Item: 9

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

BOARD 29 July 2026	
Report Title:	**Chief Executive Report**

Purpose of report

The purpose of this report is to provide an overview of recent activity carried out by the ICB team, as well as some key national policy updates.

Key points

The report includes items on:

- Interim Regional Director
- System finance
- ICB Boundary
- Neighbourhood Health
- Cyber Security
- Leadership Standards
- Castlegate and Derwent Surgery
- Movement 26.6
- Leadership Standards

Risks and issues

This report highlights ongoing areas for action linked to financial pressures, the delivery of the ICB running cost reduction, quality of services and other broader issues that impact on services.

Assurances and supporting documentation

This report provides an overview for the Board on key national and local areas of interest and highlights any new risks.

Recommendation/action required

The Board is asked to receive the report for assurance and ask any questions of the Chief Executive.

Acronyms and abbreviations explained

CDDFT - County Durham and Darlington NHS Foundation Trust
CQC – Care Quality Commission
ICB – Integrated Care Board
IHO - Integrated Health Organisation
MNP - Multi-Neighbourhood Provider
NENC – North East and North Cumbria

NECS – North of England Care System Support NHCFT - Northumbria Health Care FT NHSE – NHS England PIFU - Patient Initiated Follow-Up OPIC - Office of Pan-ICB Commissioning SPOA - Single Point of Access UEC - Urgent and Emergency Care	
Sponsor/Approving Chief Officer	Professor Sir Liam Donaldson, Chair
Date approved by Chief Officer	14 July 2026
Report author	Samantha Allen, Chief Executive

Link to ICP strategy priorities (please tick all that apply)	
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? (please tick)	**Yes**		**No**	✓	**N/A**	
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓

Essential considerations (must be completed)	
Financial implications and considerations	Not applicable – for information and assurance only.
Contracting and Procurement	Not applicable – for information and assurance only.
Commissioning Team	Not applicable – for information and assurance only.
Digital implications	Not applicable – for information and assurance only.
Clinical involvement	Not applicable – for information and assurance only.
Health inequalities	Not applicable – for information and assurance only.
Patient and public involvement	Not applicable – for information and assurance only.
Partner and/or other stakeholder engagement	Not applicable – for information and assurance only.
Other resources	Not applicable – for information and assurance only.

Chief Executive Report

1. Introduction

The purpose of this report is to provide an overview of work across the Integrated Care Board (ICB) and key national policy updates and reports.

2. NHS England North East and Yorkshire – Region Update

On 01 July 2026, I took up an Interim role as Regional Director for NHS England North East and Yorkshire. Our Chair, Sir Liam Donaldson, has agreed I can undertake this interim role to support NHS England. Arrangements have been put in place to carefully manage any potential conflicts of interest as I will remain the accountable officer for the ICB.

3. North East and North Cumbria

3.1 Financial Position

As previously noted, from 2026/27 all organisations have agreed individual financial plan limits with system financial plans no longer in place. At month 2, the ICB is reporting a breakeven position in line with plan although at this stage of the year there is always relatively limited data available. As the Commissioner we also have a role to ensure sustainability of NHS services and will continue to work closely with our 11 NHS Trusts.

There remain a number of potential financial risks acro, with a net unmitigated risk of £31m included in the final agreed plan for 2026/27. At month 2, net unmitigated risk had reduced to £24m and work will continue to review potential risks and seek further mitigations. Following discussions with Board previously, scenario planning is also underway around years two and three of the medium term financial plan.

The majority of ICB budgets are expected to be managed by relevant ICB sub-committees in 2026/27 under budget delegation arrangements. To support this, a financial accountability framework has been developed which sets out the proposed approach to budget delegation and management, including respective responsibilities of budget managers and sub-committees. This will help to ensure robust arrangements remain in place and support the continued delivery of the overall ICB financial position.

Although the joint requirement to manage the system financial position no longer applies, NHS organisations are still expected to work collaboratively across the system. At month 2, we understand the NENC ICS position overall is an adverse variance to plan of £6.7m year to date, largely reflecting additional costs due to industrial action and under-delivery of efficiencies, with a forecast position in line with plan.

