NHS
North East and North Cumbria

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

PERFORMANCE REPORT

Samantha Allen

Chief Executive

North East and North Cumbria Integrated Care Board

18 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.

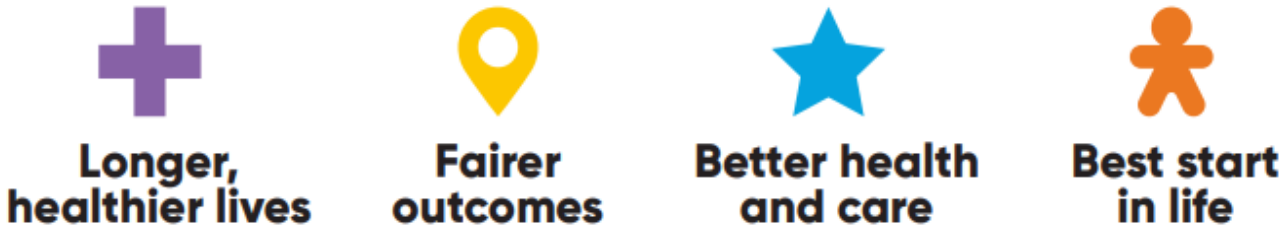
Better health and care services: high quality services no matter where you live and who you are.

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 is 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.

Table: NHS Oversight Framework (NOF) & CQC Summary

Appendix 1 - NHS Oversight Framework (NOF) & CQC Summary

NHS North East and North Cumbria

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.

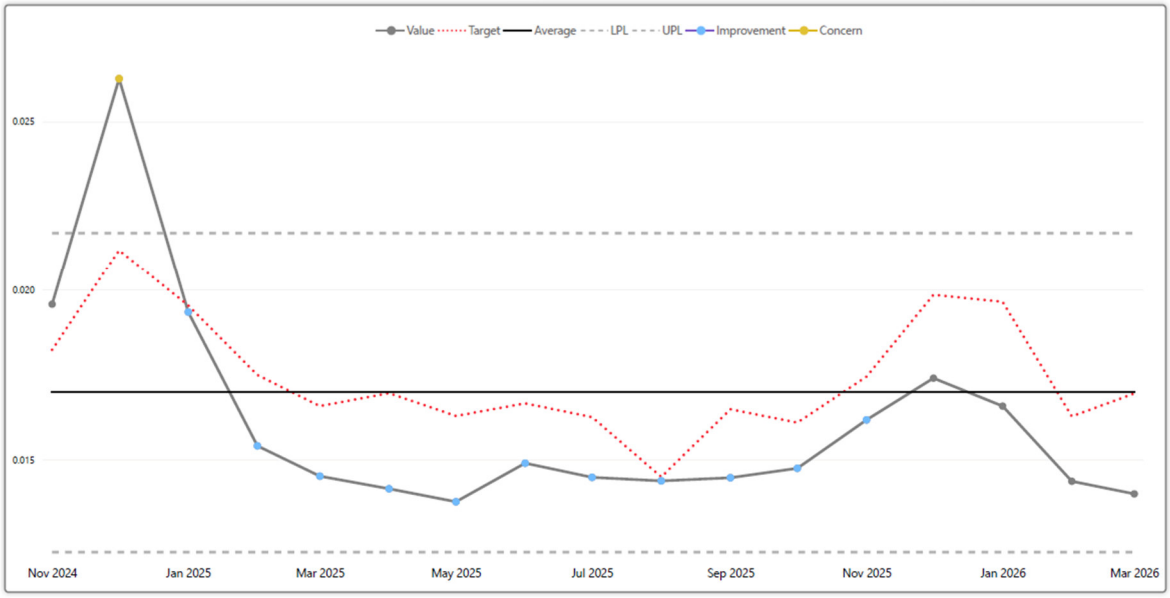
Notable improvements included:

