, training, objective setting, performance review and appraisal.

The ICB is committed to an open and honest culture whereby all staff feel able and are supported to raise concerns at work. The ICB has a Freedom to Speak Up (FTSU) Policy and Guardian who is supported in their role by the ICB's FTSU Executive Lead and Non-Executive Director.



The Audit Committee is scheduled to review the arrangements annually.

Business Critical Models

In line with best practice recommendations of the MacPherson (2013) review into the quality assurance of analytical models. I can confirm that a framework and environment is in place to provide assurance of business-critical models. The ICB's Information Governance framework ensures that business critical systems are identified and managed effectively.

Information asset owners have been appointed and trained to cover a range of business systems used by the ICB. Their responsibility in relation to business-critical systems will involve the maintenance of an information asset register relevant to their organisational remit, the maintenance of service continuity plans and the continuity of key skills to operate such systems.

Third party assurances

The ICB currently contracts with several external organisations for the provision of back-office services and functions, and as such has established an internal control system to gain assurance from these.

These external services and systems include:

- The provision of Oracle financial system and financial accounting support from NHS Shared Business Services. The use of NHS Shared Business Services is mandated by NHS England for all ICBs and is fundamental in producing NHS England group financial accounts using an integrated financial ledger system
- The provision of a range of commissioning support services from the North of England Commissioning Support Unit
- The provision of payroll services from Northumbria Healthcare NHS Foundation Trust
- The provision of the ESR payroll systems from NHS Business Services Authority (BSA)
- The provision of the Prescription Pricing Service operated by the NHS BSA
- The provision of Primary Care Support Services from NHS Property Services/Capita Business Services Limited
- The GP extraction and processing of GP data services operated by NHS England (formerly NHS Digital)

Assurance over the relevant control environments in place for these systems has been gained from independent service auditor reports for the year ended 31 March 2026, in accordance with ISAE 3000 or 3402 (International Standard on Assurance Engagements), together with additional testing of controls by the ICB's internal auditors. The outcome from these audits is reported to the Audit Committee.

Data Quality

The ICB has a data quality policy. This policy defines data and explains data standards and the importance of data validation.

The North England Commissioning Support Unit (NECS) Data Management service has processes and systems in place to assess the quality and completeness of commissioning data managed on behalf of the ICB. Data is checked at all stages of processing through NECS systems and finally on publication of reports/analysis. Data is compared against historic and planned levels to provide assurance on completeness as well as with peer organisations in the form of benchmarking analysis.

Processes are in place to raise any data quality issues with providers on a monthly basis, feedback from these challenges is utilised to alter any processing routines as required. The ICB utilises contract levers where necessary to ensure high quality data is captured at source and to minimise any updating of data once received by commissioners. Reconciliation accounts for each contract highlight any discrepancies between provider and commissioner data that are then investigated and resolved.

Significant validation steps are placed in all routine data processing tasks to ensure poor quality data is not made available for analysis and then subsequently used as the basis for commissioning decisions.

Robust data is provided to the Board, and other committees of the ICB.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by the Cyber assurance framework (CAF) (Data Security and Protection Toolkit [DSPT] and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently, and effectively.

The Cyber assurance framework aligned - Data Security and Protection Toolkit (CAF-DSPT) is the officially recognised self-assessment tool on data protection and cyber security. It was originally developed by NHS Digital for all NHS organisations to measure compliance against the ten National Data Security Standards (DSSP), and in turn compliance with their statutory responsibilities and Data Protection legislation. Within the ten data standards there are mandatory assertions items to meet to ensure compliance with their statutory responsibilities.

The ICB published a 'Standards Met' DSPT for 2024/2025. The ICB will submit its Cyber assurance framework aligned - Data Security and Protection toolkit for 2024/25 by 30 June 2026.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the DSPT toolkit. The ICB has a named Senior Information Risk Owner (SIRO) and Caldicott Guardian appointed from our Executive team. The ICB also has a named Data Protection Officer. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We have developed and introduced information and data impact risk assessments and management procedures to fully embed an information risk culture throughout the organisation against identified risks.

Control Issues

Significant control issues are those issues that could put delivery of the standards expected of the Accountable Officer at risk; that might prejudice the achievement of priorities; undermine the integrity or reputation of the ICB and/or wider NHS; make it harder to resist fraud or other

misuse of resources or divert resources from another significant aspect of the business; have a material impact on the accounts; or put data integrity at risk.

The ICB has in place a robust system of internal control. The ICB has assurances from the Head of Internal Audit and from other sources to support this assessment.

Review of economy, efficiency and effectiveness of the use of resources

The Board receives reports from its relevant committees (Finance Performance and Investment Committee, Executive Committee, Quality and Safety Committee and Audit Committee) providing assurance that the ICB uses its resources economically, efficiently, and effectively.

The ICB budget comprises the commissioning budget and the running cost budget. The Board received regular finance reports throughout the period 1 April 2025 to 31 March 2026.

The ICB commissioning budget is deployed to commission healthcare for the population of the North East and North Cumbria, in line with national guidance.

During the period 1 April 2025 to 31 March 2026 the ICB worked in close partnership with healthcare providers across the ICS to ensure that resources were utilised in the most effective way possible.

The ICB external auditors have not identified any significant weaknesses in the ICB arrangements in place for securing economy, efficiency, and effectiveness in its use of resources.

During the financial year the ICB received 'substantial assurance' for 9 audits and 'good assurance' for 7 audits undertaken by internal audit, and the Head of Internal Audit Opinion also provided an overall assessment of 'good assurance'.

In respect of the ICB running cost budget, there was an agreed staffing structure during the year with staff organised into a number of directorates each led by an executive director. Revised structures have been agreed in year, to take effect from May 2026, as part of the strategic commissioning transition programme. This will deliver the efficiencies required in 2026/27 to ensure the ICB's cost of commissioning meets the £19 per head target set by NHS England.

During the period 1 April 2025 to 31 March 2026, the ICB delivered a substantial efficiency programme, realising total efficiencies of over £130m.

A summary of our financial planning (including central management costs) and in-year performance monitoring is shown in the Performance Analysis – Financial Performance report.

The Remuneration Committee confirms the ICB pay policy including adoption of any pay frameworks for all employees including senior managers/directors (including Board members) but excluding non-executive board member directors and excluding the Chair.

Commissioning of delegated services (primary care services and specialised services)

The North East and North Cumbria Integrated Care Board has signed delegation agreements with NHS England for the commissioning of delegated primary care services and specialised services and held full commissioning responsibilities for delegated services during the 2025/26 reporting period.

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

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

Delegation of ICB functions

Delegation arrangements exist through the ICB's governance process and committee structures, as set out in the role and remit of each committee. The systems and processes to ensure resources are used economically, efficiently, and effectively, together with the related assurance mechanisms highlighted above, apply throughout the organisation, covering all relevant committees and delegations.

This includes the Board which oversees the work of all committees, with formal reporting arrangements, together with the other assurance processes summarised above.

As noted in the third-party assurances section above, the ICB has a number of outsourced services and systems which are managed by external providers. A summary of these services and the assurances obtained over them is included above.

Counter fraud arrangements

Our counter fraud activity plays a key part in deterring risks to the ICB's financial viability and probity.

Audit One, is contracted to undertake counter fraud work proportionate to identified risks. Counter Fraud Specialists are nominated to work on behalf of the ICB and approved by the Chief Finance Officer.

A counter fraud work plan was agreed by the Chief Finance Officer and approved by the Audit Committee for the period 1 April 2025 to 31 March 2026, which focuses on the deterrence, prevention, detection, and investigation of fraud. Progress against this work plan was regularly monitored by the Audit Committee within quarterly counter fraud progress reports.

Through our contract with Audit One, we have counter fraud arrangements in place that comply with the NHS Counter Fraud Authority's (NHSCFA) requirements. Audit One has provided the Audit Committee with an annual report against the Government Functional Standard GovS 013: Counter Fraud - NHS requirements and considers the relevant actions being implemented to address any identified deficiencies. There was executive support and direction for a proportionate work plan to address identified risks.

Between 1 April 2025 and 31 March 2026 the ICB was not subject to an NHSCFA engagement therefore no recommendations have been made to the ICB where action was required and reported to the Audit Committee.

A member of the Board is proactively and demonstrably responsible for tackling fraud, bribery, and corruption. Counter-fraud requirements and regulations are discussed with both the Audit Committee and Executive Committee.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 April 2025 to 31 March 2026 for the ICB the Head of Internal Audit will issue an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance, and internal control.

The Head of Internal Audit has produced a draft of the findings to date and has stated: "From my review of your systems of internal control, I am providing **Good Assurance** that there is a sound system of internal control, governance and risk management designed to meet the organisation's objectives. Controls are generally being applied consistently.

The basis for forming my opinion is as follows:

- an assessment of the design and operation of the underpinning assurance framework and supporting processes for governance and the management of risk
- an assessment of the range of individual opinions arising from audit assignments, contained within risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses
- brought forward internal audit assurances
- an assessment of the organisation's response to agreed management actions, and
- consideration of significant factors outside the work of internal audit.

Supporting Commentary

Design and operation of the assurance framework and supporting processes

The ICB has a published Risk Management Strategy, which sets out the ICB's approach to risk and the management of risk in fulfilment of its overall objectives. Oversight of the risk management agenda rests with the Audit Committee, which reports into the Board.

Our audits of risk management and the board assurance framework have been completed and were assigned substantial assurance and no fundamental issues were identified in relation to the ICB's risk management or board assurance framework processes.

In relation to the board assurance framework the following controls were found to be operating effectively:

- The BAF is firmly connected to the organisation's principal objectives as set by the Board, and is a live document, maintained on an on-going basis by the governance lead to ensure it accurately reflects current risks, controls, and assurance sources. The latest BAF reviewed at the time of the audit was fully populated for all ICB strategic goals and had been produced within the required quarterly cycle.

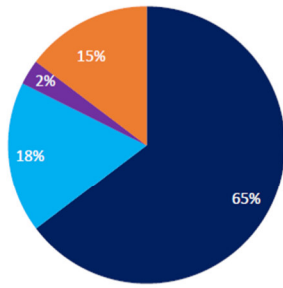
- The BAF is monitored by the Audit Committee and Board on a quarterly basis. BAF and Risk Management Reports were presented to the Audit Committee, Board, and Board Committees throughout 2025/26, with minutes evidencing presentation, discussion, and challenge (where appropriate).
- Each risk within the BAF is formally assigned to a designated executive director and the appropriate Board Committee. This allocation ensures clear ownership of the risk, accountability for the effective management of controls and mitigations, and clarity regarding which Committee is responsible for overseeing, monitoring, and challenging the risk position.
- Risk owners are required to review and update their risks at agreed intervals to ensure that the BAF remains accurate, current, and aligned with organisational priorities.
- The risks outlined in the BAF are fully aligned to, and traceable from, the Corporate Risk Register.

In relation to the risk management framework the following controls were found to be operating effectively:

- The ICB has a Board approved Risk Management Strategy. The purpose of the Strategy is to provide a support document to enable staff to undertake effective identification, assessment, control and action to mitigate or manage the risks affecting the normal business. The Strategy sets out an organisation wide approach to managing risk, in a simple, straightforward, clear manner and the intentions of the ICB for timely, efficient and cost effective management of risk at all levels within the organisation.
- Risks are recorded and escalated appropriately. The ICB maintains a corporate risk register supported by area-based registers, each updated at least quarterly. The corporate, north, and south registers were reviewed and found to be fully populated at the time of the audit.
- Risks are evaluated using the ICB's standard risk assessment matrix, considering likelihood, impact, and effectiveness of existing controls.
- The Board reviewed and approved the ICB's risk appetite during the year.
- Risks are reviewed by owners at least quarterly, with updates on control effectiveness. All risks in the Corporate Risk Register had been reviewed within required timeframes.
- Actions have been recorded for all corporate risks, including owners and target dates. No target dates had passed as at the time of the audit, and narrative entries supported the actions being undertaken.
- Risk reports have been presented to relevant ICB committees throughout 2025/26, with meeting minutes evidencing presentation, discussion, and challenge.
- The Audit Committee is responsible for reviewing the adequacy and effectiveness of risk management across ICB's activities and to highlighting any areas of weakness to the Board. It is accountable to the Board and reports to the Board on how it discharges its responsibilities. Section 8 of the Audit Committee terms of reference requires that the Committee provides the Board with an annual report, summarising its conclusions from the work it has done during the year with regards to the fitness for purpose of the assurance framework and the completeness and 'embeddedness' of risk management in the organisation. The Audit Committee's annual report was presented to the Board on 3rd June 2025.

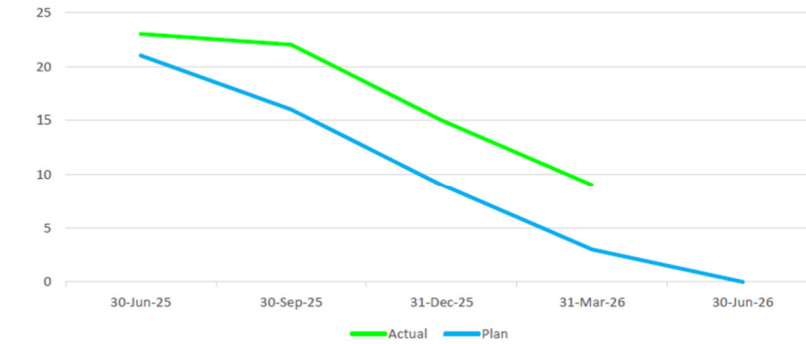
Outturn of the Internal Audit Plan

2025-26 Audit Plan Delivery



■ Not started ■ Planning ■ Fieldwork
■ Review ■ Reporting ■ Cancelled

Delivery Profile – Planned vs Actual



As of 31 May 2026, four audits were behind schedule, with draft reports originally planned to be issued. Fieldwork for these audits is ongoing, along with two additional audits for which draft reports are expected to be issued by 30 June 2026. One audit has not yet commenced due to resource constraints within the audit team.

Table 8 - Summary of internal audit assurance work undertaken:

Report Status	Assurance Rating				
	Substantial	Good	Reasonable	Limited	Advisory
Draft	0	0	0	0	0
Final	9	7	4	0	2
Total	9	7	4	0	2
Percentage	41%	32%	18%	0%	9%

As noted in the table above, 16 (80%) of the assurance reports issued during the year to date have a positive assurance level of Substantial or Good. In addition to those identified above, six audits are in progress, with fieldwork completed for two of these audits. The four reasonable assurance reports issued to date have been considered for the Head of Internal Audit Opinion for 2025/26.

In preparing this opinion, there is a significant control weakness that we recommend should be considered against the criteria derived from NHS England Annual Governance Statement guidance and applied in line with DHSC Group Accounting Manual requirements for Governance Statements, on determining whether an internal control issue is 'significant', details as follows:

- Could the issue prejudice achievement of organisational priorities?
- Could it undermine the integrity or reputation of the NHS?
- Does it risk breaching standards expected of the Accountable Officer?
- Could it result in a material impact on the accounts or resources?
- Does it increase exposure to fraud or misuse of resources?
- Has it diverted resources from key services or objectives?
- Does it pose a risk to data security or national systems?
- What is the view of the Audit Committee, Internal Audit or External Audit?

Audit	Risk identified	Status of agreed actions on 8 th June 2026
Safeguarding Arrangements (Adults and Children) (Reasonable Assurance)	Incomplete records were maintained of the status of disclosure and barring service (DBS) checks that had been carried out on staff employed within the Safeguarding Team. For some staff in the sample reviewed, there was no record to confirm that DBS checks had been undertaken and for others where a DBS check had been completed, it was not clear whether the enhanced DBS check had included a check against both the adults and children barred list. These issues were due to initial employment checks being carried out on staff when they were appointed by predecessor organisations (i.e. CCGs) and this information not being recorded in the ESR system when they have transferred to the ICB. Staff in the safeguarding children and adults teams are in roles that require high levels of trust and scrutiny. Missing or incomplete DBS records raise concerns about whether individuals have been properly vetted, potentially exposing vulnerable populations to unnecessary risk.	The agreed management action regarding reviewing which roles require a DBS check, identifying gaps in information recorded and new DBS checks being carried out for staff where no records of DBS checks were held is now substantially complete. Currently the remaining three outstanding DBS checks are being processed and the ICB is awaiting the outcomes of the checks.

Brought forward Internal Audit assurances

Our overall opinion for 2024/25 was: that good assurance can be given that there is a sound system of internal control, governance and risk management designed to meet the organisation's objectives and that controls are generally being applied consistently.

As part of the opinion, we drew attention to three reasonable assurance reports issued during 2024/25. Issues have been followed up in year and there is nothing brought forward that I wish to consider as part of the opinion for 2025/26.

Implementation of agreed management actions

The implementation of agreed actions is a key indicator of the organisation's engagement with the internal audit process and the importance it places on the actions agreed to be implemented. The Audit Committee receives updates on the progress of all agreed actions. In the year to 31st March 2026, 75 agreed management actions were due to be implemented based on initial or revised target dates, of which 65 (87%) were closed in the year. The table below provides a breakdown of the position based on the priority level of the agreed actions.

Priority	Due in the year to 31 March 2026	Closed	Outstanding
High	3	3 (100%)	0 (0%)
Medium	44	37 (84%)	7 (16%)
Low	28	25 (89%)	3 (11%)
Total	75	65 (87%)	10 (13%)

There are no management actions which are currently reported as overdue by more than 12 months past their agreed original target date for implementation.

Significant factors outside of internal audit work performed for the ICB

Whilst the Head of Internal Audit Opinion provides the ICB with assurances in relation to the areas covered by the internal audit plan, it is only one of the sources of assurance available to

the ICB. As the ICB outsources many of its functions, assurances from third parties are equally as important when the ICB draws up its Annual Governance Statement.

The main ones usually received that I have been made aware of are summarised below:

- Payroll services are provided by NHS Payroll Services hosted by Northumbria Healthcare NHS Foundation Trust. The ICB, through its membership of the Payroll Consortium, receives an annual assurance letter setting out the results of the internal audit work carried out during the year.
- Assurance in respect of the operation of the finance and accounting services provided by NHS Shared Business Services (SBS) is provided by the NHS SBS' auditors on an annual basis.
- Assurance in respect of the primary care support services provided by Capita Business Services Limited to NHS England and ICB is provided by Capita's auditors, Forvis Mazars, on an annual basis.
- Assurance in respect of the operation of the prescription payments process provided by NHS Business Service Authority and Capita is provided by the NHS BSA's auditors, PwC LLP, via an ISAE 3402 Type II report on an annual basis.
- Assurance in respect of the operation of the NHS GP Payment Service provided by NHS Digital is provided by the NHS Digital's auditors, PwC LLP, via an ISAE 3402 Type II report issued on an annual basis.
- Your counter fraud specialist is required to submit an annual Counter Fraud Functional Standard Return (CFFSR) to the NHS Counter Fraud Authority (NHSCFA) in relation to the ICB's counter fraud, bribery and corruption arrangements. This provides an overview of the ICB's counter fraud activity, progress against NHSCFA requirements and assists the chief finance officer (CFO) and audit committee in monitoring and managing the counter fraud service. The CFFSR for 2025/26 was reviewed and approved by both the audit committee chair and CFO ahead of the submission deadline. The ICB's overall rating for 2025/26 is green. The ICB has not been subject to an NHSCFA engagement meeting in 2025/26.
- The Electronic Staff Record (ESR) service is provided by IBM. An ISAE 3000 Type II report covering the operation of the national system is issued on an annual basis by their external auditors, PwC LLP.

It is for the ICB to decide what assurance to take from these reports and whether any of the weaknesses identified should be included within the ICB's Annual Governance Statement.

Delivery breakdown

Please note that this year's opinion includes nine 2024/25 audits that were concluded after the opinion for that year was finalised and reported to the Audit Committee on 12th June 2025. Every piece of audit work will be assessed in an annual opinion but may not be completely aligned to the year of the plan. The 2025/26 opinion is informed by those audits included below that are final, or with a firm opinion in a draft report, plus any from the 2024/25 plan that were not included in the opinion last year.

The operational internal audit plan for the year ended 31st March 2026 was approved by the Audit Committee on 10th April 2025. During the year progress against the plan has been reported to the Audit Committee via regular progress reports.

The plan has been subject to change during the year, with all requests presented, along with rationale, to the Audit Committee. Each change was considered and approved. The changes were:

- **Safeguarding Adults and Children audit (approved 24th July 2025)** Following a request from the Chief Nurse, the Safeguarding audit from the 2025/26 internal audit plan was delivered as part of the 2024/25 internal audit plan and replaced with audits on Continuing Health Care – Case Management and Personal Health Budgets, which were originally included in the 2024/25 internal audit plan.
- **Disciplinary audit (approved 9th October 2025)** A request was received from the Director of Workforce to cancel the disciplinary audit due to capacity within the People Team, linked to the organisational change process and the low number of disciplinary cases. This audit was replaced with an audit on patient and public engagement.
- **Continuing Healthcare – Case Management and Continuing Healthcare – High Cost Case Panel audits (approved 5th February 2026)** A request was received from the Chief Nurse that the Continuing Healthcare – Case Management and Continuing Healthcare – High Cost Case Panel audits should be combined and the scope updated so that one audit would be carried out to review the governance arrangements in place for all age continuing healthcare.
- **LeDeR audit (approved 9th April 2026)** A request was received from the Chief Nurse to cancel the LeDeR due to staffing issues within the LeDeR team, backlog of reviews, changes planned on how the processes are to be managed following the restructure and new national guidance due to be issued. This audit was replaced with an audit on Continuing Healthcare – High Cost Case Approval Process.

Delivery breakdown

Audit Area	Audit Status	Assurance Rating					Findings			
		Substantial	Good	Reasonable	Limited	Advisory	High	Medium	Low	Total
Governance, Risk & Performance										
Board Assurance Framework	Final	✓					0	0	1	1
Risk Management	Final	✓					0	0	1	1
Emergency Planning Resilience and Response	Final	✓					0	0	1	1
Patient and Public Engagement	To start									
Governance Arrangements – All Age Continuing Healthcare	Fieldwork									
Governance Framework (from 2024/25 plan)	Final	✓					0	0	1	1
System Oversight Framework (from 2024/25 plan)	Final		✓				0	1	1	2
Workstreams and Transformation (from 2024/25 plan)	Final		✓				0	3	4	7

Audit Area	Audit Status	Assurance Rating					Findings			
		Substantial	Good	Reasonable	Limited	Advisory	High	Medium	Low	Total
Finance, Contracting & Capital										
Accounts Payable	Final	✓					0	0	1	1
Accounts Receivable	Final		✓				0	1	2	3
Financial Ledger	Final	✓					0	0	1	1
Financial Reporting	Final	✓					0	0	0	0
Key Financial Controls – Post Implementation of ISFE2	Final	✓					0	0	0	0
Cost Improvement Plans	Final		✓				0	1	0	1
Disinvestments in Services	Fieldwork									
Procurement (from 2024/25 plan)	Final		✓				0	1	0	1
Human Resources & Workforce										
Right to Work Checks	Final		✓				0	1	1	2
Professional Registration Checks	Final	✓					0	0	0	0
Equality, Diversity and Inclusion Arrangements	Fieldwork									
Key Human Resources Controls Recruitment and	Final			✓			0	3	6	9

Audit Area	Audit Status	Assurance Rating					Findings			
		Substantial	Good	Reasonable	Limited	Advisory	High	Medium	Low	Total
Appointment (from 2024/25 plan)										
Public Sector Equality Duty (from 2024/25 plan)	Final			✓			0	4	1	5
Data and Digital Governance										
Cyber Assessment Framework (CAF) Aligned Data Security and Protection Toolkit – Independent Assessment	Final					✓	0	0	1	1
Data Security and Protection Toolkit (DSPT) – Interim Assessment	Final					✓	0	0	0	0
Patient Safety and Quality										
Continuing Healthcare – High Cost Case Approval Process	Fieldwork complete									
Dynamic Support Register and Care Education and Treatment Reviews	Fieldwork									
Personal Health Budgets	Fieldwork complete									
Safeguarding – Adults and Children (from 2024/25 plan)	Final			✓			1	1	0	2
Patient Safety Incident Response Framework (PSIRF) (from 2024/25 plan)	Final			✓			0	5	1	6

Audit Area	Audit Status	Assurance Rating					Findings			
		Substantial	Good	Reasonable	Limited	Advisory	High	Medium	Low	Total
Quality of Commissioned Services Follow-up (from 2024/25 plan)	Final		✓				0	1	0	1
Grand Total		9	7	4	0	2	1	22	23	46

Key

ASSURANCE LEVELS	
Substantial	Governance, risk management and control arrangements provide substantial assurance that the risks identified are managed effectively. Compliance with the control framework was found to be taking place.
Good	Governance, risk management and control arrangements provide a good level of assurance that the risks identified are managed effectively. A high level of compliance with the control framework was found to be taking place. Minor remedial action is required
Reasonable	Governance, risk management and control arrangements provide reasonable assurance that the risks identified are managed effectively. Compliance with the control framework was not found to be taking place in a consistent manner. Some moderate remedial action is required.
Limited	Governance, risk management and control arrangements provide limited assurance that the risks identified are managed effectively. Compliance with the control framework was not found to be taking place. Immediate and fundamental remedial action is required.