3.2 ICB Boundary

Parliament has recently passed the English Devolution and Community Empowerment Act 2026 which streamlines the establishment of strategic authorities and the devolution of powers, subject to local consent. As part of this we were invited to respond to a government consultation on aligning ICB footprints with strategic authorities (one or more) ‘wherever feasibly possible’.

As well as engaging with our partners on this question, our approach has been to assess any proposed boundary changes through the lens of what best supports patients and the delivery of

high-quality healthcare, rather than seeking administrative alignment for its own sake. While we recognise the Government's ambition to align ICB and strategic authority boundaries where appropriate, we believe any changes must demonstrably improve patient outcomes, strengthen integration, reduce inequalities and enhance the sustainability of services. Although there were mixed views on the position of North Cumbria within our footprint, we support the retention of the current North East and North Cumbria ICB footprint on the grounds that it reflects the reality of long-established clinical networks, patient flows and workforce arrangements. We have also committed to deepening our partnerships with the North East Mayoral Strategic Authority, the Tees Valley Combined Authority and the new Cumbria Strategic Authority to deliver shared priorities through stronger governance, place-based collaboration and integrated approaches to health, prevention and economic growth.

3.3 Office for Pan-ICB Commissioning Transition

Work continues to progress on the future hosting and commissioning arrangements for the North East and Yorkshire Office for Pan-ICB Commissioning (OPIC). The proposed model would see North East and North Cumbria ICB act as host organisation on behalf of the four ICBs across the region, subject to Board approval and completion of appropriate due diligence.

The ICB is undertaking a structured due diligence process over the coming months, covering workforce, finance, legal, information governance, estates, IT, corporate services, service continuity and future governance arrangements. This will include alignment with the national safe transfer checklist and checkpoint review before any final Board decision.

The emerging governance model is designed to ensure that, while NENC may act as host employer, commissioning accountability remains shared across all four ICBs. Further work is underway on the single North East and Yorkshire Joint Committee, OPIC leadership arrangements, formal subgroups for finance, quality, contracting and performance, and the future Partnership Board. Providers of specialist services will also be engaged and invited to be involved through the governance arrangements, particularly those organisations where over 25% of their income is through specialist services.

A particular focus is also being given to the organisational development and cultural aspects of the transition. Around 150–180 specialised commissioning and direct commissioning staff are expected to transfer into the ICB from NHS England. It will be important that onboarding is handled carefully, with clear leadership, good communication, and a strong focus on building shared ways of working between OPIC staff and ICB teams.

The current approach is therefore one of active mobilisation, with appropriate assurance. Further updates will be brought through ICB Leadership Committee and Board as the due diligence work progresses and recommendations are developed.

3.4 Neighbourhood Health

A Neighbourhood Health Task and Finish Group is meeting weekly to oversee development of the ICB Strategy for Neighbourhood Health. The strategy will support places to develop neighbourhood models that are locally tailored while remaining aligned to a shared strategic framework. This framework will set out the ICB’s core neighbourhood health priorities, including priority cohorts, enabling functions, metrics and the support offer to local neighbourhood teams. The current timeline is to review initial feedback from internal stakeholders throughout July, undertake further engagement during August and September and finalise the strategy in late autumn 2026.

The ICB was pleased to welcome Dr Claire Fuller and national colleagues to North East and North Cumbria on 07 July as part of the national neighbourhood health programme. The visit provided an important opportunity to showcase the progress already being made across the region, while

also creating space for an honest discussion about the challenges we still need to work through as we develop neighbourhood health at scale.

A key message from the visit was the richness and diversity of our communities and places. There is no single model for neighbourhood health across North East and North Cumbria, nor should there be. The solutions developing in urban communities will not always look the same as those emerging in rural, coastal and more dispersed communities. The discussions highlighted the breadth of local innovation already underway, including the work in our first wave neighbourhood health implementation sites, wider multidisciplinary models, women's health hubs, WorkWell and other place-based approaches.

