

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

**Minutes of the meeting held on Wednesday 12 August 2026, 14:10hrs in the
Tom Cowie Suite, Pemberton House**

- Present:**
- Dr Neil O'Brien, Chief Medical Officer (Chair)
 - Ben Anderson, Director of Population Health Management
 - Craig Blair, Director of Commissioning (Secondary Care Central & South Alliance)
 - Levi Buckley, Deputy Chief Operating Officer
 - David Chandler, Chief Finance Officer (until 15:15pm)
 - Karen Hawkins, Director of Commissioning (Neighbourhood South)
 - Neil Hawkins, Senior Head of Corporate Governance, deputising for Deb Cornell, Director of Corporate Governance, Involvement and Communications (Board Secretary)
 - Marc Hopkinson, Director of System Resilience
 - Robin Hudson, Medical Director
 - Dan Jackson, Director of Policy and Stakeholder Affairs
 - Alex Kent, Medical Director
 - Louise Mason-Lodge, Director of Nursing (Quality and Secondary Care)
 - Kate O'Brien, Director of Nursing (All Age Continuing Care (AACC), Mental Health, Learning Disabilities and Neurodiversity (MHLND))
 - Peter Rooney, Director of Commissioning (Mental Health and Learning Disabilities (MHLND))
 - Richard Scott, Director of Nursing (Safeguarding and Neighbourhood Health) deputising for Hilary Lloyd, Chief Nursing Officer
 - Martin Short, Director of Commissioning (Neighbourhood Newcastle Gateshead & GPOD)
 - Mike Smith, Medical Director
 - Paul Turner, Director of Commissioning (Secondary Care Northern Alliance)
 - Lynne Walton, Director of Finance (Neighbourhood Health and GPOD) deputising for David Chandler, Chief Finance Officer from 15:15pm
 - Lynn Wilson, Director of Commissioning (Neighbourhood Central)
- In attendance:**
- Rebecca Herron, Corporate Committees Manager (Committee Secretary)
 - Tara Case, Deputy Director of Planning and Project Management Office
 - Erin Harvey, Head of Commissioning (Mental Health, Learning Disability, Neurodivergence and All Age Continuing Care)

LC/2026-27/53 Agenda Item 1 - Welcome and introductions

The Chair welcomed all those present to the meeting and confirmed the meeting was quorate.

LC/2026-27/54 Agenda Item 2 - Apologies for absence

Apologies for absence were received from Sam Allen, Chief Executive, Nicola Hutchinson, Chief Executive, Health Innovation NENC (HI NENC), Hilary Lloyd, Chief Nursing Officer, Phil Argent, Director of Finance (Secondary Care), Richard Henderson, Director of Finance (Corporate and Insights), Ewan Maule, Director of Medicines and Pharmacy, Rachel Mitcheson, Director of Commissioning (Neighbourhood North & North Cumbria), Deb Cornell, Director of Corporate Governance, Involvement and Communications (Board Secretary), Kathy Petersen, Medical Director, Jacqueline Myers, Chief Operating Officer, Mark Dornan, Chief Clinical Information Officer, Mike Smith, Medical Director, and Kate Hudson-Halliday, Director of Finance (MHL D and AACC).

No further apologies for absence were received.

LC/2026-27/55 Agenda Item 3 - Declarations of interest

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

- **Item 12.1 - North East and North Cumbria (NENC) Work and Health: Next Steps and Financial Approvals**

There are a small number of indirect interests relating to Foundation Trusts and partner organisations referenced within the report.

As the conflicts are minimal as the recommendations relate to a system-wide programme involving multiple providers and no Foundation Trust or individual organisation is being favoured over another members may receive the papers and participate in the discussion and decision-making.

- **Item 12.2 - Optimise Business Case**

The Chair declared a conflict on this item due to being a partner in a GP Practice.

The Medical Director declared a conflict on this item due to being a partner in a GP Practice.

As this is a minor conflict and the extension of a service already in place with General Practice the Chair and Medical Director can

receive the report and attend the meeting and take part in the discussion/decision for this item.

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

LC/2026-27/56 Agenda Item 4 - Minutes of the previous meeting held on 9 June 2026

RESOLVED:

The Committee AGREED that the minutes of the meeting held on 9 June 2026, were a true and accurate record.

LC/2026-27/57 Agenda Item 5 - Matters arising from the minutes and action log

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

The Chief Corporate Officer informed the Committee the Chief Executive, HI NENC will provide an update to close this action. Action ongoing.

Minute reference LC/2026-27/11 Neighbourhood Health Centres Verbal Update

The Deputy Chief Operating Officer confirmed this action is now complete.

Minute reference LC/2026-27/29 Board Assurance Framework and Risk Management Report: Quarter 4, 2025/26

The Senior Head of Corporate Governance advised a paper has been prepared to be distributed to the Subcommittees. Action complete.

Minute reference LC/2026-27/34 Strategic Commissioning and Delivery Planning Update

The Deputy Chief Operating Officer confirmed this action was ongoing.

Minute reference LC/2026-27/36 Attention Deficit Hyperactivity Disorder (ADHD) and Autism Update and the draft Adult ADHD Commissioning Policy

The Director of Commissioning (MHL) confirmed these actions are now complete.

Members were asked to notify the Committee Secretary promptly when actions were completed to ensure clear audit trails and timely updates.

LC/2026-27/58 Agenda Item 5.1 - Adult ADHD Commissioning Policy

The Committee noted that Adult ADHD Commissioning Policy had been previously circulated and approved via Teams Approvals outside the meeting. It was noted that the required approvals had been received virtually and is here for formal ratification of the decision.