- 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

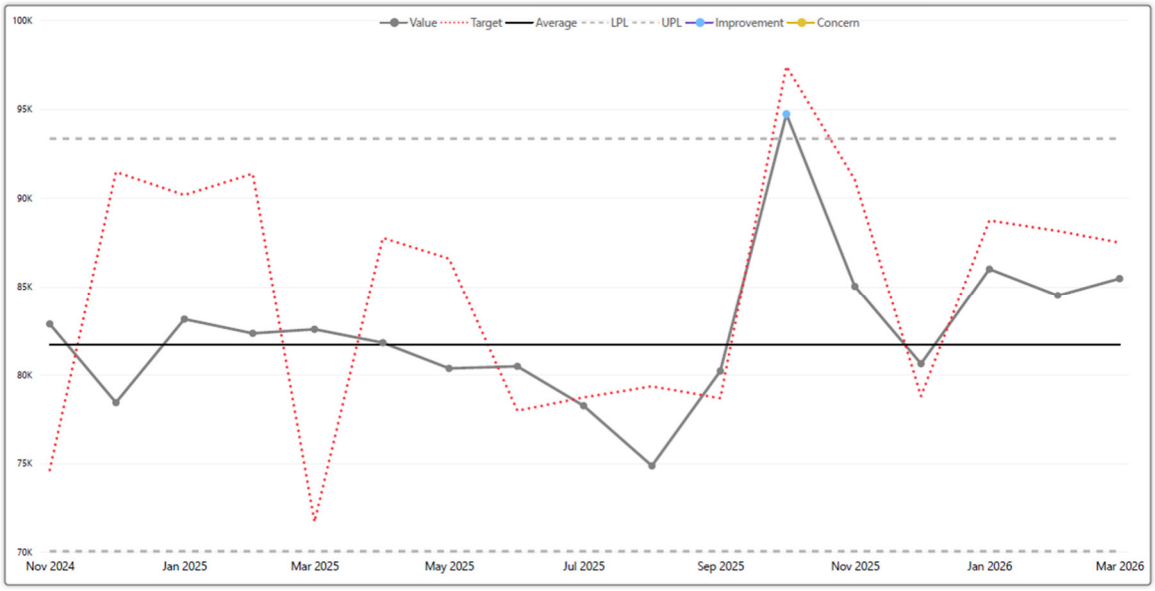
Metric	Period	Value	Plan	+/ - Plan	Target
Primary Care Appointments per Working Day	Jan 2026	85,980	88,732	-2,751.9	87,482
Number of Urgent Dental Appointments Delivered	Jan 2026	23,172	27,034	-3,862.0	26,510
Percentage of unique patients seen by NHS dentist (adult) - rolling 24m	Feb 2026	40.4%	42.0%	-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%.

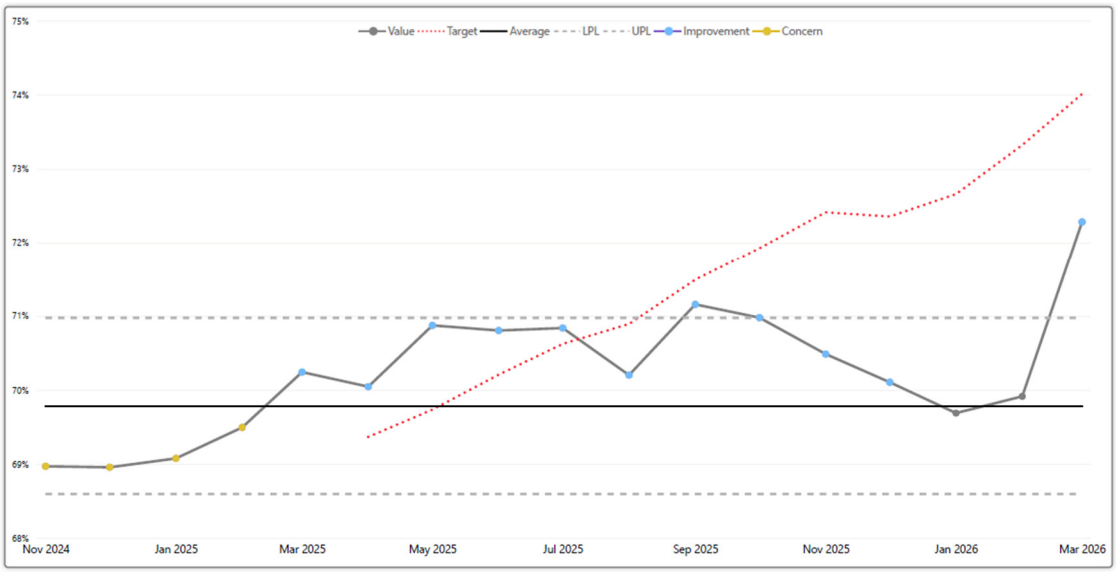
There has been a determined effort in 2025/26 to reduce the number of **long waiting patients** across NENC and as of March 2026 the number of patients waiting >52 weeks has reduced from a high of 6,977 (2024/25) to 2,379 in 2025/26. This represents 0.7% of the total waiting list against a national ambition 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) comparted 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

