NHS
North East and North Cumbria

Better health and wellbeing for all...

Annual report and accounts

1 April 2024 – 31 March 2025

Contents

Chair's Foreword

This year's annual report is published at a time of considerable change.

Since our last report, the country has had a change in Government; a moment that inevitably signals shifts in policy direction and public service priorities.

At the time of writing, we await the Government's ten-year plan, which will set the direction for health and care over the next decade, built around three strategic shifts: treatment to prevention, hospital to community, and analogue to digital.

We are also embarking on another period of change for our organisation, as part of the Government's plan to transform Integrated Care Boards, which includes significant changes to our functions and a requirement to reduce costs by £32.5 million and to do so, at pace.

These reforms will impact our staff, and I have made a personal commitment, shared by our Board, to ensure staff are supported, and compassionately, throughout this process.

It is easy in times of upheaval to overlook what has been achieved. We must ensure we build on these if we are to make the most of opportunities that can also come with reform. Much of what we report here aligns with the government's proposed strategic shifts. Delivering them will be critical, not only to improving health outcomes, but to reducing pressures on acute services and ensuring the sustainability of the NHS.

Our Integrated Care Partnership plays a key role in helping deliver our ambition of people living longer and healthier lives. By working with our Combined Authorities on devolution and wider public sector reform, we are beginning to open up new opportunities to reduce health inequalities and tackle preventable illness.

Our work on supporting better housing to improve health and helping people to stay well so they can stay in work recognises that the conditions in which people are born, grow, live, work and age are as crucial to their health as the care they receive.

This year has seen us renew our focus on tackling the growing health crisis of obesity, which is having a serious effect on our communities, leading to higher rates of long-term illnesses such as diabetes, heart disease, and mental health conditions. Unlike previous plans, our new strategy focuses on long-term investment with a focus on prevention, treatment and support to meet our goal to increase the number of people at a healthy weight by 10%.

The results of our efforts to prevent ill-health are increasingly visible, though the full benefits will unfold over time.

We are beginning to see the results of our prevention work. Smoking rates have continued to fall, and the introduction of alcohol care teams in hospitals has led to fewer admissions and attendances among those receiving support.

We also welcome the long-awaited approval of expanded water fluoridation in the North East. This is a significant step in reducing tooth decay and its impact, alongside our own multi-million-pound strategy to protect, retain and stabilise NHS dental care and services in our region.

Our report highlights continued innovation across health and care. From digital tools that support faster diagnosis and virtual wards delivering care at home, to cutting-edge research

and new treatments developed through regional partnerships, innovation is helping us to do things differently and better for the people we serve.

Safety continues to remain at the heart of everything we do. The work detailed in our annual report on patient safety culture, infection prevention, and quality improvement reflects our enduring commitment to learning and improvement.

Finally, as we manage change, financial pressures and rising demand, our shared responsibility must be to keep improving, keep innovating, and above all, keep listening to data, evidence, our staff, and the people we serve.

Professor Sir Liam Donaldson

Statement from the Chief Executive

Introduction

Samantha Allen
Chief executive, North East and North Cumbria Integrated Care Board

As I reflect on the past year, there is much to be proud of, although I had not expected to find myself ending the year having to steer such far-reaching NHS changes at such speed.

That said, the last 12 months have already been steeped in change. For too long, people in our region have experienced significantly poorer health than the rest of England. We live shorter lives, face higher rates of long-term conditions and have elevated levels of heart disease and lung cancer. One in five of us experiences anxiety or depression. This must change, and it is changing.

Working with NHS colleagues and local partners, we have set out key plans to tackle these challenges head-on.

Our new clinical conditions strategic plan identifies 12 priority areas where we can make the greatest impact. We have started to embed ambitious standards for quality and safety across all we do, and our people and culture strategy clearly sets out our goal: to make the North East and North Cumbria the best place to work in health and care. As well as taking a lead in improving the health of women in our region.

In 2024/25, we have laid strong foundations for long-term transformation. Our work has been grounded in partnership, driven by data, and shaped by the voices of local people.

We have seen real progress; our GP practices have offered more appointments than ever before, and new digital tools have helped make it easier for people to book and attend appointments.

We have expanded the services pharmacies can offer including help for minor conditions and contraception; so that patients can be treated without a visit to the GP, making it faster and more convenient.

We have invested £3m in dental services with responsibility for this transferred to us last April from NHS England). We have opened a new urgent dental treatment service in Darlington with more of these services planned in the months ahead.

Despite rising demand, we have improved access to urgent and emergency care, reduced long waits for elective procedures, seen record performance in cancer diagnostics, and strengthened system-wide support for mental health, learning disabilities, and neurodiversity. Although there is always more to do.

Thanks to the dedication and compassion of our workforce, we are the best-performing region on 18-week referral to treatment standards, and we have made significant strides in reducing the number of patients waiting more than 65 or 78 weeks. Our ambulance service, NEAS, continues to lead nationally ranking first for both category one and two response standards.

Our two new community diagnostic centres in our region welcomed their first patients this year, which will have a significant impact on helping to reduce waiting times even further.

Ensuring that mental health is as valued and treated as importantly as physical health is something I continue to be passionate about.

Over the last year, we have helped people with complex needs, some of whom have spent decades in hospital, move into their own homes with the right support in place. I have been so moved by their personal stories. These life-changing moves reflect the commitment of our teams, partners, and the voluntary sector to give people the dignity, independence and community connection they deserve.

This year, working with partners across the region, we have taken important steps to make urgent mental health support easier to access.

People in crisis can now call NHS 111 and select the mental health option connecting them 24/7 by expert teams in our mental health trusts offering a single easy-to-remember number to call. We have also launched a mental health crisis text service, providing free, confidential support at any time of day or night

In addition, new community-based services like the Whitehaven Mental Health Hub, open 24/7 in the heart of the town, and The Bothy in Northumberland is a safe, welcoming space offering support without the need for referral. They are expanding the ways people can access help, when and where they need it.

We know too many people are waiting too long for an ADHD assessment, and we recognise the impact this has on individuals and families. Need has risen sharply, and while that reflects greater awareness, it has put real pressure on services.

This year, we have increased funding for neurodiversity support and launched a region-wide review to improve access, strengthen clinical capacity, and ensure better support before and after diagnosis. This work is taking place in partnership with people with lived experience, and we will also reflect the findings of the new national ADHD Taskforce as we continue to develop and improve care across the region.

Our prevention programmes also highlights the power of partnerships. Whether tackling tobacco and alcohol dependency or promoting healthy weight, or better housing, collaboration across the NHS, local government, and voluntary sector is delivering results.

It was great to hear that adult smoking rates in our region reached a record low and we are now the second lowest in England and lower than the national average. This marks incredible progress and is credit to the partnership approach taken in the region by local authorities, Fresh and NHS partners, especially considering that back in 2005, the North East had the highest smoking rates in the country.

Reducing smoking rates further remains a priority for all partners and I'd like to thank all the teams who continue to support people to quit, as we know it saves and improves lives.

With levels of economic inactivity in our region amongst the highest in the country, we welcomed the opportunity for the NHS to take a proactive approach to addressing health driven economic inactivity, having been selected as one of only three Integrated Care Boards (ICBs) in England to be designated as a Health and Growth Accelerator site following the publication of the Government's Get Britain Working White Paper in November. We are receiving £19m of government funding to deliver tailored support so that more local people and our staff can stay well and in work through services such as work coaches. It's a vital step forward in reversing high levels of economic inactivity in our communities.

Throughout, our long-term strategy 'Better Health and Wellbeing for All' has remained our compass. It has given us a clear and consistent vision that we have continued to deliver in collaboration with our local authorities, combined authorities, NHS providers, voluntary and community partners, and most importantly, with the public.

Our learning and improvement community, Boost, and its recently launched Academy, is also serving as a hub for innovation, idea-sharing, networking, and supporting improvement efforts across the region. I am delighted we now have more than 15,000 members.

I would also like to take this opportunity to thank everyone who has played a part in what has been achieved over the past year. There is much to be proud of thanks to the dedication and compassion of our wonderful workforce which continues to shine through.

We have continued our commitment to the Staff Wellbeing Hub recognising its vital role in supporting the health of our workforce cross the region and helping to reduce sickness. Our people are the greatest asset we have, and we know many continue to work under immense pressure while showing extraordinary dedication to the communities they serve.

As we look to the future, we do so in the context of significant national reform.

Recent government announcements will see the functions of NHS England (NHSE) brought into the Department of Health and Social Care (DHSC), and the transformation of ICBs, including a requirement for our ICB to reduce running costs by around £32.5 million. Alongside this, we are working towards a system-wide medium-term financial plan, aiming to deliver financial sustainability across North East and North Cumbria by 2028 - equivalent to addressing a funding gap of over £1 billion. These changes bring considerable challenges, but also a renewed imperative to work differently, together, and with focus.

Looking ahead, we know collaboration will continue to be key as the foundations for a new NHS have been outlined by the Government, and we stand ready to respond to the forthcoming 10-Year Health Plan.

The scale of change is significant, but I remain optimistic especially as the role of ICBs as a strategic commissioner remains fundamental to the reform of the NHS.

Here in the North East and North Cumbria, we have what we need to succeed: strong foundations, collaborative partnerships across sectors, a skilled and dedicated workforce, and an unwavering commitment and passion to improving the health and wellbeing of our communities.

Samantha Allen

Performance Report

Samantha Allen
Chief Executive of North East and North Cumbria Integrated Care Board

Accountable Officer
19 June 2025

Performance Overview

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 2024/25 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. NHS England (NHSE) continues to be responsible for specialised commissioning. 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 2024/25 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.

Our joint forward plan is a delivery plan for the parts of the strategy related to NHS delivered or commissioned services. Our Joint forward plan is aligned to the Better Health and Wellbeing for All strategy. Each of these sections of the Plan are interdependent. A key challenge is to ensure links between the different elements of the Plan, summarised in the graphic below.

Figure 1 Better health and wellbeing for all – a strategy for the North East and North Cumbria Framework

Our goals are overarching commitments, supported by measurable improvements. Our enablers are cross cutting themes that will enable the delivery of our goals.

We recognise that this is a challenging time for the NHS and social care. As services continue to recover from the long lasting impact of the Covid pandemic, we have also been impacted by industrial action and rising energy costs, along with the cost-of-living crisis which has impacted significantly on the quality of life for our citizens and staff. Most measures of health and wellbeing, population health, health inequalities and performance measures for health and care services have worsened since the pandemic and continue to be impacted by industrial action. Work continued in 2024/25 on a shared ambition to deliver a programme of health and care improvement for the people of the NENC that reverses these negative trends and delivers the

healthier and fairer lives they deserve. The pandemic has further reduced life expectancy at birth of our population and there is need for focused work to ensure we recover from this position through supporting our providers to recover.

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 2024/25, in particular we have largely eliminated patients who have been waiting over 104 weeks, as well as achieving a significant reduction in patients waiting 65+ weeks. Whilst the focus in 2024/25 has been to deliver a 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 2024/25 we have consistently been the best performing ICS against this long-standing NHS Constitutional target.

In 2024/25 we have also continued to improve our performance for our patients with cancer. A significant achievement has been to meet the national priority for the 70% of our patients achieving the 62 days referrals to treatment target for cancer in NENC, achieving in excess of the 70% national ambition by March 2025.

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.
- The size of the elective waiting list and pressures in certain specialties.
- 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 2024/25 operational planning priorities, NHS Oversight framework (NHS OF) metrics, and the targets as set out in the NHS Constitution, noting nationally the impact of the pandemic. 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.

Performance management is a key element of oversight meetings with our trusts involving the Executive teams from both the ICB and trust. The frequency of these will be dependent on the NHS Oversight Framework (OF) segmentation of each trust. A segmentation decision indicates the scale and general nature of support needs (ranging from no specific support needs in segment one to a requirement for mandated intensive support in segment four) and influences the oversight arrangements that are established. NHS England holds the responsibility to review and change segmentation.

During 2024/25, NHS England continued a process introduced in 2022/23 by which trusts were allocated to tiers in relation to their elective and cancer performance. In 2024/25 the focus for cancer moved from backlog to consider Cancer Faster Diagnosis Standard (FDS) and 62 day cancer waiting times positions throughout 2024/25. In addition, NHSE has introduced tiering escalation for Diagnostics in 2024/25. During 2024/25, NENC ICB has had three trusts under the tier escalation process for cancer and elective, and one trust for diagnostics. All trusts continue to see improvements through this process, and no trusts remain under escalation for elective care at the end of March 2025, one trust remains for diagnostics and three remain for cancer at the end of quarter 4 2024/25. NHSE will review Tiering and Segmentation in early Quarter 1 of 2025/26.

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 2024/25 for UEC.

Table: NHS Trust's Oversight Framework Segmentation and Tiering

Provider	NHS OF segment	Oversight arrangements	Additional escalation/support	CQC overall rating/recent warning notices. Other external reviews of significance.
Northumbria Healthcare NHSFT	1	ICB led		Outstanding (2019) Maternity services – good overall (safe domain also good)
Cumbria, Northumberland, Tyne and Wear NHSFT	2	ICB led	*Action plan monitored via the Quality Review Group.	Outstanding (2022) (Learning disability and autism services - requires improvement Aug 2022*)
North East Ambulance Service NHSFT	2	NHSE Quality Improvement Board	Range of support including NECS support for incident reporting.	Requires improvement (2023) Awaiting outcome of independent review
North Tees and Hartlepool NHSFT	2	ICB led	National maternity Safety Support Programme.	Requires improvement (2022) Maternity services – Requires Improvement (2022)
Sunderland and South Tyneside NHSFT	2	ICB led	Progress against CQC action plan provided through the Quality Review Group. National maternity Safety Support Programme.	Requires Improvement (2023) Maternity services – Requires Improvement (2023)
County Durham and Darlington NHSFT	3	NHS E/ICB led	Removed from Tier 2 Elective (12.4.23).	Good (2019) Maternity services at UHND and DMH rated as requires improvement (March 24). UEC rated as Good Jan 25
Newcastle Upon Tyne Hospital NHSFT	3	ICB led	Removed from Tier 1 (Apr 24) for Elective & Cancer ICB Elective focus meetings in place Northern Cancer Alliance and GIRFT support in place.	Requires Improvement overall – caring good, well-led inadequate) (Jan 2024) (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).
Gateshead Health NHSFT	3	ICB led	Enhanced finance oversight/ support led by NHS E.	Good (2019) Maternity services – Good overall (2023)
North Cumbria Integrated Care NHSFT	3	ICB led from Nov 23	Escalated to Tier 2 Cancer to ICB/NCA monitoring and support (Apr 24). ICB Elective focus meetings in place Enhanced finance oversight.	Requires Improvement (Nov 2023) Maternity services – good overall (Safe domain – requires improvement)
South Tees NHSFT	3	NHSE/ICB oversight of finance	Quality - supported by ICB/NHSE. Enhanced finance oversight. Removed from Tier 2 – elective Apr 24). ICB Elective focus meetings in place	Good overall (May 2023) 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.	Requires Improvement (Oct 2023)

Performance summary 2024/25

A broad range of metrics are reviewed and monitored through strategic programmes and through ICB oversight and contracting arrangements. This supports the delivery of standards and improvement. Where appropriate this is underpinned using a Statistical Process Control (SPC) approach which is considered best practice to enable systems to understand where there is significant variation and most risk and therefore focus attention on those areas that require improvement support.

Dashboard Key: The tables which follow include the following items:

Actual: This number represents the actual performance in the most recent reported month. This is primarily monthly published data, where more recent unpublished data is available the narrative later in the report often uses this to provide an indication of the direction of travel.

The colour shading in the 'actual' column draws attention to those metrics that are well ahead or well behind plan in that month. Colour coding is not applied where the plan has been met or missed by a small margin.

	Met – well ahead of plan
	Not met – well behind plan

Trend: This indicates whether performance over time is **improving** or **worsening.**
Where Statistical Process Control (SPC) is used, the trend category relates to the variation output generated by SPC and therefore indicates significant improvement or deterioration. Where SPC is not appropriate a number of data points are used to ensure it reflects a trend rather than normal variation.