RESOLVED:

The Committee APPROVED the Adult ADHD Commissioning Policy

LC/2026-27/59

Agenda Item 6 - Notification of urgent Items of any other business

The Chief Corporate Officer requested an item on Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) reports 2024-25 to be included under any other business.

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

LC/2026-27/60

Agenda Item 7.1 – Board Assurance Framework (BAF) and Risk Management Report – Quarter One, 2026/27

The Chief Corporate Officer introduced the report which provided the Committee with a refreshed Board Assurance Framework for quarter one, 2026/27 and the updated corporate risk register.

The Chief Corporate Officer asked the Committee to satisfy itself that the framework reflected the principal risks to delivery of the ICB's objectives, together with the current controls and mitigations, and to receive the corporate risk register for assurance. It was explained that the report was a regular assurance item and that further revision was under way due to the changing organisational model. The refresh will ensure that the framework reflects the ICB's future role as a strategic commissioner rather than reproducing historic organisational arrangements.

The Chief Finance Officer advised that the finance risk entry shown in the report was out of date and confirmed that the financial risk had been updated by relevant colleagues and would be described in the finance update paper. The Senior Head of Corporate Governance confirmed that the corrected financial risk would appear in the next iteration of the BAF.

RESOLVED:

- 1) The Committee RECEIVED the BAF and Risk Management Report – Quarter One, 2026/27 for assurance**
- 2) The Committee RECOMMENDED the approval of the BAF for quarter one 2026/27 to the Board**

LC/2026-27/61

Agenda Item 7.2 – NENC ICB Audit Actions Report - July update

The Chief Corporate Officer introduced the report which provided the Committee with an update on the open audit actions for the ICB.

The Chief Corporate Officer reminded the Committee that internal audit reviews resulted in agreed management actions and that these actions formed part of the assurance provided to the organisation.

The July report identified six overdue actions across the relevant teams. Directors and action owners were asked to ensure that the actions were

not overlooked. The Committee were informed that overdue actions were regularly questioned by the Audit Committee and were also subject to scrutiny by senior audit representatives. This paper had therefore been assembled to provide a consolidated view of every action that was overdue or approaching its expected delivery point.

The Chair reinforced that anybody named in the report was accountable for progressing the relevant action and that the expectation was clear.

RESOLVED:

- 1) The Committee **RECEIVED** the Audit One monthly actions report
- 2) The Committee **NOTED** the current status of agreed audit actions
- 3) The Committee **SUPPORTED** the escalation and resolution of overdue actions where required

LC/2026-27/62

Agenda Item 7.3 - Financial Sustainability Group (FSG) Terms of Reference

The Chief Finance Officer introduced the report which provided the Committee with the proposed updated terms of reference for Financial Sustainability Group.

The Chief Finance Officer informed the Committee that the Financial Sustainability Group terms of reference had not been updated for a considerable period. The group had originally been established to provide assurance that the cost improvement programme was on track, covering both financial delivery and the associated operational actions. Following changes to the organisational committee structure, the group had been realigned to report into the Leadership Committee. Its work also supports assurance to the Board, the Audit Committee, NHS England, external audit and internal audit. It was noted that updating and approving the terms of reference would close an outstanding audit action.

The Chief Finance Officer described the changes as limited and mainly reflected the changed organisation. The Deputy Chief Operating Officer noted that a previous agreement had been that the Chief Operating Officer should be the substantive member, with the Deputy Chief Operating Officer as nominated deputy. The Chief Finance Officer accepted that amendment. The Chair also questioned whether medical representation should be retained because the group considered quality, safety and the services being commissioned. The Chief Finance Officer agreed that the issue should be considered outside the meeting.

Subject to two minor membership amendments, members approved the terms of reference.

RESOLVED:

The Committee APPROVED the updated FSG Terms of Reference

LC/2026-27/63

Agenda Item 8.1 – Neighbourhood Health Subcommittee Escalation and Assurance Report and minutes

The Deputy Chief Operating Officer introduced the report which provided the Committee with the Neighbourhood Health Subcommittee Escalation and Assurance Report and Subcommittee minutes.

The Deputy Chief Operating Officer noted the continuing concern about future contractual arrangements for Castlegate and Derwent services. It was noted that the matter was being managed locally with involvement from commissioning and medical colleagues. A potential contractual issue involving General Medical Council requirements has been reviewed in the background and is being managed through the challenged general practice group.

Members were alerted that further senior involvement may be required as the issue developed.

RESOLVED:

The Committee RECEIVED the Escalation and Assurance Report and Subcommittee minutes for assurance

LC/2026-27/64

Agenda Item 8.2 – Integrated Mental Health and Complex Care Subcommittee Escalation and Assurance Report and minutes

The Director of Commissioning (MHLD) introduced the report which provided the Committee with the Integrated Mental Health and Complex Care Subcommittee Escalation and Assurance Report and Subcommittee minutes.

RESOLVED:

The Committee RECEIVED the Escalation and Assurance Report and Subcommittee minutes for assurance

LC/2026-27/65

Agenda Item 8.3 – Acute Subcommittee Escalation and Assurance Report and minutes

The Director of Commissioning (Secondary Care Central & South Alliance) introduced the report which provided the Committee with the Acute Subcommittee Escalation and Assurance Report and Subcommittee minutes.

The Director of Commissioning updated the Committee on the third attempt to procure the North Cumbria non-emergency patient transport service. As no bidder met the required financial test, legal advice was to abandon the procurement rather than conclude it. This allows the ICB to continue working with the incumbent provider and avoid a standstill period

that would have restricted service changes. As the decision had been taken by the Acute Subcommittee it was highlighted to the Committee for information.