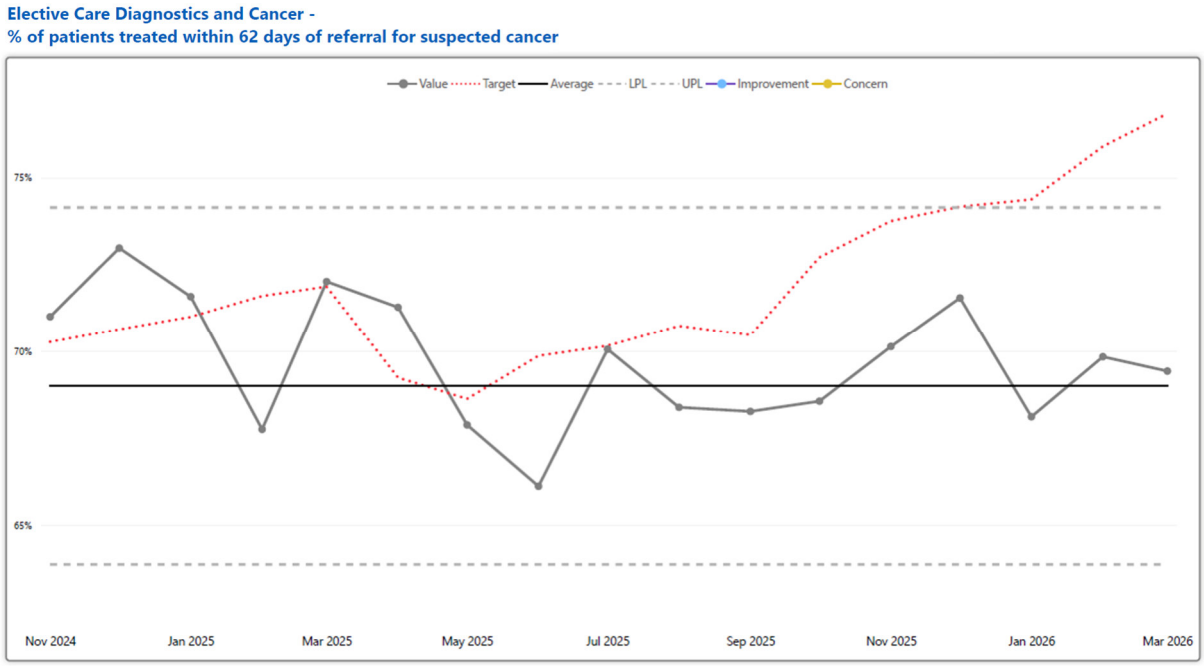
NENC ICB and The Northern Cancer Alliance (NCA) aims to speed up cancer pathways, increase diagnostics capacity, reduce waiting times and improve operational performance. Early diagnosis is key to increasing survival rates and reducing variation in treatment for our cancer patients. This in turn will 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

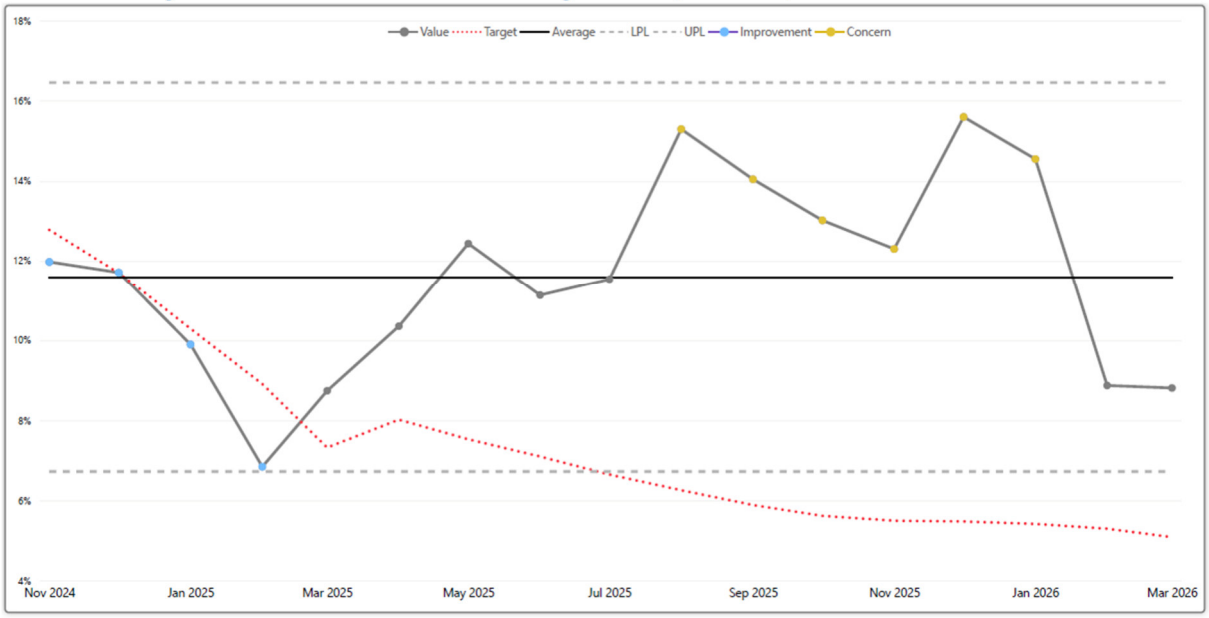
Most providers across NENC submitted an Operational Planning trajectory to deliver the **headline 62-day standard** to 75% by March 2026. Achieving a 25/26 high of 71.5% falls short of this ambition with a collection of notable challenges significantly hampering performance improvement. Additional resources 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%.



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%.