Comparison with Prior Years' Assurance Levels

A comparison showing the Head of Internal Audit Opinion assigned to NENC ICB in the period 2023/24 to 2025/26, and a breakdown of the assurance levels assigned to audit reports in that period is shown below.

Assurance Level	2025/26			2024/25			2023/24	
	Number of Reports	Percentage of Plan	Move from 2024/25	Number of Reports	Percentage of Plan	Move from 2023/24	Number of Reports	Percentage of Plan
Overall HOIAO	Good Assurance			Good Assurance			Good Assurance	
Substantial	9	41%	↑	2	11%	↑	1	6%
Good	7	32%	↓	8	45%	↔	8	47%

Assurance Level	2025/26			2024/25			2023/24	
	Number of Reports	Percentage of Plan	Move from 2024/25	Number of Reports	Percentage of Plan	Move from 2023/24	Number of Reports	Percentage of Plan
Reasonable	4	18%	↔	4	22%	↔	4	23%
Limited	0	0%	↔	0	0%	↓	2	12%
Advisory	2	9%	↓	4	22%	↑	2	12%
Total	22	100%		18	100%		17	100%

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

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

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

I have been advised on the implications of the result of this review by:

- The Board
- The Audit Committee
- The Executive Committee
- Quality and Safety Committee
- Finance, Performance and Investment Committee
- Internal audit

In particular, there are some key processes that the ICB uses throughout the year to be assured that the system of internal control is effective:

Board

The Board Assurance Framework has been regularly reviewed by the Board. The Board also receives minutes from the Executive Committee who have responsibility for the approval of new and updated policies throughout the year.

Audit Committee

The annual internal audit plan, as approved by the Audit Committee, enables the ICB to be reassured that key internal financial controls and other matters relating to risk are regularly reviewed. The Committee has reviewed the internal and external audit reports and has kept the assurance framework under review throughout the year.

Executive Committee

The Committee oversees the day-to-day operational management and performance of the ICB in support of the Chief Executive in the delivery of their duties and responsibilities to the Board. The Committee provides a forum to inform ICB's strategies and plans and in particular the Committee will undertake any commissioning and planning activity on behalf of the Board, helping to secure continuous improvement of the quality of services. The Committee also provides assurance on the implementation of the approved ICB strategies and plans.

Quality and Safety Committee

The Committee provides assurance to the Board that there are adequate controls in place to ensure the ICB is delivering on its statutory and non-statutory clinical duties and responsibilities.

Finance, Performance, and Investment Committee

The Committee provides assurance around financial planning and in-year performance monitoring alongside monitoring central management costs and efficiency controls.

Assurances of outsourced services

The ICB relies on several external support services providers in respect of some of its business functions, including the North of England Commissioning Support (NECS), the NHS Shared Business Service (SBS), Capita (primary care support services), the GP extraction and processing of GP data services operated by NHS England (formerly NHS Digital) and the NHS Business Services Authority (BSA).

These organisations provide service auditor reports as part of the evidence of assurance on their internal system of controls as required by their customers. These service auditor reports are considered by the Audit Committee and internal audit also consider service auditor reports as part of the overall year-end internal audit opinion.

The Board develops, implements, and delivers the ICB strategic priorities and receives assurances from the Audit Committee, the Quality and Safety Committee, the Executive Committee and the Finance, Performance, and Investment Committee. Good assurance has also been received from the Head of Internal Audit.

Subcommittees

Subcommittees are established by their relevant parent committee and are shown on the ICB's governance structure, and their terms of reference are shown in the scheme of reservation and delegation available [here](#).

Conclusion

The system of control described in this report has been in place in the ICB for the period 1 April 2025 to 31 March 2026 and up to the date of the approval of the annual report and accounts. I have concluded that the ICB did have a generally sound system of internal control in place continuously throughout the period, designed to meet the organisation's objectives and that the controls are being applied consistently. No significant internal control issues have been identified.

Remuneration and Staff Report

Remuneration Committee

The Remuneration Committee is a committee of NENC ICB. It was in operation throughout the twelve-month period from 1 April 2025 to 31 March 2026.

The Committee was established on 1 July 2022 and remains in place. The membership, purpose, roles and responsibilities of the Committee are set out in its terms of reference available at this [link](#).

Pay ratio information [subject to audit]

Reporting bodies are required to disclose the relationship between the total remuneration of the highest paid director in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce.

Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director in the ICB in the reporting period 1 April 2025 to 31 March 2026 was £285-290k (2024/25: £275-280k).

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

	25 th percentile	Median pay ratio	75 th percentile pay ratio
2025/26:			
Total remuneration (£)	40,823	54,710	74,896
Salary component of total remuneration (£)	38,862	54,710	74,896
Pay ratio information	7.0:1	5.3:1	3.8:1
2024/25:			
Total remuneration (£)	39,405	56,454	85,061
Salary component of total remuneration (£)	39,405	56,454	85,061
Pay ratio information	7.0:1	4.9:1	3.3:1

During the reporting period 2025/26, no employees received remuneration in excess of that of the highest paid director (2024/25: none). Excluding the highest paid director, banded remuneration ranged from £20-25k up to £195-200k (2024/25: £20-25k up to £190-195k).

Total remuneration includes salary, non-consolidated performance-related pay, and benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. Accordingly, the total remuneration figures reflected here exclude the pension related benefits shown in the salaries and allowances table on pages 146-148.

The percentage change from the previous financial period in respect of both the highest paid director and the average percentage change in respect of employees of the ICB as whole, is shown in the table below:

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial period in respect of the highest paid director	3.60%	Not applicable
The average percentage change from the previous financial period in respect of employees of the ICB, taken as a whole	-5.46%	Not applicable

The increase in the highest paid director remuneration reflects a nationally agreed 3.25% pay award together with a minor change in the estimated value of taxable benefits (estimated benefit in kind on lease car).

Other ICB employees as a whole also received a nationally agreed 3.6% pay award under Agenda for Change arrangements which is reflected in 2025/26 remuneration values. A large number of staff transferred in to the ICB from the North of England Commissioning Support Unit under Transfer of Undertakings (Protection of Employment) Regulations (TUPE) on 1 April 2025. This has significantly impacted the average percentage change in remuneration for ICB employees as a whole, with average remuneration across the ICB reducing following the transfer of staff.

This has also contributed to the increase in the ratio of highest paid director remuneration to the rest of the ICB's workforce during the year.

Policy on the remuneration of senior managers

The remuneration for senior managers for current and future financial years is determined in accordance with relevant guidance, best practice, and national policy. In particular, the ICB complies with the NHS very senior managers pay framework published by the Department of Health and Social Care and NHS England.

Continuation of employment for all senior managers is subject to satisfactory performance. Performance in post and progress in achieving set objectives is reviewed annually. There were no individual performance review payments made to any senior managers during the period and there are no plans to make such payments in future years. This is in accordance with standard NHS terms and conditions of service and guidance issued by the Department of Health and Social Care.

Contracts of employment in relation to the majority of senior managers employed by the ICB are permanent in nature and subject to between three-and six-months' notice of termination by either party.

Termination payments are limited to those laid down in statute and those provided for within NHS terms and conditions of service and under the NHS Pension Scheme Regulations for those who are members of the scheme. No awards have been made during the year to past senior managers.

Remuneration of Very Senior Managers

Reporting bodies are required to disclose where the salary of senior managers is in excess of

£150,000 on a pro rata basis. The pro rata basis represents the full-time salary for individuals who work part time. The agreement of reasonable pay and conditions for very senior managers is considered by the ICB's Remuneration Committee, which reports directly to the ICB Board. All posts which are not agenda for change have their pay determined by the Remuneration Committee

Senior manager remuneration

For the purpose of this remuneration report, the ICB has considered the definition of 'senior managers' within the 2025/26 Group Accounting Manual published by the Department of Health and Social Care Group Accounting Manual and considers that the Board members represent the senior managers of the ICB.

Details of the relevant salaries and allowances for all of the senior managers of the ICB can be found in the table below. Prior year comparative figures are included for 2024/25.

Important note regarding 'all pension related benefits' stated in table below:

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

NENC ICB senior officers' salaries and allowances - 2025/26 [subject to audit]:

Name	Position	1 April 2025 to 31 March 2026						Full time equivalent salary (bands of £5,000) £000
		(a) Salary (bands of £5,000)	(b) Expense payments (taxable) (to nearest £100)	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension- related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)	
		£000	£	£000	£000	£000	£000	
Professor Sir Liam Donaldson	Chair	70 - 75	-	-	-	-	70 - 75	70 - 75
Sam Allen	Chief Executive	280 - 285	3,700	-	-	52.5 - 55	340 - 345	280 - 285
Kelly Angus	Chief People Officer (<i>secondment 1 November 2025 to 31 March 2026</i>)	25 - 30	400	-	-	280 - 282.5	310 - 315	175 - 180
Levi Buckley	Chief Delivery Officer	175 - 180	-	-	-	67.5 - 70	245 - 250	175 - 180
David Chandler	Chief Finance Officer	190 - 195	1,100	-	-	77.5 - 80	270 - 275	190 - 195
Professor Graham Evans	Chief Digital and Infrastructure Officer (<i>until 30 June 2025</i>)	45 - 50	-	-	-	-	45 - 50	185 - 190
Dave Gallagher	Chief Procurement and Contracting Officer	145 - 150	-	-	-	70 - 72.5	215 - 220	185 - 190
Hilary Lloyd	Chief Nurse and AHP Officer	190 - 195	-	-	-	160 - 162.5	350 - 355	190 - 195
Jacqueline Myers	Chief Strategy Officer	185 - 190	1,000	-	-	95 - 97.5	280 - 285	185 - 190
Dr Neil O'Brien	Chief Medical Director	195 - 200	-	-	-	57.5 - 60	255 - 260	195 - 200
Claire Riley	Chief Corporate Services Officer	185 - 190	4,000	-	-	50 - 52.5	240 - 245	185 - 190
Professor Eileen Kaner	Independent Non-Executive Member (<i>until 31 December 2025</i>)	10 - 15	-	-	-	-	10 - 15	15 - 20
Jon Rush	Independent Non-Executive Member (<i>until 22 May 2025</i>)	0 - 5	-	-	-	-	0 - 5	15 - 20
David Stout	Independent Non-Executive Member	15 - 20	-	-	-	-	15 - 20	15 - 20
Professor Pali Hungin	Independent Non-Executive Member	15 - 20	-	-	-	-	15 - 20	15 - 20
Dr Saira Malik	Primary Medical Services Partner Member	20 - 25	-	-	-	57.5 - 60	75 - 80	20 - 25
Dr Mike Smith	Primary Medical Services Partner Member	20 - 25	-	-	-	12.5 - 15	30 - 35	20 - 25

Note – Kelly Angus, Chief People Officer was employed in multiple roles across the ICB, North Cumbria Integrated Care NHS Foundation Trust (NCIC) and NHS England during the year. Further details can be found in the notes below. The costs in the table above reflect the costs to the ICB for the year. The total annual full time equivalent salary across the ICB, NHS England and NCIC equated to £175-180k.

NENC ICB senior officers' salaries and allowances comparative figures for 2024/25:

Name	Position	1 April 2024 to 31 March 2025						Full time equivalent salary (bands of £5,000) £000
		(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) (to nearest £100) £	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension- related benefits (bands of £2,500) £000	(f) TOTAL (a to e) (bands of £5,000) £000	
Professor Sir Liam Donaldson	Chair	70 - 75	-	-	-	-	70 - 75	70 - 75
Sam Allen	Chief Executive	275 - 280	1,100	-	-	117.5 - 120	395 - 400	275 - 280
Kelly Angus	Interim Chief People Officer <i>From 28/10/2024</i>	20 - 25	-	-	-	157.5 - 160	180 - 185	145 - 150
Levi Buckley	Chief Delivery Officer	170 - 175	-	-	-	187.5 - 190	360 - 365	170 - 175
David Chandler	Chief Finance Officer	180 - 185	1,100	-	-	22.5 - 25	205 - 210	180 - 185
Professor Graham Evans	Chief Digital and Infrastructure Officer	175 - 180	-	-	-	30 - 32.5	205 - 210	175 - 180
Ann Fox	Interim Chief Nurse and AHP Officer <i>From 01/11/2024 to 02/02/2025</i>	35 - 40	2,500	-	-	-	40 - 45	150 - 155
Dave Gallagher	Chief Procurement and Contracting Officer	160 - 165	-	-	-	7.5 - 10	170 - 175	175 - 180
Hilary Lloyd	Chief Nurse and AHP Officer <i>From 03/02/2025</i>	25 - 30	-	-	-	215 - 217.5	245 - 250	185 - 190
Jacqueline Myers	Chief Strategy Officer	175 - 180	1,500	-	-	30 - 32.5	210 - 215	175 - 180
Dr Neil O'Brien	Chief Medical Director	190 - 195	-	-	-	40 - 42.5	230 - 235	190 - 195
David Purdue	Chief Nurse, AHP and People Officer <i>Until 31/10/2024</i>	110 - 115	600	-	-	-	110 - 115	190 - 195
Claire Riley	Chief Corporate Services Officer	175 - 180	2,500	-	-	35 - 37.5	215 - 220	175 - 180
Dr Hannah Bows	Independent Non-Executive Member <i>Until 30 June 2024</i>	0 - 5	-	-	-	-	0 - 5	15 - 20
Professor Eileen Kaner	Independent Non-Executive Member	15 - 20	-	-	-	-	15 - 20	15 - 20
Jon Rush	Independent Non-Executive Member	15 - 20	-	-	-	-	15 - 20	15 - 20
David Stout	Independent Non-Executive Member	15 - 20	-	-	-	-	15 - 20	15 - 20
Professor Pali Hungin	Independent Non-Executive Member	15 - 20	-	-	-	-	15 - 20	15 - 20
Dr Saira Malik	Primary Medical Services Partner Member	20 - 25	-	-	-	42.5 - 45	60 - 65	20 - 25

Name	Position	1 April 2024 to 31 March 2025						Full time equivalent salary (bands of £5,000)
		(a) Salary (bands of £5,000)	(b) Expense payments (taxable) (to nearest £100)	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)	
		£000	£	£000	£000	£000	£000	
Dr Mike Smith	Primary Medical Services Partner Member	20 - 25	-	-	-	-	20 - 25	20 - 25

Note – Kelly Angus, interim Chief People Officer was on secondment to the ICB from NHS England from 28 October 2024 for 0.4 whole time equivalent. The costs in the table above reflect the costs to the ICB for that period. The total annual full time equivalent salary across both the ICB and NHS England equated to £145-150k.

Notes:

The taxable benefits included in the table above all relate to the estimated benefit in kind on lease cars (calculated based on the value of the vehicle and relevant CO2 emissions).

No performance related benefits have been agreed for any senior officers.

All pension-related benefits disclosed in this report relate to 'officer employment' only, i.e., for any general practitioners, the figures exclude any benefits derived from practitioner employment.

All senior officer remuneration is processed through the ICB's payroll.

The following senior officers are not employed by the ICB and receive no remuneration from the ICB for their role as Board members:

Name	Position
Ken Bremner	Foundation Trust Partner Member
Dr Rajesh Nadkarni	Foundation Trust Partner Member
Tom Hall	Local Authority Partner Member
John Pearce	Local Authority Partner Member (until 31 December 2025)

The following senior officers were employed in multiple roles during the period. The remuneration shown above for these individuals represents only that relating to their role as Board members. The total remuneration earned by each individual for all work across the ICB in 2025/26 is shown below:

Name	Position	2025/26		
		Salary (bands of £5,000) £000	Expense payments (taxable) (to nearest £100) £	Total (bands of £5,000) £000
Dr Saira Malik	Primary Medical Services Partner Member	75 - 80	-	75 - 80
Dr Mike Smith	Primary Medical Services Partner Member	50 - 55	-	50 - 55
Jon Rush	Independent Non-Executive Member (until 22 May 2025)	0 - 5	-	0 - 5

Kelly Angus, Chief People Officer, was employed in multiple roles across the ICB, North Cumbria Integrated Care NHS Foundation Trust (NCIC) and NHS England during the year as follows:

- 1 April 2025 to 30 June 2025: 60% ICB and 40% NHS England
- 1 July 2025 to 31 August 2025: 100% NHS England
- 1 September 2025 to 31 October 2025: 10% ICB, 40% NHS England and 50% NCIC
- 1 November 2025 to 31 March 2026: 100% NCIC

The costs shown in the salaries and allowances table above reflect only the costs to the ICB for the year.

NENC ICB senior officers' pension benefits - 2025/26 [subject to audit]:

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2026 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2025	(f) Real increase in Cash Equivalent Transfer value	(g) Cash Equivalent Transfer Value at 31 March 2026	(h) Employer's contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Sam Allen Chief Executive	2.5 - 5	-	95 - 100	225 - 230	1,940	58	2,032	-
Kelly Angus Chief People Officer (<i>secondment 1 November 2025 to 31 March 2026</i>)	12.5 - 15	35 - 37.5	65 - 70	175 - 180	1,243	305	1,569	-
Levi Buckley Chief Delivery Officer	2.5 - 5	2.5 - 5	70 - 75	180 - 185	1,545	76	1,643	-
David Chandler Chief Finance Officer	2.5 - 5	2.5 - 5	75 - 80	195 - 200	1,719	93	1,835	-
Professor Graham Evans Chief Digital and Infrastructure Officer (<i>until 30 June 2025</i>)	-	-	40 - 45	120 - 125	139	-	-	-
Dave Gallagher Chief Procurement and Contracting Officer	2.5 - 5	2.5 - 5	95 - 100	250 - 255	172	35	226	-
Hilary Lloyd Chief Nurse and AHP Officer	7.5 - 10	10 - 12.5	90 - 95	225 - 230	2,024	-	240	-
Jacqueline Myers Chief Strategy Officer	5 - 7.5	5 - 7.5	65 - 70	155 - 160	1,331	102	1,456	-
Dr Neil O'Brien Chief Medical Director	2.5 - 5	0 - 2.5	35 - 40	60 - 65	665	51	741	-
Claire Riley Chief Corporate Services Officer	2.5 - 5	0 - 2.5	35 - 40	70 - 75	726	49	796	-

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2026 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2025	(f) Real increase in Cash Equivalent Transfer value	(g) Cash Equivalent Transfer Value at 31 March 2026	(h) Employer's contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Dr Saira Malik Primary Medical Services Partner Member	2.5 - 5	5 - 7.5	20 - 25	50 - 55	397	52	456	-
Dr Mike Smith Primary Medical Services Partner Member	0 - 2.5	-	15 - 20	-	212	9	225	-

Note – Negative values are not disclosed in this table but are substituted with a zero.

Accrued pension benefits included in this table for any individual affected by the Public Service Pensions Remedy have been calculated based on their inclusion in the legacy scheme for the period between 1 April 2015 and 31 March 2022, following the McCloud judgment. The Public Service Pensions Remedy applies to individuals that were members, or eligible to be members, of a public service pension scheme on 31 March 2012 and were members of a public service pension scheme between 1 April 2015 and 31 March 2022. The basis for the calculation reflects the legal position that impacted members have been rolled back into the relevant legacy scheme for the remedy period and that this will apply unless the member actively exercises their entitlement on retirement to decide instead to receive benefits calculated under the terms of the Alpha scheme for the period from 1 April 2015 to 31 March 2022.

NENC ICB senior officers' pension benefits comparative figures for 2024/25:

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2025 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2024	(f) Real increase in Cash Equivalent Transfer value	(g) Cash Equivalent Transfer Value at 31 March 2025	(h) Employer's contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Sam Allen Chief Executive	5 - 7.5	5 - 7.5	90 - 95	220 - 225	1,761	114	1,908	-
Kelly Angus Interim Chief People Officer <i>From 28/10/2024</i>	2.5 - 5	5 - 7.5	50 - 55	140 - 145	1,037	62	1,222	-
Levi Buckley Chief Delivery Officer	5 - 7.5	107.5 - 110	65 - 70	170 - 175	1,071	427	1,519	-
David Chandler Chief Finance Officer	0 - 2.5	-	70 - 75	190 - 195	1,636	33	1,691	-
Professor Graham Evans Chief Digital and Infrastructure Officer	2.5 - 5	-	45 - 50	115 - 120	72	43	137	-
Ann Fox Interim Chief Nurse and AHP Officer <i>From 01/11/2024 to 02/02/2025</i>	-	-	-	-	-	-	-	1
Dave Gallagher Chief Procurement and Contracting Officer	0 - 2.5	-	90 - 95	245 - 250	115	34	169	-
Hilary Lloyd Chief Nurse and AHP Officer <i>From 03/02/2025</i>	0 - 2.5	2.5 - 5	80 - 85	210 - 215	1,733	36	1,990	-
Jacqueline Myers Chief Strategy Officer	2.5 - 5	-	55 - 60	145 - 150	1,253	35	1,309	-
Dr Neil O'Brien Chief Medical Director	2.5 - 5	-	30 - 35	60 - 65	599	31	654	-

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2025 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2024	(f) Real increase in Cash Equivalent Transfer value	(g) Cash Equivalent Transfer Value at 31 March 2025	(h) Employer's contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
David Purdue Chief Nurse, AHP and People Officer <i>Until 31/10/2024</i>	-	-	80 - 85	225 - 230	2,118	-	137	-
Claire Riley Chief Corporate Services Officer	2.5 - 5	-	30 - 35	70 - 75	663	31	714	-
Dr Saira Malik Primary Medical Services Partner Member	2.5 - 5	0 - 2.5	20 - 25	45 - 50	353	30	391	-
Dr Mike Smith Primary Medical Services Partner Member	-	-	15 - 20	-	212	-	208	-

The tables above include only those senior managers who are members of the NHS pension scheme where the ICB made contributions to the scheme as an employer during the period.

The figures included above reflect total pension benefits accrued within the NHS Pension Scheme, not just those accrued from employment within the ICB. No lump sum is shown for employees who only have membership in the 2008 section of the NHS Pension Scheme. No cash equivalent transfer value (CETV) is shown for pensioners or senior managers above normal pension age. The real increase figures shown above relate only to the period each individual was in post as a senior officer.

Cash Equivalent Transfer Values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

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

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

Real Increase in Cash Equivalent Transfer Values

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

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

No compensation has been paid by the ICB during the year for early retirement (2024/25: none).

One exit package was agreed during the year for voluntary redundancy of a senior officer as shown below (2024/25: none):

Name	Position	Cost of voluntary redundancy (£)
Dave Gallagher	Chief Procurement and Contracting Officer	37,570

This exit package was agreed during the year but will not be paid until 2026/27 after the individual's employment ends and is not included within the table of salaries and allowances for 2025/26.

Payments to past directors

No payments have been made by the ICB to past directors (2024/25: none).

Staff Report

Number of senior managers

The ICB had 21 senior officers (board members) during the year which are listed in the remuneration report.

Staff numbers and costs (subject to audit)

Details of staffing costs for the year and the average number of employees can be found in notes 3.1 and 3.2 of the financial statements, respectively. The increase in staff numbers and costs during the year includes the transfer of around 300 staff from NECS to the ICB on 1 April 2025 as part of the 'in-housing' of commissioning support unit services.