Benchmark Where possible the NENC performance is compared with the England or North East and Yorkshire (NEY) position as a benchmark. The number represents the England position unless otherwise stated and the colour shading indicates:

	NENC compares favourably
	NENC does not compare favourably
	No comparative data available

This report includes a sub-set of those metrics primarily focussed on the national objectives for 2024/25. The metrics are reported at ICB level, and the narrative refers to place or organisations by exception.

2024/25 Performance summary and mitigations

Urgent and Emergency Care (UEC)

The NENC Urgent and Emergency Care Network identified three UEC System Priorities for 2024/25. These were:

- Enhancing navigation capacity and processes
- Maximising alternatives to Emergency Department
- Enhancing capacity to support winter pressures.

There has been an extensive programme of work to deliver improvements across urgent and emergency care. Key programmes of work include:

- System Co-ordination Centre deployment – 8am-8pm, 7 days per week, providing system-wide senior leadership, constructive challenge and a system level response to managing escalation and de-escalation.
- Implementation of Clinical Validation Hubs – Clinical validation of 999 Cat3/4 and Health Care Professional (HCP) generated calls

- 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)

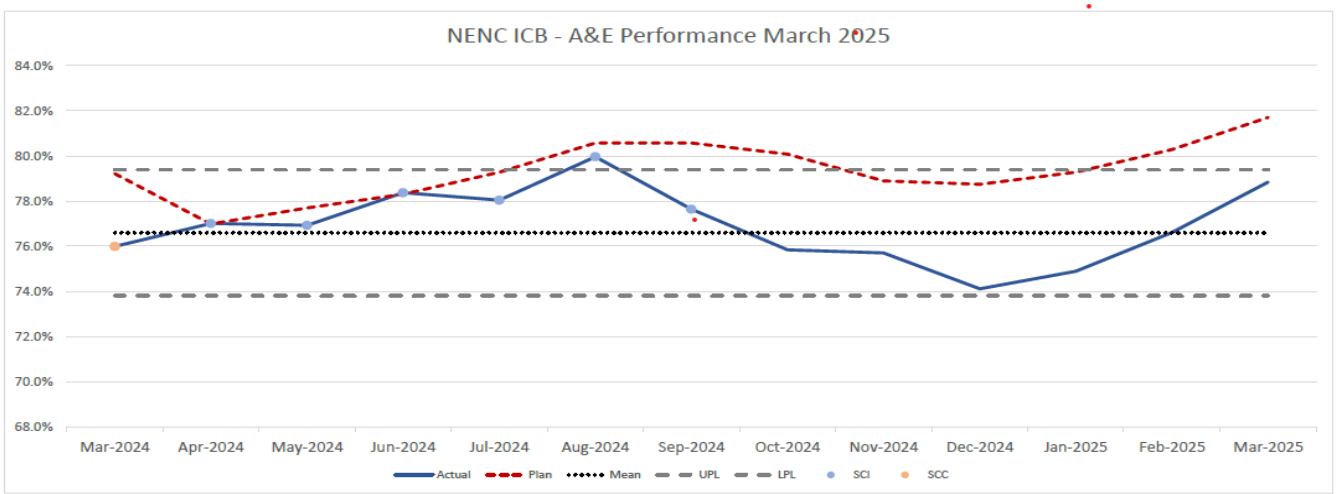
Urgent and Emergency Care – March 25					
Objective	**Plan (March 2025)**	**Plan (month)**	**Actual**	**Trend**	**Benchmark**
AandE waiting times < 4hrs (78% by March 25)	81.7%	81.7%	78.8%		75.0% 6/42
Category 2 ambulance response (NEAS)	23:52	23:52	20:54	Improving	28:34 1/11
Adult G&A bed occupancy	92.5%	92.5%	91.8%		94.3%

Key Performance Highlights

Accident and Emergency (AandE) 4-hour response time measures the percentage of patients arriving at an AandE department who are admitted to hospital, transferred to a more appropriate care setting, or discharged home within 4 hours**.**

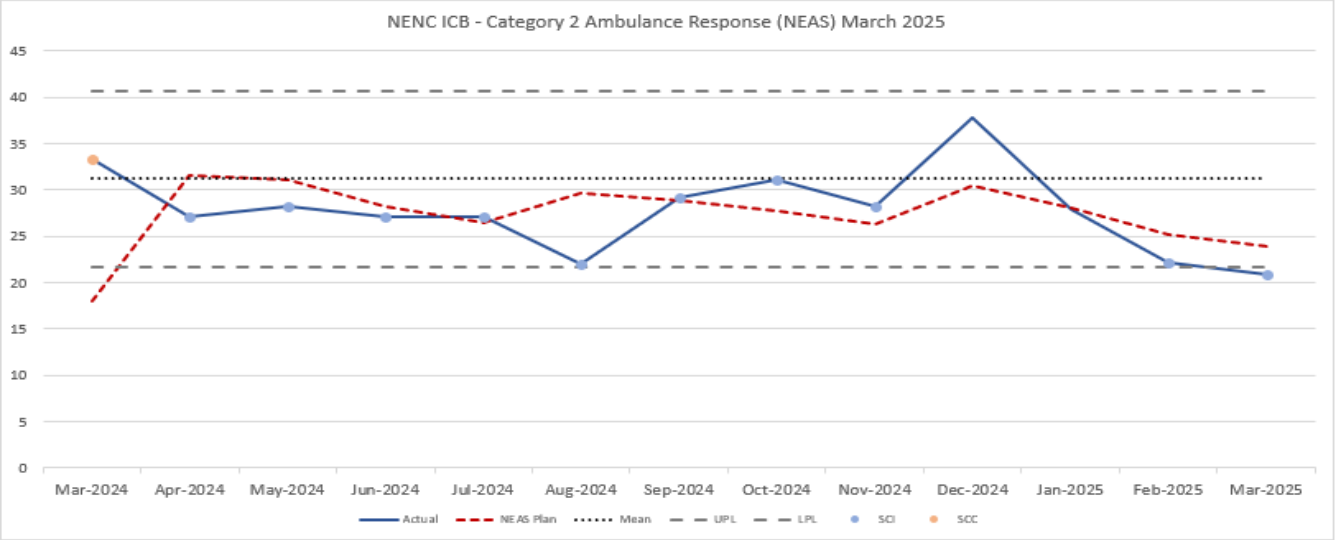
There has been a specific focus nationally on the delivery of the 78% standard for 4 hour waiting time in AandE throughout 2024/25. AandE performance has improved during 2024/25 across NENC, continuing to perform favourably when compared to the national position. The end of 2024/25 position (as at Mar-25) reported 78.8% of patients were seen within 4 hours, and although below the NENC plan for March 2025, this exceeded the national ambition of 78.0%, and NENC were ranked 6/42 ICBs across the country.

Plans are in place with our providers to maintain and further improve this comparatively strong performance into 2025/26. We continue to work collaboratively with each trust to proactively address pressures with patient flow.



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 improved throughout 2024/25 and by March 2025 was at 20 minutes:54 seconds, meeting the national ambition of 30:00 mins for 2024/25.

NEAS ranked 1/11 of ambulance providers nationally for March 2025 and 1/11 when looking at the 2024/25 YTD position.



There has been a significant programme of work taking place in 2024/25 to bring together colleagues from across the system (ICB, FT, Ambulance Trust) to look at ambulance handover improvement and transformation. This programme was externally facilitated and has led to a number of revised and standardised policies and procedures being agreed for elements of the ambulance handover process. Alongside the wider ICS programme there have also been individual improvement programmes taking place across Foundation Trusts to reduce handover delays.

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Delivery and risk into 2025/26

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.

Primary and Community Care

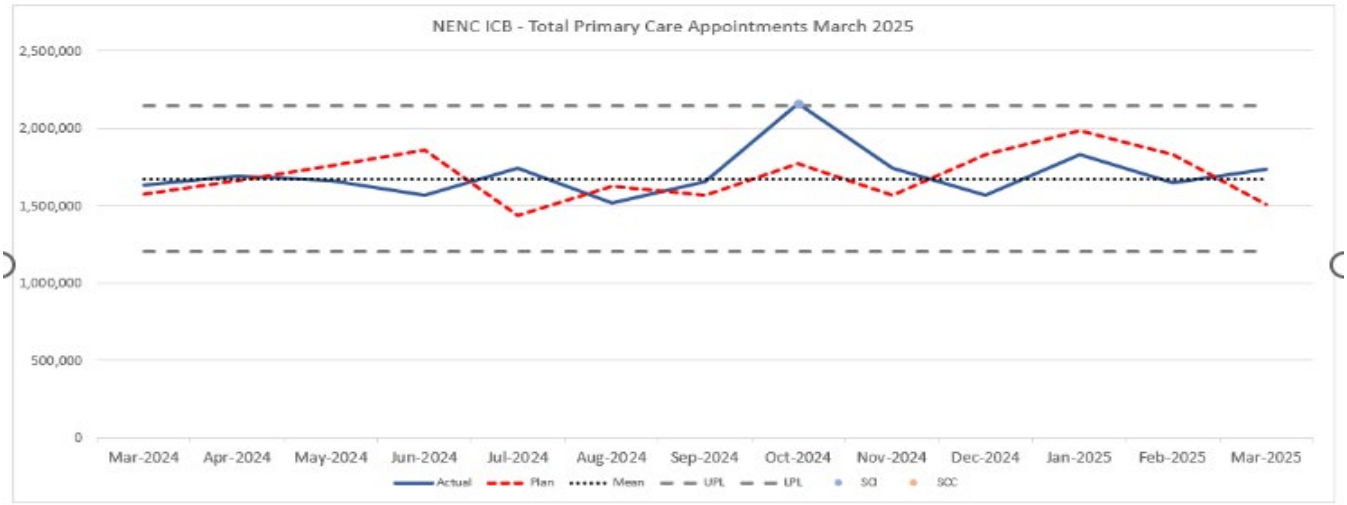
Although more General Practice (GP) appointments per working day are being provided in General Practice across the ICB in 2024/25 compared to previous years, challenges remain for some patients in getting access to the appointments that they need and capacity has been impacted by GP collective action. A key objective for 2024/25 has been to implement the Primary Care Access Recovery Plan (PCARP) to support primary care providers to increase capacity and the number of appointments that are provided and to get the most out of the capacity and resources that are available.

NENC is committed to deliver community health crisis response services as well as reablement care within 2 days of referral to patients who need it. Urgent community response (UCR)

services provide urgent care to people in their homes which helps to safely avoid hospital admissions and enable people to live independently longer.

Primary and Community Care – February 2025/March 2025					
Objective	**Plan (March 2025)**	**Plan (month)**	**Actual**	**Trend**	**Benchmark**
Monthly Appointments in General Practice (March 2025)	1.51m	1.51m	1.73m		
2-hour urgent community response (UCR) (February 2025)	70.0%	70.0%	79.9%	**Worsening**	83.2%

General Practice appointments: across NENC have remained fairly static throughout 2024/25, peaking in Q3. As at the end of March 2025 there was an increase in the number of GP appointments (1,733,523) compared to March 2024 and the plan to achieve 1.51m appointments at the end of March 2025 has been met.



Urgent Community Response (UCR) teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. **UCR** referrals seen within 2 hours has consistently exceeded the 70% threshold during the year across the ICB – all trusts are now publishing data via the National UCR Dashboard following work to increase data quality.

Delivery and risk into 2025/26

- 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

- 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.

Elective Care

During 2024/25 the Operational Planning ambitions for elective care were to:

- Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)
- Reduce the overall waiting list size
- Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 109%

The ICB and Provider Collaborative have developed strong working relationships and continue to support trusts helping to navigate pressures focussing on key improvements to deliver the Operational Planning ambitions.

2024/25 Performance summary and mitigations

Elective care – March 2025 Actual data displayed at commissioner aggregate level

Objective	Plan (March 2025)	Plan (month)	Actual	Trend	Benchmark
Number of patients waiting > 65 weeks (0 by September 2024)	0	0	153	Improving	9/42
The number of incomplete Referral to Treatment (RTT) pathways (waiting list)	327,044	327,044	349,990	Improving	
Deliver 109% value weighted activity (February 2025)	110.6%	110.7%	114.7%		

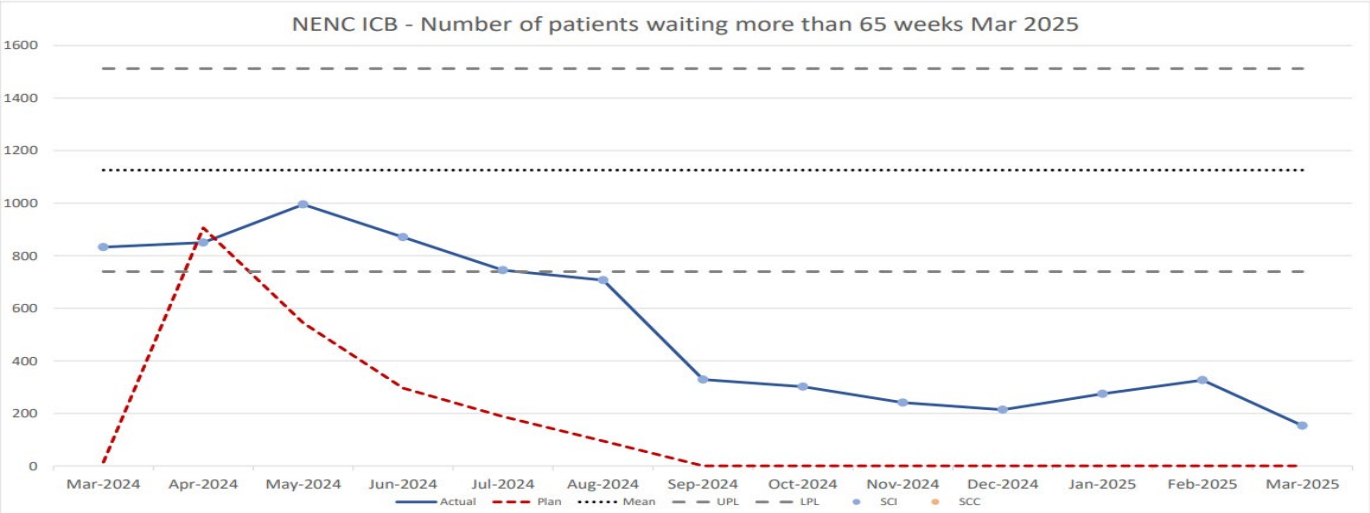
There has been a determined effort in 2024/25 to reduce the number of **long waiting patients** across NENC and as at March 2025 the number of patients waiting >65 weeks has reduced from a high of 2,229 (2023/24) to less than 153 in 2024/25.

Whilst the focus in 2024/25 has been to deliver a 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 2024/25 we have consistently been the best performing ICS against this long-standing NHS Constitutional target.

Waiting list size for non-urgent, consultant led treatments for physical health conditions were stabilised from May 2024 after sustained and relentless growth following the COVID pandemic. Whilst the waiting list is currently above planned levels (February 2025) it has been regularly decreasing in size month on month since August 2024 with the latest data showing a waiting list size of 349,990; this is substantially lower than the all-time high of 367,480 recorded in August 2023.

2024/25 has seen further development to the Elective Care infrastructure across NENC ICS which includes a comprehensive governance structure embedded across the system. Whilst not an exhaustive list the following groups have gained in both maturity and impact during 2024/25 and will continue to play a pivotal role covering the elective reform agenda in 2025/26 and beyond.

- Strategic Elective Care Board
- Mutual support coordination group
- Outpatient Leads group
- GIRFT Coordination group
- Theatres group
- Specific pathways/alliances
- Bespoke task and finish groups



Delivery and risk into 2025/26

Elective recovery continues to be a significant focus in 2025/26 and with the continued success of reducing the number of very long waiters our efforts can shift towards the following key ambitions:

- 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

NENC ICS are committed to delivering the elective care ambitions in 2025/26 though with financial constraints this will be a challenging year.