RESOLVED:

The Committee RECEIVED the Escalation and Assurance Report and Subcommittee minutes for assurance

LC/2026-27/66

Agenda Item 8.4 – Specialised Subcommittee Escalation and Assurance Report and Minutes

The Deputy Chief Operating Officer introduced the report which provided the Committee with the Specialised Subcommittee Highlight Report and Minutes.

RESOLVED:

The Committee RECEIVED the Escalation and Assurance Report and Subcommittee minutes for assurance

LC/2026-27/67

Agenda Item 9.1 – Freedom to Speak Up Report 2026/27 Quarter One

The Director of Nursing (AACC), (MHLDND) introduced the report which provided the Committee with the Freedom to Speak Up Guardian update for Quarter One 2026/27.

It was noted that twelve concerns had been received, with the majority relating to All Age Continuing Care. The three cases highlighted in the paper had subsequently closed, but recurring themes remained. Staff had described perceived detriment, favouritism, low psychological safety, reluctance to raise concerns formally with line managers and fear that their identity would be recognised. Staff therefore often wanted information to remain confidential between themselves and the Guardian.

In response to the volume and consistency of the concerns, an independent cultural review had been commissioned alongside two fact-finding exercises. These offered staff an opportunity to speak confidentially to an investigating officer and were intended to inform recommendations for change.

The Committee were assured that the Chief Executive and a Non-Executive Director had been sighted on the concerns and on the fear of identification.

No anonymous concerns had been received in quarter one, which could indicate that staff were willing to approach the Guardian directly.

Risks included continued leadership and behavioural concerns, low psychological safety, possible under-representation of staff experience in formal grievance data, and impact on wellbeing. A further operational

difficulty was noted regarding managers becoming anxious when they received broad feedback without information about who had raised it, the exact event or when it occurred. Human Resources and the Freedom to Speak Up function are working together to give proportionate thematic feedback and intend to incorporate this into supervision without inadvertently increasing distress.

The Deputy Chief Operating Officer supported the need for careful HR guidance, distinguishing Freedom to Speak Up concerns from allegations that should follow bullying or harassment routes.

The Director of Nursing (AACC), (MHLDND) linked the issues to wider discussions with provider chief nurses about when the Guardian route should be used.

The Chief Corporate Officer emphasised that many recurring employee relations issues reflected gaps in basic leadership and management practice, including confidence in difficult conversations. Leadership and management training had received positive feedback from newer managers, and refresher or bite-sized sessions can be provided.

The Committee noted the themes, recognised the impact of psychological safety, supported the independent review and endorsed continued engagement through the Big Listen and champion rollout.

RESOLVED:

- 1) **The Committee NOTED the report and emerging themes from Q1 2026/27**
- 2) **The Committee RECOGNISED the ongoing impact of psychological safety and barriers to formal reporting**
- 3) **The Committee SUPPORTED the independent culture review and thematic approach to escalation**
- 4) **The Committee ENDORSED continued proactive engagement, including the Big Listen and Champion rollout**

LC/2026-27/68

Agenda Item 9.2 – Fit for the Future

The Chief Corporate Officer introduced the report which provided the Committee with the proposed system-wide, shared communications and involvement approach.

The Chief Corporate Officer described Fit for the Future as a system-wide approach to communications and public involvement during continuing NHS change. The work reflected an established Board ambition and had been developed with regional chief executives, the Provider Collaborative and Healthwatch. Its purpose was to prepare communities for significant changes, involve people rather than communicate after decisions had been made, and build confidence that change could improve services. A second strategic purpose was to give the ICB a robust and usable body of patient

and public insight. This information could then support commissioning, contract discussions and negotiations, enabling commissioners to challenge poor public experience or recognise areas of strength.

The proposed approach included a mechanism for people to rate or comment on services through the ICB website. National colleagues had shown interest in the ICB acting as a trailblazer. The Deputy Chief Operating Officer reported strong system support from a Provider Collaborative strategy session but said providers needed a clearer understanding of their own engagement duties. It was confirmed that a further session with commissioning directors was planned.

The Medical Director queried the future of Healthwatch. The Chief Corporate Officer advised that Healthwatch would remain for at least the next 18 months and that the legislative position had not concluded. The future responsibility was expected to affect the ICB, so the programme would help prepare for change.

The Chief Finance Officer noted that funding in the current year could be provided by vacancies and slippage, but recurrent funding remained unresolved. The Committee discussed an indicative current-year investment in the region of £270,000. It was agreed that the approach and current-year investment should be supported. A longer-term recurrent solution would need to be developed separately.

The Committee supported the system-wide approach, approved investment for the current year and requested further work on sustainable funding.

RESOLVED:

- 1) **The Committee SUPPORTED a system-wide approach to shared communications and involvement aligned to common principles, standards and planning**
- 2) **The Committee APPROVED investment for 2026/27**

LC/2026-27/69

Agenda Item 9.3 – Strategy, Contracting and Improvement Directorate Update

The Deputy Chief Operating Officer introduced the report which provided the Committee with update on the key work programmes and progress in the areas of procurement, contracting, strategy, planning, PMO and improvement.

The Deputy Chief Operating Officer explained that the report covered the first three months and described how incoming work, organisational interfaces and dependencies with NHS England and partners were becoming clearer. The principal constraint remained capacity. Significant effort had been directed to contract mandates, implementation of the programme delivery model and development of the training approach.

The intention of the report is to provide visibility of the directorate's work rather than create a detailed operational review at every meeting. It was noted that further updates would be brought as the organisation entered the planning round later in the year.

The Committee agreed that the work priorities and overall direction were appropriate.

RESOLVED:

- 1) The Committee **RECEIVED** the update report
- 2) The Committee **ENDORSED** the key areas of work and direction of travel

LC/2026-27/70

Agenda Item 9.4 – ICB Programme Delivery Model and Training Programme

The Deputy Chief Operating Officer introduced the report which provided the Committee with the proposed programme delivery model and associated training programme plan.