Staff composition

The ICB staff gender profile is given in the table below. This reflects our gender representation of all ICB staff.

	Female	Male
Board members - headcount	7	14
Total employees – headcount	796	207

Sickness absence data

The ICB has an agreed policy on the management of staff absence which ensures all staff are treated fairly and equitably, with the relevant support from line managers and People Business Partners. The ICB also has access to occupational health services and an employee assist programme.

The ICB sickness absence rate was 5.12%.

Staff turnover percentages

The staff turnover for the ICB was 12.00%

Staff engagement percentages

The ICB staff survey has been undertaken in this reporting period with a 77% response rate from staff.

Staff policies

The ICB has a suite of staff policies in place. The ICB has taken positive steps throughout the reporting period to maintain and develop the provision of information to, and consultation with employees, including:

NENC ICB Staff Policies

Policy number	Policy / Version
NENC ICB HR01	Equality, Diversity and Inclusion

Policy number	Policy / Version
NENC ICB HR02a	Supporting Attendance
NENC ICB HR02b	Addiction and Dependency
NENC ICB HR02c	Mental Wellbeing and the Workplace
NENC ICB HR02d	Menopause Policy
NENC ICB HR03	Education, Training, Learning and Development
NENC ICB HR03b	Incremental Pay Progression
NENC ICB HR04	Work Life Balance
NENC ICB HR05	Annual Leave Policy
NENC ICB HR06	Family Policy
NENC ICB HR06A	Adoption Leave Policy
NENC ICB HR06B	Maternity Leave
NENC ICB HR06C	Parental Leave Policy
NENC ICB HR06D	Paternity Leave Policy
NENC ICB HR06E	Shared Parental Leave
NENC ICB HR06F	Pregnancy and Baby Loss
NENC ICB HR06G	Statutory Neonatal Care Leave
NENC ICB HR06H	Fertility Policy
NENC ICB HR07	Recruitment
NENC ICB HR07a	Recruitment and Retention Premium
NENC ICB HR09	Working Time Directive Policy
NENC ICB HR10	Induction and Probation
NENC ICB HR11	Special Leave
NENC ICB HR11a	Compassionate Leave
NENC ICB HR11b	Carers Leave
NENC ICB HR12	Secondment Policy

Policy number	Policy / Version
NENC ICB HR13	Freedom to Speak Up
NENC ICB HR14	Travel and Expenses
NENC ICB HR15	Managing Conduct and Concerns
NENC ICB HR15a	Sexual Misconduct
NENC ICB HR16	Managing Allegations Against Staff
NENC ICB HR17	Managing Work Performance
NENC ICB HR18	Respect at Work
NENC ICB HR19	Grievance and Resolution
NENC ICB HR20	Professional Registration Policy
NENC ICB HR21	Job Evaluation
NENC ICB HR22	Organisational Change
NENC ICB HR22A	Redeployment Policy
NENC ICB HR23	Domestic Abuse and the Workplace
NENC ICB HR24	Retirement Policy
NENC ICB HR25	Armed Forces, Reserves & Cadets
NENC ICB HR26	Secondary Employment
NENC ICB HR52	Pay Protection
HR18	Appraisal Policy
HR45	Work Experience Policy

Other employee matters

The ICB is committed to equality of opportunity for all employees and is committed to employment practices, policies and procedures which ensure that no employee, or potential employee, receives less favourable treatment on the grounds of gender, race, colour, ethnic or national origin, sexual orientation, marital status, religion or belief, age, trade union membership, disability, offending background, domestic circumstances, social and employment status, HIV status, gender reassignment, political affiliation or any other personal characteristic.

Diversity is viewed positively and, in recognising that everyone is different, the unique contribution that everyone's experience, knowledge and skills can make is valued equally.

Expenditure on consultancy

Details of expenditure on consultancy services can be found in note 4 of the financial statements. For 2025/26, the value of consultancy services expenditure is £90k (2024/25: £387k).

Off-payroll engagements

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as at 31 March 2026 for more than £245 per day:

	Number
Number of existing engagements as of 31 March 2026	15
Of which, the number that have existed:	
for less than one year at the time of reporting	5
for between one and two years at the time of reporting	-
for between 2 and 3 years at the time of reporting	1
for between 3 and 4 years at the time of reporting	6
for 4 or more years at the time of reporting	3

All existing off-payroll engagements have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

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

For all off-payroll engagements between 1 April 2025 and 31 March 2026, for more than £245 per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2025 and 31 March 2026	15
Of which:	
No. not subject to off-payroll legislation ⁽¹⁾	-
No. subject to off-payroll legislation and determined as in-scope of IR35 ⁽¹⁾	-
No. subject to off-payroll legislation and determined as out of scope of IR35 ⁽¹⁾	15
the number of engagements reassessed for compliance or assurance purposes during the year	-

Of which: no. of engagements that saw a change to IR35 status following review	-

⁽¹⁾ A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: Off-payroll engagements of Board members / senior officials

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	-
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements.	21

Exit packages, including special (non-contractual) payments [subject to audit]

Table 1 below details exit packages agreed in the year. There were no exit packages agreed in 2024/25.

Table 1: Exit Packages for the year ended 31 March 2026

Exit package cost band (inc. any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	1	7,295	6	39,150	7	46,445	-	-
£10,000 - £25,000	12	193,636	36	646,743	48	840,379	-	-
£25,001 - £50,000	6	222,015	31	1,074,901	37	1,296,916	-	-
£50,001 - £100,000	8	548,625	30	2,212,412	38	2,761,037	-	-
£100,001 - £150,000	3	359,436	10	1,322,021	13	1,681,457	-	-
£150,001 –£200,000	1	153,333	13	2,073,931	14	2,227,264	-	-
>£200,001	-	-	-	-	-	-	-	-
TOTALS	31	1,484,340	126	7,369,158	157	8,853,498	-	-

This table reports the number and value of exit packages agreed in the financial year ended 31 March 2026. All exit packages shown above related to the restructure of the ICB in response to the national requirement to reduce ICB costs of commissioning down to £19 per head of population by 2026/27.

All redundancy costs have been paid in accordance with Agenda for Change requirements, contractual requirements, or statutory provisions as appropriate. Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

One exit package related to a senior officer included within the remuneration report. Refer to remuneration report for further details.

Table 2: Analysis of Other Departures for the year ended 31 March 2026

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	126	7,369
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval	-	-
TOTAL	126	7,369

All 'other departures' relate to voluntary redundancies agreed during the year ended 31 March 2026 under the ICB's voluntary redundancy scheme which was approved by NHS England.

Parliamentary Accountability and Audit Report

The ICB is not required to produce a Parliamentary Accountability and Audit Report.

The ICB has no disclosures remote contingent liabilities, gifts and fees and charges. Relevant disclosure on losses and special payments can be found in note 19 of the financial statements.

An audit report is also included in this annual report on page 188 onwards.

ANNUAL ACCOUNTS

NHS North East and North Cumbria ICB Financial Statements for the year ended 31 March 2026

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NHS North East and North Cumbria ICB - Financial Statements for the year ended 31 March 2026

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

	Note	2025/26 £000	2024/25 £000
Income from sale of goods and services	2	(107,155)	(103,655)
Other operating revenue	2	(2,383)	(2,365)
Total operating income		(109,538)	(106,020)
Employee benefits	3.1	79,844	47,594
Purchase of goods and services	4	9,424,748	8,171,018
Depreciation	4	434	569
Other operating expenses	4	1,008	522
Total operating expenditure		9,506,034	8,219,703
Finance costs	6	33	33
Net operating costs for the financial year		9,396,529	8,113,716
Comprehensive net expenditure for the year		9,396,529	8,113,716

NHS North East and North Cumbria ICB - Financial Statements for the year ended 31 March 2026

Statement of Financial Position as at 31 March 2026

	Note	31 March 2026 £000	31 March 2025 £000
Non-current assets			
Right of use assets	8	3,743	3,219
Total non-current assets		3,743	3,219
Current assets			
Contract and other receivables	9	35,036	47,751
Cash	10	2,554	779
Total current assets		37,590	48,530
Total assets		41,333	51,749
Current liabilities			
Trade and other payables	11	(549,223)	(493,069)
Lease liabilities	8	(504)	(437)
Total current liabilities		(549,727)	(493,506)
Total assets less current liabilities		(508,394)	(441,757)
Non-current liabilities			
Lease liabilities	8	(3,322)	(2,841)
Total non-current liabilities		(3,322)	(2,841)
Assets less Liabilities		(511,716)	(444,598)
Financed by taxpayers' equity			
General fund		(511,716)	(444,598)
Total taxpayers' equity		(511,716)	(444,598)

The notes on pages 168 to 187 of the Annual Report form part of this statement.

The financial statements on pages 164 to 167 were approved and authorised for issue by the Board on 16 June 2026 and signed on its behalf by:

Samantha Allen
Chief Executive of North East and North Cumbria Integrated Care Board

Accountable Officer
xx June 2026

NHS North East and North Cumbria ICB - Financial Statements for the year ended 31 March 2026

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

	General fund £000	Total reserves £000
Changes in taxpayers' equity for the year to 31 March 2026:		
Balance at 1 April 2025	(444,598)	(444,598)
Changes in ICB taxpayers' equity for the year to 31 March 2026		
Net operating costs for the financial year	(9,396,529)	(9,396,529)
Net recognised ICB expenditure for the financial year	(9,396,529)	(9,396,529)
Net funding	9,329,411	9,329,411
Balance at 31 March 2026	(511,716)	(511,716)
	General fund £000	Total reserves £000
Changes in taxpayers' equity for the year to 31 March 2025:		
Balance at 1 April 2024	(512,997)	(512,997)
Changes in ICB taxpayers' equity for the year to 31 March 2025		
Net operating costs for the financial year	(8,113,716)	(8,113,716)
Net recognised ICB expenditure for the financial year	(8,113,716)	(8,113,716)
Net funding	8,182,115	8,182,115
Balance at 31 March 2025	(444,598)	(444,598)

NHS North East and North Cumbria ICB - Financial Statements for the year ended 31 March 2026

Statement of Cash Flows for the year ended 31 March 2026

	Note	2025/26 £000	2024/25 £000
Cash flows from operating activities			
Net operating costs for the financial year		(9,396,529)	(8,113,716)
Depreciation	4	434	569
Interest paid	6	33	33
Decrease / (increase) in contract and other receivables	9	12,714	(28,702)
Increase / (decrease) in trade and other payables	11	56,154	(40,343)
Net cash outflow from operating activities		(9,327,194)	(8,182,159)
Net cash outflow before financing		(9,327,194)	(8,182,159)
Cash flows from financing activities			
Grant in aid funding received		9,329,411	8,182,115
Repayment of lease liabilities	8	(442)	(607)
Net cash inflow from financing activities		9,328,969	8,181,508
Net increase / (decrease) in cash	10	1,775	(651)
Cash at the beginning of the financial year		779	1,430
Cash at the end of the financial year		2,554	779

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards (ICB) shall meet the accounting requirements of the Department of Health and Social Care's Group Accounting Manual, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2025 to 2026. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to ICBs, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of certain financial assets and financial liabilities to fair value when appropriate.

1.3 Pooled Budgets

Where the ICB has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006, the ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. The ICB has assessed that joint control does not exist for any of these arrangements, refer to note 16 for further details.

1.4 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.4.1 *Critical Judgements in Applying Accounting Policies*

Management have not made any other critical judgements in the process of applying the ICB's accounting policies that would be expected to have a significant effect on the amounts recognised in the financial statements.

1.4.2 *Key Sources of Estimation Uncertainty*

Management have not made any assumptions about the future and other major sources of estimation uncertainty that would have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

1.5 Operating Segments

Management have assessed and determined that one segment being the commissioning of healthcare services operates within the ICB, this is in line with management information used within the ICB.

An analysis of both the income and expenditure and net assets relating to the segment can be found in the Statement of Comprehensive Net Expenditure and Statement of Financial Position respectively.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.6 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- the ICB is not required to disclose information regarding performance obligations that are part of a contract that has an original expected duration of one year or less;
- the ICB is not required to disclose information where revenue is recognised in line with the practical expedient offered in the Standard, where the right to consideration corresponds directly with the value of the performance completed to date.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

The main sources of income in the ICB are prescription fees and charges and dental fees and charges.

1.7 Employee Benefits

1.7.1 Short-term Employee Benefits

Salaries, wages and employment-related payments including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including non-consolidated performance pay earned but not yet paid.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.7.2 Retirement Benefit Costs

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

For early retirements other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

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

1.8 Other Expenses

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

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the ICB recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.9 Leases

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration. The ICB assesses whether a contract is or contains a lease, at inception of the contract.

1.9.1 The ICB as Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

Lease payments included in the measurement of the lease liability comprise

- Fixed payments;
- Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
- The amount expected to be payable under residual value guarantees;
- The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
- Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use. Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

The ICB considers all of its right-of-use assets to be low value or short term and accordingly employs the depreciated historical cost model for subsequent measurement of the right-to-use assets, as an appropriate proxy for current value in existing use or fair value.

The right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.10 Cash

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

Cash and bank balances are recorded at current values.

1.11 Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the ICB.

NHS Resolution carries in its books £300k of provisions in regard to clinical negligence claims as at 31 March 2026, on behalf of the ICB.

1.12 Non-clinical Risk Pooling

The ICB participates in the Properties Expenses Scheme and Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims, are charged to operating expenses as and when they become due.

1.13 Contingent liabilities

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

Where the time value of money is material, contingencies are disclosed at their present value.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.14 Financial Assets

Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred and the ICB has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income;
- Financial assets at fair value through profit and loss;

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

All ICB assets have been classified as financial assets at amortised cost.

1.14.1 Financial Assets at Amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.14.2 Impairment of financial assets

For all financial assets measured at amortised cost, lease receivables and contract assets, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.

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

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

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

1.15 Financial Liabilities

Financial liabilities are recognised on the Statement of Financial Position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished, that is, the obligation has been discharged or cancelled or has expired.

After initial recognition, all financial liabilities are measured at amortised cost using the effective interest method, except for loans from the Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.16 Value Added Tax

Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.17 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.18 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

- IFRS 18: Presentation and Disclosure in Financial Statements (application from 1 January 2027). The Standard is not yet UK endorsed and not yet adopted by the FREM. Early adoption is not therefore permitted
- IFRS 19: Subsidiaries without public accountability (application from 1 January 2027). The Standard is not yet UK endorsed and not yet adopted by the FREM. Early adoption is therefore not permitted.

The application of the Standards as revised would not have a material impact on the accounts for 2025/26, were they applied in that year.

NHS North East and North Cumbria ICB - Financial Statements for the year ended 31 March 2026

Notes to the financial statements (continued)

2. Operating Income

	2025/26 Total £'000	2024/25 Total £'000
Income from sale of goods and services (contracts)		
Prescription fees and charges	54,280	53,504
Dental fees and charges	52,875	50,138
Other contract income	-	13
Total Income from sale of goods and services	107,155	103,655
Other operating revenue		
Other non contract revenue	2,383	2,365
Total other operating revenue	2,383	2,365
Total operating Income	109,538	106,020

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the ICB and credited to the General Fund.

NHS North East and North Cumbria ICB - Financial Statements for the year ended 31 March 2026

Notes to the financial statements (continued)

3. Employee benefits and staff numbers

3.1 Employee benefits

	2025/26			2024/25		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee benefits:						
Salaries and wages	52,191	50,921	1,270	36,028	35,151	877
Social security costs	7,547	7,547	-	3,926	3,926	-
Employer contributions to NHS Pension scheme	11,016	11,016	-	7,477	7,477	-
Other pension costs	10	10	-	8	8	-
Apprenticeship levy	227	227	-	155	155	-
Termination benefits	8,853	8,853	-	-	-	-
Gross employee benefits expenditure	79,844	78,574	1,270	47,594	46,717	877

No amounts were recovered in respect of employee benefits and no employee benefits were capitalised during the year (2024/25: none).

3.2 Average number of people employed

	2025/26			2024/25		
	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Total	904	891	13	560	551	9

None of the above people were engaged on capital projects (2024/25: none).

3.3 Exit packages agreed in the financial year

	2025/26		2025/26		2025/26	
	Compulsory redundancies		Other agreed departures		Total	
	Number	£	Number	£	Number	£
Less than £10,000	1	7,295	6	39,150	7	46,445
£10,001 to £25,000	12	193,636	36	646,743	48	840,379
£25,001 to £50,000	6	222,015	31	1,074,901	37	1,296,916
£50,001 to £100,000	8	548,625	30	2,212,412	38	2,761,037
£100,001 to £150,000	3	359,436	10	1,322,021	13	1,681,457
£150,001 to £200,000	1	153,333	13	2,073,931	14	2,227,264
Over £200,001	-	-	-	-	-	-
Total	31	1,484,340	126	7,369,158	157	8,853,498

No exit packages were agreed during 2024/25.

3.4 Analysis of Other Agreed Departures

	2025/26		2024/25	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	126	7,369,158	-	-
Total	126	7,369,158	-	-

All exit packages agreed during 2025/26 related to the restructure of the ICB in response to the national requirement to reduce ICB costs of commissioning down to £19 per head of population by 2026/27.

All redundancy costs have been paid in accordance with Agenda for Change requirements, contractual requirements or statutory provisions as appropriate.

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

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

3.5 Ill-Health Retirements

There have been no ill health retirements during 2025/26. (2024/25: 3 ill health retirements £537,285).

Notes to the financial statements (continued)

3. Employee benefits and staff numbers (continued)

3.6 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/Pensions.

Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded, defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care, in England and Wales. The Schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each Scheme is accounted for as if it were a defined contribution scheme: the cost to the ICB of participating in the Scheme is taken as equal to the contributions payable to that Scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FREM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

3.6.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FREM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

3.6.2 Full actuarial (funding) valuation

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

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

The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

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

The value of employers contributions to the NHS pension scheme for the next annual reporting period is estimated to be £9.6m (2024/25 for the next annual reporting period: £10.7m).

NHS North East and North Cumbria ICB - Financial Statements for the year ended 31 March 2026

Notes to the financial statements (continued)

4. Operating expenses

	2025/26 £000	2024/25 £000
Purchase of goods and services		
Purchase of healthcare from NHS and DHSC bodies:		
· other ICBs and NHS England	17,759	37,892
· foundation trusts	6,182,517	5,125,142
· other NHS trusts	39,643	34,192
· other WGA bodies	1	2
Purchase of healthcare from non-NHS bodies	1,170,173	1,071,245
Purchase of social care	173,737	158,430
General dental services and personal dental services	229,755	216,045
Prescribing costs	646,350	634,949
Pharmaceutical services	174,497	147,383
General ophthalmic services	33,175	32,442
Primary Medical Services Costs (GPMS/APMS and PCTMS)	713,687	663,543
Supplies and services – clinical	12,009	12,078
Supplies and services – general	2,497	2,911
Consultancy services	90	388
Establishment	6,928	6,954
Transport	379	90
Premises	17,058	21,997
Audit fees	264	244
Other non statutory audit expenditure		
· Other services	-	42
Internal audit expenditure	303	303
Other professional fees	2,105	1,941
Legal fees	1,684	1,865
Education and training	137	940
Total Purchase of goods and services	9,424,748	8,171,018
Depreciation and impairment charges		
Depreciation	434	569
Total Depreciation and impairment charges	434	569
Other operating expenses		
Chair and Non Executive Members	194	217
Grants to Other bodies	300	-
Clinical negligence	17	14
Research and development (excluding staff costs)	90	-
Expected credit loss on receivables	406	291
Other expenditure	1	-
Total other operating expenses	1,008	522
Total operating expenses	9,426,190	8,172,109

The total of £264k under Audit Fees consists of:

- Forvis Mazars LLP's Audit Fee of £264k (including VAT at 20%) for the ICB's 2025/26 External Audit (2024/25: £244k including VAT for audit fee and additional work).

- In 2024/25, other non statutory audit expenditure included £42k for Mental Health Investment Standard (MHIS) review fees this does not apply in 2025/26 due to the change in MHIS reporting now part of the statutory accounts disclosure.

NHS North East and North Cumbria ICB - Financial Statements for the year ended 31 March 2026

Notes to the financial statements (continued)

5. Better Payment Practice Code

Measure of compliance	2025/26 Number	2025/26 £000	2024/25 Number	2024/25 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the year	165,305	2,128,003	163,038	2,061,888
Total Non-NHS Trade invoices paid within target	164,670	2,119,769	161,262	2,047,254
Percentage of Non-NHS Trade invoices paid within target	99.62%	99.61%	98.91%	99.29%
NHS Payables				
Total NHS Trade invoices paid in the year	5,841	6,212,409	4,321	5,240,732
Total NHS Trade invoices paid within target	5,818	6,212,175	4,306	5,240,570
Percentage of NHS Trade invoices paid within target	99.61%	100.00%	99.65%	100.00%

The Better Payment Practice Code requires the payment of all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

The ICB is deemed to be compliant if it pays at least 95% of invoices within 30 days of receipt, or within agreed contract terms.

6. Finance costs

	2025/26 £000	2024/25 £000
Interest		
Interest on lease liabilities	33	33
Total finance costs	33	33

7. Mental Health Expenditure

	2025/26 £000	2024/25 £000
Minimum expenditure in mental health services to meet the Mental Health Investment Standard as notified by NHS England	936,914	734,451
Eligible mental health expenditure	938,457	735,273
Mental health expenditure above / (below) minimum investment required	1,543	822
Mental health expenditure as a proportion of total expenditure (%)	10%	9%

The ICB has reported achievement of the MHIS for the 12 months to 31 March 2026.

Mental Health expenditure represents 10% of the ICBs total net expenditure for 2025/26 (2024/25: 9%). From 1st April 2025, specialised commissioning was delegated to the ICB and its share of eligible Mental Health expenditure of £111m against the investment standard target of £110m is included within the table above and contributes to the increase from 2024/25.

NHS North East and North Cumbria ICB - Financial Statements for the year ended 31 March 2026

Notes to the financial statements (continued)

8. Leases

8.1 Right of use assets

	2025/26 Buildings Total £000	2024/25 Buildings Total £000
Cost at 1 April	5,130	5,130
Additions	957	-
Cost at 31 March	6,087	5,130
Depreciation at 1 April	(1,911)	(1,342)
Charged during the year	(433)	(569)
Depreciation at 31 March	(2,344)	(1,911)
Net Book Value at 31 March	3,743	3,219
Net Book Value by Counterparty:		
Leased from other group bodies	3,743	3,219

8.2 Lease liabilities

	2025/26 £000	2024/25 £000
Lease liabilities at 1 April	(3,278)	(3,852)
Additions	(957)	-
Interest expense relating to lease liabilities	(33)	(33)
Repayment of lease liabilities (including interest)	442	607
Lease liabilities at 31 March	(3,826)	(3,278)

8.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	31 March 2026 £000	31 March 2025 £000
Within one year	(514)	(442)
Between one and five years	(1,964)	(1,497)
After five years	(1,748)	(1,505)
Balance at 31 March	(4,226)	(3,444)
Effect of discounting	399	166
Included in:		
Current lease liabilities	(504)	(437)
Non-current lease liabilities	(3,322)	(2,841)
Balance at 31 March	(3,826)	(3,278)

8.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	2025/26 £000	2024/25 £000
Depreciation expense on right-of-use assets	434	569
Interest expense on lease liabilities	33	33
Expense relating to short-term leases	282	254

8.5 Amounts recognised in Statement of Cashflows

	2025/26 £000	2024/25 £000
Total cash outflow on leases under IFRS 16	(442)	(607)

NHS North East and North Cumbria ICB - Financial Statements for the year ended 31 March 2026

Notes to the financial statements (continued)

9. Contract and other receivables

	Current 31 March 2026 £000	Current 31 March 2025 £000
NHS receivables: Revenue	9,329	18,748
NHS accrued income	-	33
Non-NHS and Other WGA receivables: Revenue	13,353	13,746
Non-NHS and Other WGA prepayments	4,061	3,795
Non-NHS and Other WGA accrued income	8,983	11,885
Expected credit loss allowance - receivables	(1,686)	(1,331)
VAT	943	853
Other receivables	53	22
Total contract and other receivables	35,036	47,751

The great majority of trade is with other NHS bodies, including other ICBs as commissioners for NHS patient care services. As ICBs are funded by Government to commission NHS patient care services, no credit scoring of them is considered necessary.