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 2024/25 the Operational Planning ambitions for cancer and diagnostics were to:

- Improve performance against the headline 62-day standard to 70% by March 2025
- Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026
- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%

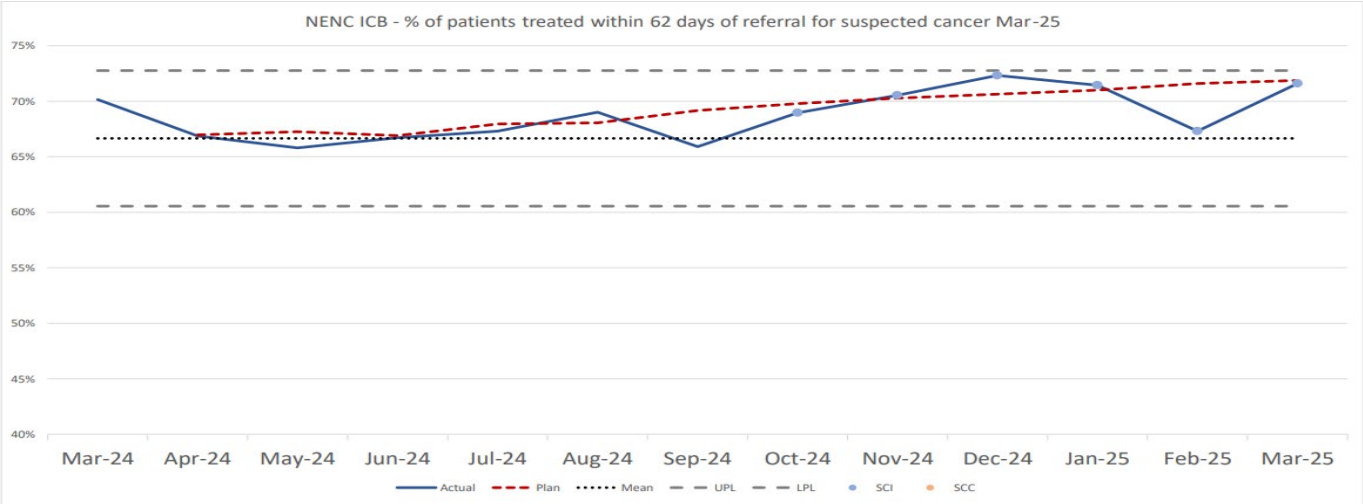
2024/25 Performance summary and mitigations

Cancer and Diagnostics – March 2025 data displayed at commissioner aggregate level

Objective	Plan (March 2025)	Plan (month)	Actual	Trend	Benchmark
Improve performance against the headline 62-day standard to 70% by Mar25	71.9%	71.9%	71.6%		71.4%
Cancer faster diagnosis standard 77% by March 2025 – ICB	79.4%	79.4%	78.6%		78.9%
% of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% (24/25 ICB plan required for 9/15 modalities only)	92.7%	92.7%	91.3%	Improving	90.3%

Each provider across NENC submitted an Operational Planning trajectory to deliver the **headline 62-day standard** to 70% by March 2025. NENC has demonstrated a generally improving position since April 2024, achieving 71.6% at the end of March 2025. Although slightly below planned levels, this is above the national ambition of 70%. Ongoing work is required to maintain this level of performance with notable challenges identified in the following pathways: Urological, Lung, Upper Gastrointestinal (GI) and Lower GI.

Faster Diagnosis Standard (FDS) – measures the percentage of patients that are diagnosed or have a cancer diagnosis ruled out within 28 days. The ICB has maintained its position above the national standard throughout 2024/25 although performance dropped slightly to 78.6% at the end of March 2025, marginally below our local ambitious plan of 79.4%, but above the national standard of 77%.



The **diagnostic performance** standard measures the percentage of patients that receive a diagnostic test within six weeks. After a challenging start to 2024/25, dedicated focus to diagnostic modality hotspots has improved performance significantly from August 2024

recovering to plan by November 2024 across NENC and delivering 91.3% at March 2025, marginally below the end of year plan of 92.7%.

Delivery and risk into 2025/26

Cancer and diagnostic performance standards continue to be a high priority for NENC ICS and we look to build on the successes delivered in 2024/25. In terms of 2025/26 the following key ambitions feature in the latest NHS Operational Planning Guidance:

- 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

Whilst we have demonstrated periods of grip during 2024/25 there remains significant issues at both organisational and tumour level. Three of our acute providers have been escalated into Tier 2 arrangements reflecting the ongoing complex challenges faced to deliver the required performance.

NENC ICS are committed to delivering further improvement and achieving the 2025/26 ambitions but are mindful of the pressures from workforce, financial resource and fragility of some services.

Mental Health and people with Learning Disability and Neurodiversity

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.

2024/25 Performance summary and mitigations

Mental Health Adults – March 2025 unless otherwise specified.

Objective	Plan (March 2025)	Plan (month)	Actual	Trend	Benchmark
Access to Transformed PCN Community Mental Health Services for Adults with SMI Number of 2+ contacts (February 2025)	30,000	28,346	30,655	Improving	
Access: Number of patients discharged having received at least 2 treatment appointments, that meet caseness at the start of treatment	2,934	2,934	2,232 (2854)*		
Talking Therapies - Reliable Recovery	50.0%	50.0%	48.8% (49.1%)*	Worsening	
Talking Therapies - Reliable Improvement	68.5%	68.5%	70.1% (69.3%)*		
Dementia Diagnosis Rate	69.8%	69.8%	68.9%	Improving	65.6%
Total number of inappropriate Out of Area (OOA) Placements	0	2	10		

NHS Talking Therapies for Anxiety and Depression (TTAD) – In 2024/25, there were three key metrics (described below) for talking therapies. * NB One NENC Talking Therapies provider did not

submit data for March 25 hence was excluded from published data, however a local calculation has provided a provisional NENC end of year position.

Caseness: A patient is determined as being at caseness where their symptom scores meet the threshold for measure of symptoms i.e. so they are appropriate for that service for treatment. Performance has shown signification variation in attainment and has not consistently been met.

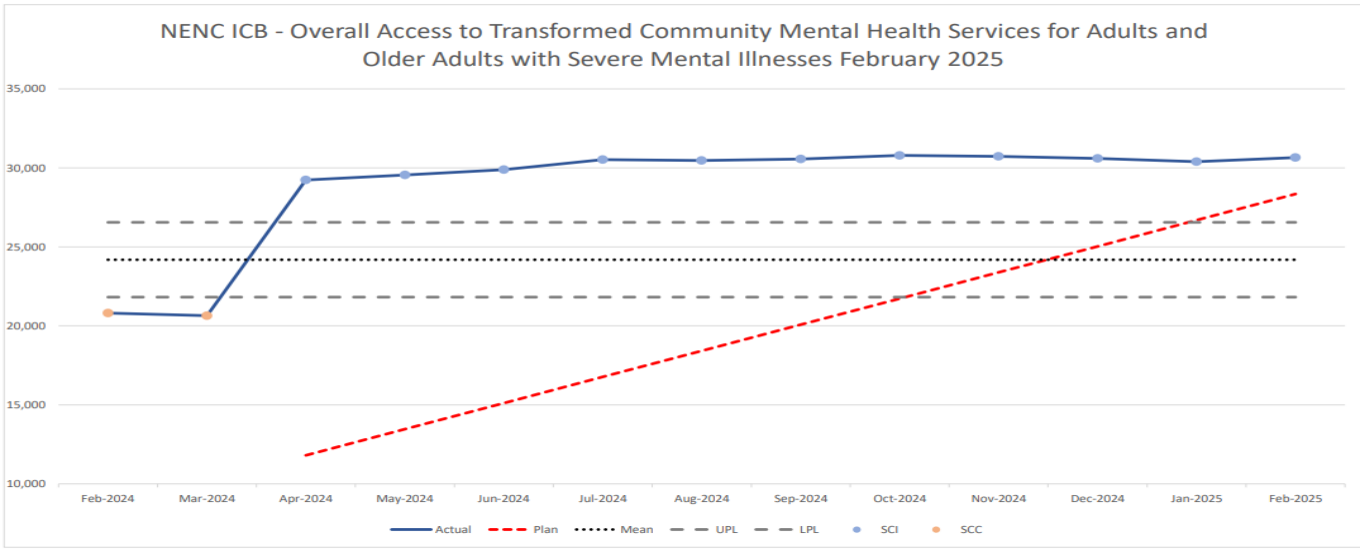
Reliable Recovery: This indicator shows the proportion of people completing treatment who have shown significant improvement and recovered. The national reliable recovery rate is set at 48%, however NENC took the decision to locally stretch this target to 50%. The national reliable recovery rate has consistently been met; however, the more stretching local target has only been met in May 2024.

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 national reliable recovery rate is set at 67%, however NENC took the decision to locally stretch this target to 68%. The national target has consistently been met, there have been few occasions where the locally stretched target has not been met.

Community mental health services play a crucial role in delivering mental health care for adults and older adults with severe mental health needs as close to home as possible. A transformed PCN aims to offer a care model that provides holistic, person-centred care for people with significant mental health difficulties. The 2024/25 metric, Access to Transformed PCN Community Mental Health Services for Adults with Serious Mental Illness (SMI), Number of 2+ contacts has seen a significant increase in performance as the number of PCNs that are declared as transformed. The February 2025 position confirmed that the year-end target has been met. Additional support is being sought for those areas that are yet to be transformed.

Out of Area (OOA) placements (bed days) – Despite being one of the higher performers against this metric in the region, NENC reported 10 out of areas placements in March 2025, specific to one provider. The increase is attributed to system pressures with high bed occupancy rates and an increase in delayed discharges due to social care and housing.

Dementia diagnosis rate – remains in excess of the national standard of 66.7%, however has not consistently met the NEC local more ambitious target of 69.8%.



Mental Health: Children and Young People (CYP) – March 2025					
Objective	**Plan (March 2025)**	**Plan (month)**	**Actual**	**Trend**	**Benchmark**
Number of CYP accessing Mental Health Services*	59,632	59,632	59,330		

The NHS has set out to improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019). **Access to mental health support for Children and Young People (CYP)** across the ICB remains static and slightly below both local plan and the national ambition, despite an increase in activity. It is anticipated that the plan for 2024/25 will carry over into 25/26 and is expected to be met. It is probable that as we support more smaller community providers with MHSDS submissions, this will increase access.

People with a learning disability and autistic people – March 2025					
Objective	**Plan (March 2025)**	**Plan (month)**	**Actual**	**Trend**	**Benchmark**
Annual Health Check and plan for people on GP Learning Disability registers (March 25)	75%	75%	79.2%		79.9%
Reduce reliance on in-patient care – adults (ICB and Secure)* (March 25)	154 (170)*	154 (170*)	165		

*Due to data recording issues which distorted baseline data when2024/25 target was set it has since been determined NENC have demonstrated one of the best reductions nationally hence revised targets for 2024/25 were agreed utilising more robust baselines. A revised target of 170 rather than the 154 has now recently been agreed with NHSE national/local team colleagues with an annotation to note we have exceeded this plan achieving 165 v 170 plan.

Annual health check and plan for people on the learning disability register: Improvement against target continues across NENC with a further spike expected at year-end in line with historical trends as patients are invited in for their annual recall.

Reducing reliance on inpatient care (IP) – NENC ICB did not meet the Q4 published trajectory to have no more than 154 people with a learning Disability or people who are autistic within an inpatient setting, with an actual position of 165 as at March 2025. A revised plan of 170 has since been agreed by NHSE due to significant improvements in 2024/25 and an accurate baseline on which the original plan was set. Compared to this revised plan, the target number of people in NENC with a Learning Disability or who are Autistic who are in an inpatient setting has been met.

Delivery and risk into 2025/26

Challenges have remained in the delivery of key ambitions in 2024/25 for mental health and for people with Learning Disabilities and Autism. The ICB is working to improve mental health pathways for our patients, as well as investing in extra support to meet emotional, mental health and wellbeing needs.

Workforce

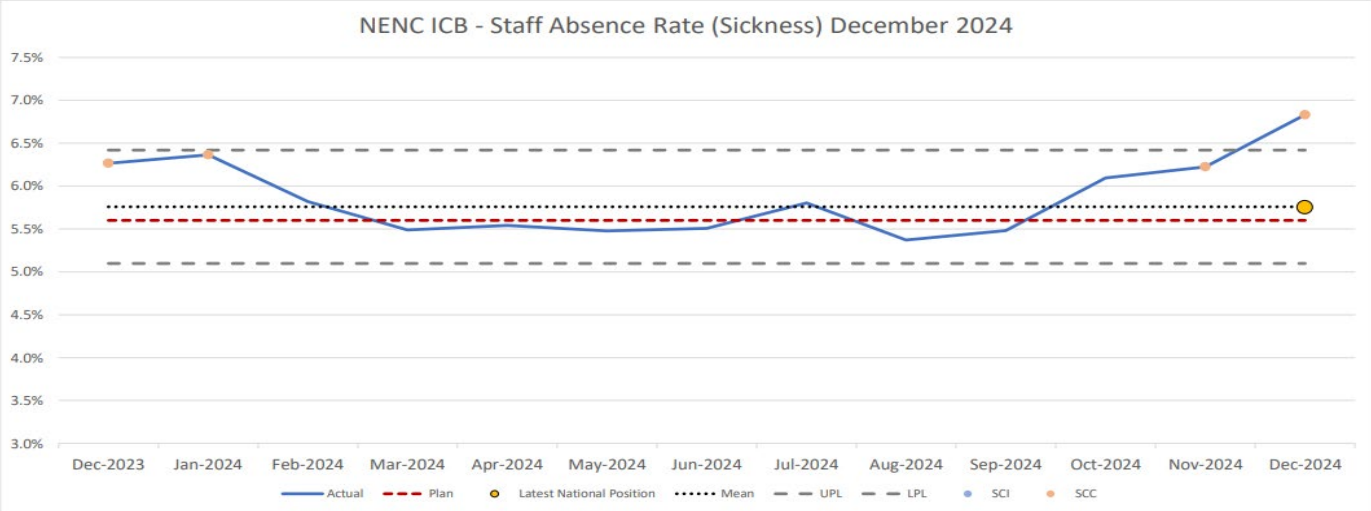
The NENC People and Culture Plan has three of the six priorities being supply, retention and health and wellbeing. Higher levels of sickness affect patient safety and quality as there are less staff available for duty. Staff turnover will impact on quality due to: Lack of continuity of care, staff shortages through vacancies putting pressure on remaining staff, time and effort

involved in recruiting, training and inducting new staff members adding further pressure to existing staff. Both sickness and turnover continue to be trust priorities for action.

2024/25 Performance summary and mitigations

Workforce – December 2024 /January 2025					
Objective	**Plan March 2025**	**Plan (Month)**	**Actual**	**Trend**	**Benchmark**
Improve the working lives of all staff and increase staff retention (January 2025)		12.1%	9.4%		11.2%
Improve the working lives of all staff and increase staff attendance (December 2024)		5.6%	6.8%		5.8%

Staff attendance – The nationally reported in-month Electronic Staff Record (ESR) recorded the sickness rate has deteriorated throughout 2024/25 in NENC and is higher than target for November 2024 (latest published period available).



Turnover – NENC continues to improve showing a 9.4% turnover rate against a plan of 12.1% as at January 2025.

Delivery and risk into 2025/26

- We are taking a learning and improvement approach to the delivery of the NENC People and Culture Strategy. Review of strategy is underway to confirm key deliverables for 2025/26.
- Governance arrangements are being reviewed to ensure link into key workstreams in the system.
- A refreshed narrative is being developed for Boost that will draw together and build upon all previous models for change

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 the Healthcare Acquired Infection (HCAI) Subcommittee where learning and good practice is shared at place and through local Quality

Review Groups. The Quality and Safety Committee monitors data relating to mortality, and the regional mortality network supports quality improvements.