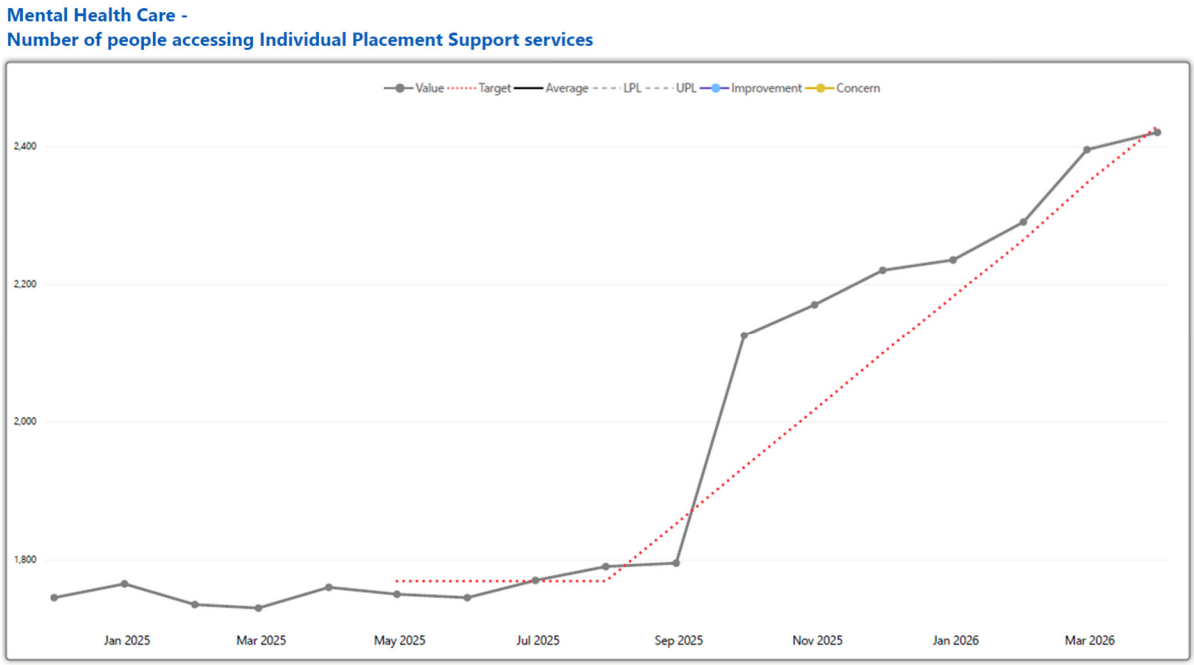
Reliable improvement - A person is defined as showing a reliable improvement if there is a significant improvement in their condition following a course of treatment, measured by the difference between their first and last scores on questionnaires which are tailored to their specific condition. The target 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.



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

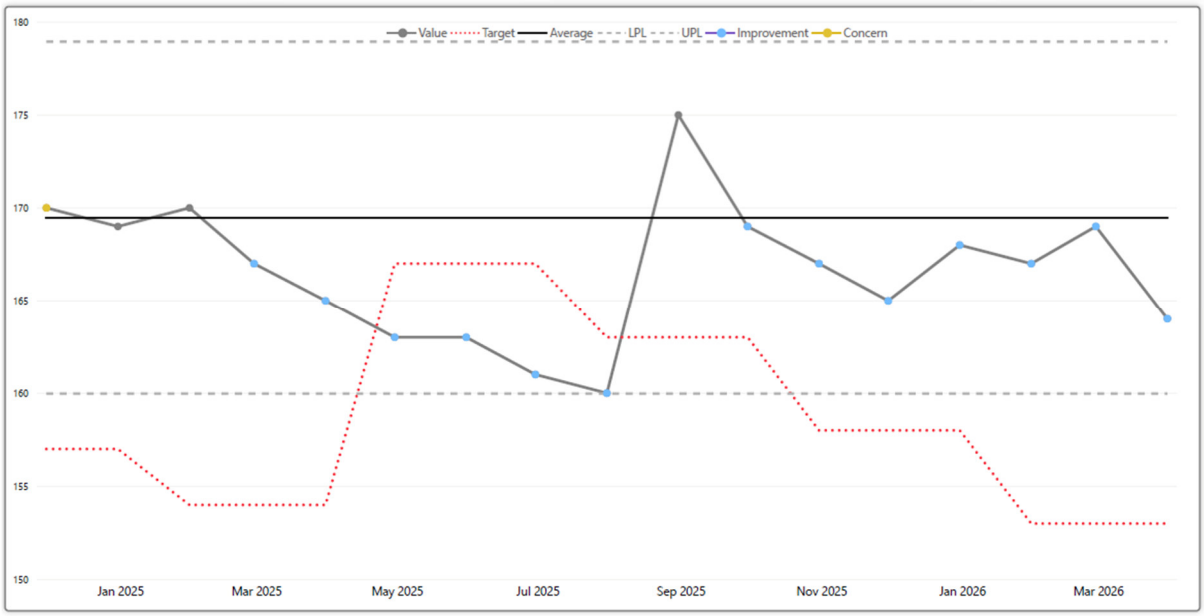
Metric	Period	Value	Plan	+/ - Plan	Target
LDA Inpatient Beds Occupied by Adults & Older Adults (from the AT database)	Feb 2026	169	153	+16.0	153

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 declined 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.

