

North East and North Cumbria Integrated Care Board

**Minutes of the Extraordinary Board meeting held on 12 February 2026
at 08:30, Durham Centre, DH1 1TN**

Present: Professor Sir Liam Donaldson, Chair
Samantha Allen, Chief Executive
Ken Bremner, Foundation Trust Partner Member
Levi Buckley, Chief Delivery Officer
David Chandler, Chief Finance Officer
Tom Hall, Local Authority Partner Member
Professor Sir Pali Hungin, Independent Non-Executive Member
Dr Hilary Lloyd, Chief Nurse and AHP Officer
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)

B/2025/121 Welcome and Introductions (agenda item 1)

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

B/2025/122 Apologies for Absence (agenda item 2)

Apologies were received from Kelly Angus Chief People Officer and David Gallagher Chief Contracting and Procurement Officer.

B/2025/123 Declarations of Interest (agenda item 3)

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

Item 7 – North East and North Cumbria Integrated Care Board Constitution

It was noted that Board members were impacted by the proposal to reduce the Board composition as detailed in the consultation. The Chair confirmed that members could however remain in the meeting and take part in the decision.

B/2025/124 Quoracy (agenda item 4)

The Chair confirmed the meeting was quorate.

B/2025/125 Notification of items of any other business (agenda item 5)

None.

B/2025/126 Strategic Commissioning Transition Programme – End of Consultation (agenda item 6)

The Board was presented with an update on the strategic commissioning transition programme which outlined the proposed amendments and modifications to the organisation's operating model and associated structures following the conclusion of the consultation process.

The Chief Executive noted that the quality of documentation did not entirely capture the extensive efforts involved in this undertaking and expressed appreciation to the Chief Strategy Officer for their leadership as Senior Responsible Officer throughout the process.

It was noted that change inevitably carries risk, and there had been organisational stress during this period of transition and staff had experienced months of uncertainty. These final structures which were based on extensive feedback would bring greater clarity and more certainty for staff.

Discussions with other ICBs indicated that the remaining clustering ICBs were considering similar approaches, and the ICB was sharing its methodology with colleagues. Whilst future changes could not be ruled out, they were likely to occur at a team level rather than organisational level. Some ICBs were addressing running cost reductions through different methods, including all age continuing care. It was crucial that the ICB's approach did not disadvantage the organisation, whilst meeting the statutory obligation to reduce running costs. The ICB remained confident in its ability to mitigate risks, and while the £19 target presented challenges, the ICB was confident the proposed structures would achieve this. Discussions on outsourcing and other technical issues continued.

The Board was asked to approve both the proposed structure and operating model. Assurance was provided that the blueprint and best practice principles had been fully considered. The operating model

should be reviewed and approved as a live document subject to further development.

The ICB wished to formally thank all staff who have participated constructively and engaged thoughtfully throughout this process, which had enabled the ICB to establish the most effective structure possible. The ICB also expressed gratitude to trade union partners for their constructive challenge and engagement, as well as to the transition and human resources teams for managing a significant workload and striving to ensure this process was delivered appropriately.

A 52-day consultation had been undertaken which commenced on 26 November 2025 and closed on 16 January 2026, consulting on organisational redesign, estates and on-call arrangements.

Voluntary Redundancy (VR) update

A total of 166 applications were received, with 111 being accepted, equating to 84.27 wte. The total cost of the VR applications being supported was £6.127m, with an additional national insurance cost of £487k. It was the ICB's intention to open a second round of VR only for those pools that remained competitive or at risk. The process would be staged starting with executives, very senior managers and Agenda for Change band 9s, then subsequently to the eligible staff in the wider organisation.

Summary of consultation feedback

The consultation generated significant feedback and engagement. The consultation inbox received 1,078 emails concerning the operating model, ways of working, job descriptions, and individual queries. There were 167 formal one-to-one meetings, along with six in person and three virtual roadshows, and two virtual on-call engagement sessions.

Ways of working framework

The consultation process highlighted staff concerns about the need for clearer roles, responsibilities, and clarity on future ways of working. Detailed feedback was shared by staff in relation to the remit of roles, the structure of teams and how teams would operate together. Feedback was also shared on how teams would work across the North East and North Cumbria geography, as well as retaining relationships at place.

Summary of changes resulting from the consultation

- The ways of working framework have been strengthened with clearer detail on the organisation's future direction, sector expectations, and governance arrangements, including how decisions and budget delegation will work.
- Across the nursing team, several structural and functional refinements had been made. In all age continuing care, job descriptions had been updated, the Band 5 role had been split into clinical and non-clinical roles, and clearer guidance had been provided on geographical working and links to commissioning,

personal health budgets, and brokerage. Safeguarding arrangements had been stabilised by retaining age-specific designate roles, adding all-age deputies for resilience, and increasing named safeguarding general practitioner capacity. The special educational needs (SEND), quality, Local Maternity and Neonatal System (LMNS) and research and evaluation and emergency planning, resilience and response (EPRR) teams had also been reshaped to provide clearer role definitions, improved skill mix, strengthened leadership and, in the case of EPRR, additional senior resilience capacity.