The report refreshed the ICB-wide programme delivery methodology, governance, delivery tool, central repository and coordinated training programme. It was noted that a trial had taken place within the directorate and feedback had been positive. Further training is planned with commissioning teams from September, and early users had acted as a test bed so that the approach could be refined.

The Deputy Chief Operating Officer stressed that the model was not intended to create additional bureaucracy. Its purpose was to simplify reporting, automate routine information, improve highlight reporting and link project information more effectively to risk management.

The ICB had previously agreed that a consistent project management approach was required. The Deputy Chief Operating Officer informed the Committee that a small governance group would be established to oversee refinement. Work was also taking place with digital colleagues to create a more user-friendly interface while retaining the technical information in the background.

The Committee were informed that more than 400 projects remained on the register, and teams were being asked to clarify if each project was still active, could be closed or should be consolidated.

The Deputy Chief Operating Officer proposed that major programmes should also be displayed through a visibility wall or equivalent overview. In the meantime, staff could access highlight reports through the shared repository.

The Committee was asked to endorse consistent adoption, participation in training from September through the autumn and communications support to promote the tool and sessions.

RESOLVED:

- 1) The Committee NOTED the PMO Delivery Model and Training Programme Plan**
- 2) The Committee APPROVED the proposed comprehensive programme plan to deliver the recommendations**

LC/2026-27/71

Agenda Item 9.5 – Review of the North East and North Cumbria Child Death Review Arrangements

The Director of Nursing (Safeguarding and Neighbourhood Health) introduced the report which provided the Committee with the outcome of the Child Death Review arrangements across North East and North Cumbria.

The Director of Nursing (Safeguarding and Neighbourhood Health) informed the Committee that the January review had found inconsistent arrangements inherited from predecessor Clinical Commissioning Groups and gaps against national guidance.

At present four panels were operating, although forthcoming changes altered the practical configuration, and some panels did not achieve the recommended scale of at least sixty child deaths a year needed to support meaningful thematic learning. The review recommendation was to move towards one panel across North East and North Cumbria, strengthen governance and resources, and improve engagement with bereaved families. This would be a reconfiguration of an existing statutory function shared with local authorities, not the creation of a wholly new service.

The Chair challenged whether a single panel could handle approximately 160 deaths a year and whether reviews would be timely. The Director of Nursing (Quality and Secondary Care) clarified that detailed multidisciplinary reviews should happen locally and clinically, while the panel's role was to oversee learning and improvement rather than conduct each review itself. A major weakness identified had been engagement with parents and families. Benchmarking against nationally recognised work showed that families often did not understand the panel, how they could contribute, or the role of key workers and advocacy. The future model needed to make family involvement meaningful and ensure learning influenced commissioning and public health.

Members discussed frequency, capacity and operational design.

The Director of Nursing (Quality and Secondary Care) explained that many other ICBs operated one strategic panel with an operational structure beneath it. The Chief Finance Officer requested clarity on what the

Committee was actually being asked to agree and what the resource consequences would be. The Committee were informed that existing funding associated with a panel chair might support transformation, but a detailed implementation plan was still required and any ongoing resource impact would need to return to the Committee and local authorities.

The Chair concluded that the wording in the paper appeared to request a final decision to reduce four panels to one, while the discussion supported only further scoping.

Members acknowledged the case for change and supported further partnership discussions to agree the most appropriate future model. The Committee supported progression to the next stage of the process and requested that the proposed operational arrangements, capacity requirements and resource implications be brought back to the Committee before it decides whether to support reducing the number of panels from four to one.

ACTION:

The Director of Nursing (Safeguarding and Neighbourhood Health) to develop the detailed implementation plan and return any proposed final model and resource requirement through the appropriate ICB and local authority governance routes.

RESOLVED:

- 1) The Committee NOTED the content of the report**
- 2) The Committee REJECTED the recommendation to recommend to the Board the reduction of the four panels to one at this point**

LC/2026-27/72

Agenda Item 10.1 - NENC ICB and ICS Finance Update Month Three

The Chief Finance Officer introduced the report which provided the Committee with an update on ICB budgets for 2026/27 and the financial position of the ICB at Month Three for the financial year ending 30 June 2026.

The ICB was reporting broadly at break-even and expected to deliver the overall plan, with more reliable information becoming available in months four and five.

It was noted that a potential pressure was emerging in ADHD and autism assessments and related services, where reconciliation work was continuing and the eventual pressure was not yet known. Prescribing pressures normally cost approximately £1m a month but are running at around £2.5m a month, creating an estimated risk of £17m-£18m if sustained.

Running costs are at break-even, although vacancies are expected to create an underspend once forecasts were refined.

The capital budget has increased to £18m, particularly for estates and digital investment.

Overall net financial risk has reduced from approximately £31m at the start of the year to £20m. However, the two largest potential recurrent pressures are All Age Continuing Care, estimated at £10m-£15m, and prescribing concessions, estimated at £15m-£18m. Together these could approach £30m. The Chief Finance Officer warned that recurrent pressures could not be solved permanently through non-recurrent slippage.

The Budget Accountability Framework clarified delegated responsibilities, action where budgets were not delivering, and the link to planning. The Chair enquired whether the efficiency programme contained enough headroom. The Chief Finance Officer confirmed plans had exceeded the target by approximately £7m-£8m at the point of setting, although not all opportunities had materialised. Most efficiencies were delivered or in delivery, but recurrent overheating remained the greater concern. The Committee also discussed whether prescribing optimisation tools dynamically reflected drug availability and cost, and it was confirmed prescriber behaviour remained an implementation factor.