9.1 Receivables past their due date but not impaired

	31 March 2026 £000	31 March 2025 £000
By up to three months	2,155	1,456
By three to six months	896	62
By more than six months	1,424	957
Total	4,475	2,475

£1,357k of the amount above has subsequently been recovered post the Statement of Financial Position date.

The ICB did not hold any collateral against receivables outstanding at 31 March 2026 (31 March 2025: none).

	2025/26 Contract and other receivables - Non DHSC Group	2024/25
	Bodies £000	Total £000
Balance at 1 April	(1,331)	(1,072)
Lifetime expected credit losses on contract and other receivables-Stage 2	(406)	(291)
Amounts written off	51	32
Allowance for credit losses at 31 March	(1,686)	(1,331)

The ICB has reviewed all receivables to determine whether an impairment value is required. In determining the recoverability of a receivable, the ICB considers any change in credit quality of the receivable from the date credit was initially granted up to the reporting date. The overall level of credit risk is considered to be relatively low due to the proportion of the customer base which is comprised of NHS bodies.

NHS North East and North Cumbria ICB - Financial Statements for the year ended 31 March 2026

Notes to the financial statements (continued)

10. Cash

	2025/26 £000	2024/25 £000
Balance at 1 April	779	1,430
Net change in period	1,775	(651)
Balance at 31 March	2,554	779
Made up of:		
Cash with the Government Banking Service	2,554	779
Cash as in Statement of Financial Position	2,554	779

The ICB held £nil cash at 31 March 2026 on behalf of patients (31 March 2025: none).

11. Trade and other payables

	Current 31 March 2026 £000	Current 31 March 2025 £000
NHS payables: revenue	2,946	5,651
NHS accruals	73,321	49,485
Non-NHS and Other WGA payables: Revenue	44,478	44,682
Non-NHS and Other WGA accruals	395,098	374,446
Social security costs	749	475
Tax	750	570
Other payables	31,881	17,760
Total trade and other payables	549,223	493,069

At 31 March 2026, the ICB had no liabilities due in future years under arrangements to buy out the liability for early retirement over 5 years (31 March 2025: none).

Other payables include £5,615k in respect of outstanding pension contributions at 31 March 2026 (31 March 2025: £5,074k).

12. Contingencies

During 2024, a joint procurement [the Procurement] was undertaken with 23 other ICBs for Primary Care Clinical Waste Collection and Disposal services. Each ICB procured an individual Lot/contract. Each contract was for an initial period of 5 years, with the option to extend for a further 4 years.

In December 2024, 9 of the ICBs, including NHS North East and North Cumbria ICB, published standstill letters with an intention to award a contract. During the subsequent standstill period, in December 2024 legal proceedings challenging the contract award decisions/outcomes of the Procurement were commenced by one of the unsuccessful bidders [the Claimant] against all 22 of the ICBs which remained involved in the Procurement [the Defendants] (2 ICBs having decided not to proceed).

During this financial year, a number of interim applications were submitted to the Court. Applications were made by the Defendants (considered together) to lift the automatic suspensions which had been invoked which precluded each Defendant from entering into a contract with its preferred bidder. Those applications were successful. An application was made by the Claimant, seeking expedition of the proceedings. That application was not successful.

The matter is now progressing. The Court has given directions leading up to a trial, which has been listed to begin in October 2027.

As the contracts have now been entered into, the remedy sought by the Claimant is that of damages. However, only very recently has the Claimant attempted to quantify those damages and it has acknowledged that any figure will need to be revisited prior to trial. Given that this is the case, and given that the Defendants have not yet had the opportunity to properly interrogate the figures advanced by the Claimant, it is not possible to estimate the financial impact of the claim being successful with any level of certainty. It is also not possible, at this stage, to accurately determine the probability of success by the Claimant. Given the uncertainty of both of these key components, NHS North East and North Cumbria ICB is classifying this claim as a contingent liability.

Notes to the financial statements (continued)

13. Commitments

There were no contracted or non-cancellable contracts entered into by the ICB at 31 March 2026 which are not otherwise included in these financial statements (31 March 2025: none).

14. Financial instruments

14.1 Financial risk management

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

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

Treasury management operations are carried out by the finance department, within parameters defined formally within the ICB's standing financial instructions and policies agreed by the Integrated Care Board. Any treasury activity would be subject to review by the ICB's internal auditors.

14.1.1 Currency risk

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

14.1.2 Interest rate risk

The ICB has no borrowings and has only limited powers to borrow funds from government for capital expenditure, subject to affordability as confirmed by NHS England. The ICB therefore has low exposure to interest rate fluctuations.

14.1.3 Credit risk

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

14.1.4 Liquidity risk

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

14.1.5 Financial Instruments

As the cash requirements of the ICB are met through the estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with the ICB's expected purchase and usage requirements and the ICB is therefore exposed to little credit, liquidity or market risk.

NHS North East and North Cumbria ICB - Financial Statements for the year ended 31 March 2026

Notes to the financial statements (continued)

14. Financial instruments (continued)

14.2 Financial assets

	Financial Assets measured at amortised cost Total 31 March 2026 £000	Financial Assets measured at amortised cost Total 31 March 2025 £000
Contract and other receivables:		
· NHSE bodies	2,727	625
· Other DHSC group bodies	6,602	18,188
· External bodies	20,703	24,290
Cash	2,554	779
Total Financial assets	32,586	43,882

14.3 Financial liabilities

	Financial Liabilities measured at amortised cost Total 31 March 2026 £000	Financial Liabilities measured at amortised cost Total 31 March 2025 £000
Trade and other payables:		
· NHSE bodies	3,569	3,468
· Other DHSC group bodies	76,590	61,195
· External bodies	467,235	426,747
Lease liabilities	3,826	3,278
Total Financial liabilities	551,220	494,688

15. Operating segments

The ICB has considered the definition of an operating segment contained within IFRS 8 in determining its operating segments, in particular considering the internal reporting to the Integrated Care Board, considered to be the 'chief operating decision maker' of the ICB, which was used for the purpose of resource allocation and assessment of performance.

All activity performed by the ICB relates to its role as a commissioner of healthcare for its relevant population. As a result, the ICB considers that it has only one operating segment, being the commissioning of healthcare services.

An analysis of both the income and expenditure and net assets relating to the segment can be found in the Statement of Comprehensive Net Expenditure and Statement of Financial Position respectively.

NHS North East and North Cumbria ICB - Financial Statements for the year ended 31 March 2026

Notes to the financial statements (continued)

16. Pooled budgets

Individual pooled budget arrangements exist between the ICB and each of the 13 Local Authorities across the North East and Cumbria in respect of the Better Care Fund, through a section 75 agreement. The ICB contribution to the pooled budget was used to commission a range of health and social care services in line with the agreed objectives of the Better Care Fund. During 2025/26, the BCF agreements also include an allocation from the Adult Social Care Discharge Fund. This contribution to the Better Care Fund is recognised within the financial statements as ICB expenditure.

A number of other pooled budget arrangements exist with Local Authorities across the North East and Cumbria as set out below.

Management have assessed that joint control does not exist for any of these arrangements. The ICB's share of expenditure handled by the pooled budget in the financial period are shown below.

			Amount recognised in entity's books only 2025/26		Amount recognised in entity's books only 2024/25	
Name of arrangement	Parties to the arrangement	Description of Principal Activities	Income £000	Expenditure £000	Income £000	Expenditure £000
Better Care Fund	NENC ICB / Durham County Council	See note (1) below on Better Care Fund		62,595	-	61,647
Better Care Fund	NENC ICB - Northumberland County Council	See note (1) below on Better Care Fund		34,525	-	33,754
Better Care Fund	NENC ICB / South Tyneside Council	See note (1) below on Better Care Fund		19,621	-	27,806
Better Care Fund	NENC ICB / Sunderland City Council	See note (1) below on Better Care Fund		34,614	-	34,464
Better Care Fund	NENC ICB / Lancashire & South Cumbria ICB / Cumbria County Council	See note (1) below on Better Care Fund		36,296	-	36,138
Better Care Fund	NENC ICB / Newcastle Local Authority	See note (1) below on Better Care Fund		33,573	-	33,036
Better Care Fund	NENC ICB / Gateshead Local Authority	See note (1) below on Better Care Fund		23,267	-	22,945
Better Care Fund	NENC ICB / Darlington Borough Council	See note (1) below on Better Care Fund		11,135	-	11,006
Better Care Fund	NENC ICB / Stockton Council	See note (1) below on Better Care Fund		20,246	-	19,866
Better Care Fund	NENC ICB / Hartlepool Council	See note (1) below on Better Care Fund		10,740	-	10,447
Better Care Fund	NENC ICB / Redcar & Cleveland Council	See note (1) below on Better Care Fund		16,077	-	15,739
Better Care Fund	NENC ICB / Middlesbrough Council	See note (1) below on Better Care Fund		16,899	-	16,570
Better Care Fund	NENC ICB / North Tyneside MBC	See note (1) below on Better Care Fund		23,840	-	23,301
Children's Preventative Care	NENC ICB / Sunderland City Council	Children's Preventative Care and improving commissioning initiatives		3,386	-	2,882
Tees Community Equipment Service	NENC ICB / Middlesbrough Council / Hartlepool Council / Stockton Council / Redcar & Cleveland Council	Tees Community Equipment Service		1,420	-	1,377
Gateshead Equipment Service	NENC ICB / Gateshead Local Authority	Purchase of home loans equipment for Gateshead residents		-	-	1,906
Gateshead Carers	NENC ICB / Gateshead Local Authority	Carers Service		-	-	510
Section 75	NENC ICB / South Tyneside Council	Care of Learning Disability Clients		-	-	13,126
Section 75	NENC ICB / South Tyneside Council	Delivery of legal advice in respect to CHC, Joint packages and S117		-	-	30
Section 75	NENC ICB / South Tyneside Council	Equipment Store		-	-	1,082
Section 76	NENC ICB / South Tyneside Council	Joint Commissioning Unit		-	-	410

(1) The Better Care Fund is a Section 75 Agreement designed to integrate health and social care services, reduce hospital based care and promote community based services.

NHS North East and North Cumbria ICB - Financial Statements for the year ended 31 March 2026

Notes to the financial statements (continued)

17. Related party transactions

During 2025/26, the ICB has undertaken transactions with the following Integrated Care Board members or members of the key management staff, or parties related to any of them:

Integrated Care Board Members	Declaration	Related Party	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
S Allen Chief Executive	Board Member	Health Innovations NENC (formerly Academic Health Sciences Network)	15,652	-	283	-
D Chandler Chief Finance Officer	Trustee of HFMA and Northern Branch chair	HFMA	12	-	2	-
Dr N O'Brien Chief Medical Officer	GP Partner	Cestria Health Centre	2,535	-	76	-
	Practice is a member	Chester-le-Street Primary Care Network	2,966	-	-	(10)
	Practice is a member	Chester-le-Street Health Ltd	89	-	4	-
	GP Partner	Coxhoe Medical Practice	1,435	-	-	-
L Buckley Chief Delivery Officer	Practice is a member	Central Durham GP Providers Ltd	393	-	4	-
	Partner is Chief Executive of Healthworks	Healthworks	120	-	37	(22)
D Gallagher Chief Contracting and Procurement Officer	Daughter is a partner and shareholder	Specsavers Peterlee & Seaham	758	-	-	-
C Riley Chief Corporate Services Officer	Trustee of Helpforce	Helpforce Charity	100	-	-	-
Dr M Smith Partner Member - PMS	GP Partner and PCN Clinical Director	Claypath & University Medical Group	5,238	-	-	-
	Practice is member	Central Durham GP Providers Ltd	393	-	4	-
Professor G Evans Chief Digital and Infrastructure Officer	Wife is a Trustee	Butterwick Hospice Trust	1,218	-	-	-
J Rush Partner Member - NHS	Trustee for Cumbria CVS	Cumbria CVS	338	-	-	-
J Pearce Local Authority Partner Member	LA Partner Member	Durham County Council	80,370	-	5,424	(162)
T Hall Local Authority Partner Member	LA Partner Member	South Tyneside Council	35,770	-	7,293	(14)
K Bremner Foundation Trust Partner Member	Board member	Health Innovations NENC (formerly Academic Health Sciences Network)	15,652	-	283	-

The Department of Health and Social Care (DHSC) is regarded as the parent department. During the period the ICB has had a significant number of material transactions with entities for which the DHSC is regarded as the parent Department. For example:

- NHS England;
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Resolution; and,
- NHS Business Services Authority.

In addition, the ICB has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Local Authorities across the North East and North Cumbria.

Notes to the financial statements (continued)

17. Related party transactions (continued)

During 2024/25, the ICB has undertaken transactions with the following Integrated Care Board members or members of the key management staff, or parties related to any of them:

Integrated Care Board Members	Declaration	Related Party	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
S Allen Chief Executive	Board Member	Health Innovations NENC (formerly Academic Health Sciences Network)	4,059	-	1,071	-
D Chandler Chief Finance Officer	Trustee of HFMA and Northern Branch chair	HFMA	6	-	2	(6)
Dr N O'Brien Chief Medical Officer	GP Partner	Cestria Health Centre	2,441	-	63	-
	Practice is a member	Chester-le-Street Primary Care Network	2,520	-	314	-
	Practice is a member	Chester-le-Street Health Ltd	1	-	1	-
	GP Partner	Coxhoe Medical Practice	1,335	-	30	-
	Practice is a member	Central Durham GP Providers Ltd	2,866	-	572	-
L Buckley Chief Delivery Officer	Partner is Chief Executive of Healthworks	Healthworks	392	-	-	-
Professor G Evans Chief Digital and Infrastructure Officer	Wife is a Trustee	Butterwick Hospice Trust	1,428	-	46	-
C Riley Chief Corporate Services Officer	Trustee of Helpforce	Helpforce Charity	40	-	-	-
Dr M Smith Partner Member - PMS	GP Partner and PCN Clinical Director	Claypath & University Medical Group	4,941	-	276	-
	Practice is member	Central Durham GP Providers Ltd	2,866	-	572	-
J Rush Partner Member - NHS	Trustee for Cumbria CVS	Cumbria CVS	511	-	-	-
J Pearce Local Authority Partner Member	LA Partner Member	Durham County Council	77,982	-	3,870	-
T Hall Local Authority Partner Member	LA Partner Member	South Tyneside Council	39,189	-	16,258	(14)
C McEvoy-Carr Local Authority Partner Member	LA Partner Member	Newcastle City Council	69,778	-	12,183	-
K Bremner Foundation Trust Partner Member	Board member	Health Innovations NENC (formerly Academic Health Sciences Network)	4,059	-	1,071	-

NHS North East and North Cumbria ICB - Financial Statements for the year ended 31 March 2026

Notes to the financial statements (continued)

18. Events after the end of the reporting period

There are no post balance sheet events which would have a material effect on the financial statements of the ICB.

19. Losses and special payments

There have been a total of nine losses recorded during the year for the total value of £51k, in relation to administrative write offs of eight aged debts and one salary overpayment. There has also been two special ex gratia payments made for the total value of £1k. In 2024/25 there were six losses recorded for the total value of £32k, in relation to administrative write offs of six aged debts. These amounts are reported on an accruals basis but excluding provisions for future losses.

20. Financial performance targets

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

The ICB's performance against those duties was as follows:

	2025/26 Target £000	2025/26 Performance £000	Duty Achieved?
Capital resource use does not exceed the amount specified in Directions	957	957	Yes
Revenue resource use does not exceed the amount specified in Directions	9,431,384	9,396,529	Yes
Revenue administration resource use does not exceed the amount specified in Directions	58,987	51,099	Yes

Prior year comparatives:

	2024/25 Target £000	2024/25 Performance £000	Duty Achieved?
Capital resource use does not exceed the amount specified in Directions	-	-	Yes
Revenue resource use does not exceed the amount specified in Directions	8,125,905	8,113,716	Yes
Revenue administration resource use does not exceed the amount specified in Directions	54,943	48,945	Yes

ICB financial performance is reported on an in-year basis. The figures within this note reflect only the in-year position, being the difference between the in-year allocation (plus any pre-approved surplus drawdown) and total expenditure.

The ICB received £957k capital resource during 2025/26 and incurred the equivalent capital expenditure in relation to IFRS16 lease for Pemberton House (2024/25: none).

Performance against the revenue expenditure duties is further analysed below:

	2025/26 Programme Resource £000	2025/26 Administration Resource £000	2025/26 Total £000
Revenue resource	9,372,397	58,987	9,431,384
Net operating cost for the financial year	9,345,430	51,099	9,396,529
Underspend against revenue resource	<u>26,967</u>	<u>7,888</u>	<u>34,855</u>

The ICB delivered an in-year surplus of £34,855k for 2025/26. This was planned in order to offset deficits within other organisations within the Integrated Care System.

Prior period comparatives:

	2024/25 Programme Resource £000	2024/25 Administration Resource £000	2024/25 Total £000
Revenue resource	8,070,962	54,943	8,125,905
Net operating cost for the financial year	8,064,771	48,945	8,113,716
Underspend against revenue resource	<u>6,191</u>	<u>5,998</u>	<u>12,189</u>

The ICB has delivered an in-year surplus of £12,189k for 2024/25. This was planned in order to offset deficits within other organisations within the Integrated Care System.

ICB Accounts for 12 months to 31 March 2026

ANNUAL ACCOUNTS BRIEFING NOTE

Introduction

All ICBs are required to prepare annual accounts. The accounts follow the requirements of the Group Accounting Manual (GAM) published by the Department of Health and Social Care and are based on a standard national template.

The accounts cover the financial year ended 31 March 2026. Comparative figures for the previous year are included.

The purpose of this briefing note is to provide a basic understanding of the ICB annual accounts for 2025/26, including explanation of any significant balances or movements for example.

An additional disclosure has been included in the accounts this year (note 7) relating to mental health expenditure (compliance with the mental health investment standard), which will be subject to audit. This was previously subject to its own separate independent review but from 2025/26 is to be included as a note to the accounts.

There have been no other significant changes to the form or content of the accounts since last year.

Content of the Accounts:

There are four 'primary statements' within the accounts:

- Statement of Comprehensive Net Expenditure (SoCNE);
- Statement of Financial Position ('balance sheet');
- Statement of Changes in Taxpayers' Equity; and
- Statement of Cash Flows.

In addition, there are a number of supporting notes to the accounts, including:

- Accounting Policies; and
- Additional analysis to support primary statements.

These are all explained in further detail below.

Statement of Comprehensive Net Expenditure (SoCNE) for the year ended 31 March 2026

The purpose of this statement is to summarise, on an accruals basis*, the net expenditure of the ICB. The statement identifies gross operating costs less miscellaneous income to arrive at the net operating costs of the ICB.

* The accruals basis means revenue and expenses are recorded when a transaction occurs, rather than when a payment is received or made (cash basis).

Note – the ICBs funding allocation received is not shown in this statement, hence it is to be expected that all ICBs will have significant net expenditure balances at the bottom of this statement.

The SoCNE is as follows:

		2025/26 £'000	2024/25 £'000
Income from sale of goods and services	<i>Any money received from other bodies (largely dental fees and prescription fees).</i>	(107,155)	(103,655)
Other operating revenue	<i>Note – this does not include the ICBs allocation received from NHS England.</i>	(2,383)	(2,365)
Total operating income		(109,538)	(106,020)
Employee benefits / Staff costs	<i>Pay costs in respect of staff directly employed by the ICB.</i>	79,844	47,594
Purchase of goods and services	<i>The cost of purchasing services from other providers of healthcare, including the provision of hospital care, cost of drugs and non NHS care (i.e. day to day running costs).</i>	9,424,748	8,171,018
Depreciation	<i>Estimated reduction in fixed asset values over the year</i>	434	569
Other operating costs	<i>Any other operating costs, including Chair and non-executives, miscellaneous costs.</i>	1,008	522
Total operating expenditure		9,506,034	8,219,703
Finance costs	<i>This reflects any interest charges on lease liabilities for example</i>	33	33
Total operating expenditure		9,396,529	8,113,716
Total Net Expenditure for the year		9,396,529	8,113,716

Expenditure in 2025/26 includes specialised commissioning budgets which were delegated to the ICB from 1 April 2025 (£788m) and contributes to the increase in total net expenditure since 2024/25. The remaining increase reflects growth funding and additional allocations received in 2025/26.

Other operating income / revenue:

This would include any miscellaneous revenue received by the ICB. It does not include the ICB's main funding allocation ('parliamentary funding') which does not appear in the Statement of Comprehensive Net Expenditure. The main funding allocation is drawn down directly into the ICB's bank account and credited to the General Fund (see Statement of Changes in Taxpayer's Equity).

The main operating income within the ICB is for prescriptions and dental fees and charges and totals £107m, the £3.5m increase from 2024/25 is mainly due to an increase in number of items issued.

Employee benefits:

This is the cost of the staff directly employed by the ICB, including salaries and wages, social security costs and pension costs. This is further analysed in the relevant note to the accounts (see below). The increase from prior year largely reflects the transfer of over 300 staff from NECS to the ICB from 1 April 2025, along with the impact of redundancy costs in 2025/26. Further detail is provided under note 3 below.

Depreciation:

Depreciation is the process of writing off the value of fixed (non-current) assets over their useful life. Expenditure on operating leases has now been replaced by interest on lease liabilities and depreciation on right-of-use assets.

The depreciation charge shown in the ICB accounts for the year reflects depreciation on these 'right-of-use' assets.

Other operating costs:

Essentially this includes all other non-staff costs, i.e. the cost of purchasing services from other providers of healthcare, including the provision of hospital care, cost of drugs and non NHS care. As a result, this represents the vast majority of the ICB's expenditure.

A detailed analysis of gross operating expenses is included in the relevant note to the accounts (see below).

Finance costs:

Finance costs represents interest charges on leases or borrowings. The costs shown here reflect the interest charge on lease liabilities, following the change in accounting treatment under IFRS 16.

Aside from the IFRS 16 impact, we would not typically expect to see finance costs for the ICB.

Statement of Financial Position as at 31 March 2026

The Statement of Financial Position states the assets and liabilities of the ICB as at the end of the financial year being reported on and is made up of two parts: the upper part shows the net assets/liabilities of the ICB and the lower part identifies the source of finance used to fund those net assets/liabilities.

It is usual for ICBs to have a negative value for Total Assets Employed and the General Fund because of the way they receive funding from NHS England. The ICB is funded on a cash basis, however, it accounts on an accruals basis and therefore this generally is reflected in the Balance Sheet by a negative value in respect of Total Assets Employed and General Fund.

The figures in the Statement of Financial Position reflect assets and liabilities at a point in time (rather than over a period of time). For the current accounts, this is the closing ICB balances at 31 March 2026, with comparative figures for 31 March 2025.

The Statement of Financial Position is as follows:

		31 March 2026 £'000	31 March 2025 £'000
Non-current assets			
	<i>Asset now recognised under IFRS 16 'Leases' reflecting ICB's right to use an asset under a lease (generally buildings).</i>		
Right of use assets		3,743	3,219
Total non-current assets		3,743	3,219
Current assets			
Contract and other receivables	<i>Money owed to the ICB which is due to be received in the coming year.</i>	35,036	47,751
Cash and cash equivalents	<i>Cash balances and deposits held at the end of the year.</i>	2,554	779
Total current assets		37,590	48,530
Total assets		41,333	51,749
Current liabilities			
Trade and other payables	<i>Money owed to suppliers, HMRC & other NHS bodies that is due to be paid within the next year.</i>	(549,223)	(493,069)
Lease liabilities	<i>Payments due under leases within the next year (offsets right of use assets above)</i>	(504)	(437)
Total current liabilities		(549,727)	(493,506)
Total assets less current liabilities		(508,394)	(441,757)
Non-current liabilities			
Lease liabilities	<i>Payments due under leases beyond the next 12 months (offsets right of use assets above)</i>	(3,322)	(2,841)
Total non-current liabilities		(3,322)	(2,841)
ASSETS LESS LIABILITIES		(511,716)	(444,598)
FINANCED BY TAXPAYERS' EQUITY:			
General Fund	<i>General Fund consists of capital held by the ICB, accumulated surpluses/deficits and amounts owed to the ICB from NHS England.</i>	(511,716)	(444,598)
TOTAL TAXPAYERS' EQUITY		(511,716)	(444,598)

Refer to the notes to the accounts below for further details of the balances above and movements since prior year.