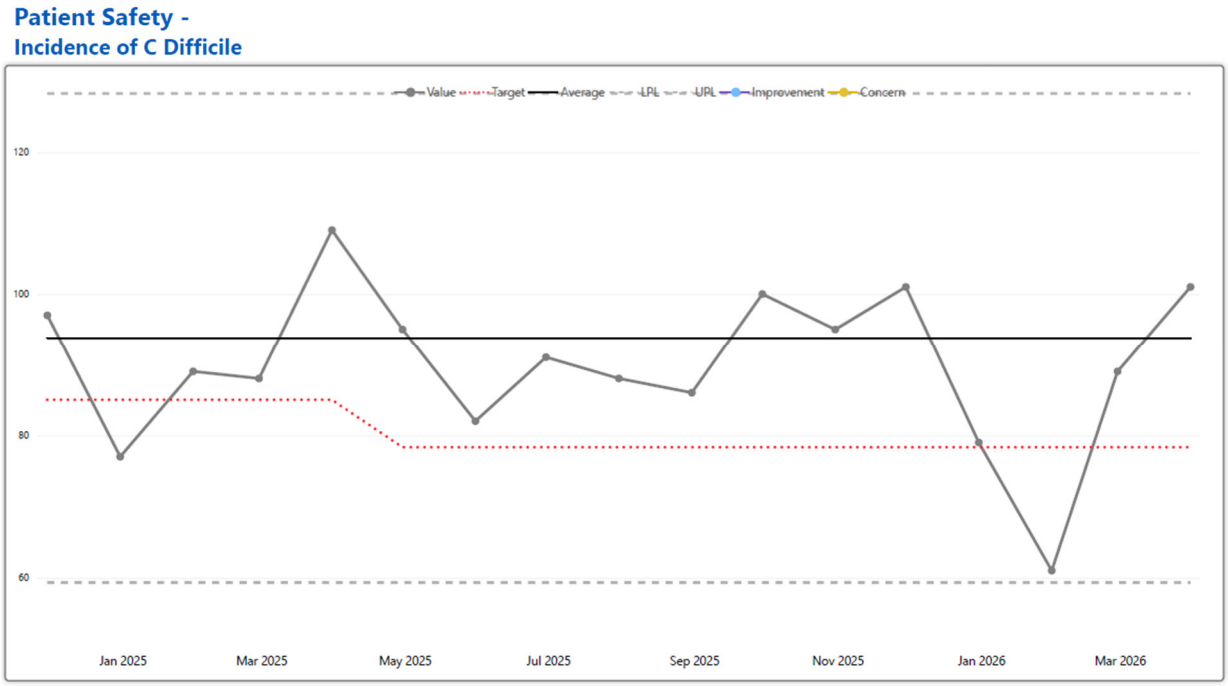
2025/26 Performance summary and mitigations

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.



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)).

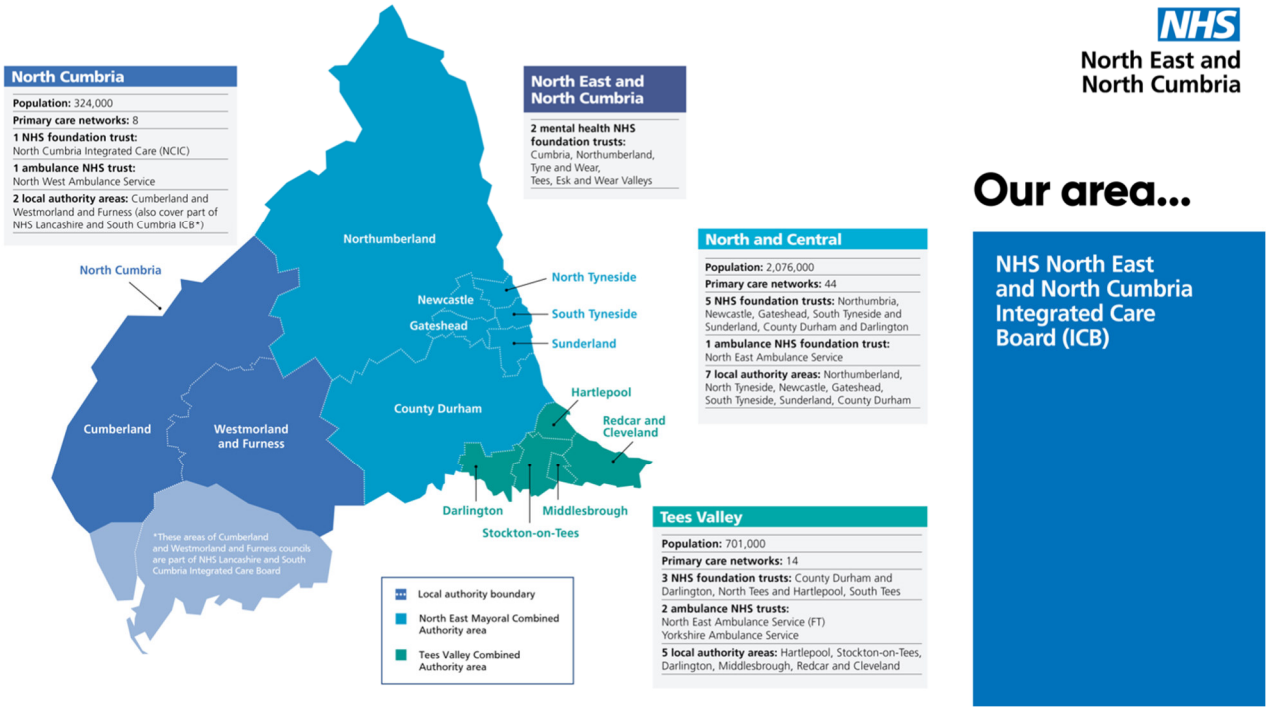
- **Social Value and Anchor Institutions**: The ICB uses its commissioning power to support local economic development, recognising that employment is a key driver of health.