The visit also reinforced the importance of partnership. Progress is being made because colleagues across primary care, local government, the voluntary and community sector, providers, communities and the ICB are working together around a shared ambition for population health, prevention and community wellbeing. This collaborative approach will be central to moving from individual examples of good practice to a more consistent and sustainable model across the region.

Claire encouraged us to take time to recognise and celebrate the work already happening, as well as focusing on the next set of challenges. This was an important reflection. There was much to be proud of in the examples shared, and the visit provided further confidence that North East and North Cumbria has strong foundations on which to build.

The visit also identified areas for further development, including governance, financial delegation, data and intelligence, and how we scale some of the work already underway. Claire's team will share their formal assessment with us in August for local review, ahead of national publication in September. We will use this feedback to support the next phase of our neighbourhood health work and to inform the development of our wider strategy and commissioning approach.

3.5 Urgent and Emergency Care

Following comparatively good urgent and emergency care (UEC) performance in 2025/26 the NENC system is committed to further improving our UEC performance and meeting the national UEC planning requirements in 2026/27, whilst continuing our improvement journey towards the NHS UEC Constitutional Standards.

Whilst performance in the first quarter of 2026/27 remains strong, we acknowledge there is still more to do to ensure our patients get the best service and experience possible. Performance highlights in quarter 1 include:

- NEAS ranked 1/11 (11 Ambulance Trusts across the country) for all 4 ambulance response time categories.
- Reducing numbers of Ambulance Handover Delays, both in terms of average time and those waiting over 15 minutes.
- Ranking 4/36 ICBs for A&E 4-hour performance.
- Reducing number of patients waiting over 12hrs in an A&E department.

In April 2026, the UEC Network Board facilitated a NENC system Winter Debrief where, as a system, we reviewed our performance over the previous winter, highlighted areas for improvement and areas of best practice, and set our system wide UEC priorities for 26/27. These are:

1. Enhancing the respiratory pathway
2. Maximising preventative & home facing offer
3. Improve in-hospital flow and discharge

The priorities are underpinned by an extensive programme of work to deliver improvements across urgent and emergency care.

To enhance our approach to, and oversight of, winter planning across NENC we have re-established a Winter Planning Assurance & Delivery Group, which was successfully introduced during 25/26, to co-ordinate the production of our system plan and monitor its delivery throughout 2026/27. This system plan will be co-produced with our front-line services, identifying any risks and issues across our system and provide targeted interventions to support mitigation and improvement, building on our existing programmes of work. We will also gain assurances that the 'Model ED' NHSE guidance (published in February 2026) is, where appropriate, being adhered to across our system, this work has already commenced.

3.6 Outpatient Transformation

Transformation of outpatient services remains a key priority for delivering modernised services for patients and also productivity. The ICB has delegated responsibility for outpatient transformation to the Provider Collaborative.

The NENC Outpatient Transformation Programme is making good progress against national outpatient reform priorities. The programme is focused on clinically led pathway redesign rather than solely delivering activity targets, with strong engagement from provider organisations across the region.

Key areas of focus and progress are outlined below.

Reducing unnecessary outpatient follow-up appointments

- Reducing low-value follow-up appointments is identified as one of the largest opportunities to improve access, increase capacity and support RTT recovery.
- GIRFT analysis suggests that improving follow-up to first appointment ratios could release 346,149 outpatient appointment opportunities annually across NENC.
- All providers are conducting specialty-level reviews to identify low-value follow-up activity and redesign pathways.
- Strong Medical Director oversight and clinical leadership are in place.

Reducing non-attendance (DNA)

- NENC outpatient DNA rate is 6.3%, slightly better than the national average of 6.5%.
- Every 1% reduction in DNA rates releases additional outpatient capacity.
- South Tyneside and Sunderland reduced gynaecology DNA rates from 7.2% to 4.8% through improved patient communication, digital reminders and pathway redesign.
- North Cumbria has one of the lowest DNA rates in the system at 5.6%.