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

The Statement of Changes in Taxpayers Equity records the movement on the General Fund and reserves in the period and reconciles to the lower part of the Statement of Financial Position.

		General Fund £'000	Total £'000
Balance at 1 April 2025		(444,598)	(444,598)
Changes in ICB taxpayers' equity for 2025/26:			
Net operating cost for the year	<i>Net operating cost from the SoCNE above</i>	(9,396,529)	(9,396,529)
Net recognised ICB expenditure for the financial year		(9,396,529)	(9,396,529)
Net Funding	<i>This is the allocation the ICB receives from NHS England</i>	9,329,411	9,329,411
Balance at 31 March 2026		(511,716)	(511,716)

The General Fund contains the Net Parliamentary Funding received (i.e. the ICBs funding allocation for the year) offset by the net operating cost for the year.

There are no other reserves held by the ICB to report in this statement. Other reserves that potentially could be included here would be a revaluation reserve for example, but this is not currently relevant for the ICB.

Statement of Cash Flows for the year ended 31 March 2026

The Statement of Cash Flows provides information on ICB liquidity, viability and financial adaptability. The Statement summarises the cash coming in and out of the ICB in the accounting year. It starts with the total costs for the year and adjusts for any items that are not cash related.

		2025/26 £'000	2024/25 £'000
Cash flow from operating activities			
Net operating cost for the year		(9,396,529)	(8,113,716)
Depreciation	<i>This is the cash spent on operating activities in the year less any cash received as miscellaneous income.</i>	434	569
Interest paid		33	33
(Increase) / decrease in Contract and Other Receivables	<i>Net operating costs for the year are adjusted to remove any non-cash transactions, i.e. movements in working capital and depreciation</i>	12,714	(28,702)
Increase / (decrease) in Trade and Other Payables		56,154	(40,343)
Net cash outflow from operating activities		(9,327,194)	(8,182,159)
Net cash outflow before financing		(9,327,194)	(8,182,159)
Cash flows from financing activities			
Net funding received	<i>Cash received from NHS England to enable the ICB to pay for its activities</i>	9,329,411	8,182,115
Repayment of lease liabilities	<i>Cash payments made against lease liabilities during the year</i>	(442)	(607)
Net Cash inflow from financing activities		9,328,969	8,181,508
Net increase / (decrease) in cash and cash equivalents		1,775	(651)
Cash and cash equivalents at the beginning of the financial year		779	1,430
Cash and cash equivalents at the end of the financial year		2,554	779

The balances within the Statement of Cash Flows all come from other notes within the accounts. Net operating costs (from the SoCNE above) are adjusted for non-cash items, to show total cash paid in respect of operating costs.

Generally for ICBs the main non-cash items would relate to movements in receivables and payables balances. Following the change to lease accounting (see SoCNE above) the ICB also has a small depreciation charge which is also a non-cash item.

Trade and other receivables represent amounts owed to the ICB but not yet paid, so any increase in those balances will reduce the cash available to the ICB. Conversely trade and other payables represent costs which have not yet physically been paid by the ICB, hence an increase in those balances increases the cash available to the ICB.

The other item included in the Statement of Cash Flows is the funding allocation received from NHS England.

NOTES TO THE FINANCIAL STATEMENTS

NOTE 1 - ACCOUNTING POLICIES

Note 1 to the Annual Accounts describes the accounting policies followed by the ICB in preparing the Accounts. These are standard policies as published by NHS England (NHSE) in the template Annual Accounts.

The Group Accounting Manual confirms that any accounting policies which are not relevant for the ICB can be removed, hence the accounting policies have been tailored in the ICB accounts to remove any policies where there are no balances to report (e.g. property, plant and equipment, intangible assets, PFI and LIFT assets etc.).

The main elements of the wording of the policies required to be tailored by the ICB are those on critical judgements in applying accounting policies and key sources of estimation uncertainty (note 1.5).

There have been no significant changes to the accounting policies since the prior year.

The going concern basis continues to be applied as it is anticipated that the services provided by the ICB will continue in the future. ICB funding allocations have been published by NHS England for a three year period from 2026/27 to 2028/29 and the ICB has developed a medium term financial and operational plan covering that period which demonstrates a breakeven financial position for the ICB in each year.

Although certain changes to the role and function of the ICB are expected as part of the transition to strategic commissioner and required savings to deliver the £19 per head cost of commissioning target, the ICB's primary role as commissioning of healthcare services is not expected to significantly change. As a result it is not considered this change has any impact on the adoption of the going concern basis in preparing the accounts.

NOTE 2 - OTHER OPERATING REVENUE

This note provides further analysis of any other operating revenue for the period.

As highlighted above, this only includes any 'miscellaneous' income and does not include the main funding allocation received from NHS England.

Total operating income in the 2025/26 ICB accounts amounts to £109,538k (2024/25: £106,020k). This includes:

- Prescription fees and charges (£54,280k),
- Dental fees and charges (£52,875k),
- Other non-contract revenue (£2,383k), largely made up of £2,280k income for BCF contribution and Safeguarding SC contribution of £93k from Lancashire & South Cumbria ICB and LMNS income of £10k from NHS England.

NOTE 3 - EMPLOYEE BENEFITS AND STAFF NUMBERS

Note 3.1 - Employee benefits

This provides further analysis of the total employee benefits figures shown in the SoCNE above, showing costs broken down into salaries and wages, social security costs, pension contributions and apprenticeship levy.

The vast majority of employee benefits in the ICB accounts relate to permanent employees. Any agency or fixed term staff would be shown in 'other'.

It should be noted that the figures in this note exclude non-executive Board members (chair and non-executive directors) but include executive directors. The costs of the non-executive Board members are included within other operating expenses (see following note below).

An analytical review has been performed to compare total costs for 2025/26 to the total costs from 2024/25.

In total employee benefits have significantly increased by around 49% (excluding exit packages) which largely reflects the TUPE transfer of over 300 staff from NECS into the ICB from 1 April 2025 as part of the 'in-housing' of CSU services. There has been a slight increase in agency costs to cover vacancies within the All Age Continuing Care service and complex case management.

Social security costs have increased by over 90% from the prior year which reflects the additional staff transferred from NECS together with the impact of increases to National Insurance costs from April 2025 (increase in NI rates and lowering of threshold) and estimated NI impact on exit packages (over £700k).

The employee benefits note also includes the following:

Note 3.2 - Staff Numbers

This note provides an analysis of average staff numbers for the ICB – The definition for staff numbers in this note is contracted whole time equivalent (WTE) rather than headcount or WTE worked or paid.

In comparison to 2024/25, the total average staff number has increased by 344. This reflects the impact of the NECS service transfer of CSU staff into the ICB where they are now directly employed.

Note 3.3 - Exit Packages

For 2025/26 there have been 157 exit packages agreed at an estimated cost of £8.9m (2024/25: no exit packages). The exit packages relate to the restructure of the ICB to deliver the required £19 per head target for ICB 'costs of commissioning' and include 126 voluntary redundancies agreed under the voluntary redundancy scheme, along

with 31 expected compulsory redundancies where individuals do not currently have a role in the future ICB structure.

Note 3.5 – Ill-health retirements

For 2024/25 there have been no retirements on the grounds of ill health (2024/25: 3 ill health retirements at a cost of £537k).

Note 3.6 - Pension Costs

This element of the note provides certain narrative disclosures regarding the NHS Pensions Scheme, all of which are taken directly from the template accounts disclosures published by NHS England.

NOTE 4 - OPERATING EXPENSES

This note provides a detailed analysis of gross operating costs for the year, the total of which agrees back to gross operating costs shown in the SoCNE.

Significant items included in this note are:

Services from other ICBs and NHS England	This includes the cost of commissioning support services received from the North of England Commissioning Support (NECS), who are hosted by NHS England. The reduction from 2024/25 reflects the transfer of services from NECS into the ICB with a reduction in the NECS SLA of over £20m.
Services from Foundation Trusts and Services from other NHS Trusts	This represents the largest element of operating expenditure as would be expected since the ICBs main healthcare contracts are with NHS Foundation Trusts and hence are included in this line. Over £786m of the increase from last year relates to specialised commissioning expenditure following the delegation to the ICB from 1 April 2025. The remaining increase (around 5%) reflects the net tariff uplift, including pay award for 2025/26, growth funding and other NR funding agreed in year.
Purchase of healthcare from non-NHS bodies	This also represents a significant element of ICB operating expenditure and includes a range of healthcare services commissioned from the independent and voluntary sector. This includes: • significant continuing healthcare costs (CHC) and other packages of care (e.g. s117 packages), • independent sector acute contracts, • services from local authorities (including some Better Care Fund payments) • community services provided by non-NHS providers • services provided by the voluntary sector including hospice contracts

	• payments to GP practices for locally commissioned services and primary care transformation funding The increase in expenditure reflects the inflation uplifts and growth in packages seen for CHC and s117s. Investment in Mental Health to achieve the MHIS target (4.93%) and increasing costs on ADHD/ASD assessments through right to choose. Contract uplifts for non NHS community contracts for pay award and SDF funding. New expenditure linked to Health & growth accelerator funding.
Purchase of Social Care	This largely relates to Better Care Fund payments, where funding is supporting social care with the increase reflecting the BCF uplift for 2025/26 (c4%) and the remaining increase due to additional BCF costs reclassified from purchase of healthcare from non-NHS bodies across a number of Local authorities.
General services and personal dental services	This relates to dental budgets for which the ICB was granted delegated authority from NHS England with effect from 1 st April 2024. This is funded via a separate funding allocation. The increase reflects growth in dental funding and investment plans agreed by the ICB to increase access to dental services across NENC.
Prescribing	This represents the prescribing costs for the year which largely comprise of changes from the Prescription Pricing Division (PPD). As costs are charged in arrears, this includes a significant estimate of costs for two months.
Pharmaceutical services	This relates to pharmacy budgets for which the ICB was granted delegated authority from NHS England with effect from 1 st April 2024. This is funded via a separate funding allocation. The increase from prior year reflects changes in the Community Pharmacy Contractual Framework for 2025/26, with an increase in funding levels of 15%.
General ophthalmic services	This relates to ophthalmic budgets for which the ICB was granted delegated authority from NHS England with effect from 1 st April 2024. This is funded via a separate funding allocation.
Primary Medical Services Costs	This relates to Primary Medical Care budgets for which the ICB has delegated authority from NHS England. This is funded via a separate funding allocation. The increase largely reflects GP contract uplifts for 2025/26 (over 8%).
Supplies and services - clinical	This predominantly relates to oxygen.
Establishment	This includes the costs relating to computer hardware, software and licences and also telecoms and travel costs.

Premises	This includes the costs relating to the ICBs office buildings (within administrative costs) together with a recharge of costs from NHS Property Services (NHSPS) and Community Health Partnerships (CHP) in respect of void space at various buildings. The reduction from 2024/25 reflects work undertaken as part of ICB efficiency plans to reduce the cost of property voids and subsidies, as well as reducing ICB office estate.
Other professional fees	This includes interpreting services within delegated primary care.
Chair and non-executive members	This includes the costs of the Chair and non-executive directors which are reported within operating expenses rather than employee benefits.

A full review of each line in this note has been performed as part of the Annual Accounts working papers.

As with employee benefits, an analytical review has been performed to compare total costs for 2025/26 to 2024/25. No significant issues or unexpected movements have been identified. The significant increase in expenditure shown in this note reflects the inclusion of specialised commissioning expenditure following delegation to the ICB from 1 April 2025 (c£788m) along with growth in funding and additional allocations received during 2025/26.

NOTE 5 - BETTER PAYMENT PRACTICE CODE

The Better Payment Practice Code (BPPC) requires the ICB to aim to pay undisputed NHS and non-NHS trade invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

This note shows the ICB's performance against that target (performance has also been reported each month as part of the monthly finance report).

The ICB is deemed to be compliant if it pays at least 95% of all valid invoices within 30 days of receipt.

NOTE 6 - FINANCE COSTS

This note just analyses out the finance costs shown in the SoCNE, which as explained previously simply reflects interest on lease liabilities following the adoption of IFRS 16.

NOTE 7 – MENTAL HEALTH EXPENDITURE

This note was added to the template ICB accounts for 2025/26 to report performance against the mental health investment standard (MHIS).

All ICB's are required by NHS England to spend a proportion of their overall allocation on mental health services to meet the MHIS, with the required level of spend being set by NHS England for each ICB.

Previously performance against the MHIS was the subject of a separate independent review process but from 2025/26 this is included in the statutory accounts subject to audit.

The note shows relevant ICB expenditure in mental health services in 2025/26 was a total of £1.5m above the required minimum expenditure as notified by NHS England, i.e. the ICB has complied with the MHIS for 2025/26.

The significant increase in both eligible mental health expenditure and minimum required expenditure compared to 2024/25 reflects the delegation of specialised commissioning budgets from 1 April 2025, with a proportion of specialised commissioning expenditure also spent on mental health services.

NOTE 8 - LEASES

Following the adoption of IFRS 16, this note now includes the following:

8.1 Right of use assets

Analysis of the right of use assets showing the gross cost, depreciation charge for the year and resulting net book value at 31 March 2026.

8.2 Lease liabilities

Analysis of movements in the lease liability balance during the year. This shows the increase in the balance for the interest charge (per SoCNE) and reduction for any repayments made, to give the net liability at 31 March 2026.

8.3 Maturity analysis of lease liabilities

Shows the split of the lease liability balance between amounts due within one year, amounts due in 1-5 years and amounts due after more than 5 years.

8.4 Amounts recognised in SoCNE

This shows the depreciation expense, interest expense and expense relating to short term leases as shown in the SoCNE.

8.5 Amounts recognised in Statement of Cash Flows

Being the cash outflow on lease repayments.

The only right of use assets and lease liabilities recognised under IFRS 16 relate to the lease of buildings. Any other leases, e.g. photocopiers are wholly immaterial and thus not recognised under IFRS 16. The addition in the year (£957k) relates to a new lease agreed for Pemberton House.

NOTE 9 - CONTRACT AND OTHER RECEIVABLES

Contract and other receivables represent amounts due to the ICB but not yet collected as at the end of the year (i.e. 31 March 2026). These are split between current (i.e. expected to be paid within 12 months) and non-current (i.e. due after more than 12 months). All of these balances are expected to be paid within 12 months hence are shown as current.

The total contract and other receivables balance includes prepayments, effectively where payments are made in advance for goods or services to be received at a subsequent date. Significant prepayment balances would not usually be expected as prepayments should only be agreed where this is in the normal course of business (e.g. where lease payments for example might be made in advance) or in exceptional circumstances where it provided an economic benefit.

NHS receivables revenue balance has reduced by over £9m from the prior year primarily down to the previous year including an agreed redistribution of funding across the North Providers of circa £16m with no equivalent balance in the current year.

Note 9.1 - The contract and other receivables note also includes an analysis of receivables past their due date but not impaired, split by those past due date by up to three months, three to six months and more than six months.

Local authorities account for almost 70% of receivables past their due date but not impaired and is one of the main reasons for the increase from the previous year of c£1m along with Chiesi of £1.1m for prescribing rebates recharges.

The note highlights the amount of receivables past due date which have subsequently been recovered.

Note 9.2 – the note also includes a summary of expected credit losses or loss allowance. This is effectively the allowance for potential losses if receivables need to be written off (or 'bad debt provision').

NOTE 10 - CASH AND CASH EQUIVALENTS

This note provides an analysis of the total cash and cash equivalents balance, which reflects amounts held in the ICB bank account. The final cash balance is within the cash targets expected by NHS England.

NOTE 11 - TRADE AND OTHER PAYABLES

Trade and other payables is effectively the opposite of trade and other receivables and represent amounts owed by the ICB but not yet paid as at the end of the year (i.e. 31 March). As with trade and other receivables, these are split between current (i.e. expected to be paid within 12 months) and non-current (i.e. due after more than 12

months). Again all of the ICB balances are expected to be paid within 12 months hence are shown as current.

The total trade and other payables balance includes both payables and accruals. Payables balances are essentially where invoices have been received but had not yet been paid. Accruals represent an estimate of costs expected to be received where invoices had either not been received at 31 March, or had not been processed.

NHS payables are relatively small balances at 31 March 2026 due to the monthly block payment process in place with NHS provider trusts.

The increase in NHS accruals at 31 March 2026 largely relates to additional funding allocations received from NHS England at the end of March to be paid to a number of provider trusts within the system, including over £34m of additional deficit support funding.

The vast majority of the trade and other payables balance in the ICB relates to non-NHS accruals. This includes in particular the estimate of prescribing costs to be paid by May 2026 (Prescribing charges are paid in arrears) and significant estimates of continuing healthcare costs not yet invoiced by suppliers for example.

The increase in non NHS and other WGA accruals is mainly due to 3 local authorities for packages of care. There is also an increase in other payables largely due to an accrual for estimated redundancy costs not yet paid.

NOTE 12 - CONTINGENCIES

Where relevant, this note includes the details of any contingent liabilities or contingent assets where a possible obligation and or (asset) arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB.

Last year the ICB disclosed a contingent liability relating to a legal challenge made for the procurement of Primary Care Clinical Waste Collection and Disposal contract from an unsuccessful bidder. The legal challenge remains ongoing and at this stage it is still not possible to accurately determine the probability of success by the Claimant, nor is it possible to estimate the financial impact of a successful claim with any level of certainty. Given this uncertainty of both of these key components, the ICB continues to report this as a contingent liability.

For context, the potential exposure to the ICB if we are unsuccessful in defending the claim has been estimated to be between £1.6m and £2.9m, although this is purely an estimate based on implied information about likely profit margins on the contract.

The legal challenge impacts a number of ICBs with the response being co-ordinated by Humber and North Yorkshire (HNY) ICB.

NOTE 13 - COMMITMENTS

Where relevant, this note includes details of any contractual capital or other financial commitments as at the balance sheet date which had not been recognised as a liability in the accounts.

There are no such items to note here for the ICB.

NOTE 14 - FINANCIAL INSTRUMENTS

The template accounts includes a standard narrative disclosure around financial instruments risk which is included at Note 14.1. The ICB is not considered to be exposed to any material financial instrument risk

Notes 14.2 and 14.3 then provide an analysis of financial assets and financial liabilities included within the accounts. The trade and other receivables balances and cash and cash equivalents balance are taken from the relevant notes above. Similarly, the payables and borrowings balances within financial liabilities are taken from the relevant notes above.

NOTE 15 - OPERATING SEGMENTS

This disclosure is required under International Financial Reporting Standards (IFRS) to analyse information over certain 'operating segments'. These segments are determined by the ICB and should reflect the internal reporting to the ICB Board (as the 'chief operating decision maker') which is used to allocate resource and assess performance of the ICB.

It is considered that there is only one operating segment to report as all of its activities relate to the ICBs role as commissioner of healthcare for its relevant population.

As all activities relate to the one operating segment, all relevant disclosures in terms of income, costs and net assets of the segment are already included in the other notes to the accounts.

NOTE 16 - POOLED BUDGETS

Certain disclosures are required in the accounts in respect of any pooled budget arrangements that the ICB is party to with any other organisations. The ICB has pooled budget arrangements with all relevant local authorities in respect of the Better Care Fund, managed through s75 agreements.

A number of places within the ICB have additional pooled budget arrangements with relevant local authorities relating to community equipment and joint commissioning arrangements for example. Certain additional pooled budget arrangements in South Tyneside have ended and are no longer reflected in 2025/26 values.

NOTE 17 - RELATED PARTY TRANSACTIONS

This note contains details of transactions and balances with any related parties of the ICB Board members or 'key members of management staff'.

The Chief Executive has confirmed the list of 'Senior Managers' to be included in this note and it is considered that the voting Board members represent the relevant senior managers for the ICB. This is consistent with the guidance published by NHS England and approach taken in previous years.

All Board members are required to confirm any related parties on the register of interests and searches have been performed on the ICBs ledger system for any transactions with these parties, along with any balances outstanding at 31 March 2026.

There is no requirement to publish details of transactions or balances with other DHSC bodies, hence no details of transactions with NHS Foundation Trusts for example are shown here.

NOTE 18 - EVENTS AFTER THE REPORTING PERIOD

This note is required to include any events occurring between the end of the financial year (31 March 2026) and the date of signing the accounts, which would have a material effect on the financial statements of the ICB (e.g. a major restructuring, significant capital purchase, refinancing, etc.)

At this stage there are no post balance sheet events which would have a material effect on the financial statements of the ICB.

NOTE 19 – LOSSES AND SPECIAL PAYMENTS

The ICB is required to disclose any losses or special payments agreed during the year:

- A loss refers to any case where full value has not been obtained for money spent or committed.
- Special payments include any compensation payments, extra-contractual or ex-gratia payments.

There are nine losses to report amounting to £51k in total (2024/25: 6 losses, £32k). Eight of these relate to administrative write-offs for debtor invoices and were fully provided for with one relating to a salary overpayment. There are two special ex gratia payments with a total value of £1k. All have been appropriately approved and reported to audit committee previously.

NOTE 20 - FINANCIAL PERFORMANCE TARGETS

This note is intended to show how the ICB fared against its financial performance targets. ICB's have a number of statutory financial duties which are contained within section 223 of the NHS Act (as highlighted in the note).

This includes:

- maintaining overall expenditure within available revenue resource,
- maintaining administration spend within running cost allowances, and
- maintaining any capital spend within capital allocations.

The financial targets included in this note are taken from the accounts directions published by NHS England.

The first table within this note has been taken from the template accounts and is the disclosure required by NHS England.

Further analysis has been included within the note in the ICB accounts to identify the total resource available (split between programme and administration) and relevant expenditure to provide the overall under-spend (surplus) against resource available. For 2025/26, the ICB has delivered a £34,855k surplus in total, including an underspend on running costs of £7,888k.

The note demonstrates that all relevant financial duties were achieved by the ICB during the year.

In respect of capital spend, the ICB has received a direct capital allocation of £957k in 2025/26 relating to IFRS 16 and lease for Pemberton House, and equivalent capital spend has been shown in this note.

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

BOARD	
16 JUNE 2026	
Report Title:	ICB Management letter of representation
Purpose of report	
To present the Board with a copy of the management letter of representation to be signed by the ICB Chief Executive and sent to the external auditors, Forvis Mazars LLP, as part of their audit of the ICB financial statements.	
Key points	
The management representation letter sets out relevant responsibilities of management and includes a number of representations designed to support the audit of the financial statements of the ICB. This is a standard letter provided to the external auditors each year and the content of the letter is largely consistent with 2025/26. The letter includes a schedule of unadjusted misstatements which includes a small number of misstatements identified through the audit process which have not been adjusted in the financial statements as they are not material. This schedule is complete at the time of writing however final audit completion procedures are continuing. Any changes to the unadjusted misstatements schedule will be highlighted to the Board at the meeting on 16th June 2026.	
Risks and issues	
The letter is required to support the audit of the financial statements.	
Assurances and supporting documentation	
The letter includes assurances from management which support the audit of the financial statements.	
Recommendation/action required	
The Board is asked to receive the management representations letter and note that this will be signed by the ICB Chief Executive.	
Acronyms and abbreviations explained	
NENC ICB – North East and North Cumbria Integrated Care Board DHSC – Department of Health and Social Care GAM – Group Accounting Manual IFRS – International Financial Reporting Standards AGS – Annual Governance Statement SOCNE – Statement of Comprehensive Net Expenditure SOPF – Statement of Financial Position	

Sponsor/Approving Executive Director	David Chandler, Chief Finance Officer					
Date approved by Executive Director	11 June 2026					
Report author	Richard Henderson, Director of Finance					
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						
Note any relevant Acts, regulations, national guidelines etc						
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	Not Applicable					
Contracting and Procurement	Not Applicable					
Local Delivery Team	Not Applicable					
Digital implications	Not Applicable					
Clinical involvement	Not Applicable					
Health inequalities	Not Applicable					
Patient and public involvement	Not Applicable					
Partner and/or other stakeholder engagement	Not Applicable					
Other resources	Not Applicable					

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3 Wellington Place
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LS1 4AP

North East and North Cumbria ICB
Pemberton House
Colima Avenue
Sunderland Enterprise Park
Sunderland
SR5 3XB

By Email:
mark.kirkham@mazars.co.uk

16 June 2026

Dear Mark,

NHS North East and North Yorkshire ICB - Audit for Year Ended 31 March 2026

This representation letter is provided in connection with your audit of the financial statements of NHS North East and North Cumbria (the ICB) for the year ended 31 March 2026 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with the DHSC Group Accounting Manual 2025/26 (the GAM).