- Within corporate functions, communications, governance, digital, and people teams had been updated to reflect required capacity and clearer lines of responsibility. This included rebalancing communications roles, strengthening governance capacity, modernising the digital structure, and embedding health inequalities responsibilities across executive roles. The people function would retain interim senior leadership until 2026 while developing a new people and organisational development strategy, and a new Deputy Director of Health Inclusion role had been added.
- Finance and medical functions had also seen targeted refinements. Finance now benefited from clearer reporting arrangements, updated ways of working, and improved skill mix. The medical directorate had increased clinical leadership capacity, clarified expectations for clinical lead roles, strengthened the individual funding requests team, and adjusted certain posts to reflect operational priorities.
- Commissioning changes focussed on clarifying roles, strengthening leadership, and rebalancing capacity across teams. Neighbourhood health responsibilities had been better defined; children and young people's commissioning and thematic leadership strengthened, and additional capacity had been added to support commissioning of individual packages of care. Neighbourhood teams had been reorganised into four geographic groups to improve relational working, with additional senior posts added to support this. Primary care functions were now hosted within a neighbourhood team, and contracting oversight had been bolstered with additional senior capacity.

Northern Cancer Alliance

Since the consultation period was launched, there had been further discussions in relation to hosting arrangements for the Northern Cancer Alliance. It had been agreed that another organisation will look to host this team in the future, therefore Northern Cancer Alliance staff had been removed from the ICB's consultation process as they were no longer affected. These individuals would be subject to a separate consultation to transfer their employment to another organisation, and this had been discussed with affected individuals directly.

Estates and Hybrid Working

The ICB planned to consolidate from 13 office locations to four main sites, plus a few satellite offices to support community based roles such

as all age continuing care. Only those staff whose current basis was closing would change base, with moves phased and new bases chosen closest to home. It was anticipated that 239 staff would have a change of base.

A new hybrid working policy was in development with an expectation that staff would work two 2 days per week (pro rata'd for part time staff) in an office or in the field with partners or patients.

Response to ICB Blueprint and Best Practice Guides

The ICB had reviewed all of the functions identified as in scope for potential transfer over time and confirmed that these functions were appropriately reflected in the design work. It was confirmed that none of the transfers created a material impact on the proposed new structures. In addition, the ICB had reviewed all of the functions required for retention in 2026/27 and confirmed that they were fully reflected in the proposed operating model.

On-call

Following consultation, on call arrangements had been reviewed. A two-tier system would be implemented consisting of a first on call (tactical) and second on call (strategic) rota.

Equality Impact Assessment (EIA)

This review assessed the impact and representation of protected characteristics, noting that some were already underrepresented compared to the population served. The analysis showed no disproportionate impact of the process to date. An updated EIA was provided to members on the day of the meeting due to time constraints.

Quality Impact Assessment (QIA)

A quality impact assessment reviewed potential effects on the ICB's statutory functions, identifying and mitigating various risks. After mitigation, there were no high or 'red' rated risks.

Update on financial position

The total expected future costs 'in-scope' amounted to £77.9m compared to a target £19 per head figure, which equated to £68.8m. A number of non-cash releasing adjustments had been made, in particular around contracting/commissioning arrangements, which reduced the expected costs within the scope of the £19 per head calculations to £68.3m.

Accordingly, under the proposed new structures (and estimated non-pay costs) the ICB would be spending £18.85 per head, £539k under the £19 per head target.

Within 2026/27 ICB funding allocations, the ICB had been defunded by £25.1m reflecting the expected level of savings to deliver against the £19 per head target. Actual cash releasing savings were estimated at £22.5m leaving a £2.6m shortfall on a cash releasing efficiency basis,

i.e. whilst the ICB expected to be able to manage costs within the £19 per head target, there was an overall pressure of £2.6m to still manage. This pressure had been reflected in current draft financial plans for 2026/27, to be funded within running cost allowance, and was not expected to impact on commissioning plans and priorities.

Questions from Members of the Board

1. Today's agenda provided significant assurance, especially regarding the clarity of new working methods. It was pleasing to see that the ICB still had key leadership roles filled by the Medical Director, Nursing Director, and Finance Director; their resilience is essential as the ICB moves forward. The £0.5m contingency report was reassuring, though the organisational structure may require further adjustments. Given the NHS' history of lengthy leases, was the ICB currently tied to any long-term agreements before we can implement changes?

Some properties had break clauses and would be exited as soon as possible. Exit dates varied, with plans to void certain buildings. Loftus House would be vacated by the end of March, and others would follow in stages.