Expanding Advice & Guidance (A&G) & Implementing Single Point of Access (SPOA)

- All providers are working towards SPOA implementation across ten priority specialties by October 2026.
- Some providers, including Northumbria and Gateshead, already have elements of SPOA operating.
- A provider peer-support model has been agreed, with targeted support for University Hospitals Tees and County Durham & Darlington during summer 2026.
- Risks to delivery relate to delays to national e-RS development and guidance; consultant workforce and job-planning constraints; and the need for sustained engagement with primary care.

Increasing Patient Initiated Follow-Up (PIFU)

- PIFU is one of the most significant transformation opportunities within the outpatient programme.
- Approximately 12,000 patients could potentially move onto appropriate PIFU pathways.
- Priority specialties include but are not limited to: Trauma & Orthopaedics, Gynaecology, Urology, Rheumatology, Gastroenterology ENT
- Current PIFU utilisation is 3.8% of follow-up activity against an NHS England ambition of 5% by March 2029.
- Providers with strong utilisation are Gateshead: 7.1 and Northumbria: 6.7%

Using clinical alliances to redesign pathways

- Clinical alliances are a key mechanism for delivering transformation at scale, with ENT and gynaecology alliances currently in place.
- Alliances are prioritising pathway redesign linked to the Strategic Approach to Clinical Services programme and the integration of PIFU into specialty redesign work. The Gynaecology Alliance has reduced waiting lists from approximately 27,000 patients to almost half; reduced first appointment waits from 14 months to 2 weeks through multiple interventions; and increased PIFU utilisation from 2.7% to 3.39%.

Overall, the programme is progressing well with strong clinical engagement and cross-provider working. Further delivery of opportunities is however paramount.

3.7 Aubrey System Learning Event

Following the identification of failings in breast services across County Durham and Darlington NHS Foundation Trust (CDDFT), the Trust commissioned an independent governance review from governance specialist Mary Aubrey. This review identified serious and long-standing weaknesses in clinical oversight, leadership action and accountability, and governance processes which enabled poor clinical practice to persist. The Trust accepted the findings of the review.

Noting the important learning and improvements required, the ICB determined the need to ensure all partners reviewed the findings to support broader system learning and improvements. The main areas of observation and learning across NENC included strong evidence of established governance frameworks including Board/committee structures with NED oversight across all Trusts, widespread use of Board Assurance Frameworks, risk registers and escalation processes, but found variable in the maturity of implementation, particularly in relation to consistent challenge and triangulation, policy oversight and external assurance.

Most organisations demonstrated alignment with the Aubrey principles, however improvement priorities, suggested the opportunity for system-wide learning. The ICB held a system wide learning event with senior leaders which took place in April 2026, reflecting on the early findings and experiences of the new Chair and CEO of CDDFT. Following the event, it was agreed trusts will ensure robust mechanisms are in place for learning, develop a peer review approach for shared learning across our system as required, and ensure transparency on reports commissioned linked to patient safety.

3.8 Integrated Care Strategy Refresh

The Board has also started a discussion on the refresh of the Integrated Care Strategy. The current strategy, *Better health and wellbeing for all*, remains a strong and relevant strategic foundation for the North East and North Cumbria health and care system. The proposal is therefore to undertake a refresh rather than a wholesale rewrite.

The fundamental vision and long-term goals remain broadly consistent, but the context for delivery has changed significantly since the strategy was first published. This includes the national 10-Year Health Plan, the development of neighbourhood health as a core organising model, the ICB's transition towards strategic commissioning, and the need for a sharper focus on outcomes, value, population health management and financial sustainability.

The refresh will apply the lens of the ICB as a strategic commissioner, recognising that partner organisations will take an increasingly important role in delivery and implementation. The ICB's role will be to set strategic direction, define outcomes and expectations, align commissioning levers, and provide oversight, assurance and support where delivery is off track.

Work will take place during 2026 to develop the refresh, including engagement with partners and a review of the metrics associated with our key goals. This will help ensure the refreshed strategy remains ambitious and relevant, while providing a clearer line of sight between our long-term goals, neighbourhood health, the five-year strategic commissioning plan and the delivery responsibilities of partners across the system.