I confirm that the following representations are made on the basis of enquiries of management and staff with relevant knowledge and experience (and, where appropriate, inspection of supporting documentation) sufficient to satisfy myself that I can properly make each of the following representations to you.

My responsibility for the financial statements and accounting information

I believe that I have fulfilled my responsibilities for the true and fair presentation and preparation of the financial statements in accordance with the GAM, and relevant legislation and International Financial Reporting Standards (IFRS) as adapted and adopted by HM Treasury.

My responsibility to provide and disclose relevant information

I have provided you with:

- access to all information of which I am aware that is relevant to the preparation of the financial statements such as records, documentation and other material;
- additional information that you have requested from us for the purpose of the audit; and
- unrestricted access to individuals within the ICB you determined it was necessary to contact in order to obtain audit evidence.

I confirm as Accountable Officer that I have taken all the necessary steps to make me aware of any relevant audit information and to establish that you, as auditors, are aware of this information.

As far as I am aware there is no relevant audit information of which you, as auditors, are unaware. I confirm that there is no information provided to you as part of the audit that I consider legally privileged.

Accounting records

I confirm that all transactions that have a material effect on the financial statements have been recorded in the accounting records and are reflected in the financial statements. All other records and related information, including minutes of all Board and relevant committee meetings, have been made available to you.

Accounting policies

I confirm that I have reviewed the accounting policies applied during the year in accordance with the GAM and International Accounting Standard 8 and consider these policies to faithfully represent the effects of transactions, other events or conditions on the ICB's financial position, financial performance and cash flows.

Accounting estimates, including those measured at current and/or fair value

I confirm that the methods, significant assumptions and the data used by the ICB in making the accounting estimates, including those measured at current and/or fair value, are appropriate to achieve recognition, measurement or disclosure that is in accordance with the applicable financial reporting framework.

Contingencies

There are no material contingent losses including pending or potential litigation that should be accrued where:

- information presently available indicates that it is probable that an asset has been impaired or a liability had been incurred at the balance sheet date; and
- the amount of the loss can be reasonably estimated.

There are no material contingent losses that should be disclosed where, although either or both the conditions specified above are not met, there is a reasonable possibility that a loss, or a loss greater than that accrued, may have been incurred at the balance sheet date.

There are no contingent gains which should be disclosed.

All material matters, including unasserted claims, that may result in litigation against the ICB have been brought to your attention. All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to you and accounted for and disclosed in accordance with the GAM and relevant legislation and IFRSs as adapted and adopted by HM Treasury.

Laws and regulations

I confirm that I have disclosed to you all those events of which I am aware which involve known or suspected non-compliance with laws and regulations, together with the actual or contingent consequences which may arise therefrom.

The ICB has complied with all aspects of contractual agreements that would have a material effect on the accounts in the event of non-compliance.

Fraud and error

I acknowledge my responsibility as Accountable Officer for the design, implementation and maintenance of internal control to prevent and detect fraud and error and I believe I have appropriately fulfilled those responsibilities.

I have disclosed to you:

- all the results of my assessment of the risk that the financial statements may be materially misstated as a result of fraud;
- all knowledge of fraud or suspected fraud affecting the ICB involving:
 - management and those charged with governance;
 - employees who have significant roles in internal control; and
 - others where fraud could have a material effect on the financial statements.

I have disclosed to you all information in relation to any allegations of fraud, or suspected fraud, affecting the ICB's financial statements communicated by employees, former employees, analysts, regulators or others.

Related party transactions

I confirm that all related party relationships, transactions and balances, have been appropriately accounted for and disclosed in accordance with the requirements of the GAM and relevant legislation and IFRSs.

I have disclosed to you the identity of the ICB's related parties and all related party relationships and transactions of which I am aware.

Charges on assets

All the ICB's assets are free from any charges exercisable by third parties except as disclosed within the financial statements.

Future commitments

The ICB has no plans, intentions or commitments that may materially affect the carrying value or classification of assets and liabilities or give rise to additional liabilities.

Subsequent events

I confirm all events subsequent to the date of the financial statements and for which the GAM, relevant legislation and IFRSs, require adjustment or disclosure have been adjusted or disclosed. Should further material events occur after the date of this letter which may necessitate revision of the figures included in the financial statements or inclusion of a note thereto, I will advise you accordingly.

Impacts of military conflict including the Middle East and Ukraine

I confirm that I have carried out an assessment of the potential impact of military conflict including the Middle East and Ukraine on the business, including the impact of mitigation measures and uncertainties, and no disclosures are required in the financial statements.

Tariffs

I confirm that I have carried out an assessment of the potential impact of changes in US trade policy in respect of tariffs, including the impact of reciprocal tariffs by other countries, including the impact of mitigation measures and uncertainties, and no disclosures are required in the financial statements.

Going concern

To the best of my knowledge there is nothing to indicate that the ICB will not continue as a going concern in the foreseeable future. The period to which I have paid particular attention in assessing the appropriateness of the going concern basis is not less than twelve months from the date of approval of the accounts.

Annual Governance Statement

I am satisfied that the Annual Governance Statement (AGS) fairly reflects the ICB's risk assurance and governance framework and I confirm that I am not aware of any significant risks that are not disclosed within the AGS.

Annual Report

The disclosures within the Annual Report and Remuneration and Staff Report fairly reflect my understanding of the ICB's financial and operating performance over the period covered by the financial statements.

Unadjusted misstatements

I confirm that the effects of the uncorrected misstatements are immaterial, both individually and in aggregate, to the financial statements as a whole. A list of the uncorrected misstatements is attached to this letter as an Appendix.

Arrangements to achieve economy, effectiveness and efficiency in Use of Resources (Value for Money arrangements)

I confirm that I have disclosed to you all findings and correspondence from regulators for previous and ongoing inspections of which I am aware. In addition, I have disclosed to you any other information that would be considered relevant to your work on value for money arrangements.

Yours sincerely,

Samantha Allen

Accountable Officer on behalf of the ICB

Date: 16 June 2026

Appendix

Schedule of unadjusted misstatements

Unadjusted misstatements		SOCNE		SOFp	
Description	Nature	Dr (£ '000)	Cr (£ '000)	Dr (£ '000)	Cr (£ '000)
Dr: trade and other payables: accruals	Actual			7,847	
Cr: purchase of goods and services: prescribing costs			-6,150		
Cr: purchase of goods and services: pharmacy costs			-1,697		
Being the over-accrual of estimated prescribing and pharmacy costs for February and March					
Dr: purchase of healthcare from non-NHS bodies	Extrapolated	15,673			
Cr: trade and other payables: non-NHS and other WGA accruals					-15,673
Being the specific errors understated by £104,000 extrapolated over the value of the sample					
Aggregate effect of unadjusted misstatements		15,673	-7,847	7,847	-15,673

Schedule of unadjusted disclosure misstatements

- Note 3.4 exit packages agreed in the financial year: the disclosure includes one case where alternative employment has been secured since the date of publication of the financial statements and annual report, there are a small number of further individuals included who are still seeking alternative employment. Total potential impact on the disclosure has been estimated at £500,000.

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

BOARD

16 JUNE 2026

Report Title:

**Annual Report including the Head of Internal Audit Opinion
2025/26**

Purpose of report

The purpose of the Internal Audit Annual Report is to provide the audit committee with:

- the Head of Internal Audit Opinion for the year ended 31st March 2026, which provides an independent opinion on the adequacy and effectiveness of the ICB's framework of governance, risk management, and internal control.

The annual Head of Internal Audit Opinion supports the assurances provided to the Accountable Officer and the Board, forming a key part of the ICB's own evaluation of the effectiveness of its system of internal control. This opinion also contributes directly to the preparation of the Annual Governance Statement.

Key points

Overall Opinion

Based on the work undertaken during the year and the assurances received, I am able to provide Good Assurance that there is a sound system of internal control, governance and risk management designed to meet the organisation's objectives. Controls are generally being consistently applied.

The 2025/26 opinion has been formed based on the following, of which the levels of assurance assigned to audits is only one of the elements considered:

- An assessment of the design and operation of the underpinning assurance framework and supporting processes for governance and the management of risk.
- An assessment of the range of individual opinions arising from audit assignments, contained within the risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.
- Brought forward internal audit assurances.
- An assessment of the organisation's response to agreed management actions.
- Consideration of significant factors outside the work of internal audit.

In preparing this opinion there is a significant control weakness that we recommend should be considered against the criteria derived from NHS England Annual Governance Statement guidance and applied in line with DHSC Group Accounting Manual requirements for Governance Statements, on determining whether an internal control issue is 'significant'.

We have raised one high priority finding in the audit below, which we would bring to the attention of the Accountable Officer for consideration for inclusion in the AGS. Full details are included in the annual report.

- Safeguarding Arrangements (Adults and Children) - Incomplete records were maintained of the status of disclosure and barring service (DBS) checks that had been carried out on staff employed within the Safeguarding Team. Staff in the safeguarding children and adults teams are in roles that require high levels of trust and scrutiny. Missing or incomplete DBS records raise concerns about whether individuals have been properly vetted, potentially exposing vulnerable populations to unnecessary risk.

Management has advised that the action taken to address this issue is now substantially complete. Currently the remaining three outstanding DBS checks are being processed and the ICB is awaiting the outcomes of the checks.

Sufficient work has been completed during 2025/26 to enable the Head of Internal Audit to provide an opinion. In summary, we have issued 22 final reports with a split of assurance levels for the reports as follows:

- nine substantial assurance
- seven good assurance
- four reasonable assurance
- two advisory audits (assurance level is not assigned)

Risks and issues

Individual risks arising out of audit work will be reported separately in individual internal audit reports. Final reports will be brought to the Audit Committee when issued.

Assurances and supporting documentation

Assurances are provided by individual audit reports which will be linked, where possible, to the Board Assurance Framework.

Recommendation/action required

The Audit Committee is requested to receive the Head of Internal Audit Opinion for information.

Acronyms and abbreviations explained

N/A

Sponsor/Approving Executive Director	Claire Riley, Chief Corporate Officer
Date approved by Executive Director	11 June 2026
Report author	Sharon Fatkin, Senior Internal Audit Manager, AuditOne

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

Note any relevant Acts, regulations, national guidelines etc

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	The internal audit plan is delivered within the fee envelope agreed by the Chief Finance Officer and Chief Corporate Officer.					
Contracting and Procurement	Not applicable					
Local Delivery Team	Not applicable					
Digital implications	Not applicable					
Clinical involvement	Not applicable					
Health inequalities	Not applicable					
Patient and public involvement	Not applicable					
Partner and/or other stakeholder engagement	Not applicable					
Other resources	Not applicable					

ANNUAL REPORT 2025/26

INCLUDING HEAD OF INTERNAL AUDIT OPINION

North East and North Cumbria Integrated Care Board

I am pleased to present the Internal Audit Annual Report for the year ended 31st March 2026. This report summarises the work undertaken by the Internal Audit function during the year and provides my independent opinion on the adequacy and effectiveness of the organisation's framework of governance, risk management, and internal control.

In forming this opinion, I have considered the outcomes of all internal audit reviews conducted throughout the year, the organisation's response to agreed management actions, and the overall risk environment in which the NHS organisation operates. I have also considered the assurance provided by other internal and external sources.

The opinion does not imply that internal audit has reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans, generated from a robust and organisation-led Assurance Framework. As such, it is one component that the accountable officer considers in making the Annual Governance Statement. The accountable officer will need to integrate these results with other sources of assurance when making a rounded assessment for the purposes of the Annual Governance Statement.

Based on the work undertaken during the year and the assurances received, I am able to provide **Good Assurance** that there is a sound system of internal control, governance and risk management designed to meet the organisation's objectives. Controls are generally being consistently applied.

This opinion supports the organisation's Annual Governance Statement and reflects our commitment to continuous improvement and robust assurance across all areas of operation.

I would like to take this opportunity to thank the staff at North East and North Cumbria Integrated Care Board for the co-operation and assistance provided to my team during the year. Their support and willingness to collaborate with my team have greatly contributed to the success of our work.

It is through their dedication and professionalism that we have been able to effectively carry out our responsibilities. Thank you for your commitment and partnership in achieving our shared goals.



A Coulson



April Coulson – Associate Director Internal Audit

Report Title: Internal Audit Annual Report Including the Head of Internal Audit Opinion

Organisation: North East and North Cumbria Integrated Care Board

Author: April Coulson

Role: Associate Director Internal Audit

Date draft issued: 11th June 2026

Date final issued: 16th June 2026

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Head of Internal Audit Opinion



The Opinion

The purpose of this annual Head of Internal Audit Opinion is to support the assurances provided to the Accountable Officer and the Board, forming a key part of the organisation’s own evaluation of the effectiveness of its system of internal control. This opinion also contributes directly to the preparation of the Annual Governance Statement. The opinion is structured as follows:

Overall Head of Internal Audit Opinion

From my review of your systems of internal control, I am providing **Good Assurance** that there is a sound system of internal control, governance and risk management designed to meet the organisation’s objectives. Controls are generally being applied consistently.

Basis for the Opinion

The basis for forming my opinion is as follows:

- an assessment of the design and operation of the underpinning assurance framework and supporting processes for governance and the management of risk
- an assessment of the range of individual opinions arising from audit assignments, contained within risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management’s progress in respect of addressing control weaknesses
- brought forward internal audit assurances
- an assessment of the organisation’s response to agreed management actions, and
- consideration of significant factors outside the work of internal audit.

Our Definitions & Assurance Ratings

Head of Internal Audit Opinion Rating

Substantial	Good	Reasonable	Limited	Click here to read rating descriptions

Assurance Rating (Risk Based Audits)

Substantial	Good	Reasonable	Limited	Click here to read rating descriptions

Assurance Rating (Compliance Audits)

Substantial	Good	Reasonable	Limited	Click here to read rating descriptions

Assurance Rating (Follow Up Audits)

Substantial	Good	Reasonable	Limited	Click here to read rating descriptions

Findings Prioritisation Definitions

Low	Medium	High	Click here to read rating descriptions

Supporting Commentary

Design and operation of the assurance framework and supporting processes

The ICB has a published Risk Management Strategy, which sets out the ICB's approach to risk and the management of risk in fulfilment of its overall objectives. Oversight of the risk management agenda rests with the Audit Committee, which reports into the Board.

Our audits of risk management and the board assurance framework have been completed and were assigned substantial assurance and no fundamental issues were identified in relation to the ICB's risk management or board assurance framework processes.

In relation to the board assurance framework the following controls were found to be operating effectively:

- The BAF is firmly connected to the organisation's principal objectives as set by the Board, and is a live document, maintained on an on-going basis by the governance lead to ensure it accurately reflects current risks, controls, and assurance sources. The latest BAF reviewed at the time of the audit was fully populated for all ICB strategic goals and had been produced within the required quarterly cycle.
- The BAF is monitored by the Audit Committee and Board on a quarterly basis. BAF and Risk Management Reports were presented to the Audit Committee, Board, and Board Committees throughout 2025/26, with minutes evidencing presentation, discussion, and challenge (where appropriate).
- Each risk within the BAF is formally assigned to a designated executive director and the appropriate Board Committee. This allocation ensures clear ownership of the risk, accountability for the effective management of controls and mitigations, and clarity regarding which Committee is responsible for overseeing, monitoring, and challenging the risk position.
- Risk owners are required to review and update their risks at agreed intervals to ensure that the BAF remains accurate, current, and aligned with organisational priorities.
- The risks outlined in the BAF are fully aligned to, and traceable from, the Corporate Risk Register.

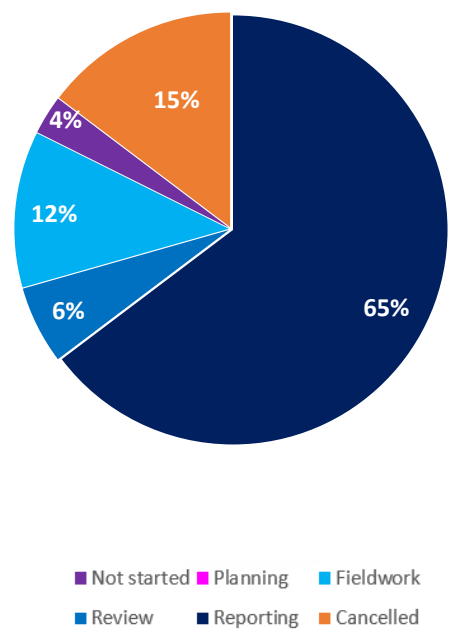
In relation to the risk management framework the following controls were found to be operating effectively:

- The ICB has a Board approved Risk Management Strategy. The purpose of the Strategy is to provide a support document to enable staff to undertake effective identification, assessment, control and action to mitigate or manage the risks affecting the normal business. The Strategy sets out an organisation wide approach to managing risk, in a simple, straightforward, clear manner and the intentions of the ICB for timely, efficient and cost-effective management of risk at all levels within the organisation.
- Risks are recorded and escalated appropriately. The ICB maintains a corporate risk register supported by area-based registers, each updated at least quarterly. The corporate, north, and south registers were reviewed and found to be fully populated at the time of the audit.
- Risks are evaluated using the ICB's standard risk assessment matrix, considering likelihood, impact, and effectiveness of existing controls.
- The Board reviewed and approved the ICB's risk appetite during the year.
- Risks are reviewed by owners at least quarterly, with updates on control effectiveness. All risks in the Corporate Risk Register had been reviewed within required timeframes.
- Actions have been recorded for all corporate risks, including owners and target dates. No target dates had passed as at the time of the audit, and narrative entries supported the actions being undertaken.

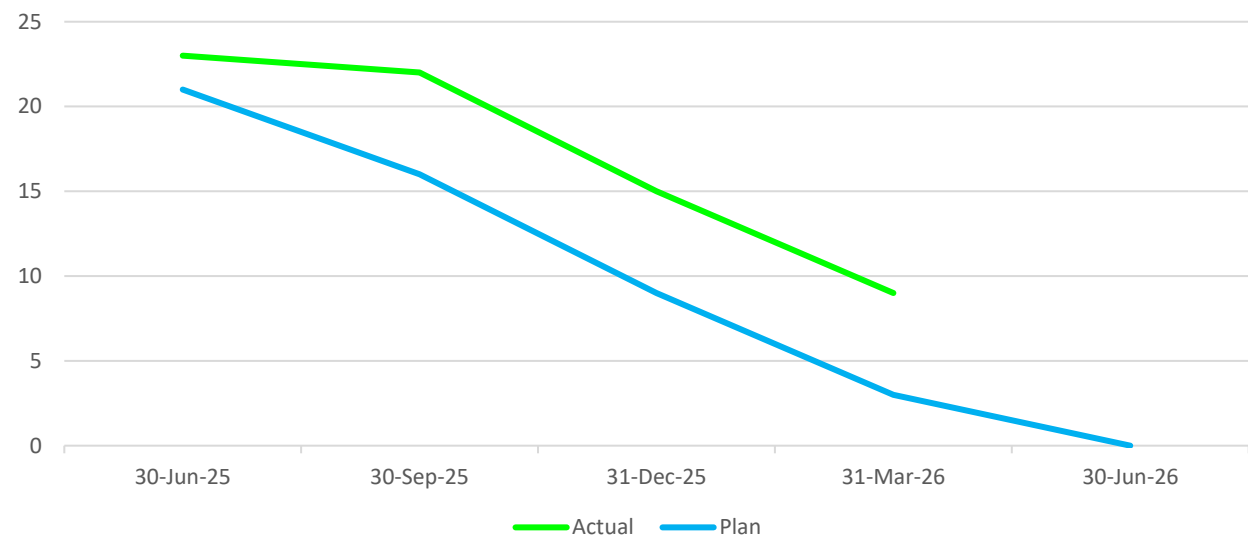
- Risk reports have been presented to relevant ICB committees throughout 2025/26, with meeting minutes evidencing presentation, discussion, and challenge.
- The Audit Committee is responsible for reviewing the adequacy and effectiveness of risk management across ICB’s activities and to highlighting any areas of weakness to the Board. It is accountable to the Board and reports to the Board on how it discharges its responsibilities. Section 8 of the Audit Committee terms of reference requires that the Committee provides the Board with an annual report, summarising its conclusions from the work it has done during the year with regards to the fitness for purpose of the assurance framework and the completeness and ‘embeddedness’ of risk management in the organisation. The Audit Committee's annual report was presented to the Board on 3rd June 2025.

Outturn of the Internal Audit Plan

2025-26 Audit Plan Delivery



Delivery Profile – Planned vs Actual



As of 11th June 2026, four audits were behind schedule, with draft reports originally planned to be issued. Fieldwork has been completed for two of these audits and these are in review and fieldwork is ongoing for the remaining two audits, along with two additional audits for which draft reports are expected to be issued by 30th June 2026.

Assurance Rating

Report Status	Substantial	Good	Reasonable	Limited	Advisory
Draft	0	0	0	0	0
Final	9	7	4	0	2
Total	9	7	4	0	2
Percentage	41%	32%	18%	0%	9%

As noted in the above table above, 16 (80%) of the assurance reports issued during the year to date have a positive assurance level of Substantial or Good. In addition to those identified above, six audits are in progress, with fieldwork completed for two of these audits. The four reasonable assurance reports issued to date have been considered for the Head of Internal Audit Opinion for 2025/26.

In preparing this opinion there is a significant control weakness that we recommend should be considered against the criteria derived from NHS England Annual Governance Statement guidance and applied in line with DHSC Group Accounting Manual requirements for Governance Statements, on determining whether an internal control issue is 'significant', details as follows:

- Could the issue prejudice achievement of organisational priorities?
- Could it undermine the integrity or reputation of the NHS?
- Does it risk breaching standards expected of the Accountable Officer?
- Could it result in a material impact on the accounts or resources?
- Does it increase exposure to fraud or misuse of resources?
- Has it diverted resources from key services or objectives?
- Does it pose a risk to data security or national systems?
- What is the view of the Audit Committee, Internal Audit or External Audit?

We have raised one high priority finding in the audit below, which we would bring to the attention of the Accountable Officer for consideration for inclusion in the AGS:

Audit	Risk identified	Status of agreed actions on 8 th June 2026
Safeguarding Arrangements (Adults and Children) (Reasonable Assurance)	Incomplete records were maintained of the status of disclosure and barring service (DBS) checks that had been carried out on staff employed within the Safeguarding Team. For some staff in the sample reviewed, there was no record to confirm that DBS checks had been undertaken and for others where a DBS check had been completed, it was not clear whether the enhanced DBS check had included a check against both the adults and children barred list. These issues were due to initial employment checks being carried out on staff when they were appointed by predecessor organisations (i.e. CCGs) and this information not being recorded in the ESR system when they have transferred to the ICB. Staff in the safeguarding children and adults teams are in roles that require high levels of trust and scrutiny. Missing or incomplete DBS records raise concerns about whether individuals have been properly vetted, potentially exposing vulnerable populations to unnecessary risk.	The agreed management action regarding reviewing which roles require a DBS check, identifying gaps in information recorded and new DBS checks being carried out for staff where no records of DBS checks were held is now substantially complete. Currently the remaining three outstanding DBS checks are being processed and the ICB is awaiting the outcomes of the checks.

Brought forward Internal Audit assurances

Our overall opinion for 2024/25 was: that good assurance can be given that there is a sound system of internal control, governance and risk management designed to meet the organisation's objectives and that controls are generally being applied consistently.

As part of the opinion, we drew attention to three reasonable assurance final reports issued during 2024/25. Issues have been followed up in year and there is nothing brought forward that I wish to consider as part of the opinion for 2025/26.