The Deputy Chief Operating Officer asked for greater rigour in investment and discretionary spend requests through the new policy and standard form.

The Director of Nursing (AACC) (MHLND) described the scale of individual All Age Continuing Care decisions, the pressure on clinical teams, bespoke market pricing and insufficient finance, business intelligence, population health and programme capacity to undertake detailed analysis. High-cost packages over £250,000 were frequently being approved by one director with limited time for review. A pilot examining the top five per cent of spend has been proposed with NHS England.

Members supported a targeted, multidisciplinary approach, potentially a six-month focused team including finance, business intelligence and complaints expertise. The Chair requested a written proposal showing what additional resource was required and how investment could produce savings or improved decisions.

ACTION:

The Director of Nursing (AACC) (MHLND) to develop a written, multidisciplinary proposal to strengthen All Age Continuing Care review, commissioning and financial control.

RESOLVED:

- 1) The Committee NOTED the latest year to date and forecast financial position for 2026/27, including the potential financial risks to be managed**
- 2) The Committee SUPPORTED the accountability framework**

At 15:15pm the Chief Finance Officer left the meeting.

LC/2026-27/73

Agenda Item 11.1 - Integrated Delivery Report

The Director of Population Health Management introduced the report which provided the Committee with an overview of quality and performance, highlighting any significant changes, areas of risk and mitigating actions.

The Committee was informed of the key messages as follows:

- Accident and Emergency performance stands at 80% Ranking sixth out of 42 ICBs
- Category two ambulance response times were at 18 minutes 30 seconds, ranking first nationally
- 4% of patients are waiting over 12 hours in Accident and Emergency
- For elective care, 72.2% of patients are seen within 18 weeks, and just 0.7% wait over 52 weeks - both better than national averages
- Dementia diagnosis prevalence is 68.9%, consistently meeting targets
- Dental access for unique adult patients stands at 40.5%, now at national target
- 71% of patients receive a faster cancer diagnosis, and 68.9% are treated within 62 days
- 70.8% of patients experience reliable improvement in talking therapies, with a 49.5% reliable recovery rate

The Director of Population Health Management advised that this was to be the final report in its current format. From the following month, the Committee would receive a more focused report based on exception reports first considered by the relevant subcommittees. Insights colleagues would identify statistically significant variation and request explanatory reports, enabling subcommittee discussion to strengthen the narrative before information reached the Board. An example from the Acute Subcommittee demonstrated that total waiting-list figures were insufficient without the corresponding eighteen-week data. The revised process was intended to improve discussion and provide assurance that issues had received appropriate professional and governance scrutiny.

It was noted that the current metrics did not fully reflect the refreshed ICB strategy or necessarily represent the best measures of local priorities. The strategy refresh would be used to identify the appropriate outcomes and measures for Board oversight. National operating framework and outcomes measures also needed to be incorporated. The report would

therefore evolve over the next several cycles. Red indicators would be supported by exception reports and decisions about whether escalation to the Board was necessary.

The Deputy Chief Operating Officer noted that the original ICB blueprint had not assumed a dedicated performance management function and the current structure did not include a separate performance team and responsibilities were still being clarified.

The emerging position was that subcommittees owned provider contract management and that contract management could not be separated from performance, quality, safety, outcomes and experience. Work with NHS England was expected to clarify roles further. It was proposed that the Committee's role would be to receive collective assurance from subcommittees and commission further scrutiny where assurance was insufficient.

Members accepted that the process remained in transition but supported the proposed governance route.

RESOLVED:

The Committee RECEIVED the report for information and assurance

LC/2026-27/74

Agenda Item 11.2 - Deep Dive Presentation

Agenda Item 11.2.1 - Community Waiting Lists

The Director of Population Health Management introduced the presentation which provided the Committee with an update on the Community Waiting list performance and associated actions.

The Director of Population Health Management explained that community data was less mature than secondary care data and contained significant caveats. National providers whose headquarters were in the region could distort the North East position. Long waits had been above expected levels for much of the year, but waiting-list size had to be interpreted alongside weekly appointment capacity. A large list was not necessarily poor performance if throughput was correspondingly high. Changes in provider data submissions had also created step changes. Approximately two-thirds of the recorded backlog related to high-volume musculoskeletal, podiatry, therapy and physiotherapy services. Podiatry was among the areas with genuine long waits. 18week performance was close to plan, but the overall picture remained difficult to interpret.

The Director of Population Health Management confirmed that data integrity varied by provider. A significant share of the reported total related to Connect Health and did not all represent services commissioned locally. County Durham and Darlington accounted for a large proportion because of its service footprint. Improvement plans had been requested and formal

contract management discussions had begun. Community services in Durham were under review ahead of a possible procurement when the current contract ended in March 2028. Paediatric activity sometimes sat in acute contracts and could therefore be absent from community analysis. Some children's services were not reported through the national dataset and instead used historic local reporting, making outcome assessment difficult.

The Director of Commissioning (Secondary Care Central & South Alliance) informed the Committee that the issue had been moved into formal contract management. Providers had been asked for a formal response and plan. Poor waiting-list management in another area had resulted in 10,000 additional patients being identified, illustrating that the reported position might worsen before it improved as data quality increased. The Director of Nursing (Quality and Secondary Care) stressed the need to triangulate activity with quality, patient experience and health inequalities.

The Chair asked whether the ICB genuinely understood the major pressures, gaps, expenditure and outcomes in community services. Members accepted that knowledge was incomplete and that both providers and commissioners lacked consistent visibility.