3.9 Integrated Health Organisation

The Integrated Health Organisation (IHO) for Northumberland and North Tyneside is progressing well, with both the ICB and Northumbria Healthcare Boards supporting a phased implementation approach. This will establish a start-state contract from April 2027, focused on a defined initial scope, with additional services and responsibilities added over time as the model develops towards a population health approach.

The IHO is intended to support the national shifts from hospital to community, analogue to digital, and sickness to prevention, with neighbourhoods as the primary unit of delivery.

Initial areas of focus, although not confirmed, are expected to include primary care, digital, estates and prescribing, alongside priority pathways such as frailty, last year of life care and long-term conditions.

Significant progress has been made in programme development and stakeholder engagement. Several workshops involving the Trust, ICB, primary care and local authority partners have been undertaken, helping to build consensus around the model and identify key areas for further development. A Multi-Neighbourhood Provider (MNP) is now established in Northumberland, with North Tyneside expected to follow shortly, strengthening primary care's role within the emerging arrangements. This is a key building block to support the new ways of working within an IHO.

A procurement to appoint a partner to support the business case development has been awarded to Ernest and Young, who start on the 15 July. They will support the ICB and Northumbria Health Care FT (NHCFT) project teams to develop a completed business case expected for the ICB and NHCFT Boards in October.

Progress continues in establishing the strategic direction, governance arrangements, and stakeholder support; wider engagement with all of primary care via a webinar approach is scheduled for the end of July. A more detailed critical path is in development, which will include work around, financial modelling, risks and the final scope of services.

The ICB and Trust are linked into NHSE workshops which focus on contracting and commissioning arrangements. We are still waiting for national contractual guidance or arrangements.

The focus over the coming months will be on completing the business case, refining governance arrangements, agreeing outcome measures and setting out the plan for a safe and effective implementation from April 2027.

3.10 Castlegate and Derwent Surgery

Castlegate and Derwent Surgery serve around 18,000 patients in Cockermouth. Following a CQC inspection in February, the practice was found to be in breach of key regulations relating to safe care and treatment, governance, safeguarding, and complaints handling.

CQC published its full findings on 03 June, rating the practice as Inadequate overall, with inadequate ratings for Safe, Effective, Caring and Well-led, and Requires Improvement for Responsive. The practice has been placed in special measures and will receive a further CQC inspection within six months.

The ICB responded immediately following the inspection, putting support measures in place including temporary clinical support, medicines management input, regular provider meetings, and support from system partners to improve internal processes. The ICB's Neighbourhood Team has maintained regular contact with the provider throughout.

The contracting team identified several contractual breaches and considered these capable of remedy. As a result, a Remedial Notice was served in line with the contractual arrangements. Ongoing assurance arrangements remain in place, including weekly multi-professional meetings and regular updates to NHSE.

As part of the ICB's assurance process, a multi-professional visit was undertaken on 18 June. During the visit, issues raised in the CQC report were explored further through patient record reviews, discussions on progress against the CQC action plan aa well as any ongoing concerns, and opportunities for staff to raise any issues.

An early concern found on the assurance visit related to a subcontracted triage service. All subcontracting arrangements require ICB approval, which had not been obtained. In addition, there were clinical concerns that patient records were not being accessed as part of the triage process. This issue was raised and resolved promptly, resulting in the termination of the subcontract and the implementation of a new triage arrangement.

Cumberland Council's overview and scrutiny committee meets on 30 July where the ICB will provide an update on progress and support carried out since the CQC inspection in February. The practice has also been asked to attend. The ICB's Neighbourhood Sub-Committee will receive the assurance visit report in early August for consideration and all current meetings and support arrangements will remain in place.

3.11 Cyber Security Risk

NHS England has written to NHS Trusts and ICB's to reinforce the need for strong Board-level oversight of cyber security risks. The letter highlights the increasing cyber threat landscape and emphasises that cyber security should be managed as an organisation-wide risk, supported by appropriate governance, assurance and continuous improvement.