Implementation of agreed management actions

The implementation of agreed actions is a key indicator of the organisation's engagement with the internal audit process and the importance it places on the actions agreed to be implemented. The Audit Committee receives updates on the progress of all agreed actions. In the year to 31st March 2026, 75 agreed management actions were due to be implemented based on initial or revised target dates, of which 65 (87%) were closed in the year. The table below provides a breakdown of the position based on the priority level of the agreed actions.

Priority	Due in the year to 31 st March 2026	Closed	Outstanding
High	3	3 (100%)	0 (0%)
Medium	44	37 (84%)	7 (16%)
Low	28	25 (89%)	3 (11%)
Total	75	65 (87%)	10 (13%)

There are no management actions which are currently reported as overdue by more than 12 months past their agreed original target date for implementation.

Significant factors outside of internal audit work performed for the ICB

Whilst the Head of Internal Audit Opinion provides the ICB with assurances in relation to the areas covered by the internal audit plan, it is only one of the sources of assurance available to the ICB. As the ICB outsources many of its functions, assurances from third parties are equally as important when the ICB draws up its Annual Governance Statement.

The main ones usually received that I have been made aware of are summarised below:

- Payroll services are provided by NHS Payroll Services hosted by Northumbria Healthcare NHS Foundation Trust. The ICB, through its membership of the Payroll Consortium, receives an annual assurance letter setting out the results of the internal audit work carried out during the year.
- Assurance in respect of the operation of the finance and accounting services provided by NHS Shared Business Services (SBS) is provided by PWC, on an annual basis.
- Assurance in respect of the primary care support services provided by Capita Business Services Limited to NHS England and ICB is provided by Forvis Mazars, on an annual basis.
- Assurance in respect of the operation of the prescription payments process provided by NHS Business Service Authority (BSA) is provided by Grant Thornton, on an annual basis.
- Assurance in respect of the operation of the NHS GP Payment Service provided by NHS England is provided by PwC, on an annual basis.
- Your counter fraud specialist is required to submit an annual Counter Fraud Functional Standard Return (CFFSR) to the NHS Counter Fraud Authority (NHSCFA) in relation to the ICB's counter fraud, bribery and corruption arrangements. This provides an overview of the ICB's counter fraud activity, progress against NHSCFA requirements and assists the chief finance officer (CFO) and audit committee in monitoring and managing the counter fraud service. The CFFSR for 2025/26 was reviewed and approved by both the audit committee chair and CFO ahead of the submission deadline. The ICB's overall rating for 2025/26 is green. The ICB has not been subject to an NHSCFA engagement meeting in 2025/26.

- Assurance in respect of the Electronic Staff Record (ESR) service operated by NHS Business Services Authority is provided by Grant Thornton, on an annual basis.
- Assurance in respect of the calculating quality reporting service (CQRS), delivered by a Commissioning Support Unit (CSU) Collaborative, led by South Central West CSU, is provided by Deloitte on an annual basis.
- Assurance on the dental payments process system, operated by NHS BSA, is provided by Grant Thornton, on an annual basis.

It is for the Accountable Officer to decide what assurance to take from these reports and whether any of the weaknesses identified should be included within the ICB's Annual Governance Statement.



SUMMARY OF ASSURANCE WORK UNDERTAKEN

Please note that this year's opinion includes nine 2024/25 audits that were concluded after the opinion for that year was finalised and reported to the Audit Committee on 12th June 2025. Every piece of audit work will be assessed in an annual opinion but may not be completely aligned to the year of the plan. The 2025/26 opinion is informed by those audits included below that are final, or with a firm opinion in a draft report, plus any from the 2024/25 plan that were not included in the opinion last year.

The operational internal audit plan for the year ended 31st March 2026 was approved by the Audit Committee on 10th April 2025. During the year progress against the plan has been reported to the Audit Committee via regular progress reports.

The plan has been subject to change during the year, with all requests presented, along with rationale, to the Audit Committee. Each change was considered and approved. The changes were:

- **Safeguarding Adults and Children audit (approved 24th July 2025)**

Following a request from the Chief Nurse, the Safeguarding audit from the 2025/26 internal audit plan was delivered as part of the 2024/25 internal audit plan and replaced with audits on Continuing Health Care – Case Management and Personal Health Budgets, which were originally included in the 2024/25 internal audit plan.

- **Disciplinary audit (approved 9th October 2025)**

A request was received from the Director of Workforce to cancel the disciplinary audit due to capacity within the People Team, linked to the organisational change process and the low number of disciplinary cases. This audit was replaced with an audit on patient and public engagement.

- **Continuing Healthcare – Case Management and Continuing Healthcare – High Cost Case Panel audits (approved 5th February 2026)**

A request was received from the Chief Nurse that the Continuing Healthcare – Case Management and Continuing Healthcare – High Cost Case Panel audits should be combined and the scope updated so that one audit would be carried out to review the governance arrangements in place for all age continuing healthcare.

- **LeDeR audit (approved 9th April 2026)**

A request was received from the Chief Nurse to cancel the LeDeR due to staffing issues within the LeDeR team, backlog of reviews, changes planned on how the processes are to be managed following the restructure and new national guidance due to be issued. This audit was replaced with an audit on Continuing Healthcare – High Cost Case Approval Process.

Delivery breakdown

Audit Area	Audit Status	Assurance Rating						Findings			
		Substantial	Good	Reasonable	Limited	Advisory		High	Medium	Low	Total
Governance, Risk & Performance											
Board Assurance Framework	Final	✓						0	0	1	1
Risk Management	Final	✓						0	0	1	1
Emergency Planning Resilience and Response	Final	✓						0	0	1	1
Patient and Public Engagement	To start										
Governance Arrangements – All Age Continuing Healthcare	Fieldwork										
Governance Framework (from 2024/25 plan)	Final	✓						0	0	1	1
System Oversight Framework (from 2024/25 plan)	Final		✓					0	1	1	2
Workstreams and Transformation (from 2024/25 plan)	Final		✓					0	3	4	7

Audit Area	Audit Status	Assurance Rating				
		Substantial	Good	Reasonable	Limited	Advisory
Finance, Contracting & Capital						
Accounts Payable	Final	✓				
Accounts Receivable	Final		✓			
Financial Ledger	Final	✓				
Financial Reporting	Final	✓				
Key Financial Controls – Post Implementation of ISFE2	Final	✓				
Cost Improvement Plans	Final		✓			
Disinvestments in Services	Fieldwork					
Procurement (from 2024/25 plan)	Final		✓			
Human Resources & Workforce						
Right to Work Checks	Final		✓			
Professional Registration Checks	Final	✓				
Equality, Diversity and Inclusion Arrangements	Fieldwork					
Key Human Resources Controls Recruitment and	Final			✓		

Findings			
High	Medium	Low	Total
0	0	1	1
0	1	2	3
0	0	1	1
0	0	0	0
0	0	0	0
0	1	0	1
0	1	0	1
0	1	1	2
0	0	0	0
0	3	6	9

Audit Area	Audit Status	Assurance Rating					Findings			
		Substantial	Good	Reasonable	Limited	Advisory	High	Medium	Low	Total
Appointment <i>(from 2024/25 plan)</i>										
Public Sector Equality Duty <i>(from 2024/25 plan)</i>	Final			✓			0	4	1	5
Data and Digital Governance										
Cyber Assessment Framework (CAF) Aligned Data Security and Protection Toolkit – Independent Assessment	Final					✓	0	0	1	1
Data Security and Protection Toolkit (DSPT) – Interim Assessment	Final					✓	0	0	0	0
Patient Safety and Quality										
Continuing Healthcare – High Cost Case Approval Process	Review									
Dynamic Support Register and Care Education and Treatment Reviews	Fieldwork									
Personal Health Budgets	Review									
Safeguarding – Adults and Children <i>(from 2024/25 plan)</i>	Final			✓			1	1	0	2
Patient Safety Incident Response Framework (PSIRF) <i>(from 2024/25 plan)</i>	Final			✓			0	5	1	6

Audit Area	Audit Status	Assurance Rating						Findings			
		Substantial	Good	Reasonable	Limited	Advisory		High	Medium	Low	Total
Quality of Commissioned Services Follow-up (<i>from 2024/25 plan</i>)	Final		✓					0	1	0	1
Grand Total		9	7	4	0	2		1	22	23	46



ANNUAL BENCHMARKING

Comparison with Prior Years' Assurance Levels

A comparison showing the Head of Internal Audit Opinion assigned to NENC ICB in the period 2023/24 to 2025/26, and a breakdown of the assurance levels assigned to audit reports in that period is shown below.

Assurance Level	2025/26			2024/25			2023/24	
	Number of Reports	Percentage of Plan	Move from 2024/25	Number of Reports	Percentage of Plan	Move from 2023/24	Number of Reports	Percentage of Plan
Overall HOIAO	Good Assurance			Good Assurance			Good Assurance	
Substantial	9	41%	↑	2	11%	↑	1	6%
Good	7	32%	↓	8	45%	↔	8	47%

Assurance Level	2025/26			2024/25			2023/24	
	Number of Reports	Percentage of Plan	Move from 2024/25	Number of Reports	Percentage of Plan	Move from 2023/24	Number of Reports	Percentage of Plan
Reasonable	4	18%	↔	4	22%	↔	4	23%
Limited	0	0%	↔	0	0%	↓	2	12%
Advisory	2	9%	↓	4	22%	↑	2	12%
Total	22	100%		18	100%		17	100%

Internal Audit Performance



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AuditOne is committed to a programme of continuous improvement and an important part of that journey is listening and responding to our client’s feedback. The following section provides details of our performance against the agreed consortia wide key performance indicators and feedback from your organisation throughout the year.

KEY PERFORMANCE INDICATORS

Number	KPI	Target	Performance
1	Draft report issued within 15 working days of fieldwork completion date.	90%	46%
2	Draft report issued within assigned quarter deadline.	90%	23%
3	Client to provide management responses within 10 working days of issue of draft report.	90%	64%
4	Final report issued within 5 working days of receiving the last management comments.	90%	100%

We are strengthening compliance with audit reporting KPIs through a structured and continuous improvement approach focused on earlier engagement, clearer ownership, and tighter delivery discipline. This includes embedding real-time report drafting during fieldwork, agreeing findings upfront with auditees, and introducing more robust planning aligned to quarter deadlines to prevent delays. We are also improving accountability by implementing enhanced tracking, regular performance reporting, and escalation processes where timelines are at risk. In parallel, standardised templates, streamlined review processes, and clearer expectations for management responses will reduce inefficiencies and rework. Ongoing root cause analysis of missed KPIs, combined with targeted training and consistent management oversight, will ensure lessons are learned and sustained improvements are achieved over time, reinforcing a culture where timely, high-quality reporting is a core priority.

POST AUDIT QUESTIONNAIRES

To support continuous improvement and enhance the effectiveness of our audit process, we issued post-audit questionnaires to key stakeholders following the completion of each audit. These questionnaires provide valuable insights into the audit experience, including clarity of communication, responsiveness, and the relevance of audit findings. The feedback collected helps us identify areas for refinement, strengthen stakeholder engagement, and ensure our audit approach remains aligned with organisational needs and expectations.

Historically, we have provided year-on-year benchmark data in relation to post audit questionnaire feedback. However, in 2025/26 we introduced a new set of survey questions meaning we are not able to provide a year-on-year comparison of the feedback. This will be available from next year.

Summary of questionnaires output

Total number of questionnaires issued?	11	Responses received:	3	Response rate:	27%

Audit Planning Stage

Was a copy of the Audit Planning Memo shared with you in advance of the audit taking place?

Did the Audit Planning Memo set out the proposed audit areas, the AuditOne staff assigned, the main objectives and scope of the audit and the reporting processes?

Positive	Neutral	Negative
3	0	0
3	0	0

Fieldwork Stage

Did you agree a timetable for audit fieldwork to be carried out?

Was the fieldwork carried out during the agreed timetable?

3	0	0
3	0	0

Draft Report Stage

Were you given the opportunity to discuss the draft findings at an arranged exit meeting?

Did you receive a copy of the draft report?

Were you given the opportunity to confirm the factual accuracy of the report and agree the management actions and timescale for implementation?

3	0	0
3	0	0
3	0	0

Final Report Stage

Were you provided with a copy of the final audit report?

Was the report clear, concise, accurate and provide adequate detail?

3	0	0
3	0	0

Our Team

The auditor(s) demonstrated professional courage, competency, integrity and objectivity throughout the audit?

3	0	0

Other free text feedback received:

- Both auditors very helpful, it's really nice to deal with auditors who listen to clients and work alongside them to get desired results rather than being told with an opportunity to correct that you have done something incorrectly.
- I was happy to contribute to the proposed management actions and suggest possible solutions. This was a constructive way to work.
- The auditors were clear in the requirements and were constructive and informative in all meetings which supported us in compiling evidence.

- The audit process was cathartic but the collaborative and supportive approach by the auditor allowed us to identify areas we could continue to enhance and resulted in a positive audit experience.
- Fieldwork was broadly completed as expected but splitting the previous key financial controls audit into separate elements made the process feel elongated and less efficient so may be one to review again for next year.
- Process worked well.
- Good to have an experienced member of the team with background knowledge and understanding of the processes etc.

ANNUAL FEEDBACK SURVEY

To ensure our internal audit service continues to meet the strategic needs of the organisation, we conducted an annual survey targeting executive and senior stakeholders. This survey seeks feedback on key aspects of the audit function, including its value, responsiveness, and alignment with business priorities. The insights gathered help us assess performance, identify opportunities for enhancement, and maintain a high level of service quality and relevance across the organisation.

Historically, we have provided year on year benchmark data in relation to annual survey feedback. However, in 2025/26 we introduced a new set of survey questions meaning we are not able to provide a year-on-year comparison of the feedback. This will be available from next year.

The results of the 2025/26 survey are shown below. Detailed analysis of the individual results for NENC ICB has not been provided, due to a low response rate of less than 50%. However, individual feedback has been / will be addressed with the survey respondents on an individual basis. The positive feedback received will be recognised and further action taken where appropriate to ensure continuous improvement of the internal audit service. An anonymous analysis of the overall survey results as well as continuous improvement actions will be provided to the AuditOne board in accordance with the quality assurance and improvement plan in place.

Summary of survey output – all AuditOne clients

Total number of questionnaires issued	205	Responses received:	35	Response rate:	17%

Summary of survey output – North East and North Cumbria Integrated Care Board

Total number of questionnaires issued	14	Responses received:	3	Response rate:	21%

CONFORMANCE WITH THE GLOBAL INTERNAL AUDIT STANDARDS

AuditOne is committed to maintaining the highest standards of internal audit practice and is required to comply with the Global Internal Audit Standards issued by The Institute of Internal Auditors (IIA). These standards provide a robust framework for delivering independent, objective assurance and advisory services that add value and improve organisational operations.

AuditOne has a well-established internal quality assurance and improvement programme (QAIP) which is reviewed annually and approved by the AuditOne board. This forms part of a wider approach to meeting the requirements of the standards and independent external assessment which we are required to carry out at least every five years. AuditOne's next external quality assessment will be carried out in 2026.

All internal audit work undertaken by AuditOne has been carried out in line with our established methodology which has been designed to comply with the Global Internal Audit Standards.

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

BOARD	
16 JUNE 2026	
Report Title:	Forvis Mazars LLP (external auditor) Audit Completion Report 2025/26
Purpose of report	
Findings of the statutory external audit of the ICB's 2025/26 financial statements.	
Key points	
Key points: - unqualified opinion on the 2025/26 financial statements proposed; - no material unadjusted misstatements; - no significant deficiencies in internal control identified; and - no significant risks in respect of the external auditor's Value for Money arrangements review.	
Risks and issues	
An update has been provided to the Audit Committee on matters marked as 'outstanding' in the report.	
Assurances and supporting documentation	
Audit Completion Report presented to Audit Committee 11 June 2026.	
Recommendation/action required	
The Board is asked to consider the external auditor's report and highlight any points for discussion as part of two-way communication with the external auditor.	
Acronyms and abbreviations explained	
Not applicable	
Sponsor/Approving Executive Director	David Chandler Chief Finance Officer
Date approved by Executive Director	11 June 2026
Report author	Mark Kirkham, Partner, Forvis Mazars LLP Cath Andrew, Senior Manager, Forvis Mazars LLP
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						
Local Audit and Accountability Act 2014 Code of Audit Practice issued by the National Audit Office						
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	N/A					
Contracting and Procurement	N/A					
Local Delivery Team	N/A					
Digital implications	N/A					
Clinical involvement	N/A					
Health inequalities	N/A					
Patient and public involvement	N/A					
Partner and/or other stakeholder engagement	N/A					
Other resources	N/A					



Audit Completion report
NHS North East and North Cumbria Integrated Care Board
Year ended

June 2026

Private and confidential

Audit Committee
NHS North East and North Cumbria Integrated Care Board
Pemberton House
Colima Avenue
Sunderland
SR5 3XB

June 2026

I am pleased to present our Audit Completion Report (“ACR”) for NHS North East and North Cumbria Integrated Care Board (the ‘ICB’) for the year ended 31 March 2026. The purpose of this report is to summarise our audit findings and conclusions.

This report is intended solely for Audit Committee for the purpose of communicating certain matters that, in our professional judgement, are relevant to your oversight of the financial reporting process. This report should not be disclosed, reproduced, or lent to third parties, or used or quoted for other purposes.

We appreciate the courtesy and co-operation extended to us by NHS North East and North Cumbria Integrated Care Board throughout our audit. We would be happy to discuss the contents of this report, or any other matters regarding our audit, with you in more detail.

Yours faithfully,

{{_es_:signer1:signature }}

Mark Kirkham

Forvis Mazars LLP

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Appendix C: Draft audit report

Appendix D: Confirmation of our independence

Appendix E: Other communications

This document is to be regarded as confidential to NHS North East and North Cumbria ICB. It has been prepared for the sole use of Audit Committee as the appropriate group charged with governance by the Board. No responsibility is accepted to any other person in respect of the whole or part of its contents. Our written consent must first be obtained before this document, or any part of it, is disclosed to a third party.

Executive summary

Scope

We have been engaged to audit the financial statements of NHS North East and North Cumbria ICB for the year ended 31 March 2026 which are prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2025/26.

We have conducted our audit in accordance with International Standards on Auditing (UK) ('ISAs'), relevant ethical and professional standards, and the terms of our engagement communicated in our engagement letter.

Audit status

Our audit procedures are now substantially complete.

Please refer to the '*Status of our audit*' section for a list of significant audit matters outstanding at the date of this report. We will provide an update to you on completion of those outstanding matters by way of a follow up letter.

Areas of focus and audit approach, and significant findings

We have not made any changes to our initial risk assessment and planned audit approach that was communicated to you in our Audit Strategy Memorandum.

Audit misstatements

A summary of the adjusted and unadjusted misstatements above our reporting threshold we have identified to date is set out in the '*Summary of misstatements*' section.

Significant control deficiencies

We did not identify any significant deficiencies in internal control.

The non-significant control observations that we have identified to date are set out in '*Appendix A: Internal control conclusions*'.

Audit opinion

At the time of issuing this report and subject to the satisfactory conclusion of our remaining audit work, we anticipate issuing an unqualified opinion, without modification, as set out in Appendix C.

Executive summary

Qualitative aspects of ICB's accounting practices

We have reviewed ICB's accounting policies and disclosures and conclude that they comply with the DHSC Group Accounting Manual 2025/26, appropriately tailored to the ICB's circumstances.

Draft accounts were received from the ICB on 27 April 2026 and were of a good quality, supported by comprehensive working papers.

We noted the Financial Performance disclosure includes a split of expenditure and revenue into programme and admin categories; this is technically not permitted per the Government Accounting Manual; however, we are satisfied the disclosure is reasonable.

Significant matters discussed with management

During our audit, we communicated the following significant matters to management:

- data migration: we challenged the actions taken locally to address the weaknesses in control which occurred as part of the national implementation of the new general ledger system;
- accruals: as part of our testing, we challenged the basis of expenditure accruals and whether they were appropriately recognised;
- contingent liability disclosure: we discussed with management the approach taken in respect of the on-going waste contract possible liability; and service organisation report control exceptions: we discussed with management their assessment of the impact on the ICB of the control

exceptions reported by the auditor for NHS SBS, in order to satisfy ourselves there were no new risks of material misstatement.

Significant difficulties during the audit

We have not encountered any significant difficulties, and we have had the full co-operation of management.

Other matters of significance

We encountered no significant difficulties during our audit and had no significant disagreements with management. There was effective co-operation and communication between Forvis Mazars, management, and you during our audit. All requested information and explanations were provided to us.

Other matters we are required by ISA (UK) 260 *Communication with Those Charged with Governance* to communicate to you have been set out in Appendix E.

Status of our audit

Our audit work is substantially complete and there are currently no matters of which we are aware that would require modification of our audit opinion, subject to the satisfactory resolution of the outstanding matters set out below.

Item outstanding	Action to resolve	Forvis Mazars	Audit Committee	Management	Urgent
Journals	Finalisation of our detailed testing.	●		●	No
Expenditure	Detailed testing of payables, mental health investment standard spend, pooled budgets and cut-off testing.	●		●	No
Whole of Government Accounts	On receipt of a final version of the ICB’s accounts and forms, we will conclude our work on the WGA and consistency checks.	●		●	No
Closure procedures	We will complete our final review of the accounts upon receipt of the signed version.	●		●	No
Subsequent events review	Completion of subsequent events review up to the date of signing the Audit Report	●		●	No
Financial Statements	To be approved and signed at the meeting of Audit Committee		●	●	No
Management Representation Letter	To be approved and signed at the meeting of Audit Committee		●	●	No
Audit Report	To be issued on receipt of the signed financial statements.	●			No

Likelihood to result in a material adjustment or significant change to disclosures		
Likely	Potentially	Not considered likely

Audit approach and risk summary

Changes to our audit approach

There have been no changes to the audit approach we communicated in our Audit Strategy Memorandum, issued in February 2026.

Materiality

Our provisional materiality at the planning stage of our audit was set at £164.4m using a benchmark of 2% of total operating expenditure.

Based on the final financial statement figures the final overall materiality we applied was £194m, (final performance materiality: £142.5m; final clearly trivial threshold: £0.3m).

Audit approach and risk summary

	Audit risk/ key area of judgement	Fraud risk	Judgement	Error	Substantive audit procedures	Tests of controls	Misstatement identified	Control recommendations	Conclusion	Page ref to finding
Significant risks	Expenditure recognition	●	●	○	●	●	○	○	Risk satisfactorily addressed, subject to completion of cut-off testing	9
	Management override of controls	●	●	●	●	○	○	○	Risk satisfactorily addressed, subject to completion of journals testing	9
Other key areas of judgement and enhanced risks	Prescribing accrual	○	●	●	●	○	●	○	Non-material misstatement	10

Significant findings

Significant risks

Expenditure recognition	Description of the risk Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom highlights that, as most public-sector bodies are net spending bodies, the risk of material misstatement as a result of fraud related to expenditure may in some cases be greater than the risk relating to revenue recognition.
	How we addressed this risk We evaluated the design and implementation of controls the ICB has in place which mitigate the risk of expenditure being recognised in the wrong period. We also undertook a range of substantive procedures including sample testing material period-end accruals and contract variations.
	Audit conclusion Risk satisfactorily addressed, subject to completion of cut-off testing.
Management Override	Description of the risk In all entities, management at various levels within an organisation are in a unique position to perpetrate fraud because of their ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. Due to the unpredictable way in which such override could occur, we consider there to be a risk of material misstatement due to fraud and thus a significant risk on all audits.
	How we addressed this risk In line with our methodology, we addressed the management override of controls risk by carrying out audit work on: • accounting estimates; • journal entries; and • significant transactions outside the normal course of business or otherwise unusual.
	Audit conclusion Risk satisfactorily addressed, subject to completion of journals testing.