2. A query was raised concerning whether additional information would be presented to the Board regarding the ways of working, specifically the Strategic Commissioning Assurance Committee, along with how the ICB could ensure that patient voice and inclusion were effectively integrated and how the new ways of working and retaining relationships at place would work in practice.

Detailed proposals would be presented at a Board development session in February for discussion and the submitted to an extraordinary meeting in April for approval. The ICB's responsibilities were transitioning as providers assumed a leadership role in neighbourhood health delivery. The ICB was reviewing how involvement and engagement would work across the system and was encouraging organisations to improve their engagement with the populations they served. The aim was to set a standard for incorporating the patient voice. This transition did not signify a withdrawal, rather, it reflected the ICB's commitment to enhancing its role in strategic commissioning.

As the ICB transferred responsibilities for neighbourhood commissioning, it would ensure that accountability and overarching responsibilities would be preserved. Neighbourhood health guidance, originally expected in February, was now delayed until March. The ICB's collaborative approach would continue, reaching those communities that may not typically engage. The ICB aimed to evaluate engagement work with North East Ambulance NHS Foundation Trust, Healthwatch and the Voluntary and Community

Enterprise sector to understand how both organisations added value and used to influence how the neighbourhood model evolved.

The Freedom to Speak Up function remained in place, aiming to foster an open and restorative culture offering psychological safety training to all staff. There were ongoing discussions with primary care, who had expressed real positivity in guardians. Additionally, a network of Freedom to Speak Up champions was being established.

3. The roles and responsibilities of executive officers were clearly defined and vital to achieving the desired outcomes. When reviewing board committees, it was recommended to revisit guidance documents, incorporating relevant suggestions from the Dr Penny Dash Review. It was essential that the ICB's new structure and committees maintained oversight of these areas to ensure a continued focus. Additionally, it was important to effectively discharge commissioning functions whilst addressing these considerations.

A quality management and monitoring framework was being developed and evolved to enhance commissioning processes. Collaborative efforts would ensure this framework informed quality-related decisions and the development of relevant metrics. Moving forward, patient experience data would play a significant role in commissioning decisions and would be integrated with clinical effectiveness and patient safety measures.

The Chair personally thanked the executive team for handling this transitional work with care and sensitivity.

RESOLVED:

The Board **APPROVED** the amendments to the structures and ways of working framework, acknowledging the continuation of more detailed work on the ways of working framework.

The Board **NOTED** the contents of the equality impact assessment and quality impact assessment.

The Board was **ASSURED** that the statutory, delegated and blueprint-based responsibilities had been fully considered, national frameworks had been reviewed in full, and relevant actions had been incorporated into the ways of working and structures. The Board was confident that the proposed structures achieved the £19 per head target.

B/2025/127 North East and North Cumbria Integrated Care Board Constitution (agenda item 7)

Board members were impacted by the proposal to reduce the Board composition as detailed in the consultation. The Chair agreed that members could however remain in the meeting and take part in the decision.

The Board was presented with an updated Constitution for the North East and North Cumbria Integrated Care Board which had been reviewed and amended to align with the requirements set out by NHS England and the Model ICB Blueprint.

The main proposed changes were:

- Primary medical services wording updated to align to that of the model constitution issued by NHS England.
- A reduction in partner membership as part of the Board composition, reducing from nine to four.
- A reduction in the number of regular participants in attendance at Board.
- An updated position for all executive director roles following the consultation.
- The addition of an associate non-executive member (non-voting)
- Minor changes to wording and reference numbers throughout.

The Board noted the likelihood of further statutory changes affecting the Constitution in coming years, recognising it was a living document.

RESOLVED:

The Board **APPROVED** the amendments to the constitution and **AGREED** for the Constitution and letter of support signed by the Chief Executive to be submitted to NHS England for formal approval, with the caveat that changes would be effective from 1 May 2026.

B/2025/128 North East and North Cumbria Integrated Care Board Medium Term Planning Submission (agenda item 8)

The Board was provided with the ICB's medium term planning submission for 2026/27 to 2028/29. The submission included the Board Assurance Framework and five-year strategic commissioning plan for 2026/27 to 2030/31 for review and approval for submission.

Finance Plan

Revenue allocations had now been published for three financial years, 2026/27 to 2028/29. Allocations for 2027/28 and 2028/29 remained indicative however and the focus at this stage was on the plan for 2026/27.

The allocations and detailed technical guidance published included:

- ICB allocation growth on average of 2.7%
- Cost uplift factor set at 2.03% with an efficiency requirement of 2%, making net uplift of 0.03%.
- Remaining uplifts split out between acute, community, mental health and prescribing growth.
- Nationally calculated uplifts of 7% to deliver improvements such as waiting times.
- Elective recovery funding to be issued to ICBs on a fair share basis.
- Removal of NHS England foundation trust deficit support funding

- at 2% of NHS income per annum.
- Contract rebasing - expectation to move acute foundation trusts to cost of providing acute services at maximum of 2.5% per annum of contract value.
- Additional funding to flow if pay award exceeds estimate in allocations.
- An expectation that all NHS organisations break even.