The ICB continues to work closely with NECS and partner organisations to maintain compliance with national cyber security requirements and strengthen organisational resilience. In support of the national expectations, the ICB has already commissioned an independent review of cyber supply chain management by AuditOne, providing additional assurance regarding supplier governance and third-party cyber risk management. The findings and recommendations from this review are being incorporated into ongoing assurance and improvement activities.

Board members are expected to seek assurance that the organisation:

- Maintains an accurate record of its critical systems, data and technology assets, with clear ownership and accountability for each.
- Understands and manages cyber risks associated with suppliers, contractors and third-party providers that support NHS services.
- Ensures only authorised staff have access to systems and information appropriate to their role, with robust controls for joining, moving and leaving staff.
- Identifies and addresses cyber vulnerabilities in a timely manner, reducing the likelihood of service disruption or data compromise.
- Maintains secure backups of critical information and regularly tests recovery arrangements to ensure services can be restored following a cyber incident.
- Monitors systems for signs of cyber threats or suspicious activity and has processes in place to respond quickly when issues are detected.
- Has clear cyber incident response and business continuity plans that are regularly tested and updated, including arrangements for prolonged disruption to digital services.
- Receives appropriate executive oversight of cyber security risks and regular assurance reporting on organisational resilience.

NHSE has also signalled that cyber security requirements will strengthen from September 2026, with enhanced national expectations relating to multi-factor authentication, endpoint protection and management of critical cyber risks. Organisations will be expected to demonstrate continued annual improvement in cyber resilience and compliance with the evolving Data Security and Protection Toolkit and Cyber Assessment Framework requirements.

The Board is asked to note the national guidance and the assurance activity already undertaken by the ICB, including the independent AuditOne review of cyber supply chain management, and to support continued focus on cyber resilience, governance and organisational preparedness.

3.12 Corporate IT and GPIT Service Transition

Work continues on the transition of Corporate IT and GPIT services from the former Commissioning Support Unit arrangements, with a particular focus on services currently delivered by North East Commissioning Support (NECS). This remains a significant component of the wider national programme to transfer commissioning support functions into Integrated Care Boards and NHS organisations.

Within North East and North Cumbria, a dedicated task and finish group continues to meet weekly, bringing together the ICB, NECS and NHCFT. Northumbria is acting as host organisation for Phase 1 of the arrangements during the current financial year, providing an important platform for continuity of service whilst longer-term arrangements are developed and assured.

Progress continues to be made across workforce, finance, information and technical due diligence workstreams. Northumbria has commissioned an independent due diligence process to inform decisions regarding the future hosting arrangements from April 2027 (Phase 2). There is a broadly positive expectation regarding the future arrangements, supported by constructive engagement between all parties and a shared commitment to maintaining service continuity. However, the ICB remains appropriately cautious pending completion of the due diligence work and formal confirmation of future arrangements.

A longer-term financial pressure has been identified within the emerging arrangements and work is ongoing between finance colleagues across the organisations involved to understand the underlying detail, validate assumptions and identify sustainable solutions. Alongside this, partners continue to maintain contingency planning and regular assurance discussions with NHSE to ensure risks are managed effectively as the programme progresses.

This remains a complex but important programme, and current assurance is that progress is being made in line with expectations, with close oversight in place to support delivery of the next phase of transition.

3.13 Hope Haven Visit

In March, I had the opportunity to visit Hope Haven at its recently opened centre in Carlisle, where I was able to see first-hand the invaluable support provided by the team to people across the Copeland area.

The service enables local residents to access immediate, walk-in support and receive the assistance they need without the delays often associated with referrals or waiting lists. Hope Haven offers a broad range of support, including physical and mental health services, addiction support, and advice relating to housing, employment and financial wellbeing.

A particular strength of services such as Hope Haven is their person-centred approach. Where individuals require support across multiple areas, the team works collaboratively to coordinate and deliver that support, reducing the need for people to navigate multiple services independently.

Hope Haven is one of several similar services established across the region in recent years. A new service in Redcar was opened by Teesside Mind in February, while Everyturn Mental Health has secured a contract to continue operating two successful Safe Haven services for the next four years. To date, The Bothy in Northumberland has supported 9,731 people, and The Anchorage in North Tyneside has supported 2,401 people.