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

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 sigma, 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 Bourne Virus (BBV) Peer Support project - supports the NHS England programme Blood Bourne 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 Cumbia (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 incudes

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.

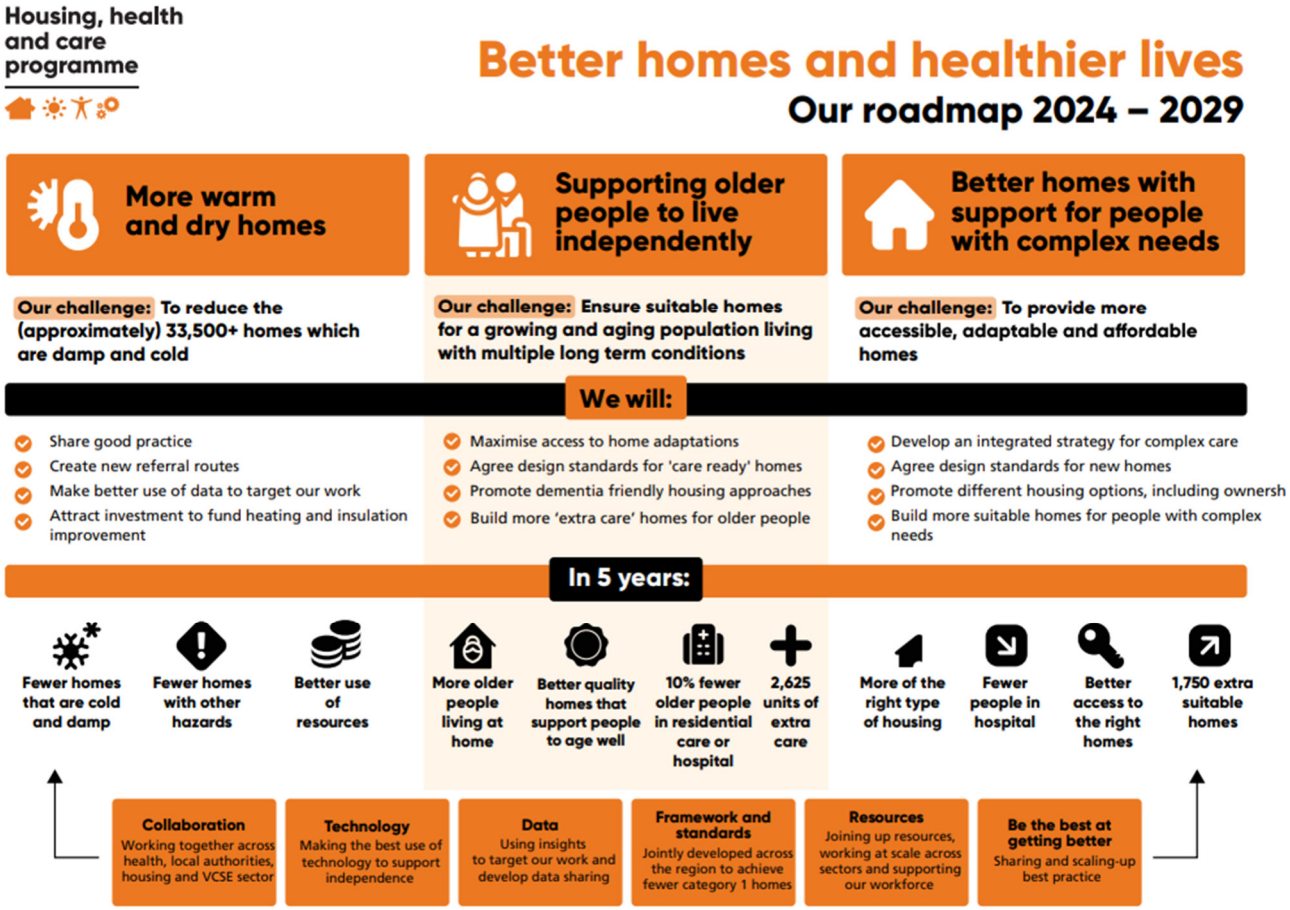
We have partnered with the Housing Learning and Improvement Network (LIN) to develop a baseline review of housing needs in the region. This, along with feedback from events, and discussions, and our community of practice has shaped our plans for the next five-years.