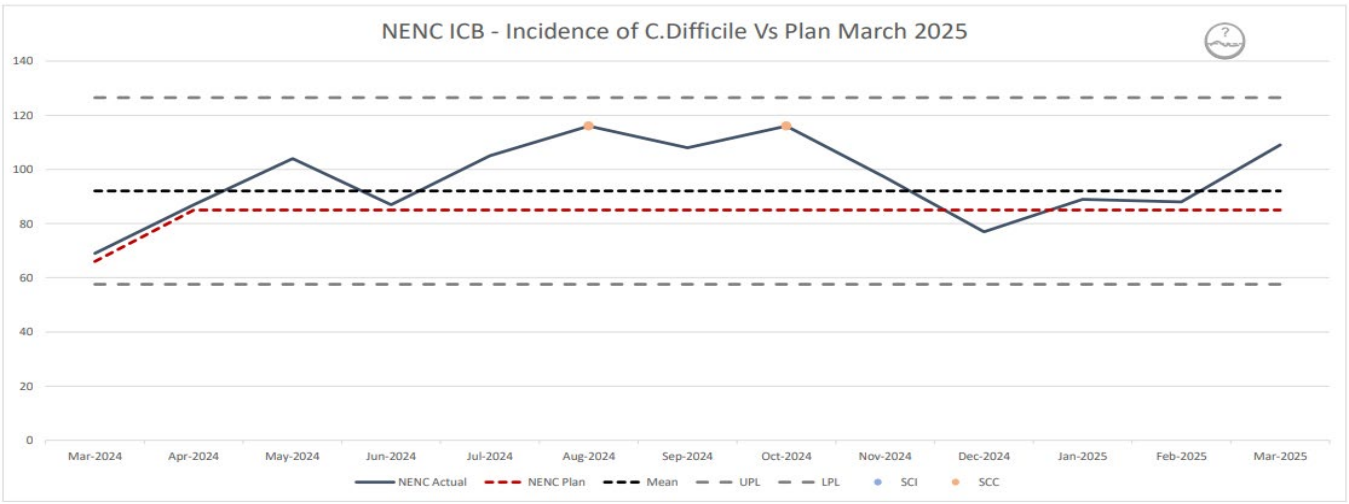
2024/25 Performance summary and mitigations

Safety – March 2025						
	National objective	**Latest Period**	**Plan**	**YTD Plan**	**Actual**	**YTD Actual**
Never Events	Number of Serious Incident Never Events reported	March-25	0	0	2	23
Infection Prevention Control	Incidence of MRSA	March-25	0	0	6	68
	Incidence of C Difficile	March-25	85	1,020	**109**	1,183
	Incidence of E Coli	March-25	235	2,823	249	3038
Mortality	One Trust (CDD FT) is showing higher than the expected range for SHMI					

Never Events – themes are closely monitored to gain appropriate assurances to ensure learning has been identified and shared. Themes for Never Events are monitored to gain appropriate assurances to ensure learning has been identified and shared.

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 key infections remain over target year to date. An ICB wide plan has been developed and agreed for Clostridium Difficile (C diff) and Gram Negative Bacterial Infections.



Delivery and risk into 2025/26

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

During 2024/25, the ICB has continued to implement an oversight framework which provides a comprehensive set of arrangements for effective oversight of NHS services within the ICB and the management of risk.

The purpose of the oversight arrangements is to facilitate the delivery of the ICB's statutory duties and strategic priorities. This has been achieved through scrutiny of all relevant indicators and the agreement of remedial action where necessary, including the deployment of additional support arrangements.

The oversight framework is a comprehensive framework and includes arrangements for the oversight of delivery of all elements of the ICB's statutory duties and strategic and operational priorities, incorporating all the measures of success included within the NHS Oversight Framework and monitoring the delivery of the strategic plan. Oversight within the ICB is examined through the lens of the overall ICB, provider trusts, 14 places, primary care providers and programme and clinical networks. Place and programme oversight as well as provider oversight has been implemented across NENC in 2024/25.

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.

Statement of activities

The statement of activities section outlines the ICB's main areas of work and highlights of our workstream priorities and key achievements 1 April 2024 – 31 March 2025.

During 2024/25 the ICB developed and implemented a programme of change to transfer services from its Commissioning Support Unit (North of England Commissioning Support) building on the outputs of the ICB 2.0 programme that was implemented the prior year.

In developing this programme of work the ICB produced a business case which was reviewed and approved by NHS England in the summer of 2024. The business case outlined plans to in-house a range of services and the benefits of doing so. Services impacted by this programme were predominantly those whereby the majority of staff delivering the service formed part of an embedded team within the ICB as determined through the ICB 2.0 programme.

During the autumn of 2024 work commenced to transact the service transfer through the establishment of a Programme Steering Group and a Programme Board that held responsibility for overseeing the successful TUPE (Transfer of Undertakings) like transfer of 350 staff from NECS into the ICB, as well as ensuring the safe transfer of the associated services, tools and systems.

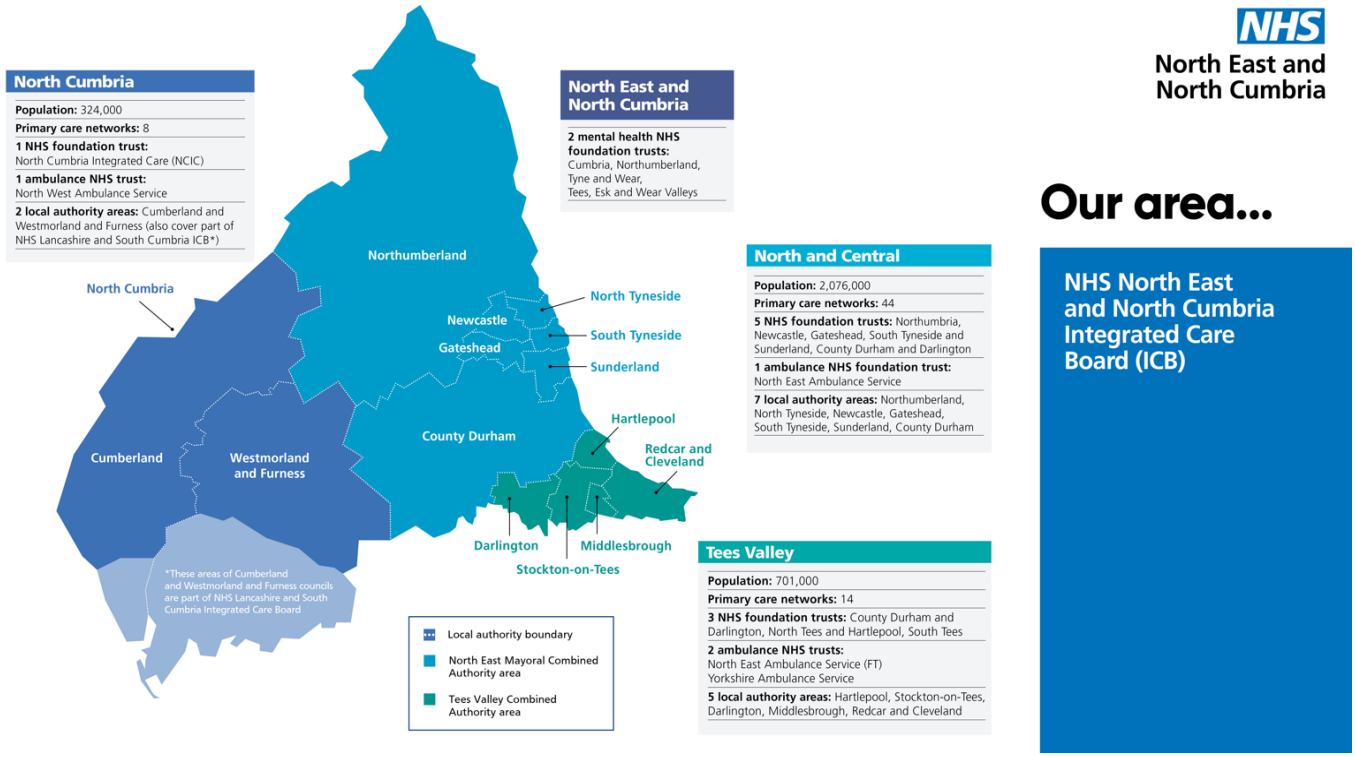
All staff transferring from NECS will become part of the ICB structure from 1 April 2025.

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 detail of our governance and partnership arrangements was initially developed through a Joint Management Executive Group (JMEG) of senior leaders from across the NHS, local authorities, and wider partners. The feedback from JMEG helped us to develop our ICB constitution and board membership, our unique Integrated Care Partnership (ICP) model, and our arrangements for delegating ICB functions and resources to each of the fourteen local authority 'places' within the North East and North Cumbria.

In 2024 we have seen the implementation of our 'place committee' model with delegated functions and resources and supported by our six ICB locality teams. Following the creation of the North East Combined Authority and the publication of the Government's Devolution White Paper, we commissioned an external review of our current ICP arrangements led by Professor John Tomaney of University College London. This review will report in the Spring/Summer of 2025 with recommendations on how we can further strengthen our ICP arrangements.



In terms of our Integrated Care Partnership, we have reviewed the geography of our Area ICPs and aligned them to the geographies of the Tees Valley Combined Authority and the North East Mayoral Combined Authority – alongside the existing North Cumbria Area ICP.

We are committed to working together through a single overarching ICP alongside three 'Area ICPs'. These Area ICPs help us to develop a strategic picture of health and care needs from

their constituent local authority places, working with partners including existing health and wellbeing boards.

Our ICP covers the largest resident population in England at just under three million people (2021 census) and covers a large and diverse geography – from cities and towns to rural and coastal communities.

Better Health and Wellbeing for All

The North East and North Cumbria Integrated Care Partnership (ICP) is a statutory committee of fourteen local authorities and the Integrated Care Board (ICB). Each ICP in England is required to publish a long term integrated care strategy.

The North East and North Cumbria ICP published its strategy, Better Health and Wellbeing for All, in December 2022. The strategy is heavily informed by the views of a wide group of stakeholders, and was finalised following extensive engagement including a 'call for evidence' process during 2022. The engagement and call for evidence process has strongly informed the strategy, alongside the population health data.

It is an ambitious, long term, population health focussed 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: everyone does not have the same opportunities for good health, because of where they live, their income, education, and employment.
- Best start in life: enabling children and young people to thrive, have great futures and improve lives for generations to come.
- Better health and care services: high quality services no matter where you live and who you are.

The delivery of the four goals is supported by five key enabling programmes:

2024/25 became year two of the implementation of the strategy. Delivery is supported by the ICB and wider NHS, and our equal partners in local authorities, other public sector organisations, the voluntary, community and social enterprise sector and the independent sector delivering NHS commissioned free at the point of delivery services.

Joint Forward Plan

In 2023/24 NHS England introduced a new duty for ICBs and their partner NHS Trusts to publish a joint forward plan, covering a five-year period. The North East and North Cumbria joint forward plan was approved by the ICB Board in September 2023. A draft of the plan had been published in early July for stakeholder feedback as part of ongoing engagement.

ICBs and partner NHS Trusts are required to publish an updated joint forward plan every March. The plan is required to describe how the ICB and its partner NHS Trusts:

- Intend to arrange and/or provide NHS services to meet their population's physical and mental health needs
- Will deliver the NHS long term plan and universal NHS commitments
- Will address the ICS four core purposes and meet the ICB legal requirements

The North east and North Cumbria plan is intended to act as the medium term delivery plan for our Integrated Care Partnership (ICP) strategy Better Health and Wellbeing for All. As part of our Joint Forward Plan, we have developed action plans including:

- The integrated care strategy goals
- The integrated care strategy enablers
- Each local authority Place or groups of Places
- Key service areas, for example urgent and emergency care

As the first joint forward plan was only agreed in September 2023, in-line with national guidance chose to refresh and recommit to the existing plan, rather than re-write the plan. The refreshed plan included updates to most sections, many of which were minor. The refreshed plan also included some new sections in response to stakeholder feedback as outlined in the September 2023 version, including:

- Working with the voluntary, community and social enterprise sector
- Long term condition management
- Dementia and organic mental health
- Gender dysphoria services
- Individual care packages and neurorehabilitation

As a result of the 10 year NHS plan which is due to be released in the Spring, we will not update the Joint Forward Plan until later in the Summer of 2025 which will be informed by the views of stakeholders. We are committed to developing a much clearer set of impact/outcome metrics to measure the success of our plan implementation. This will be incorporated into the ICB Strategy Deployment Framework, to be published twice annually.

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 2024/2025, 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. The ICB also planned and led on a successful regional communicable disease outbreak exercise in November 2024 designed to further enhance understanding between internal and external stakeholders. 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.

During 2025/2026 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.

Healthier and Fairer Programme

We are working together across the health system to make things healthier and fairer for everyone. This means different organisations are joining forces to prevent illness, address the root causes of health differences, and help the NHS boost our local economy. This program guides our work to improve everyone's health and reduce unfair health gaps, as we are required to do. We are focusing on what will make the biggest difference for people's health and wellbeing, so everyone has a chance to thrive.

Healthier and Fairer is a system-wide transformation programme that continues to strengthen leadership and accountability in addressing health and healthcare inequalities by bringing senior ICB leads (Executive and non-Exec Medical Directors) together with NENC Directors of Public Health, senior leaders from the Office for Health Improvement and Disparities (OHID), Foundation Trust Public Health Consultants, and the Voluntary and Community Sector (VCS). Our programme has three workstreams, prevention, healthcare inequalities (including CORE20Plus5) and broader social and economic determinants. Each workstream has aligned projects which are clinically/expert led and managerially enabled.

Our approach to delivery is based on ensuring:

- Partnership with place, building on the work of local health and well-being boards
- That we achieve the biggest impact with the strongest evidence base
- By doing things once, we reap the benefit of at-scale working

During 2024/25 we have continued to develop the programme, working with stakeholders across our system to develop and implement projects which have an impact on our local communities.

Prevention
Within this workstream we have been delivering whole system approaches to prevention in reducing alcohol intake, reducing tobacco usage, promoting healthy weight, and treating obesity. The following section highlights some of the work which has been developed and implemented in 2024/25.

Tobacco

- The North East and North Cumbria (NENC) integrated care system have an ambition to reduce smoking to 5% by 2030, as outlined in the Better Health and Wellbeing for All Strategy. The NENC has seen steady drop in smoking prevalence from 13.1% (2022) to 10.9% (2023).
- Throughout 2024/25 the Smokefree NHS/Treating Tobacco Dependency Taskforce, with representation from regional partners continued to meet and drive forward transformation and the delivery of key services aimed at tacking tobacco dependency in our region.
- The Tobacco Dependency Treatment Services (TDTS) have been operational throughout 2024/25 in all 10 hospitals across NENC providing systematic screening of smoking status on admission, opt out referral for all smokers to see an inhouse specialist trained TD advisor. There is also a maternity pathway across all 8 acute Trusts supporting pregnant smokers and partners to quit now as routine maternity care.
- Between Oct 2023 and Sept 2024, 32,035 smokers were identified on admission or at maternity booking, 22,150 referred to in-house service,17,005 were seen by the TDTS and supported, 3,775 set a quit date and 860(23%) successfully quit across maternity, acute and mental health in-patient pathways.
- A regional pregnancy incentives scheme has been in operation since July 2022 and several Trusts have since transitioned to the National Pregnancy Incentives Scheme (NPIS). The region has seen a drop in Smoking Status at Time of Delivery rates from 10% 2023 to 8.1% in Q2,2024.
- Consolidation of workstreams such as digital NENC smoking cessation offer, tobacco dependency treatment for adults with Severe Mental Illness in Community and work to improve access to evidence based quitting aids (e.g. vapes Varenicline and Cytisine via regional Patient Group Directions and updates to ICS formulary).
- The Taskforce works closely with the Fresh and Balance programme which is jointly funded by all 12 North East Local Authorities and the NENC ICB. The programme is closely aligned with the ‘North East Declaration’ for a Smokefree Future.
- Fresh ran four phases in 2024 of acclaimed Smoking Survivors campaign featuring real stories of former smokers across the region across TV, catch up TV, radio, outdoor advertising, and across Facebook and Instagram. The campaign had reach of 1.3M adults (TV), 1.5M people (Radio), 22M potential impacts (Outdoor campaign) ,1.6M people across 11M exposures (Facebook /Insta) and over 72,400 clicks to FreshQuit.co.uk from Facebook and ITVX.