Hope Haven is delivered through a partnership comprising Cumbria Health; Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust; Everyturn Mental Health; Home Group; iCan Wellbeing Group CIO; The WELL Communities CIC; and Whitehaven Community Trust.

3.14 HMP Low Newton Visit

In April, I attended the opening of the women's health Hub at HMP Low Newton. This is a new way of working designed to support women in the prison environment and better meet their health needs. I had the opportunity to speak with women and prison staff and learn more about the trauma, mental illness, substance misuse, poverty and worse health outcomes they can often experience. Whilst many prisons have improved access to health services the availability of support and quality can vary and prisoners often experience other barriers to healthcare such as access to timely treatment, privacy and an under recognition of women's health needs. The new health hub designed specifically to meet women's needs also has educational aspects and gives the opportunity to meet their needs more holistically.

3.15 Movement 26.2

In the 10 Year Health Plan, there was a commitment to deliver a movement campaign, led by Sir Brendan Foster:

“Sir Brendan Foster has agreed to advise and help assemble a group of expert partners to set up a campaign to motivate millions to walk – and where possible to run – on a regular basis.”

NENC ICB was requested, by NHSE, to be the national NHS lead for the development of this work and is working closely with Sir Brendan on the delivery of this programme. The initial launch of this, Movement 26.2, commenced in July and attracted significant national media attention.

Movement 26.2 is a bold national campaign designed to inspire millions of people across England to move more - rekindling our innate drive to move while making it rewarding, social, and achievable. Led by the science, and the World Health Organisation and Chief Medical Officer

guidelines (150 minutes of moderate activity a week), the campaign reframes the iconic marathon distance (26.2 miles) as an achievable monthly goal, based on walking ~30 minutes a day, five times a week.

This campaign has the potential to create a genuine step change in how we promote and increase physical activity while also addressing health inequalities by ensuring benefits are accessible irrespective of income.

At this juncture, it is important to note that this programme is not NHS led. However, the NHS is a key partner and will remain so as this evolves.

3.16 Leadership Standards

It was confirmed this month that the NHS College of Leadership and Management will be the national home for NHS leadership, management and talent excellence. It is expected that the College will build on the work of the Leadership Academy and will help to strengthen professional identity, support learning and career development, improve talent management alongside providing a recognised quality mark for leadership and management excellence.

In addition, the DHSC has published the new NHS Staff Standards which includes the first national NHS staff standard on line management. NHS England have also launched the new NHS Leadership and Management Framework, which sets out clear expectations for all NHS leaders and managers.

All organisations are being asked to begin to embed the framework within development, appraisal, recruitment and talent processes, and to support leaders and managers to use the self assessment as part of their normal appraisal and development conversations during 2026/27.

We are embedding this with our Organisational Development work and will support staff as we play our part in raising standards in leadership and management across the NHS.

3.17 ICB Staff Conference

500 of our staff came together in July for our yearly staff conference. Our focus was on the transition into becoming a strategic commissioner and it was fantastic to hear about the work we are already delivering as strategic commissioners. This includes areas such as;

- Work and Health which is seeing demonstrable results regarding supporting people to stay in work. This has already been reported to Board and further updates will be reported over the coming months ahead.
- Medicines strategy and decommissioning decisions that has taken account of the views of the population and stakeholders whilst driving through savings for the NHS.
- COPD – optimise programme – identification of high risk COPD patients to support them and reducing demand on UEC. As a result of this work, we have seen from this cohort of patients, a 74.6% reduction in 111 contacts, 89% reduction in 999 calls, 53% reduction in A&E attendances and a 58% reduction in respiratory non elective admissions.

These examples represent just a small number of examples that are making a difference across the North East and North Cumbria.

4. Recommendations

The Board is asked to receive the report and ask any questions of the Chief Executive.

Name of Author: Samantha Allen, Chief Executive

Name of Sponsoring Director: Sir Liam Donaldson, Chair

Date: 14 July 2026