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.



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

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 CO_2 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 therapeutical 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 that 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 and 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 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 muti 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.	✓

Target	Target Met?
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.	✓

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

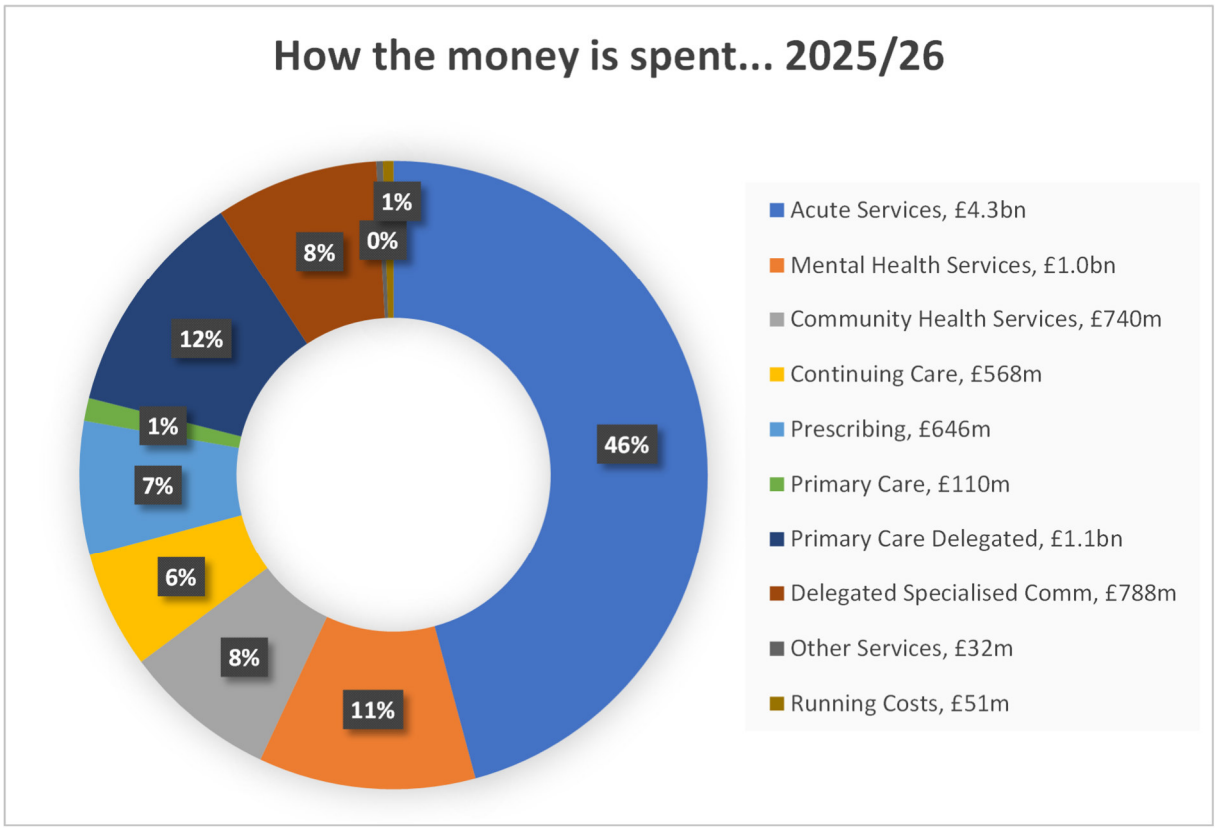
In addition to the above statutory duties, ICBs have similar responsibilities to other NHS organisations in respect of the Better Payment Practice Code (BPPC). The BPPC requires the payment of all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

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.

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.

Samantha Allen

Chief Executive

North East and North Cumbria Integrated Care Board

18 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 polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The Parliamentary Accountability and Audit Report 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 31st 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 22nd 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 Avantaggiato-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 is 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 is 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 is 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 is 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 is 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.