Alcohol

- From 2023 Alcohol Care Teams (ACT) have delivered services within all acute Foundation Trusts across NENC. ACTs provide specialist care to reduce severe health risk among dependent drinkers admitted to hospital. Local analysis has demonstrated

over 6500 patients were referred to ACTs during 23/24, and the ACTs have reduced AandE attendances by 30% and length of stay by 39% in those that engaged with the service.

- The Programme for Alcohol Studies, a comprehensive NENC alcohol training platform available to the health, social care and voluntary sector workforce is now available via the Boost Learning Academy and over 600 registrants have accessed learning modules on the Programme to date.
- The NHS APA Stigma Kills campaign has been implemented across NENC, with local resources developed to highlight the damaging impact stigma can have to people accessing the care they need to reduce alcohol related harm
- The programme continues to use a population health management approach to support and develop pathways between NHS and other services and has piloted a pathway from primary care to fibroscan provision within community treatment.

Healthier weight and treating obesity (HWTO)

- Early 2024 agreed to expand the workstream to cover primary, secondary and tertiary prevention in the NHS and to develop a strategy with a goal of increasing the number of people in our region at a healthy weight and reducing those living with severe obesity
- April 2024 held stakeholder engagement event to build consensus across the system and to gather perspectives on priorities for a NENC HWTO strategy and agreed 4 strategic priorities for the HWTO strategy;

    - Whole System Approach
    - Advocacy – food environment and commercial determinants of health
    - Service provision
    - Workforce
    - 2 enablers include comms and engagement and data and intelligence

- Health Care Needs Assessment completed for adults and children and young people; recommendations included in subgroup action plans to be implemented in 2025/26
- New governance structure agreed and implemented that considers the HWTO 4 strategic themes
- Delivered webinars to primary care system covering what is Digital Weight Management Programme, case finding, how to refer (EMIS and SystmOne) and patient journey with close to 200 attendees. 5332 eligible patients referred to DWMP, 82% of GP's across NENC referring in, and achieved 70% of referral target. Aiming to achieve 6000 referrals by the end of March.
- Primary care pathway development sub group established and working on pathways to support implementation of prescribing guidance NICE Technical Appraisal for Tirzepatide.
- Submitted proposed pathway to NHSE in line with funding variation to support prioritised implementation of NICE TA for Tirzepatide
- Tier 3 Weight Management Services meeting the minimum standards up and running and over 800 additional patients seen to date of commissioned 1000 extra places.
- Working closely with Health Literacy Team and Learning Disability/Serious Mental Illness to review approaches in South Tees and starting to work with Newcastle
- Evaluation of Tier 3 Weight Management Service and maternal weight approaches commissioned
- Launched online school of HWTO on boost platform to provide training on diet, physical activity, psychology, weight stigma, commercial determinants of health for

health and social care staff. Over 100 individuals registered and over 100 modules completed
- Developed and launched Healthy Weight and Treating Obesity data dashboard

Healthcare Inequalities

Within the healthcare inequalities workstream, projects have continued to deliver in 2024/25. Here are some of the key achievements from this year:

Deep End

Delivery of Deep End Network projects within general practices who are 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.
- 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
- Provision of training and education to practice staff on a range of subjects, including homelessness, trauma informed practice, and substance misuse and alcohol excess
- Network engagement with member practices to foster the Deep End community in NENC, identify challenges, generate ideas and inform future initiatives
- Engagement with practice nurses to provide support and identify and address their priorities, including webinars on the menopause and chronic pain
- Established four GP Fellowships 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

Waiting Well

- The waiting well programme continued to identify, make contact, and provide intervention and sign posting for those waiting on surgical waiting lists at greatest need of support
- Artificial Intelligence waiting well hubs were operational by March 2023 and as at December 2023, 7696 patients were contacted and offered support

Core20PLUS5

- Clinical and managerial leadership across the 10 clinical pathways within the 2 Core20Plus5 frameworks have ensure progress on narrowing healthcare inequalities continues to make progress. Key to this work has been an improved understanding

of the nature and extent of the inequalities existing within these pathways through improved population health analytics, and targeted interventions.

- The bi-annual Health and Healthcare Inequalities Report sets out in detail the nature of the inequalities, the reasons that are driving these inequalities, and the actions being undertaken to address them. This report also fulfils the requirement of the ICB to report on the Legal Statement on Health Inequalities. This year's report starts to articulate the ICB's ambitions on reducing these to 2030 by the setting of ambitions and the steps required to achieve these. This report can be found here.

Inclusion Health

- Development of Our Approach to Inclusion Health, which is the ICB response to the NHSE requirement to understand and address the healthcare inequalities of stigmatised and marginalised communities, including people experiencing homelessness, Roma and Traveller communities, veterans, sex workers, and rural and coastal communities. The Approach has been co-produced with Voluntary and Community Sector organisations that support inclusion health groups, NENC Healthwatch, academic partners undertaking research with these communities, and NHS teams across our Foundation Trusts and within the ICB.
- Supporting our Local Authority partners in commissioning and delivering services for people with multiple and complex needs, including substance misuse, victims of domestic abuse, vulnerable migrants and refugees. These services ensured improved access to healthcare, including cancer screening and access to preventative treatments that are often more challenging to access for people with complex needs.

Broader Social and Economic Determinants

Within this workstream there are several projects which were delivered in 2024/25 and during the next year we will continue to evaluate and demonstrate improvement outcomes.

Poverty proofing

- 7 services have completed or are undertaking full Poverty Proofing interventions with 572 patient consultations and 231 staff trained in person, and half-day workshops designed for services to self-assess.
- Poverty Proofing Programme of Studies is available on the Learning Academy website with 6 different training modules (Poverty Awareness, Stigma and Unconscious Bias, Poverty and Maternity, How to Signpost Effectively, Poverty and Paediatric Diabetes, Taking About Poverty) with 530 people having completed these.
- 6 Poverty Proofing toolkits have been created (Travel, Access to Appointments, Cost of Heath, Staff Awareness and Guidance, Patient Empowerment, Communication), with Poverty Proofing standards in place for each.

Health literacy

Health literacy is about people being able to understand health information. It's about us making it easier for them to do this. Across the North East and North Cumbria region, an average of 62% of people struggle to understand information containing words and numbers.

Our health literacy principles are:

- We will try to understand what our communities want and need
- We will give people health information that is clear and easy to understand
- We will learn from what others are already doing. We will build relationships with those people and build on what they've done

In 2024/25 we have:

- Established the regional health literacy team
- Launched our programme of health literacy studies on the Learning Academy and trained over 1200 staff from over 45 organisations. Training sessions include health literacy awareness, how to write simply, and speaking simply
- Delivered bespoke sessions to teams and delivered a mastery level session for communication and engagement leads
- Delivered health literacy training to medical students at the University of Sunderland
- Started work on making patient pathways health literate, including working with the North of Tyne bowel screening pathway, the fibroscan (liver scan) pathway for County Durham Drug and Alcohol services, the South Tees maternity booking pathway, the South Tees healthy weight and obesity pathway, and the ICB complaints process
- We have launched our health literacy grant scheme that involves offering organisations up to £5k to support their health literacy work
- Both as part of the pathway work and with ad-hoc requests, we have edited over 70 documents to meet the health literacy standards

Anchor institutions

Anchor Institutions are large, public-sector organisations that are unlikely to relocate and have a significant stake in a geographical area. They have sizable assets that can be used to support local community wealth building and development, through procurement and spending power, workforce and training, and assets such as buildings and land anchors. Their mission is to advance the welfare of the populations they serve, and they tend to receive (or are significant stewards of) public resources, often having a responsibility to meet certain standards on impact and value.

Through a Neighbourhood Promise we have a vision to influence the health and well-being of communities, by facilitating work at scale that invests in working with others locally and responsibly, to impact on wider factors that make us healthy.

This year we have:

- Undertaken an audit to understand what is happening across our NHS system, what is happening regionally and what is happening nationally
- Scanned the evidence base about what works in this space
- Created a framework and brand for this approach, 'Our Neighbourhood Promise'.
- Held an anchor network launch event with over 80 stakeholders from across the system
- Scoped a programme of work and developed a business case to support action across each of the 5 pillars of anchor – action on education, action on employment, action on the economy, action on the environment and action on inequalities

Digital Inclusion

Digital inclusion is about ensuring that everyone, including employees, has equitable access to and understanding of digital technologies. This leads to a more accessible, efficient, and effective health and care system. As an ICS, we are working together to find new ways to:

- Provide everyone who is able and interested with the choice to access and interact with digital technologies and services
- Acknowledge introducing new digital technologies can create barriers and inequalities to those not digitally connected
- Ensure no one is 'left behind' as we introduce new digital services.
- Put people at the heart of everything we do

In our region, it has been identified that our population is more likely to experience health inequalities. We must ensure that digital technologies do not exacerbate these inequalities Based on research findings approximately:

- 6% of people have no home internet connection, equating to around 30,000 households
- 9% of adults in our region have never used the internet, compared to 6% nationally.
- 10 million people in the UK are lacking basic digital skills

In 2024/25 we have:

- Continued to build upon the NENC ICS Digital Inclusion Steering Group which includes over 30 representatives from across the region, providing a community of practice and support
- Conducted regional engagement with digital inclusion partners in health, social care and VCSE to gather insights into regional needs for digital inclusion and workshops with regional partners that help shape the strategic plan for digital inclusion across NENC
- 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
- Developed our first NENC ICS Digital Inclusion Strategy (more detail is available within the digital and Infrastructure annual report)
- Secured funding to support projects aligned to the delivery of our Strategy
- Created Digital Inclusion modules on the Learning Academy that enables partners to learn more about digital inclusion across the region and consider it in all digital work

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.

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)

Clinical Conditions Strategic Plan

As part of our ambition for 'Better Health and Wellbeing for all' we used population health data to understand our population's greatest health challenges. This year we worked with our clinical community to review our current data which identified key clinical conditions which have the greatest impact on our population. The process was underpinned by population health data which was interrogated using clinical curiosity and debate.

As a result, there were clinical conditions identified for both children and young people and adults, where the local system felt we could have the greatest impact on population outcomes. This formed the basis of our Clinical Conditions Strategic Plan 2025-2030.

The clinical conditions identified for adults were;

- Lung cancer
- Cardiovascular health
- Anxiety and depression
- Lower back pain
- Respiratory health

For children and young people, the conditions were;

- Diabetes
- Epilepsy
- Learning disabilities and autism
- Mental health and anxiety
- Asthma
- Obesity
- Oral health

The strategic plan has been launched, and the delivery of this plan now begins. Each clinical condition has associated actions to be implemented with details of stakeholder accountability and timescales for delivery. Working in partnership with the North East Quality Observatory Service (NEQOS), each of the conditions has a list of outcomes to measure delivery of recommendations. Baseline data has been recorded for the outcome framework, and this will be reviewed over the coming years to ensure we have made a difference for our population.

Physical health and long-term conditions

During 2024/25 we have developed our key workstreams for delivery, in line with the Clinical Conditions Strategic Plan which includes;

- Cardiovascular health
- Respiratory health
- Diabetes
- Stroke
- Cardiac

These workstreams are part of the Long Term Conditions Programme Group, which is aligned to the Healthier and Fairer Programme, ensuring that prevention is at the heart of our approach. The workstreams have a multi-disciplinary approach with medical, nursing, pharmacy and managerial support.

Over the last year we have established a way of working and agreed actions to deliver against the Clinical Conditions Strategic Plan as well as the national mandate as set out in the NHS Plan. Our delivery plan ensures that we prioritise areas for development, with engagement from our local clinical community as well as patients and carers.

Diabetes

- Increased new referrals into the National Diabetes Prevention Programme across the North East and North Cumbria
- Expansion of the Low-calorie Diets programme across the ICB geography
- Implementation of the Type 2 diabetes in the young programme within general practice

Stroke

- The two tertiary centres within the region have worked collaboratively to develop a model for a 24/7 mechanical thrombectomy service. Work will continue in 2024/25
- The North East and North Cumbria Integrated Stroke Delivery Network has secured national catalyst funding for 8 workstreams and will continue to roll these projects out into 2024/25
- This includes the establishment of health and wellbeing groups, stroke rehabilitation in care homes, enhancing access to therapy within existing rehabilitation services, roll out of Psychological Adjustment After Stroke Training to key staff within existing services
- Work has continued to focus on delivering against the national Integrated Community Stroke Service model and needs based community rehabilitation

Respiratory

- In collaboration with the Learning Disabilities Network, the Respiratory Network have designed a tool kit to consider reasonable adjustments for people with Learning Disabilities
- A review of diagnostics for respiratory patients has been undertaken and recommendations for future commissioning will be considered for implementation
- Work has been ongoing with providers to develop a model for future delivery of post COVID services into 2024/25

Women's Health

During 2024/25, we continued to implement the NENC ICB women's health ambition and programme aims, which are designed to:

- Make sure women's voices are heard by tackling taboos and stigmas and increasing representation of women at all levels of the health and care system
- Improve access to even more services for women by making sure they meet their reproductive health needs across their lives and prioritising services for conditions such as endometriosis

- Support women by making sure a woman's age, ethnicity, sexuality, disability, or where she is from does not impact upon her ability to access services, or the treatment she receives
- Share a regional approach to safeguard women and girls against violence
- Ensure better information and education by helping women and wider society equip themselves with accurate information about women's health
- Have a greater understanding of how women's health affects their experience in the workplace by normalising taboo conversations such as periods and menopause, helping women to feel supported in the workplace
- Ensure better research – addressing the lack of research into women's health conditions and improving representation of women from all demographics in research
- Tackling sexual safety and violence against women and girls

Women's Health Conference

Following our first Women's Health Conference in October 2023 where we launched our ambition, our second Women's Health Conference in July 2024 focussed on Women's health innovation and opportunities to learn and collectively improve women's health in the North East and North Cumbria. It was attended by around 300 people and enabled sharing best practice around innovative women's health in the region, whilst providing an opportunity for connection and inspiration to tackle the health equity of women's health.

Feedback from the conference showed a high level of satisfaction and confidence in the event as 77% of participants felt the conference focused on important priorities for driving the women's health agenda forward and 82% said they would recommend the conference to their colleagues.

Women's Health Needs Assessment

Our Women's Health Needs Assessment [led by North East Office for Health Improvement and Disparities] was published following our Women's Health Conference in July 2024. This was developed using existing women's health data profiles, women's voice intelligence taken from a variety of local sources from across our health and social care and VCSE partners and from mapping of current commissioned women's health services to identify gaps with existing provision. This has helped lay the foundation for the development of the NENC Women's Health implementation plan.

Women's Health Implementation Plan

We have designed our Women's Health Programme to deliver our priorities through the development of an implementation plan, which will contribute to the longer-term outcomes contained in the national long-term strategy. This has been co-designed with healthcare professionals and wider stakeholders across the region, with an interest in Women's Health. This has also been informed by our:

- Women's Health Needs Assessment
- The Big Conversation, a survey developed in partnership with Healthwatch, which included a series of focus groups, to better understand what matters to women about their health, which reached 4,500 respondents from across the region
- Explain Market Research report, which sought feedback from young women across NENC to understand their thoughts, experiences, and priorities regarding the health of young women

In 2024/25, to help inform our implementation plan, we developed in collaboration with Health Inequalities North East and North Cumbria (HI NENC) a series of 'Innovation Design Sprints' (IDS), each aimed to have a deep dive into a focus priority area of work, by bringing together key stakeholders from across the region to support holistic, innovative approaches to collaboratively overcome system challenges.

Our implementation plan will provide a picture of the demographics of women in our region and an understanding of the deprivation and disadvantage faced by women who have a combination of issues impacting on their health status. For example, we are looking at evidence from VCSE reports and Healthwatch surveys into women's health including menopause, and data such as prescribing of antidepressants in women of menopausal age and child poverty data.