The Deputy Chief Operating Officer noted that national attention had historically focused on urgent, elective and acute performance. The ICB had begun looking at 52week community waits earlier than some systems, but hidden or unreported activity remained. Provider Board reports gave limited attention to community services. Contract disaggregation had improved the ability to identify nominal community expenditure, but specifications created during the pandemic often lacked clear outcomes. New procurements offered an opportunity to introduce greater specificity. Members described monthly operational and quarterly director-level contract meetings, community-specific quality improvement plans and the need for standard coding so services were reported like for like.

The Committee agreed that a coherent programme, strategy or action plan was required. It should describe the current position, standardise coding and data capture, strengthen contract levers, include clinical and multi-professional analysis, triangulate quality and experience, explain what was being bought and provide a route to Board assurance.

The Neighbourhood Health Subcommittee was asked to oversee this work and return it to the Committee. It was proposed that this should be scheduled for a Board development session.

The Committee were informed that a community rebasing programme due in September was expected to improve standard currencies and pricing information.

Agenda Item 11.2.2 - Cancer Recovery Performance

The Director of Commissioning (Secondary Care Northern Alliance) introduced the report and presentation which provided the Committee with further detail on Cancer performance.

The Director of Commissioning (Secondary Care Northern Alliance) presented performance against the three principal cancer standards and the trajectories agreed with NHS England. Faster Diagnosis Standard performance had improved since April, particularly for skin. Non-recurrent capacity and use of an independent-sector model had increased skin performance, with the latest June position reported at approximately 93%. A recurrent and consistent teledermatology approach was being developed across the region, including a pilot with Newcastle Upon Tyne Hospitals Foundation Trust and consideration of incentives for primary care. The initial focus was on areas requiring the greatest improvement, while the intended end state was consistent provision.

Providers below plan were significantly affected by breast service issues. A dedicated group led by commissioning and nursing colleagues was overseeing improvement. The Cancer Alliance had identified £600,000 of non-recurrent funding for immediate insourcing and outsourcing capacity. Longer-term work was examining demand and capacity and potential future use of the elective recovery fund. Most providers were achieving the 31day standard, while further radiotherapy improvement required work with specialised commissioning. 62day performance remained below expectation. Breast recovery would help, but lung and other tumour pathways also required improvement plans.

The Director of Commissioning (Secondary Care Northern Alliance) outlined a substantial performance and improvement infrastructure involving the ICB, Cancer Alliance and NHS England. Capacity investment was only one lever. Providers also needed reliable tracking and compliance with best-practice pathways. Tier meetings had already improved basic patient-tracking processes in some organisations.

The Committee was informed that there was no shortage of meetings, but roles and activity needed refinement to avoid duplication. The ICB remained responsible for performance management, while the Cancer Alliance contributed expertise and improvement support. Further arrangements with NHS England were being clarified, including an expected memorandum of understanding about intervention and escalation responsibilities.

The Chair challenged whether the trend represented genuine improvement, noting that May data showed deterioration in faster diagnosis at several trusts. The Director of Commissioning (Secondary Care Northern Alliance) confirmed June 2026 showed an early upturn, including a 2% point improvement in breast, but one month did not establish a sustained recovery.

Members stressed that improvement in skin metrics must not obscure outcomes in cancers with higher mortality. The Chief Corporate Officer enquired what contractual levers were being used. The Director of Commissioning (Secondary Care Northern Alliance) confirmed that performance notices, improvement plans and executive meetings had been used where necessary, despite provider challenge, and that this had begun to gain traction.

It was noted that skin pathways were not fully resolved. Current performance had been supported by expensive additional capacity and inconsistent reliance on unpaid primary care work. The efficiency of teledermatology needed to be assessed, including how many images were reviewed, how many patients subsequently required clinic attendance, whether artificial intelligence could improve productivity, and how the pathway compared with direct consultation.

The Committee agreed that plans should continue and that cancer and community performance should be considered for future Board development session. A Board session should also explain how the ICB, Cancer Alliance and NHS England collectively managed cancer performance.

ACTION:

The Committee Secretary to inform the Board Secretary to schedule Cancer and Community Waiting Lists Deep Dive for a Board development session

RESOLVED:

The Committee RECEIVED the reports/presentations for information and assurance

LC/2026-27/75

Agenda Item 11.3 - Dashboard and Tools Access Model

The Director of Population Health Management introduced the report which provided the Committee with the proposed changes to the access model for data and insight tools.

The Director of Population Health Management described the existing access process as unnecessarily slow and dependent on individual approval. Staff can request access from within a dashboard, but authorisation might arrive after the immediate need had passed.

The proposed model would treat dashboards as part of the standard toolkit for a role. Commissioning staff, quality staff and other groups would receive access to the appropriate suite of non-patient-identifiable tools according to their job. This would move the organisation from a high-control, low-use model to role-based access with clearer information about what each tool contained and how it should be used.

The Deputy Chief Operating Officer strongly supported wider access and encouraged liberalisation where the data was not patient identifiable. Some tools would remain individually controlled where sensitivity justified this.

The Director of Population Health Management asked that future work considers whether voluntary, community and social enterprise partners could appropriately use selected data to support prevention and inequalities work. This was recognised as a planned piece of work rather than an immediate change.

RESOLVED:

- 1) The Committee SUPPORTED the transition from a request-based to a role-based access approach**
- 2) The Committee ENDORSED the proposed governance framework, including defined roles, exception management, audit processes and access reviews**
- 3) The Committee NOTED the requirement for clear accountability and operational processes to support joiner, mover and leaver controls**

LC/2026-27/76

Agenda Item 11.4 - Strategic Commissioning and Quality and the Quality Management Framework

The Director of Nursing (Quality and Secondary Care) introduced the report which provided the Committee with the proposed approach to discharging its statutory responsibilities for quality within its role as a strategic commissioner.