From 2026/27 all organisations had been set individual financial plan limits and, although organisations were still expected to work collaboratively across the system, the joint requirement to manage the system financial position no longer applied and there was no system financial plan submission required.

Where ICBs and NHS trusts had a surplus or breakeven plan in 2025/26, they would be set a breakeven plan limit, therefore for the plan limit for the ICB was breakeven.

Where ICBs had a surplus plan position in 2025/26, that was supporting a deficit system financial position (and the system had received deficit support funding in 2025/26) this would need to be released in 2026/27 to NHS trusts in the system. For the ICB this meant £11.8m of funding, representing the agreed surplus plan for 2025/26 and the needed to be provided to NHS trusts within the system (to those providers with deficit plans).

In relation to capital growth there was substantial investment planned over the next five years, particularly in 2026/27. The ICB remained confident in its ability to invest in the transition from analogue to digital systems and improvements in estate safety, although notable delays were anticipated for 2026/27.

A compliant plan had been developed for the ICB, however there was concern that NHS England may not be able to approve plans for the three foundation trusts in deficit.

Performance

A high-level summary across the key performance domains in the final draft submission showed:

- Elective, diagnostics and cancer: not compliant for the ICB with variation at trust level.
- Primary and community care: compliant for all metrics except for 52-week waiters for children and young people in community services.
- Urgent and emergency care (trust submissions): compliant for all metrics at North East and North Cumbria trust aggregate level.
- Mental health, learning disabilities and autism: compliant for all metrics except individual placement support. The ambition is to be compliant for this in year three.

The ICB continued to communicate regularly with trusts and expect further progress before their final plans were submitted to NHS England. The ICB was confident that it was commissioning enough activity to meet referral to treatment standards.

Workforce

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

Board Assurance Framework

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

ICB Strategic Commissioning Plan

The ICB had developed a five-year strategic commissioning plan which was a key component of the medium-term planning requirements for the NHS. This set out the ICB's approach as a strategic commissioning organisation and the strategic priorities over the next five years, building on the commissioning intentions for 2026/27 which the Board had approved in November 2025.

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

Board Discussion

NHS England was currently undergoing a transition between two organisational structures and over the next few weeks regional teams would begin implementing changes. The ICB Chair and Chief Executive had been invited to attend assurance meetings for all trusts.

As commissioners, the focus was on driving best value and consistency of expectations, ensuring the organisation had the strongest possible foundation through agreed contract mandates, growth, and uplifts.

The coming weeks would be critical as NHS England determined its approach where systems were unable to maintain balanced plans. Regional teams were expected by NHS England to deliver balanced system plans for their entire region. Data would be an important asset; if the ICB failed to develop its capability as strategic commissioners, there was a risk of financial instability, potentially requiring additional funding for secondary care and limiting the ICB's ability to pursue other priorities. Building goodwill and clear relationships was essential, especially since regulatory oversight was not within the ICB's remit. There remained uncertainty regarding the financial reserves retained throughout this process, and further discussions would inevitably be required.

This year's plan resulted in a surplus of £11.8m, achieved by taking non-recurrent risks to balance the budget. Nationally, it had been determined that surpluses would be distributed on a pro rata basis to organisations with deficits. All deficit support funding would be gradually withdrawn according to national policy; consequently, other forms of national deficit support were also being phased out. Although these funds were not recurrent, their removal remained challenging.

The Board agreed it was important to make explicit the risks associated with the surplus transferring to foundation trusts, including the specific figures and awareness of the non-recurrent nature of this funding.

The ICB had created a balanced plan for the next three years and was confident in its direction. However, there were still opportunities to invest in left shift initiatives, which may require some difficult choices about service reform and improving efficiency. The budget was set up to support these efforts. As strategic commissioners, the ICB's main concern was that investments might be redirected to acute services due to payment-by-results incentives. This could cause unsustainable growth in areas where the ICB may struggle to meet performance targets for the acute sector. Additionally, foundation trusts offered community services, signalling a possible shift of focus from traditional acute care to community-based services.

RESOLVED:

The Board **APPROVED** the full ICB three-year finance workforce activity and performance submissions for 2026/27 to 2028/29, including the Board Assurance Framework.

The Board **APPROVED** the ICB five-year strategic commissioning plan for 2026/27 to 2030/31.

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

The Board **NOTED** the content within the accompanying planning update side deck and the requirement for robust equality quality impact assessments to be carried out for efficiency schemes in-line with the approved ICB policy.

B/2025/129 **Any other business**

None

The meeting closed at 10:10.