Governance and Leadership

In 2024/25, we updated governance and leadership structure was re-designed to compliment existing ICB networks and align to the organisation's overall strategic aims. This includes:

- A quarterly ICB Women's Health Group: Established to provide leadership and strategic direction to the Women's Health programme, which feeds into ICB Executive Committee
- Fortnightly 'Check In': Provides the opportunity to have a deep dive into one of the strategic work streams, which feed into recommendations for the Women's Health Group
- Task and Finish Groups: Established to progress key priorities across the whole programme

Women's Health Hubs

Context

A national fund for the establishment of Women's Health Hubs totalling £25 million was provided in an equal distribution to all 42 ICBs in the country in 2023/24, over a 2-year period. The £595k awarded to the NENC ICB was utilised to establish three pilot hubs in Sunderland, Gateshead and North Cumbria, all with different models of service delivery, with agreements in place to share best practice with a view to scaling up successes across the NENC footprint.

Health hubs aim to bring together healthcare professionals and existing women's health services to provide more integrated care in the community, enabling women to get more of their health needs met at one time, with less need for appointments in different places.

This means easier access to care tailored to women's needs, including gynaecology, sexual health, menstrual problems, contraception, pelvic pain, menopause care and more.

2024/25 Developments

With the NHS England investment coming to an end on the 31 March 2025, the 3 hubs are finalising plans to carry out their evaluations, which will be used alongside the findings of an IDS, delivered on 11 November 2024 with a range of key stakeholders, to create a blueprint for establishing future Women's Health Hubs. This work is expected to conclude in the Spring of 2025.

Throughout 2024/25, our 3 Women's Health Hub Pilots have reported positive impact and benefits for local women accessing enhanced services and all have the intention to continue to

provide services delivered through their current models of delivery post April 2025. Highlights included:

- In Gateshead, the hub has deployed a mobile outreach unit, which has engaged with local women at various community settings, specifically targeting those who do not usually engage with healthcare services, which include menstrual problems, assessment and treatment; menopause assessment and treatment; contraceptive counselling and provision and cervical screening
- In Sunderland, the hub continues to provide a range of core services including specialist menopause clinics; contraceptive and Long Acting Reversible Contraception (LARC) services; cervical smears; ultrasound services and training and menstrual health issues. The hub is also exploring the delivery of enhanced outreach clinics, which meet the needs of more diverse cohorts of the local female population e.g. culturally diverse communities more effectively.
- In North Cumbria, virtual menopause clinics, led by a menopause specialist, are operational. Referrals from general practice for the virtual specialist menopause clinics are being triaged and advice and guidance provided to the referring clinician. The hub is working collaboratively with the Local Delivery Team and ICB Project Management Office to identify potential menopause training needs in general practice. The hub is co-located within sexual health services across North Cumbria and able to schedule clinics for Mirena fit for Hormone Replacement Therapy (HRT), and opportunistic cervical screening.

Year 1 (2024/25) Priorities Updates

Menopause

Clinical leadership capacity has been secured for a further 12 months until 31st March 2026, which will enable identified priority areas of work to be progressed seamlessly and will include:

- Increasing the prescription of HRT and lowering the prescription of anti-depressants across the NENC footprint, especially in our more deprived areas
- Embedding menopause policies across all NHS organisations, which provide more effective support, experiencing perimenopause and menopause symptoms
- Reduce the need for inappropriate multiple GP appointments for women experiencing perimenopause and menopause symptoms
- Exploring avenues to improve coding in healthcare settings for menopause assessment and treatment

Contraception

Following a recent training needs assessment, the publication of the Women's Health Needs Assessment in July 2024 and following conversations with the three commissioned Women's Health Hubs, revealed that low numbers of LARC fitters (coil and implant) is impacting on ability to provide accessible contraceptive service options for women across the region.

We have therefore collaborated with a local training provider to develop a plan to:

- Identify system gaps and provide the opportunity to train up to 10 clinicians, which are FSRH Standard for coil and implant fittings
- Develop a new model to support our regional LARC fitters

- Showcase a local Primary Care Network, which is demonstrating a good practice model to ensure the suitable availability of skilled fitters within the community per head of population and ensure this model is upscaled (as appropriate) across the region

A key priority for this agenda will also be to review our commissioning pathways for non-contraceptive LARC fittings and establish a collaborative approach with Public Health colleagues and ICB local delivery teams to assess the opportunities to reduce referrals into secondary care, whilst providing ease of access for local women.

Cancers

Throughout 2024/25, our colleagues in the Northern Cancer Alliance have been instrumental in reviewing their regional priorities through a women's health lens, which has helped to highlight the following priorities to support women and girls, at risk of or have been diagnosed with cancer:

- Gynae-oncology – enhancing access to services for all women
- Menopause – ensuring women experiencing the early onset of Menopause, as a result of being diagnosed with cancer are appropriately supported, which improves the wellbeing of the patient and reduces the demand on existing services
- To establish a Breast Pain pathway, which reduces the 2 week wait referrals on suspected breast cancer pathways
- Prevention – improving preventative treatment for women deemed as high risk of developing cancer, following genetics testing
- Screening – to increase screening rates and the uptake of Human Papilloma Virus vaccines
- Lung – Improving early diagnosis rates across the entire NENC footprint

Year 2 (2025/26) Priorities

Programme plans for 2025/26 are currently being finalised for other Women's Health Year 2 priorities, which is aligned to the national Women's Health Strategy, namely:

- Menstrual Health and Gynaecological conditions
- Mental Health and Wellbeing
- Health Impacts of Violence Against Women and Girls
- Healthy Ageing and Long-Term Conditions.

Primary Care Achievements

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.

Primary Care Access Recovery

In 2024/25 focussed on the continuation of the two-year Primary Care Access Recovery Plan (PCARP) for the Integrated Care Board (ICB). This plan aimed to reduce the 8am rush for appointments in general practice and develop the service model to improve patient experience and empower patients to make the right choice of care for their needs.

The ICB successfully improved the shift from digital to analogue telephony and introduced new digital infrastructure to support the empowerment of patients when accessing care from general practice.

Through local patient experience surveys we have identified there is still work to be done to improve communication with patients on how to improve their experience when accessing services. This work will continue to be a priority are of focus going forward.

There has also been a strong focus on strengthening the relationship between primary and secondary care, when transferring care between the two providers. Ensuring the patient is at the centre of all decision making and identifying key improvements to the pathways of care.

Stability and Resilience; Improving Access; Enabler services such as workforce, estates, and premises.

The ICB has a statutory duty to assure the quality and safety of the services it commissions and the GP Quality Assurance Framework has been developed and rolled out across the ICB to provide a method for monitoring and improving the quality general practice across the NENC ICB footprint.

Further enhancements to the use of data and local intelligence have been developed to support early identification of opportunities for the ICB to support practices in their journey when improving services to patients, and the resilience of service provision.

Investment has been prioritised to convert non-clinical space across a number of practices in the ICS during 2024/25 and we are now seeing this result in the ability for practices to provide the infrastructure to deliver additional appointment capacity.

Through an Additional Roles Reimbursement Scheme, national funding has been targeted to invest in primary care workforce across a number of health care professions. As a result,

general practices across NENC are employing nearly 2,000 more staff to delivery core general medical services.

Integration

The health of our population and the prioritisation of equity and equality has been central to the development of Integrated Neighbourhood Teams. General Practices through Primary Care Networks have been driving projects focussed on local patient needs and integrating services with providers such as community services, voluntary sector organisation and social care.

This will form the basis for future developments in line with national policy and improving collaboration between providers to focus on local neighbourhood health and community based care closer to our patients' normal place of residence.

Community Pharmacy

Community pharmacies in the North East and North Cumbria engaged strongly in the national Pharmacy First initiative to provide direct access to a range of services for seven conditions from sore throats and sinusitis to shingles and uncomplicated urinary tract infections. This makes good use of pharmacists' clinical expertise to avoid the need to see a GP. Across NENC 98% of pharmacies are registered to provide the service, with over 60,000 consultations per month being undertaken in pharmacies across the region. Local coaches funded by the ICB have supported practices and pharmacies in adopting the service, resolving IT issues and developing local pathways.

The oral contraception service is building momentum and capacity following the upskilling of the pharmacy workforce through advanced clinical skills workshops in each LPC area. With over 8000 consultations per month now being provided the service has the ability to widen access to patients and build capacity for more complex cases to be seen by the sexual health teams.

The community pharmacy PCN lead role has continued to build effective relationships across PCNs. With 66 out of 67 posts filled the post holders have been provided with ongoing leadership and support for their role. A number of locations have been identified as demonstrating best practice which have been showcased to other networks.

We have an independent prescribing project with 10 pharmacies engaged (3 live) and we have ensured the pharmacists have peer support sessions, led by Primary Care Medical Director.

There are regular meetings with all HWB pharmaceutical needs assessment l (PNA) leads and have fully supported HWBs in writing their PNA, due to be published October 2025

In NENC community pharmacies deliver over 50% of Covid vaccinations.

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

Living and Ageing Well

Our ambition is to support people to live well throughout their lifetime, to enjoy life, and be able to contribute to their communities for as long as possible. In 2024/25 we have strengthened our focus on living and ageing well by establish a Living and Ageing Well Partnership (LAWP) across our ICS, bringing together partners from all organisations and sectors including the ICB local place based teams, Foundation Trust providers, ambulance providers, local authority partners and the voluntary sector to help strengthen our combined focus on community services and to introduce parity of focus alongside our existing Urgent Emergency Care Network approach. We have continued our focus on transformational programmes of work that commenced under our Ageing Well programme over the last few years, but we have widened the scope to encompass all adults and a wider range of community and primary care services.

Living and Ageing Well Dashboard

Our business intelligence team have produced a Living and Ageing Well dashboard which brings together national and local health metrics which can be viewed at system and local levels. This data enables us to understand the impact of a range of service developments across the region, share areas of innovation and good practice and highlight opportunities to further improve, to ensure we deliver the best possible outcomes for our local populations. We plan to enhance the data richness in the future by incorporating data sources and intelligence from our partner organisations to identify our joint priority areas for development and transformation.

Urgent Responsive Care

We have combined our transformation programmes of work encompassing Virtual Wards (Hospital at Home), Urgent Community Response and Care Co-ordination (Single Point of Access) into a single working group with the aim of sharing good practice and identifying ICS wide enablers to improve equitable access to community based services for patients, so that they receive care closer to home, when they need it. This working group brings together local teams and strategic partners with the aim of agreeing strategic principles for the delivery of community models of care for services to be responsive to patient's needs, wrapped around the person, in line with the local and national ambition for an acute to community based service shift.

Care Co-ordination Hubs – Single point of Access

Self-assessment metrics have been used to map the current provision and co-ordination of services at place level to give an ICS view of the landscape and scope for development of services and working practices across the geography. The national ambition is that patients are managed via co-ordinated access arrangements with senior clinical decision making capacity and a multi-disciplinary team via a single point of access for urgent care services delivered in local communities. This is to assist 999 and NHS 111 providers to direct patients to appropriate services and to avoid unnecessary acute hospital admissions and attendances. A full scoping exercise has been undertaken to understand the areas of good practice, gaps and where appropriate standardisation of access and principles that could be applied to make navigation of services easier for NHS 111, 999 services and patients. Work is ongoing to develop a model of care for the future with ICS wide principles and enablers over the next 5 years.

Urgent Community Response (UCR)

(UCR) teams provide urgent care to people in their homes which helps to avoid unnecessary hospital admissions and enable people to live independently for longer. Through these teams, people who urgently need care can get fast access to a range of health and care professionals within two hours. Over the past year, there has been a continued upward trend in the number of 2-hour urgent community response referrals across the NENC ICB and we have able to consistently evidence that we are exceeding the 70% 2-hour standard threshold. We continue to work collaboratively with the NHS 111 and 999 services and providers via our URS group to strengthen referrals pathways for a 2-hour community response, when clinically appropriate to do so, thereby providing a real and safe alternative to taking people to hospital.

Virtual Wards (Hospital at Home) provide hospital level acute care for patients in their own homes for a variety of specialities across NENC. Hospitals continue to expand the numbers of patients that are managed in this way either for a faster discharge from inpatient care or as a step up option from community care services for remote monitoring and treatment of conditions overseen by a hospital level team. Over the past year, there has been a continued upward trend in utilisation and access to virtual wards via step-up routes. Virtual wards across the ICB continue to explore digitally enhanced pathways, with the ‘Health-call’ solution being rolled out across a number of our virtual wards. Local evaluations show both patients and staff see the real benefit of virtual wards as a true alternative to acute care in hospital. The gathering of insights into our virtual ward across the ICB has helped us start to focus on reducing variation and improving the offer across all places.

Proactive Care – Integrated Neighbourhood Health

Over the past year, learning from local places and our proactive care pilot, together with the national direction of travel (Neighbourhood Health and NHS operational planning guidance) we have continued to support local places in setting up ‘proactive care’ models for people living with frailty. The North Cumbria feasibility study with the 'Year of Care Partnership' was completed and shared with local places and teams. Work continues to be explored around the strategic enabling support for local places in their delivery of proactive frailty care and is a priority for the ICB transformation team. Background work has been undertaken around the development of a ‘proactive care outcomes dashboard’ together with other supporting resources e.g. template development. For people with end of life and frailty needs, we have started an ICB-wide pilot that is focusing on education and training of community teams around advanced care planning, coupled with the possible development of a digital community Treatment Escalation Plan.

Enhanced Health in Care Homes

Most people residing in our care homes are living with frailty. All our frailty work is therefore benefiting this vulnerable population. We have explored insights into our care home population, trying to understand better alternatives to hospital. This insights report has been shared by local UCR teams and partners to help with further local conversations to offer targeted support to staff within our care homes at times of crisis. We have also gathered insights into the amount of time our care home population are spending within ‘urgent responsive care services’ to help further understand service pathway development, such as end of life care, Same Day Emergency Care and Urgent Community Response. We are exploring the further development of our Care Co-ordination Hubs with a particular focus on our care home population; people who most benefit from care coordination and better alternatives to hospital. We are also helping to join-up conversations across the system, to share learning and best practice such as across digital pathways, nursing care home workforce challenges and improving quality insights.

Community Health Services Digital

We aim to support community health services to deliver better care for patients and service users by maximising the use of digital technology, including remote monitoring support. Our community of practice remains a key vehicle for connecting and sharing best practice and collaboration opportunities across partner organisations in the NENC integrated care system. We have also continued efforts to address interoperability of clinical systems, working with the Great North Care Record team, to identify and connect community providers to the shared care record, particularly around End-of-Life Care and Advance Care Plans. We have engaged with NHS England and local providers of community health services in relation to the faster data flows programme which aims to improve community services data flows.

The Community Health Services Digital strategy has recently been approved and will be signed off by the ICB Executive Committee.

Workforce support

Throughout 2024/25 we have increased uptake and utilisation of the Enhanced Care of Older People (EnCOP) competency-based framework as a workforce development programme across the ICB for frailty. We are aware that older people are the biggest consumers of care and workforce development specific to meeting their needs is a vital enabler. To date, over 1000 health and care professionals have enrolled on the EnCOP programme across the NENC

footprint with requests for support for engagement nationally from other ICS areas who are expressing a keen interest in the programme.

Cancer alliance workstream

Cancer Alliances bring together providers, commissioners and third sector organisations to work in partnership and with the public to improve cancer outcomes.

Faster diagnosis pathways

The Alliance has continued to support the embedding of **breast pain pathway** in all Trusts and for patients to be seen outside of the urgent suspected cancer (USC) referrals, through the provision of pathway transformation funding and supporting training and development of staff, with the aim of ensuring appropriate capacity and capability, and making the pathway resilient. This supports by aligning processes across NENC including the establishment of well-defined clear routes of escalation for patients with more worrying symptoms. To date pathways are in place in 5 of the 6 providers.