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 though 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 legals 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:

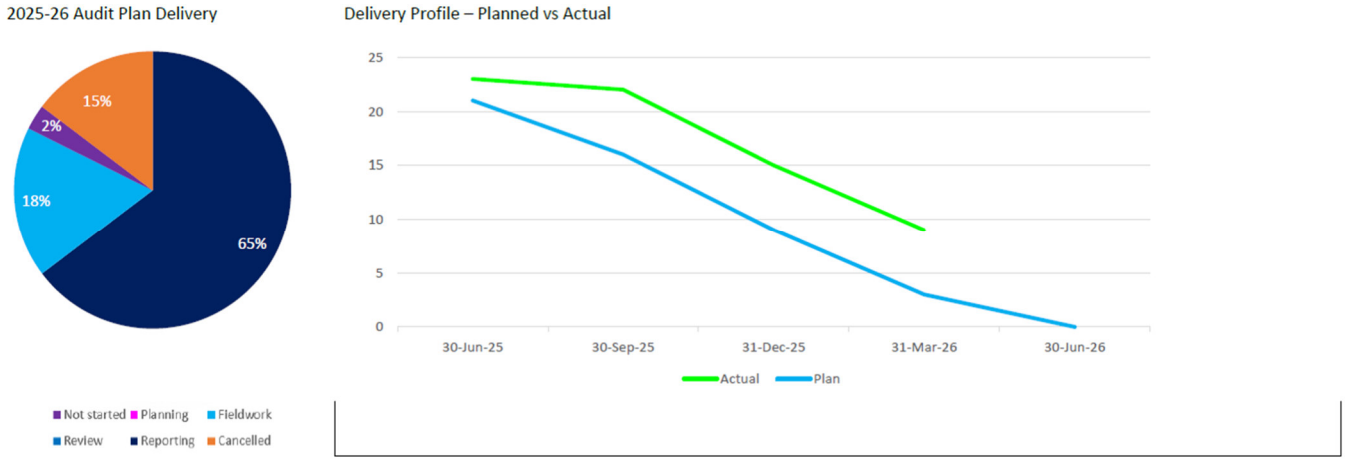
- The BAF is firmly connected to the organisation's principal objectives as set by the Board, and is a live document, maintained on an on-going basis by the governance lead to ensure it accurately reflects current risks, controls, and assurance sources. The latest BAF reviewed at the time of the audit 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



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:

	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 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 8th 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:

	25th percentile	Median pay ratio	75th 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						
		(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)	*Full time equivalent salary (bands of £5,000)*
		£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 *(secondment 1 November 2025 to 31 March 2026)*	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 *(until 30 June 2025)*	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 *(until 31 December 2025)*	10 - 15	-	-	-	-	10 - 15	*15 - 20*
Jon Rush	Independent Non-Executive Member *(until 22 May 2025)*	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						
		(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)	*Full time equivalent salary (bands of £5,000)*
		£000	£	£000	£000	£000	£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 *From 28/10/2024*	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 *From 01/11/2024 to 02/02/2025*	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 *From 03/02/2025*	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 *Until 31/10/2024*	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 *Until 30 June 2024*	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						
		(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)	*Full time equivalent salary (bands of £5,000)*
		£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 *(secondment 1 November 2025 to 31 March 2026)*	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 *(until 30 June 2025)*	-	-	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 *From 28/10/2024*	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 *From 01/11/2024 to 02/02/2025*	-	-	-	-	-	-	-	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 *From 03/02/2025*	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 *Until 31/10/2024*	-	-	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

CONTENTS **Page Number**

The Primary Statements:

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**

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
18 June 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)**

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.

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.

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 Compulsory redundancies		2025/26 Other agreed departures		2025/26 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).

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.

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.

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)

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).

9.2 Expected credit losses on financial assets

	2025/26 Contract and other receivables - Non DHSC Group Bodies £000	2025/26 Total £000	2024/25 Total £000
Balance at 1 April	(1,331)	(1,331)	(1,072)
Lifetime expected credit losses on contract and other receivables-Stage 2	(406)	(406)	(291)
Amounts written off	51	51	32
Allowance for credit losses at 31 March	**(1,686)**	**(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.

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.

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.

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.

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 Prinicipal 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.

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	-
	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	-
Dr N O'Brien	GP Partner	Coxhoe Medical Practice	1,435	-	-	-
Chief Medical Officer	Practice is a member	Central Durham GP Providers Ltd	393	-	4	-
L Buckley						
Chief Delivery Officer	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	GP Partner and PCN Clinical Director	Claypath & University Medical Group	5,238	-	-	-
Partner Member - PMS	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)
	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	-
Dr N O'Brien	GP Partner	Coxhoe Medical Practice	1,335	-	30	-
Chief Medical Officer	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	GP Partner and PCN Clinical Director	Claypath & University Medical Group	4,941	-	276	-
Partner Member - PMS	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	-

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	**26,967**	**7,888**	**34,855**

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	**6,191**	**5,998**	**12,189**

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.

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.

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.

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;
- 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.

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.

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.

Mark Kirkham, Partner
For and on behalf of Forvis Mazars LLP (Local Auditor)

5th Floor

3 Wellington Place

Leeds

LS1 4AP

18 June 2026