The report outlined how the ICB would discharge its responsibilities through the Quality Management Framework in line with the national quality strategy. The framework would be operationalised through Quality Management Groups and would also be presented to the Quality and Safety Committee. It was noted a standalone version would be shared with providers as the groups were established. The Committee was asked to acknowledge the approach and note the framework as a precursor to implementation.

The Deputy Chief Operating Officer supported the principle but enquired how it would be embedded in everyday work, including service specifications, contract management, financial decisions, programme management and analytics. It was noted that there were no additional resource implications, but applying a quality lens could create new work or require reprioritisation. The Director of Nursing (Quality and Secondary Care) gave the Equality and Quality Impact Assessment process as one practical example and explained that Quality Management Groups would feed quality intelligence back through the commissioning cycle. Variation and health inequalities needed to be considered in decisions rather than treated as separate reporting topics.

Community coding was used as an example. Improving coding could provide better visibility of outcomes and experience but would require an active programme and therefore had an opportunity cost. The Director of Nursing (Quality and Secondary Care) informed the Committee that the organisation already held extensive data; the need was to organise it around clear local priorities rather than add more dashboards.

The Director of Commissioning (Secondary Care Central & South Alliance) described work in the Acute Subcommittee to integrate the framework into performance management, contract action and transformation, including a contract assurance report. Members agreed that further cross-directorate thinking was required to embed the framework into the Project Management Office, improvement work, specifications and contract processes.

RESOLVED:

- 1) The Committee SUPPORTED the approach needed as a Strategic Commissioner in relation to Quality**
- 2) The Committee NOTED that our approach to quality is delivered in accordance with the Quality Strategy for NHS-funded care in England 2026 with its focus on quality as the organising principle underpinning all commissioning, contracting, improvement, transformation and resource allocation decisions across NENC**
- 3) The Committee NOTED the Quality Management Framework its principles and mechanisms and as a precursor to the establishment of the Quality Management Group**

LC/2026-27/77

Agenda Item 11.5 - Aubrey Self-Assessment for NENC ICB

The Chief Corporate Officer introduced the report which provided the Committee with the self-assessment of NENC ICBs current governance, assurance and Foundation Trusts' self-assessment in response to the Aubrey Report.

The Committee were informed that the Aubrey work had arisen from concerns associated with County Durham and Darlington Foundation Trust breast services and had identified governance issues both for the provider and for the ICB. The self-assessment summarised the recommendations and provided assurance on progress, while recognising that further work was required to establish a robust and consistent evidence base across audits, reviews and reporting. The report also raised wider questions about how performance concerns were escalated and converted into timely action.

The Chair focused on the recommendation that assurance reports commissioned in connection with patient safety should be published through public Boards and shared with the ICB. The Chief Corporate

Officer said there was a national expectation that externally commissioned reports should be publicly available. The Chair questioned whether providers understood the practical extent of that commitment, noting that trusts commissioned many reviews that were not routinely shared with commissioners. Members agreed that contract and governance processes should explicitly ask whether external reviews had been commissioned and request access to the reports.

The Committee were cautioned that receiving a large volume of reports would create an obligation to review, understand and respond to findings and that the operating model for doing so had not yet been designed.

Similar cultural themes had appeared in other reviews, which strengthened the case for triangulation. A maternity and neonatal improvement visit on 5 August 2026 had reportedly raised cultural and behavioural concerns, with further review expected in early September 2026.

Members stressed that the system could not rely on individual leadership relationships and needed a standard process. The Committee were assured that the Chief Nursing Officer and Chief Medical Officer were working with provider nurse and medical directors.

RESOLVED:

- 1) The Committee RECEIVED the report for information**
- 2) The Committee NOTED there is further work required to ensure the ICB have an evidence base of robust and consistent audits, reviews and reporting across all domains within the self-assessment**

LC/2026-27/78

Agenda Item 12.1 - North East and North Cumbria (NENC) Work and Health: Next Steps and Financial Approvals

There are a small number of indirect interests relating to Foundation Trusts and partner organisations referenced within the report.

The Chair noted that these conflicts are minimal as the recommendations relate to a system-wide programme involving multiple providers and no Foundation Trust or individual organisation is being favoured over another members may receive the papers and participate in the discussion and decision-making.

The Director of Policy and Stakeholder Affairs introduced the report which provided the Committee with the progress to date and impact of the Work and Health Programme.

The Director of Policy and Stakeholder Affairs informed the Committee that health-related economic inactivity had become a major regional challenge, with around one in three working-age adults economically inactive because of poor health in a number of local authority areas. The North East and

North Cumbria had been selected as one of three health and growth accelerator ICB sites.

The programme had received just under £20m in 2025/26 and a further £7.8m in 2026/27 to test innovative approaches. The model combined WorkWell health and employment coaching with enhanced access to selected clinical interventions, particularly for common mental health and musculoskeletal conditions.

Because the initial funding arrived late, services had been mobilised on short timescales and required extensions to the end of 2026/27. The report requests approval of the detailed Department of Work and Pensions-led delivery plan, extension of WorkWell contracts valued at £1,427,723.33 and Health and Growth Accelerator contracts valued at £1,353,651.48, and investment in the Neighbourhood Promise, reasonable adjustments and small and medium enterprise support.

Early information suggested that approximately half of referrals had taken up the voluntary offer. Of those receiving support, around three quarters reported a positive impact on remaining in or returning to work. More than 2,000 NHS colleagues had used the staff mental health and wellbeing offer, and 92% of completers reported support in remaining in or returning to work.