The **Unscheduled Bleeding on HRT** Task and Finish Group, has used the national guidance to support GPs to identify and manage patients through the correct referral route for cancer and non-cancer symptoms, work with Diagnostic colleagues / departments to ensure the correct capacity at the right time, and put in place robust triage and stratified pathways in place where required. A Pilot of the **Unscheduled Bleeding pathway** has started in Newcastle Gateshead with plans to evaluate and further roll out the pathway in 2025/26.

Teledermatology has been embedded into standard referral practice across NENC at 3 out of 4 skin MDT providers delivering urgent suspected cancer (USC) specific pathways. During 24/25 the alliance has led on the review of all existing Teledermatology pathways working toward the delivery of a commissioning recommendation for Teledermatology across the NENC to the ICB in early 2025/26.

Lung Cancer

Lung Cancer is the leading cause of cancer death, with a background prevalence in the North East and North Cumbria exceeding the national average. In NENC, we see an excess of late-stage presentations and presentations via emergency admissions, both of which are associated with poorer outcomes. Lung cancer is an agreed ICB clinical priority and a Lung Cancer Strategy was presented to the Northern Cancer Alliance Board in May 2024; and subsequently adopted by the ICB in 2024/25 and beyond. Our aims are to increase early diagnosis of lung cancer, reduce the number of late-stage diagnoses made through emergency routes, and provide the best care and treatment to patients diagnosed with lung cancer.

Lung Cancer Screening (formally Targeted Lung Health Checks) has been one of the key programmes of work to drive improvements in early diagnosis. The Northern Cancer Alliance continues to lead the programme across the North East and North Cumbria working with the providers who deliver the checks and associated Computerised Tomography scans. Lung cancer screening aims to detect lung cancer sooner, often before symptoms develop and when treatment is more likely to be successful. From 1 February 2025, the NHS Targeted Lung Health Check (TLHC) Programme will become known as the NHS Lung Cancer Screening Programme. The name change is an important milestone in the scaling up and transformation of the TLHC initiative into a new national screening programme.

The service is now active in every part of the North East and North Cumbria. The aim is to invite every current or former smoker aged 55-74 in the region to have a check by 2028. As of November 2024, more than 180,000 people in the region had been invited for a lung health check and more than 500 people have been diagnosed with lung cancer earlier as a result of the programme.

Non-Surgical Oncology

Non-Surgical Oncology (NSO) services provide drug and radiotherapy treatments for cancer patients. The purpose of the NSO work programme is to co-design, plan and implement a new and more robust networked model of NSO across the North East and North Cumbria to provide long-term safe, sustainable, high quality and equitable levels of patient care.

To date, public engagement work has been conducted, with a particular emphasis on seldom-heard groups. Patients and relatives have provided valuable feedback on proposed service changes, including temporary measures implemented within the North, and the broader NSO service. In response, various mitigations have been put in place, for example assistance with patient transportation.

Timely Presentation

We have continued to deliver a programme of campaigns, community engagement and partnership activity to increase symptom knowledge and encourage earlier presentation. This includes a focus on reducing inequalities in access, care and outcomes by building community partnerships to deliver effective campaigns informed by data and insights that help make a difference for people affected by cancer.

A network of Community Cancer Awareness Workers plays a key role across the region in promoting the benefits of national cancer screening programmes to encourage uptake in populations with low coverage rates. For example, targeted work with women known to the criminal justice system and those living in women's refuges and housing projects because of domestic violence; and working with staff and volunteers from a Fisherman's mission to specifically engage working and retired fishermen in head and neck cancer symptom awareness.

The Alliance continues to implement and embed Behavioural Science as a methodology across several programmes and pathways. This helps to better understand individuals' behaviours and attitudes that influence them to not access services. Projects for this year have included completion of the targeted Head and Neck Cancer Symptom Awareness Campaign, developing new education and information assets to support South Asian men to engage in bowel screening and a comprehensive review of cervical screening communication assets to improve coverage rates in cervical screening.

Living With and Beyond Cancer

The Living with and Beyond Cancer work programme aims to ensure people affected by cancer receive the help and support they need to live as full, healthy and active a life as possible both during and after cancer treatment.

In 2024 the NCA Improving Mental Wellbeing Steering Group was established. This groups main aim is to improve the mental wellbeing of people affected by cancer across the North East and North Cumbria. The group have used the commissioning guidance for Cancer Psychosocial Support (2020) developed by the London Transforming Cancer Services Team. The London model algorithm has indicated additional workforce will be required in psycho-oncology services and next year we will do a focused piece of work to better understand this in lung cancer. Scoping work has also identified a lack of appropriate training for the specialist and non-specialist workforce for level 2 psychological skills, Advanced Communication and long-term conditions training delivered to Talking Therapy colleagues. The aim is to develop a system wide training plan to enable the workforce to support people affected by cancer.

Building on work started in 2023/24, we have continued to work with our Trusts to further develop prehabilitation services and make them sustainable. Prehabilitation helps people living with cancer prepare their body and mind for treatment. There is strong evidence that improving fitness preoperatively can improve outcomes postoperatively. All 8 Trusts have Cancer Alliance funding in place, 5 out of the 8 have Prehabilitation leads in place. To support our local workforce an online education resource that shares the evidence and promotes the benefits of prehabilitation has been developed and is planned to be launched in March 2025.

In addition, a successful partnership with the Local Community Foundations has been established to support VCSE services to implement personalisation, rehabilitation and health and wellbeing support for people affected by cancer. These funding awards will allow for a broad range of interventions to be provided particularly within underserved communities and to address health inequalities.

Faecal Immunochemical Testing (FIT)

We continue to consolidate the appropriate use of FIT in primary and secondary care leading performance nationally on its utilisation. Extending the use of the test beyond the bowel screening programme, supports triage in primary and secondary care to determine if the patient has low or high-risk symptoms. This means a better patient experience of care and helps to target investigations to those patients who are most clinically urgent. It also supports endoscopy services to reduce waiting lists effectively and ensure earlier treatment.

Innovation

We encourage the adoption of innovative care practices and new models of working to deliver benefits to patients and to the wider cancer workforce.

Robotic process automation (RPA) involves the use of software robots to automate repetitive, rule-based tasks and processes. Automating functions like patient scheduling and data management saves time and reduces human error, allowing healthcare providers to focus more on patient care. RPA has been rolled out in 6 of the 8 Trusts in the ICB with advanced discussion with the 2 remaining Trusts. RPA is being used in a variety of areas including FIT data collection and MDT, extracting data from diagnosis letters to populate Cancer systems.

In October 2024 to promote innovation in earlier diagnosis and detection of cancer, and patient experience, an 'Unmet Need' call was run in partnership with Health Innovation NENC. Innovators across a range of sectors were encouraged to collaborate and develop solutions. 33 bids were received, and 10 bids were shortlisted. Examples of projects include using a predictor tool to identify patients who require additional support to access appointments to improve DNA rates in Radiology Diagnostic Appointments preventing Faster Diagnostic

Standard breaches; and a trial of the IBEX Galen Prostate A-I powered solution to assist pathologist in detection and grading of prostate cancer.

Elective care

Key achievements

Elective performance data for the reporting period is included within the performance overview and analysis section of this report. As a system, NENC last achieved the 92% standard in August 2018, while England last achieved this in February 2016.

Despite outperforming England overall, NENC 18-week Referral to Treatment (RTT) performance remains below the 92% standard, at around 60-70% since early 2023.

Although the constitutional standard has not been achieved during this reporting period, NENC has consistently exceeded the England 18-week RTT rate and since the pandemic, this is often by around 10%.

Throughout this year, the national focus has been to reduce the number of patients on the list with the longest waits. We have almost eliminated waits of 104 weeks or more and significantly reduced waits of more than 65 weeks.

In November 2024, NENC reported just 1% of people waiting 52 weeks or more with the national rate at 3% for the same period. As a system, looking across the reporting period, we can see that NENC consistently accounts for 5% of the national RTT incomplete pathways total and therefore impacts on the national performance overall.

To support and enable delivery of the constitutional standards, an Elective Care Recovery and Improvement Programme supported by the NENC Provider Collaborative was set up to help restore and transform elective care services with the aim of eliminating long waits for treatment, reducing the overall waiting times and addressing health inequalities by managing demand and maximising capacity.

The work programme is structured around three focus areas which include performance, productivity and pathways, examples of success this year can be demonstrated as follows:

Performance - Mutual Support

In the past year, the continued values of transparency and mutual respect has been instrumental in driving forward sharing of best practice and innovation through an inclusive approach to mutual support.

The Mutual Support Coordination Group established in November 2023, has facilitated conversations regarding over 1,200 patients across 20 specialities resulting in over 612 moving.

RTT performance is regularly best in the country and in the top **5** performance for waits of 65 and 52 weeks.

Learning from digital tools (e.g. Federated Data Platform) is helping us on our journey to reduce variation in patient waiting lists across Trusts in the NENC system.

Productivity – Getting it Right First Time (GIRFT)

Robust processes are now in place for supporting the NENC System GIRFT visits with our acute providers, and we have supported 7 elective GIRFT visits during the year.

We refreshed the governance and relaunched our GIRFT Co-ordination Group in September 2024; and have also developed a strong relationship with the national GIRFT team including Professor Tim Briggs.

Productivity – Outpatients Group

Our Outpatients Transformation Group was reset in 2024 with clear priorities in the three key work areas identified as Specialist Advice and Guidance, Patient Initiated Follow Up (PIFU) and Missed Appointments.

Operational information was shared between Trusts, examples have included Attend Anywhere tools to improve virtual consultation rates and work on clinic templates. We have also reviewed system wide Patient Engagement Portal (PEP) implementation in response to the Elective Reform Plan.

Patient waiting list validation practices and learning has been shared across the system and NENC sits in the top quartile nationally.

Work on development of the interface between Primary and Secondary Care is underway and is being further developed with the Primary Care Collaborative.

Productivity – Theatres

A Theatres and Peri-Operative group was established late 2024 informed by a system wide workshop.

Optimising capacity of Elective Hubs in the system is a priority; the interface with the Mutual Support Coordination Group is key to make best use of all resource available.

Pathways – Clinical Alliances

Providers have been brought together across the system to look at where pathways can be standardised, and access improved for patients.

Areas of focus have been Musculoskeletal (MSK) supporting a proposal on the national back pain pathway, Eye Care developing an option for a single point of access, Children and Young People (CYP) reducing waiting times.

The work this year has been challenging and will continue to be so into 2025/26, particularly given the additional financial constraints. As a result of financial pressures on the NHS, the value of Elective Recovery Funding available for systems to support additional elective activity is expected to more limited than in recent years; this will bring challenges for the system.

To respond to the challenges, the NENC Elective Care Programme has developed an Elective Reform Local Delivery Plan aimed at enhancing elective care services in the region. Supported by a structured governance framework, initiatives will be delivered by operational groups led by

senior members of the Acute Foundation Trusts to facilitate the achievement of key priorities and align with the national NHS Elective Reform Plan 2025.

Over the next twelve months, the NENC system will address over 71 national commitments related to elective care. Key areas of focus include optimising outpatient and theatre capacity to alleviate waiting lists and enhance patient experiences.

Initiatives to enhance our Outpatient services include substantially increasing GPs use of Advice and Guidance to ensure patients are seen in the most appropriate setting and that only patients who absolutely need to be referred receive an out-patient appointment, achieving a minimum Patient Initiated Follow-Up (PIFU) rate of 5% to reduce unnecessary follow up appointments, reducing Did Not Attend (DNA) rates.

We will develop an Independent Sector strategy which optimises the use of Independent Providers in ensuring we address our waiting list challenges while empowering patients in their right to choose where they have their treatment.

Additionally, a comprehensive review of surgical hubs and theatre utilisation will be conducted, with the expectation of a clear NENC approach, to ensure efficient resource allocation and enhanced patient care delivery.

Through these strategic efforts, the NENC system aims to achieve a more efficient and effective elective care, ultimately improving service delivery, patient outcomes and quality of experience across the region.

We absolutely recognise the importance of working together across the system to achieve the best for our patients; by cultivating a culture of collaboration and innovation, leaders can engage their teams and foster commitment to these transformative initiatives. The collective effort is essential for reforming elective care and ensuring the delivery of high-quality, timely services to patients, with this in mind we will be holding an annual Elective Spring Conference that helps us to unite and drive forward our work for the for the coming year. The 2025 conference is aimed at *"Learning Together, Delivering Together".*

Call to Action

The NENC system should be proud of what it has achieved over the past 12 months, despite the current challenges, there is real optimism that our continued approach in working together to transform our elective services and design pathways of care that better meets local priorities can make significant strides in reforming elective care and delivering high-quality, timely services to our patients. As we continue with the journey, your continued engagement and support is paramount to help shape delivery and innovation to achieve best care and outcomes for our patients and we look forward to working with you all in the year ahead.

Mental Health, Learning Disabilities, Neurodiversity and Wider Determinants

Introduction

The North East and North Cumbria (NENC) Integrated Care Board (ICB) is committed to improving mental health, learning disability, and autism services across the region. In an environment of increasing financial pressures, collaboration and partnership working are more critical than ever. By working together with NHS trusts, local authorities, voluntary sector organisations, and people with lived experience, we are striving to deliver high-quality, accessible, and sustainable services. Our collective focus is on ensuring that individuals receive the right care, at the right time, in the right place, while also making the most effective use of available resources.

These priority areas are being driven by the ICB's mental health, learning disability, neurodiversity and wider determinants transformation team, which adopts a matrix approach alongside place-based delivery teams and leaders. Place teams play a crucial role in shaping and delivering, ensuring that transformation is effectively embedded at a local level and aligned with the unique needs of communities and neighbourhoods. Their collaboration alongside other ICB teams and partners to ensure the improvements in mental health, learning disabilities, neurodiversity, and wider determinants are successfully implemented effectively across NENC.

Through this section, we outline some of our key achievements in 2024/25 and priorities for 2025/26, demonstrating our commitment to service transformation, quality improvement, and reducing health inequalities across the system.

Mental Health, Learning Disability, and Autism Inpatient Quality Transformation Programme (IPQT)

Introduction

The Inpatient Quality Transformation (IPQT) programme focuses on transforming mental health, learning disability, and autism inpatient care across NENC. It aims to reimagine inpatient care models, drive cultural change, and improve the quality of care delivered to individuals in these settings.

Key Deliverables

- Drive cultural change and reimagine inpatient care models across all NHS-funded mental health, learning disability, and autism inpatient settings

Achievements during 2024/25

- Established oversight and repatriation plans for individuals placed outside NENC
- Launched the Culture of Care Programme with participation from NHS and independent sector providers
- Allocated funding to enhance prevention and admission avoidance strategies
- Developed a system-wide lived experience strategy
- System group established to ensure multi-agency collaboration
- Conducted two system bed censuses to inform inpatient provision redesign

Priorities for 2025/26

- Publish NENC bed census and alternatives to crisis report.
- Conclude the work of the established task and finish groups for:
    1) Acute inpatient services for adults
    2) Inpatient services for older adults
    3) Inpatient services for autistic adults and adults with a learning disability
    4) Acute mental health rehabilitation services
- Launch Version 1 of the NENC ICB mental health inpatient dashboard
- Continue the Culture of Care Programme into 2026/27
- Strengthen involvement of individuals with lived experience and carers
- Reduce length of stay in adult acute mental health inpatient services
- 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 with the longest lengths of stay
- Publish a long-term implementation plan for the IPQT programme aligned with national commissioning guidance

All-Age ADHD and Autism Transformation

Introduction

This transformation focuses on the redesign of ADHD and Autism pathways for all ages across NENC. By reimagining these pathways, the aim is to provide timely, effective, and equitable care that meets the needs of individuals at all stages of their journey.