Significant findings

Other key areas of management judgement / enhanced risks

Prescribing expenditure estimate	Description of the risk/area of management judgement The ICB's accounts contain estimates of prescribing expenditure at the year-end. The ICB receives information on actual February and March 2026 prescribing expenditure before the draft accounts are prepared so a significant prescribing expenditure estimate is needed. In most years, the accounts contain an estimate based on NHS Business Services Authority (BSA) profiling which is reported two months in arrears.
	How we addressed this [risk/area of management judgement] We addressed the risk by testing the prescribing accrual included in the accounts by: • comparing the reasonableness of the estimate to the outturn for the prior year and actual expenditure for February and March 2026 when this becomes available; • reviewing the basis upon which the estimate has been made; • agreement to the BSA notification; and • reviewing and considering the assurance we receive from BSA (Type II service audit report).
	Audit conclusion Risk satisfactorily addressed.

Summary of misstatements

Unadjusted misstatements

Our overall materiality, performance materiality, and clearly trivial (reporting) threshold were reported in our Audit Summary Memorandum, issued in February 2026. Any subsequent changes to those figures are set out in the ‘Executive summary’ section of this report.

Management has assessed the misstatements in the table below as not being material, individually or in aggregate, to the financial statements and does not plan to adjust. We only report to you unadjusted misstatements that are either material by nature or which exceed our reporting threshold.

Unadjusted misstatements		SOCNE		SOFp	
Description	Nature	Dr (£ '000)	Cr (£ '000)	Dr (£ '000)	Cr (£ '000)
Dr: trade and other payables: accruals	Actual			7,847	
Cr: purchase of goods and services: prescribing costs			-6,150		
Cr: purchase of goods and services: pharmacy costs			-1,697		
Being the over-accrual of estimated prescribing and pharmacy costs for February and March					
Dr: purchase of healthcare from non-NHS bodies	Extrapolated	15,673			
Cr: trade and other payables: non-NHS and other WGA accruals					-15,673
Being the specific errors understated by £104,000 extrapolated over the value of the sample					
Aggregate effect of unadjusted misstatements		15,673	-7,847	7,847	-15,673

We will obtain written representations confirming that, after considering the unadjusted misstatements, both individually and in aggregate, in the context of the financial statements taken as a whole, no adjustments are required.

Summary of misstatements

Adjusted misstatements

We report all individual misstatements above our reporting threshold that we identify during our audit and which management had adjusted and any other misstatements we believe the Audit Committee should be made aware of.

There are no adjusted misstatements.

Disclosure misstatements

We identified the following disclosure misstatements during our audit that have been corrected by management:

- Note 1 accounting policies, minor amendments have been made to accounting policies, such as changes to wording.
- Notes 9 and 11 receivables and payables, rows removed as all are classified as current.
- Note 14.3 financial liabilities, basis of measurement corrected.
- Note 20 financial performance targets, reference to Agenda for Change removed, footnotes moved to be below the correct year's disclosure tables.
- Remuneration and staff report, additional disclosures relating to compliance with the very senior managers pay framework, more details of staff sharing arrangements, clarification of which parts are subject to audit and correction of highest banding.
- Annual report, updated disclosures on climate change (Task Force on Climate Change).

There were also a few minor amendments to wording and headings.

We identified the following disclosure misstatements during our audit that have not been corrected by management:

- Note 3.4 exit packages agreed in the financial year, the disclosure includes one case where alternative employment has been secured since the date of publication of the financial statements and annual report, there are a small number of further individuals included who are still seeking alternative employment. Total potential impact on the disclosure has been estimated at £500,000.

We will obtain written representations confirming that, after considering the unadjusted disclosure misstatements, both individually and in aggregate, in the context of the annual report and financial statements taken as a whole, no adjustments are required.

Fraud considerations

We have a responsibility to plan and perform our audit to obtain reasonable assurance that the financial statements are free from material misstatement, whether due to fraud or error.

Your responsibilities

Management has primary responsibility for the prevention and detection of fraud. It is important that management, with your oversight, place a strong emphasis on fraud prevention, which may reduce opportunities for fraud to take place, and fraud deterrence, which could persuade individuals not to commit fraud because of the likelihood of detection and punishment. This involves a commitment to creating a culture of honesty and ethical behaviour which is reinforced by your active oversight.

Our responsibilities

We have a responsibility for obtaining reasonable assurance that the financial statements taken as a whole are free from material misstatement, whether due to fraud or error. The distinguishing factor between fraud and error is whether the underlying action that results in a misstatement is intentional or unintentional. Two types of intentional misstatements are relevant to us – misstatements resulting from fraudulent financial reporting, and misstatements resulting from the misappropriation of assets.

ISA presumed fraud risks

As set out in the 'Audit approach and risk summary' section, the risks of fraud in expenditure recognition and management override of controls were identified as significant risks.



Value for money arrangements

Our approach

We are required to form a view as to whether the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The NAO issues guidance to auditors that underpins the work we are required to carry out in order to form our view and sets out the overall criterion and sub-criteria that we are required to consider.

It is our responsibility to be satisfied that the ICB has proper arrangements in place, and to report in the auditor's report where we are not satisfied that arrangements are in place. Where we have issued a recommendation in relation to a significant weaknesses this indicates we are not satisfied that arrangements are in place. Separately we provide a commentary on the ICB's arrangements in the Auditor's Annual Report.

The Code requires us to structure our commentary to report under three specified criteria:

1. **financial sustainability** – how the ICB plans and manages its resources to ensure it can continue to deliver its services;
2. **governance** – how the ICB ensures that it makes informed decisions and properly manages its risks; and
3. **improving economy, efficiency and effectiveness** – how the ICB uses information about its costs and performance to improve the way it manages and delivers its services.

At the planning stage of the audit, we undertook work to understand the arrangements that the ICB had in place under each of the reporting criteria and we identified risks of significant weaknesses in those arrangements. Although we describe this work as planning work, we keep our understanding of arrangements under review and update our risk assessment throughout the audit to reflect emerging issues that may suggest significant weaknesses in arrangements exist.

The table overleaf outlines the risks of significant weaknesses in arrangements that we have identified, the risk-based procedures we have undertaken, and the results of our work.

Where our risk-based procedures identify actual significant weaknesses in arrangements we are

required to report these and make recommendations for improvement. Where such significant weaknesses are identified, we report these in the audit report by exception. We will also highlight emerging issues or other matters that do not represent significant weaknesses but still require attention from the ICB.

The primary output of our work on the ICB's arrangements is the commentary on those arrangements that forms part of the Auditor's Annual Report. This commentary will provide a summary of the work we have undertaken and our judgements against each of the specified reporting criteria. We intend to issue the Auditor's Annual Report in June 2026.

Status of our work

We have completed our work in respect of the ICB's arrangements for the year ended 31 March 2026 and we have not identified any significant weaknesses in arrangements that have required us to make a recommendation. Our draft audit report at Appendix C confirms that we have no matters to report in respect of significant weaknesses. As noted above, our commentary on the ICB's arrangements will be provided in the Auditor's Annual Report in June 2026.

Appendix A: Internal control conclusions

Other deficiencies in internal control

A deficiency in internal control exists if:

- a control is designed, implemented, or operated in such a way that it is unable to prevent, detect, and/or correct potential misstatements in the financial statements; or
- a control that is necessary to prevent, detect, and/or correct misstatements in the financial statements on a timely basis is missing.

The purpose of our audit was to express an opinion on the financial statements. As part of our audit, we have considered NHS North East and North Cumbria Integrated Care Board's internal controls relevant to the preparation of the financial statements to design audit procedures to allow us to express an opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of NHS North East and North Cumbria Integrated Care Board's internal controls or to identify any significant deficiencies in their design or operation.

The matters reported in Appendix A are limited to those deficiencies and other control recommendations that we have identified during our normal audit procedures and which we consider to be of sufficient importance to merit being reported. If we had performed more extensive procedures on internal control, we might have identified more deficiencies to report or concluded that some of the reported deficiencies need not in fact have been reported. Our comments in Appendix A should not be regarded as a comprehensive record of all deficiencies that may exist or improvements that could be made.

This Appendix sets out the internal control observations that we have identified as at the date of this report. These control observations are not, in our view, significant control deficiencies but have been reported to management directly and are included in this report for your information. In our view, there is a need to address the deficiencies in internal control set out in this section to strengthen internal control or enhance business efficiency. Our recommendations should be actioned by management in the near future.

2025/26 internal control recommendations and prior year follow-up

At the time of issuing this report, we have not identified any significant deficiencies in controls.

In this section, we have set out our follow-up of a prior year internal control recommendation.

Appendix A: Internal control conclusions

Follow up on previous internal control points

We set out below an update on internal control points raised in prior periods.

Prescribing costs
Description of deficiency The ICB discloses its estimate of prescribing costs in the accounts as follows: <i>“(a) the estimate of prescribing and community pharmacy expenditure for the final two months of the year; this is informed by scenario analysis undertaken by management, utilising the forecast expenditure profile provided by the NHS Business Services Authority, historical prescribing patterns and profile of dispensing days, together with local intelligence and analysis of the impact of price concessions for example. The total accrual recognised in the financial statements amounts to £134,088k of which prescribing is £107,747k and community pharmacy is £26,341k”.</i> The calculation of the February and March 2025 prescribing accrual separated out specific drugs that had seen a significant increase in the previous 10 months. The calculation showed that charges in respect of these drugs were estimated to increase by £8,126k (24.0%) from the previous year's February and March costs (£33,876k). The increase in costs for all drugs was assessed at 5.1% and this was applied to the remaining February and March 2024 drugs cost (£62,535k) and a further £3,210k was added to the estimate. However, the overall increase of 5.1% included the significant increase in costs previously identified. Using a 5.1% uplift across all drugs would have resulted in a total uplift of £4,917k, compared to that accrued of £11,336k. In the months April 2024 to January 2025, year-on-year monthly prescribing costs showed changes in the range of -7.0% to +8.3%. The calculated increases within the prescribing accrual for February and March 2025 were +12.11% and +11.41% respectively. The actual outturn equated to -3.1% and +2.1%. Managers listed various factors that could impact on drug costs, demonstrating the complexity involved. However, the accrual was out of line with the previous 10 months' costs. Current year update: The ICB has followed a similar estimation process but has eliminated any double-counting.
Potential effects The prescribing estimate, in effect, double counts the impact of significant increases in specific drugs, which has resulted in costs being overstated.
Recommendation The estimation calculation should not include any double-counting. When finalised, the estimate should be subject to a “stand back” assessment of whether the accrual is reasonable
Management response Prescribing figures are highly volatile, and January 2025 costs were particularly high, so were difficult to forecast (and will never be correct). We consider we had a reasonable basis for the accrual, and the difference is not significant. We will ensure we do a ‘stand back’ to assess the accrual and ensure any double-counting is eliminated.

Appendix B: Draft management representation letter

5th Floor
3 Wellington Place
Leeds
LS1 4AP

[Date]

Dear Mark,

NHS North East and North Yorkshire ICB - Audit for Year Ended 31 March 2026

This representation letter is provided in connection with your audit of the financial statements of NHS North East and North Cumbria (the ICB) for the year ended 31 March 2026 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with the DHSC Group Accounting Manual 2025/26 (the GAM).

I confirm that the following representations are made on the basis of enquiries of management and staff with relevant knowledge and experience (and, where appropriate, inspection of supporting documentation) sufficient to satisfy myself that I can properly make each of the following representations to you.

My responsibility for the financial statements and accounting information

I believe that I have fulfilled my responsibilities for the true and fair presentation and preparation of the financial statements in accordance with the GAM, and relevant legislation and International Financial Reporting Standards (IFRS) as adapted and adopted by HM Treasury.

My responsibility to provide and disclose relevant information

I have provided you with:

- access to all information of which I am aware that is relevant to the preparation of the financial statements such as records, documentation and other material;
- additional information that you have requested from us for the purpose of the audit; and
- unrestricted access to individuals within the ICB you determined it was necessary to contact in order to obtain audit evidence.

Appendix B: Draft management representation letter

I confirm as Accountable Officer that I have taken all the necessary steps to make me aware of any relevant audit information and to establish that you, as auditors, are aware of this information.

As far as I am aware there is no relevant audit information of which you, as auditors, are unaware.

I confirm that there is no information provided to you as part of the audit that I consider legally privileged.

Accounting records

I confirm that all transactions that have a material effect on the financial statements have been recorded in the accounting records and are reflected in the financial statements. All other records and related information, including minutes of all Board and relevant committee meetings, have been made available to you.

Accounting policies

I confirm that I have reviewed the accounting policies applied during the year in accordance with the GAM and International Accounting Standard 8 and consider these policies to faithfully represent the effects of transactions, other events or conditions on the ICB's financial position, financial performance and cash flows.

Accounting estimates, including those measured at current and/or fair value

I confirm that the methods, significant assumptions and the data used by the ICB in making the accounting estimates, including those measured at current and/or fair value, are appropriate to achieve recognition, measurement or disclosure that is in accordance with the applicable financial reporting framework.

Contingencies

There are no material contingent losses including pending or potential litigation that should be accrued where:

- information presently available indicates that it is probable that an asset has been impaired or a liability had been incurred at the balance sheet date; and
- the amount of the loss can be reasonably estimated.

There are no material contingent losses that should be disclosed where, although either or both the conditions specified above are not met, there is a reasonable possibility that a loss, or a loss greater than that accrued, may have been incurred at the balance sheet date.

There are no contingent gains which should be disclosed.

All material matters, including unasserted claims, that may result in litigation against the ICB have been brought to your attention. All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to you and accounted for and disclosed in accordance with the GAM and relevant legislation and IFRSs as adapted and adopted by HM Treasury.

Appendix B: Draft management representation letter

Laws and regulations

I confirm that I have disclosed to you all those events of which I am aware which involve known or suspected non-compliance with laws and regulations, together with the actual or contingent consequences which may arise therefrom.

The ICB has complied with all aspects of contractual agreements that would have a material effect on the accounts in the event of non-compliance.

Fraud and error

I acknowledge my responsibility as Accountable Officer for the design, implementation and maintenance of internal control to prevent and detect fraud and error and I believe I have appropriately fulfilled those responsibilities.

I have disclosed to you:

- all the results of my assessment of the risk that the financial statements may be materially misstated as a result of fraud;
- all knowledge of fraud or suspected fraud affecting the ICB involving:
 - o management and those charged with governance;
 - o employees who have significant roles in internal control; and
 - o others where fraud could have a material effect on the financial statements.

I have disclosed to you all information in relation to any allegations of fraud, or suspected fraud, affecting the ICB's financial statements communicated by employees, former employees, analysts, regulators or others.

Related party transactions

I confirm that all related party relationships, transactions and balances, have been appropriately accounted for and disclosed in accordance with the requirements of the GAM and relevant legislation and IFRSs.

I have disclosed to you the identity of the ICB's related parties and all related party relationships and transactions of which I am aware.

Appendix B: Draft management representation letter

Charges on assets

All the ICB's assets are free from any charges exercisable by third parties except as disclosed within the financial statements.

Future commitments

The ICB has no plans, intentions or commitments that may materially affect the carrying value or classification of assets and liabilities or give rise to additional liabilities.

Subsequent events

I confirm all events subsequent to the date of the financial statements and for which the GAM, relevant legislation and IFRSs, require adjustment or disclosure have been adjusted or disclosed.

Should further material events occur after the date of this letter which may necessitate revision of the figures included in the financial statements or inclusion of a note thereto, I will advise you accordingly.

Impacts of military conflict including the Middle East and Ukraine

I confirm that I have carried out an assessment of the potential impact of military conflict including the Middle East and Ukraine on the business, including the impact of mitigation measures and uncertainties, and no disclosures are required in the financial statements.

Tariffs

I confirm that I have carried out an assessment of the potential impact of changes in US trade policy in respect of tariffs, including the impact of reciprocal tariffs by other countries, including the impact of mitigation measures and uncertainties, and no disclosures are required in the financial statements.

Going concern

To the best of my knowledge there is nothing to indicate that the ICB will not continue as a going concern in the foreseeable future. The period to which I have paid particular attention in assessing the appropriateness of the going concern basis is not less than twelve months from the date of approval of the accounts.

Annual Governance Statement

I am satisfied that the Annual Governance Statement (AGS) fairly reflects the ICB's risk assurance and governance framework and I confirm that I am not aware of any significant risks that are not disclosed within the AGS.

Appendix B: Draft management representation letter

Annual Report

The disclosures within the Annual Report and Remuneration and Staff Report fairly reflect my understanding of the ICB’s financial and operating performance over the period covered by the financial statements.

Unadjusted misstatements

I confirm that the effects of the uncorrected misstatements are immaterial, both individually and in aggregate, to the financial statements as a whole. A list of the uncorrected misstatements is attached to this letter as an Appendix. Please make sure the appendix is attached to the letter and not cross-referenced to the appendix in the ACR.

Arrangements to achieve economy, effectiveness and efficiency in Use of Resources (Value for Money arrangements)

I confirm that I have disclosed to you all findings and correspondence from regulators for previous and ongoing inspections of which I am aware. In addition, I have disclosed to you any other information that would be considered relevant to your work on value for money arrangements.

Yours sincerely,

Accountable Officer on behalf of the ICB

Date: XXXX

Appendix

Schedule of unadjusted misstatements

Appendix C: Draft audit report

Independent auditor’s report to the Board of NHS North East and North Cumbria Integrated Care Board

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of NHS North East and North Cumbria Integrated Care Board (‘the ICB’) for the year ended 31 March 2026, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers’ Equity, the Statement of Cash Flows, and notes to the financial statements, including material accounting policy information.

The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury’s Financial Reporting Manual 2025/26 as contained in the Department of Health and Social Care Group Accounting Manual 2025/26, and the Accounts Direction issued by NHS England with the approval of the Secretary of State as relevant to Integrated Care Boards in England.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2026 and of its net expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2025/26; and
- have been properly prepared in accordance with the requirements of the Health and Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the “Auditor’s responsibilities for the audit of the financial statements” section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC’s Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

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

Based on the work we have performed, and taking into account the requirements of the Department of Health and Social Care Group Accounting Manual, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB’s ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Appendix C: Draft audit report

Other information

The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

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

We have nothing to report in this regard.

Opinion on regularity

In our opinion, in all material respects the expenditure and income reflected in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Responsibilities of the Accountable Officer for the financial statements

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

The Accountable Officer is required to comply with the Department of Health and Social Care Group Accounting Manual 2025/26 and prepare the financial statements on a going concern basis, unless the ICB is informed of the intention for dissolution without transfer of services or function to another public sector entity. The Accountable Officer is responsible for assessing each year whether or not it is appropriate for the ICB to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

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

Appendix C: Draft audit report

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

Based on our understanding of the ICB, we considered that non-compliance with the following laws and regulations might have a material effect on the financial statements: employment regulation, health and safety regulation, data protection, environmental protection, corruption and anti-bribery, anti-money laundering regulation.

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

- gaining an understanding of the legal and regulatory framework applicable to the ICB, the environment in which it operates, and the structure of the ICB, and considering the risk of acts by the ICB which were contrary to the applicable laws and regulations, including fraud;
- inquiring with management and the Audit Committee, as to whether the ICB is in compliance with laws and regulations, and discussing their policies and procedures regarding compliance with laws and regulations;
- inspecting correspondence, if any, with relevant licensing or regulatory authorities; and
- reviewing minutes of relevant meetings in the year; communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and considering the risk of acts by the ICB which were contrary to applicable laws and regulations, including fraud.

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

In addition, we evaluated management's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to **posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates,** and significant one-off or unusual transactions.

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

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

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

Appendix C: Draft audit report

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

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

Report on the ICB’s arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

We have nothing to report in this respect.

Responsibilities of the Accountable Officer

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

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

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

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in March 2026.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

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

Appendix C: Draft audit report

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

We are required to report to you if:

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

We have nothing to report in these respects.

Use of the audit report

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

Delay in certification of completion of the audit

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

[Signature]

Mark Kirkham, Partner
For and on behalf of Forvis Mazars LLP (Local Auditor)

5th Floor
3 Wellington Place
Leeds
LS1 4AP

Appendix D: Confirmation of our independence

We communicate any matters which we believe may have a bearing on the independence or the objectivity of Forvis Mazars LLP and the audit team. As part of our ongoing risk assessment, we monitor our relationships with you to identify any new actual or perceived threats to our independence within the regulatory or professional requirements governing us as your auditors.

We remain available to the Audit Committee to discuss any matters relating to our independence, should such a discussion be required.

Confirmation of independence

We confirm that the firm, Forvis Mazars LLP, and all covered persons remain independent of NHS North East and North Cumbria ICB in accordance with the requirements of the FRC Ethical Standard.

Relationships disclosure

A review of relationships between the firm, covered persons, and NHS North East and North Cumbria ICB, including its directors, senior management, affiliates, and connected parties, has identified no matters that bear on our integrity, objectivity, or independence during the engagement period.

Non-audit and additional services

The firm has not provided any non-audit or additional services to NHS North East and North Cumbria ICB or its affiliates during the relevant period, and no fees have been charged in respect of such services.

Breaches

There have been no breaches of the relevant Ethical Standard, and no actions or remedial measures have been necessary.

Use of component auditors

We have not made arrangements for any of our activities as auditor to be conducted by another firm that is not a Forvis Mazars' member firm.

Use of experts

We have not used the work of external experts.

Appendix E: Other communications

Other communication		Response
	Compliance with Laws and Regulations	We have not identified any significant matters involving actual or suspected non-compliance with laws and regulations. We will obtain written representations from management that all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements have been disclosed.
	External confirmations	We did not experience any issues with respect to obtaining external confirmations.
	Related parties	We did not identify any significant matters relating to the audit of related parties. We will obtain written representations from management confirming that: - they have disclosed to us the identity of related parties and all the related party relationships and transactions of which they are aware; and - they have appropriately accounted for and disclosed such relationships and transactions in accordance with the requirements of the applicable financial reporting framework.
	Going Concern	We have not identified any evidence to cause us to disagree with you and the directors that the ICB will be a going concern, and therefore we have not identified any evidence to cause us to consider that the use of the going concern assumption in preparation of the financial statements is not appropriate.

Appendix E: Other communications

Other communication		Response
	Subsequent events	We are required to obtain evidence about whether events occurring between the date of the financial statements and the date of the auditor’s report that require adjustment of, or disclosure in, the financial statements are appropriately reflected in those financial statements in accordance with the applicable financial reporting framework. We will obtain written representations from management that all events occurring subsequent to the date of the financial statements and for which the applicable financial reporting framework requires adjustment or disclosure have been adjusted or disclosed.
	Matters related to fraud	Our audit was designed to obtain reasonable assurance whether the financial statements as a whole are free from material misstatement due to fraud. Please refer to the section titled ‘Fraud considerations’ for our fraud considerations and conclusion. We will obtain written representations from management and, where appropriate, Audit Committee, confirming that - they acknowledge their responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud; - they have disclosed to the auditor the results of management’s assessment of the risk that the financial statements may be materially misstated as a result of fraud; - they have disclosed to the auditor their knowledge of fraud or suspected fraud affecting the ICB involving: - management; - employees who have significant roles in internal control; or - others where the fraud could have a material effect on the financial statements; and - they have disclosed to the auditor their knowledge of any allegations of fraud, or suspected fraud, affecting the entity’s financial statements communicated by employees, former employees, analysts, regulators or others.

Appendix E: Other communications

Other communication		Response
	System of Quality Management	To address the requirements of ISQM (UK) 1, our firm’s System of Quality Management team completes, as part of an ongoing and iterative process, a number of key steps to assess and conclude on our firm’s System of Quality Management, including: • ensuring there is an appropriate assignment of responsibilities under ISQM (UK) 1 and across Leadership; • establishing and reviewing quality objectives each year, ensuring ISQM (UK) 1 objectives align with our firm’s strategies and priorities; • identifying, reviewing, and updating quality risks each quarter, taking into consideration a number of input sources (such as FRC / ICAEW review findings, internal monitoring findings, findings from our firm’s root cause analysis and remediation functions, etc.); • identifying, designing, and implementing responses as part of the process to strengthen our firm’s internal control environment and overall quality; and • evaluating responses and remediating control gaps or deficiencies. We perform an evaluation of our system of quality management on an annual basis. We publish the details of our annual evaluation, and our conclusion, in our Transparency Report, which can be accessed on our website at: https://www.forvismazars.com/uk/en/who-we-are/corporate-publications/transparency-reports.

Contact

Forvis Mazars

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Partner
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