The Deputy Chief Operating Officer highlighted the heavy procurement and contracting workload created by late funding, numerous provider selection and transparency requirements, and the risk of non-compliance if temporary capacity was not provided. The Director of Policy and Stakeholder Affairs confirmed that resources were intended to cover additional capacity. The Committee were assured that a funded WorkWell team and dedicated programme support were in place. The Director of Finance (Neighbourhood Health and GPOD) clarified that existing single tender waiver and direct award processes remained applicable and that wording suggesting governance routes had not been confirmed was a legacy drafting error.

The Chair sought assurance that contract extensions had followed the necessary procurement and finance governance. Members noted that urgent or direct awards could be extended for a limited period, but dedicated oversight was essential

The Committee approved the delivery plan, contract extensions and named investments, subject to ensuring the required procurement, contracting and programme capacity was funded and maintained.

RESOLVED:

- 1) The Committee NOTED the content of the paper and the progress made in addressing the rise in health-related economic inactivity in NENC**

- 2) The Committee **APPROVED** the full delivery plan for WorkWell (Appendix 2)
- 3) The Committee **APPROVED** extension of contracts to the value of £1,427,723.33 for WorkWell for 2026/27 and £1,353,651.48 for Health and Growth Accelerator for 2026/27 as outlined in the tables.
- 4) The Committee **APPROVED** investment and business cases for Neighbourhood Promise – Action on Education and Employment (Appendix 5) (£190 000), Reasonable Adjustments (Appendix 4) (£223,585) and support for Small and Medium Enterprises (Appendix 3) (£650 000).
- 5) The Committee **NOTED** the current programme risks and issues and mitigation of these

LC/2026-27/79

Agenda Item 12.2 - Optimise Business Case

The Chair and the Medical Director declared a conflict for this item due to being partners in a GP practice.

The Senior Head of Corporate Governance noted that as it is a minor conflict and the extension of a service already in place with General Practice the Chair and Medical Director can receive the report and attend the meeting and take part in the discussion/decision for this item.

The Director of Commissioning (Secondary Care Central & South Alliance) introduced the report which provided the Committee with the business case for the continuation and expansion of the OPTIMISE COPD programme for 2026/27.

The Committee were informed that the Neighbourhood Health Subcommittee had supported the proposal on 1 July 2026, and executive directors had subsequently discussed it. The business case requested up to £268,000 a year to support full rollout across general practice.

The proposal was based on evidence from partial implementation in the previous year, which had indicated improved patient management, reduced urgent and emergency activity and system benefit. Early mobilisation was intended to secure benefits during winter 2026/27.

The Chair questioned whether a decision had already been made regarding this investment. The Director of Commissioning (Secondary Care Central & South Alliance) explained that the Subcommittee had supported implementation but did not hold a budget, so the Committee needed to confirm the funding route. The Director of Finance (Neighbourhood Health and GPOD) advised that current-year implementation had been approved from existing non-recurrent resources, while recurrent funding for future years needed to be considered through commissioning intentions and the planning process. Members recalled that

executive discussion had been intended as endorsement and ratification rather than a fresh decision.

The Committee established that £500,000 of non-recurrent winter planning resource was available and could support the programme in the current year. There was therefore nothing preventing mobilisation. The unresolved issue was whether the annual cost would become recurrent from the following year. Members agreed that this should be considered alongside other priorities in the planning round rather than implied to be permanently funded by the current decision. The current-year programme was treated as already agreed and able to proceed; the recurrent element was deferred for further work outside the meeting and through the formal planning process.

RESOLVED:

The Committee RATIFIED the implementation for 2026/27 and that recurrent funding for future years needed to be considered through commissioning intentions and the planning process.

LC/2026-27/80 Agenda Item 13 – Strategic Plans and Partnerships

No update for this Item.

LC/2026-27/81 Agenda Item 14 – Policy Management

No update for this Item.

LC/2026-27/82 Agenda Item 15 – Any Other Business

Agenda Item 15.1 - Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) reports 2024-25

The Chief Corporate Officer introduced the report which provided the Committee with an update on the Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES).

The Chief Corporate Officer presented a high-level summary of the Workforce Disability Equality Standard and Workforce Race Equality Standard position. The Committee were informed that although the ICB was not required to continue reporting in exactly this manner, the organisation considered annual reporting important as it provided visibility of the experience of disabled and minority ethnic staff. Work on reasonable adjustments had been influenced by a staff working group.

The data covered the period to 31 March 2026, which was before the new reasonable adjustments policy had been implemented, so the effect of that policy would be assessed in future reporting.

The Chief Corporate Officer noted that differences in staff experience were not acceptable. Disabled and minority ethnic colleagues reported a poorer experience than non-disabled and white colleagues. The findings were linked to the organisation's values and behaviours, leadership and management development and the broader staff experience action plan. The ICB intend to continue examining the data and acting until results showed a position it could be proud of. The Chief Corporate Officer informed the Committee that the annual staff survey was due in September 2026 and would provide further evidence.

Members were advised that only the highlight or front sheet had been included in the pack and that the full reports would be circulated.

The reports and continued publication approach were supported in principle, with the detailed action plans to continue through the appropriate workforce governance route.

ACTION:

The Committee Secretary to circulate the WDES and WRES reports to members

RESOLVED:

- 1) **The Committee Approved the WDES and WRES reports and support the delivery of actions outlined in linked action plans.**
- 2) **The Committee Approved the report for publication and supporting actions.**
- 3) **The Committee Noted the WDES and WRES will be reported in the same manner each year (March 2027 and soon), despite this being non-mandatory**

LC/2026-27/83 Agenda Item 16 - New Risks to add to the Risk Register

No further risks were identified.

LC/2026-27/84 Agenda Item 17 - CLOSE

The meeting was closed at 16:45pm.

Leadership Committee Chair

A handwritten signature in black ink, appearing to read 'Neil O'Brien', followed by a period.

Dr Neil O'Brien, Chief Medical Officer
12 August 2026