Key Deliverables

- System-wide transformation of ADHD and Autism pathways, supported by the newly established All-Age ADHD and Autism Transformation Steering Group

Achievements during 2024/25

- Conducted a comprehensive assessment of current pathways, waiting list demand, and system capacity
- Initiated the design of clinically led pathways to meet current and future demand

Priorities for 2025/26

- Develop and implement revised pathways for:
    - Needs-led pre-assessment support
    - Referral, screening, and triage for diagnostic assessment
    - Comprehensive diagnostic assessment
    - Post-assessment support
- Establish a single version of data truth across the ICB footprint to improve decision-making and resource allocation
- Ensure all design proposals address health inequalities, ensuring that underserved communities receive the support they need
- Explore and consider additional relevant pathway development, e.g. improving pathways for individuals with Fetal Alcohol Spectrum Disorder (FASD), ensuring they receive timely and appropriate assessment and support

Anxiety and Depression Clinical Conditions Strategic Plan

Introduction

This strategy is aligned with the broader goals of the Integrated Care System (ICS) and aims to ensure that individuals with anxiety and depression receive timely and effective care, guided by evidence-based practices. A central aspect of the strategy is the emphasis on prevention, screening, and early intervention, which are key drivers in improving long-term outcomes and reducing the need for more intensive treatment later on.

Key Deliverables

- Addressing the significant mental health challenges in the NENC region, we seek to promote standardised, comprehensive, accessible, and community-centered care.

Achievements during 2024/25

- Development of the NENC Clinical Conditions Strategic Plan for Anxiety and Depression
- The ICB's mental health, learning disabilities and autism subcommittee approval for broader socialisation of the plan
- Socialisation plan developed to gather feedback from stakeholders to ensure the plan reflects the needs and priorities of communities and neighbourhoods

Priorities for 2025/26

- The Clinical Strategic Plan for Anxiety and Depression will be socialised across the NENC region to ensure the plan is relevant and effective
- All feedback received during the socialisation process will be collated and carefully analysed, appropriate changes will be made to the plan based on feedback
- Final endorsement by the ICB's mental health, learning disabilities and autism subcommittee
- Following endorsement, a detailed implementation plan will be developed with clear priorities and milestones for the coming years

Talking Therapies

Introduction

Talking therapies are essential in providing mental health support and improving access to psychological care. This project focuses on ensuring equitable access across NENC, enhancing infrastructure, and driving improvements in service delivery and performance.

Key Deliverables

- Ensure equitable access to talking therapies across NENC, improving infrastructure to enhance performance against national trajectories

Achievements during 2024/25

- National trajectories for reliable improvement and recovery met
- A NENC-wide transformation plan agreed, including the establishment of task and finish groups to enhance regional infrastructure. Focus areas include:

- Defining a core talking therapies model that ensures consistency while accommodating local needs
- Transforming workforce structures to optimise expertise and capacity
- Exploring digital innovations to enhance clinical capacity, improve care delivery, and support individuals awaiting treatment
- Proposals developed for consideration under the Health and Growth Accelerator site pilot's project

Priorities for 2025/26

- Support implementation of the Health and Growth Accelerator site project
- Develop a regional talking therapies digital innovation plan with measurable productivity outcomes
- Confirm and standardise step two and three talking therapies models across NENC
- Collaborate with NHS England workforce, education, and training team and higher education institutions to enhance workforce development, including a regional supervision model for specific therapy modalities

Assertive and Intensive Community Mental Health Care

Introduction
Some individuals in our communities or neighbourhoods experience mental health needs that significantly impact their daily functioning, and these challenges cannot always be fully addressed through medication or therapeutic treatment alone. In certain cases, when their mental health deteriorates, they may pose a risk to themselves or others. It is therefore crucial that we are able to provide timely, stepped-up care to ensure these individuals receive the support they need when they need it most.

Key Deliverables

- Ensure across the system that the model of care delivered for individuals who need assertive and intensive care is effective and safe

Achievements during 2024/25

- Service reviews were completed as per the national guidance, the outcomes shared with NHS England
- Cost gap proposals were developed and provided to NHS England to inform the comprehensive spending review
- A task and finish group was established with key activities including developing a system action plan to address gaps found in the service reviews

Priorities for 2025/26

- Share the iterative action plan with Provider Trust and ICB Board by the end of June 2025, as nationally required
- Implement the key system objectives of agreeing our local definition, cohort scoping and model development
- Ensure we stay aligned with national and regional projects, maintaining agility in responding to evolving needs and expectations

Trauma Informed Approaches

Introduction

Trauma informed approaches recognise the connection between individual's life experiences and the development of mental health challenges. This approach focuses on understanding and responding to trauma in a sensitive, strengths-based manner. It operates on the principle that trauma can affect anyone, and that it is the collective responsibility of all to adopt a trauma informed perspective in their work and interactions.

Key Deliverables

- Describe a trauma informed approaches cross-sector programme including positioning of project logistics and key focus areas.

Achievements during 2024/25

- Development of a draft theory of change which outlines the focus areas of NENC wide transformation opportunities
- Collaboration across partnerships at NENC level to input to the theory of change draft and developing programme

Priorities for 2025/26

- Seek broad system commitment to the programme and set up the NENC wide working groups to take forward priority areas around lived experience, research, pathways, training and implementation and prevention.

Perinatal and Maternal Mental Health

Introduction

The transformation of perinatal and maternal mental health services is crucial in providing specialised care for individuals during pregnancy and the postnatal period. The focus is on ensuring access to mental health services for women and their families, aligned with national strategies.

Key Deliverables

- Define commissioning intentions for perinatal and maternal mental health services aligned with the Mental Health Long-Term Plan and three-year maternity plan

Achievements during 2024/25

- Improved perinatal mental health access trajectory
- Secured investment to level up specialist community perinatal mental health teams
- Additional funding secured for a NENC-wide maternal mental health offer
- Evaluation data from early adopter sites shared

Priorities for 2025/26

- Establish standardised principles for maternal mental health services, leveraging learning from early adopter sites

- Support local commissioning and implementation of maternal mental health services to ensure equitable access across NENC

Mental Health in School Teams (MHST)

Introduction

The expansion of mental health support teams in schools aims to provide early interventions for children and young people, reducing inequalities and ensuring timely access to mental health support within the educational setting.

Key Deliverables

- Continue expansion of mental health support teams to provide evidence-based interventions for mild to moderate mental health issues in schools

Achievements during 2024/25

- Achieved wide coverage, with 56% of schools within the region having access to mental health support teams
- Mental health support teams linked to formal specialist mental health services, reducing inequalities across Index of Multiple Deprivation (IMD) areas

Priorities for 2025/26

- Fully embed wave 11 teams and ensure full coverage across the ICB footprint
- Secure further waves as NHS England funding and training places are released, with priority placed on:
    1) Areas with lower current coverage
    2) Deprivation levels and areas with the highest need
    3) Readiness of school systems to implement mental health support teams

Children's Eating Disorder Services (CEDS)

Introduction

The development of a community eating disorder service for children and young people aims to provide accessible, high-quality care that adheres to NICE guidelines and improves outcomes for children facing eating disorders across the region.

Key Deliverables

- Develop a NENC-wide, NICE-compliant service specification for community eating disorder services for children and young people

Achievements during 2024/25

- Engaged stakeholders, including providers and those with lived experience, to develop the specification
- Final specification endorsed by the mental health, learning disability, and autism subcommittee in February 2025
- Invested in national training for all community eating disorder service teams commencing April 2025

Priorities for 2025/26

- Support the full implementation of the service specification across NENC
- Collaborate with the Provider Collaborative to implement recommendations from forthcoming intensive mental health services commissioning guidance

Building the Right Support

Introduction

"Building the Right Support" is a key principle within the North East and North Cumbria (NENC) Integrated Care Board's strategy, aimed at ensuring individuals with learning disabilities, autism, and complex mental health needs receive the right care and support in the right place. This work focuses on reducing reliance on institutional care, improving the quality and accessibility of community-based services, and ensuring that people have the opportunity to live fulfilling, independent lives.

The aim is to create an integrated, person-centered system where individuals have access to services that are flexible, responsive, and tailored to their specific needs, preferences, and aspirations. By collaborating with local authorities, providers, and individuals with lived experience, we can create a more inclusive, supportive environment for people across NENC.

Key Deliverables

- Ensure the development of community-based, person-centered services that prioritise prevention, early intervention, and integrated care
- Establish clear pathways to support individuals to live independently and prevent avoidable admissions
- Improve accessibility to mental health, learning disability, and autism services across NENC, ensuring that individuals have the support they need close to home

Achievements during 2024/25

- Developed a regional housing strategy that provides more community-based supported living options for people with complex care needs, including mental health, autism, and learning disabilities (Housing, Health and Care Programme)
- Mapping exercise undertaken of all NENC place delivery teams enhanced community models of care in line with building the right support
- Working to complete and implement the senior strategic intervenor system barriers recommendations

Priorities for 2025/26

- Implement a regional housing strategy that provides more community-based supported living options for people with complex care needs, including mental health, autism, and learning disabilities (Housing, Health and Care Programme)
- Continue reducing reliance on inpatient care, focusing on alternatives to admission and ensuring people receive care closer to home through enhanced community services
- Sharing analysis following mapping exercise of all NENC place delivery teams enhanced community models of care in line with building the right support
- Strategic commissioning development sessions to be facilitated to agree and develop priorities and plans for coming years

Housing, Health, and Care Programme

Introduction

This programme seeks to address the housing needs of individuals who require complex care, including those with learning disabilities, autism, and severe mental health conditions. It focuses on ensuring access to high-quality housing and support to help people live independently and avoid unnecessary institutionalisation.

Key Deliverables

- Improve housing access and quality for individuals needing complex care, particularly those with a learning disability, autism, and severe mental health conditions

Achievements during 2024/25

- Established a clear regional baseline of housing need for people requiring complex care and support
- Developed a regional development pipeline for supported housing over the next five years
- Received approval for up to £8.4m of NHS England capital investment to develop supported housing
- Began developing consistent design standards for supported housing

Priorities for 2025/26

- Publish a regional strategy and market position statement for complex care
- Agree design standards for supported housing for individuals with complex care needs
- Begin delivery of two sub-regional supported living schemes to support discharge from hospital by 2027
- Support local authority partners in delivering critical capital investment in supported housing
- Initiate a two-year Small Supports programme with six local authorities to develop new social care providers

Mental health spending

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. All ICBs are required to publish a statement after the end of the financial year to state whether they consider that they have met their obligations regarding the MHIS, as well as appointing an independent, appropriately qualified reporting accountant to carry out a reasonable assurance review on the MHIS compliance statement.

The ICB has reported achievement of the MHIS for the 12 months to 31 March 2025, with total growth in mental health spend of 6.71% during the year.

The table on the following page summarises mental health spend as a proportion of

recurrent programme allocations for 2023/24 and 2024/25:

Financial Years	2023/24	2024/25
Mental Health Spend	£688,966	£735,273
ICB Programme Allocation	£6,035,724	£6,421,691
Mental Health Spend as a proportion of ICB Programme Allocation	11.41%	11.45%

Local maternity and neonatal system

The Local Maternity and Neonatal System (LMNS) continues to implement the Three Year Delivery Plan for Maternity and Neonatal Services, published in March 2023, which outlines the strategic plan for making maternity and neonatal care safer, more personalised and more equitable for women, babies and families.

The plan is based on the following four themes:

- Theme 1: Listening to and working with women and families with compassion
- Theme 2: Growing, retaining, and supporting out workforce
- Theme 3: Developing and sustaining a culture of safety, learning and support
- Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care

The LMNS has developed a response to the plan to ensure each of the requirements under the above 4 themes are delivered through each of their programmes of work.

Delivering this plan requires the dedication of everyone working in NHS maternity and neonatal services in England who are working tirelessly to support women, babies and families and improve care.

The following has been achieved by the LMNS in the last 12 months:

Staff Appointments

The LMNS has strengthened its clinical leadership capacity with additional midwifery, obstetric, neonatal and specialist advice e.g. digital, fetal medicine, maternal medicine, preterm birth and intrapartum care. This clinical expertise and advice is critical to the delivery of LMNS programmes of work and ensure that the LMNS is clinically led.

The LMNS Programme Management team capacity has been increased through the appointment of key roles to support programme delivery.

Service User Engagement

The LMNS continues to remunerate the Maternity and Neonatal Voices Partnership (MNVP) representatives and patient public voice representatives to ensure meaningful engagement with service users. Service users with lived experience were involved in the commissioning of the NENC Perinatal Pelvic Health Service.

Perinatal Quality Surveillance Oversight

Perinatal Quality Surveillance Provider meetings take place on a quarterly basis with each of the Trust Quadrumvirates (Director of Midwifery, Obstetric Clinical Director, Neonatal Clinical Director and General Manager. The meetings are chaired by an LMNS Clinical Lead to review the trust quarterly perinatal quality surveillance provider reporting submissions which include a range of quality and safety issues. A report is shared with each trust following the meeting which highlights key discussion points and identifies any issues raised including mitigation and what needs to be done to rectify the risk.

Perinatal Quality Surveillance Annual Assurance Peer Review Visits took place between 23 September 2024 and the 12 December 2024. The aim of the 2024 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.

The visits were supportive in nature, sharing areas of good practice that can be disseminated across the eight Trusts and highlighting areas of concern that the LMNS can support. This aligns with the Perinatal Quality Surveillance Model (PQSM) guidance, which emphasises continuous improvement, collaboration, and transparency by seeking to ensure issues and concerns related to the safety of maternity and neonatal services trigger action, escalation, and intervention at the earliest opportunity.

Equity and Equality

The Vulnerable Migrant Task and Finish Group which is a sub group of the NENC LMNS Equity and Equality Steering Group developed a NENC pathway which standardises care for vulnerable migrant women and birthing people, to ensure their social, economic, health and safeguarding needs are addressed by the wider health and social care system and that those providing maternity care are able to address their complex needs. This work includes:

- **Maternity Migrant Care Pathway**: identifies specific additional needs for migrant women, birthing people using maternity services, provides a pathway to complement standard maternity care
- **My Maternity Profile**: supports individualised maternity care for those may find it difficult to do themselves
- **NENC Local Directory:** charities and services that provide support and advice to migrant women, birthing people and their families

The NENC LMNS is committed to producing a range of materials, including Easy Read formats in the top five languages spoken in maternity and neonatal services in the NENC and where appropriate, across the top five languages within each Trust.

In January 2025, the LMNS reviewed the top 5 spoken languages other than English within maternity and neonatal services within each Trust. Across the NENC they are:

1) Arabic
2) Kurdish Sorani
3) Romanian
4) Polish
5) Malayalam

Nationally, there is an evaluation of the Equity and Equality Guidance for Local Maternity and Neonatal Systems underway. As part of the evaluation a set of three case studies will be produced. NENC LMNS have been asked to be part of a case study to include the Equity and Equality Steering Group and the NENC Maternity Migrant Care Pathway.

Personalised Care

NENC LMNS working with service users and staff have coproduced a personalised care toolkit to respond to service user feedback. It was agreed to take forward the work specifically around the areas identified as a challenge:

- Defining personalised care for maternity and neonatal services
- Place of birth
- Induction of labour
- Accessing BadgerNotes for service users and staff

As a result, a personalised care toolkit has been developed which includes a range of materials including leaflets and videos for women and their families, and staff.

#FixingTheDigital Divide

Technology has become an integral part of our lives. For people who can easily access devices and connectivity they can access health-related information and services. However, digital exclusion in maternity can be a barrier to some women, birthing people and families. Within the NENC, as we have moved away from paper-based notes to digital which can present a challenge to some of the people we care for.

The national maternity and neonatal team have launched an initiative called #FixingTheDigitalDivide. This work was inspired by the South Tees approach to digital inclusion. Trusts across England are invited to register with The Good Things Foundation to become a maternity 'hub' so that all women, birthing people and families can have the same access to devices and data. The LMNS Team, trust digital midwives, the ICB, Health Innovation NENC, alongside service users are working together to implement effective solutions to increase digital inclusion. All 8 Trusts are able to 'prescribe' free handsets and free data to individual women when required.

Maternity Service Electronic Patient Record

The Great North Care Record (GNCR) and the NENC LMNS, have delivered the ‘first of type’ integration using BadgerNet, the maternity services electronic patient record (EPR).

By using this connection, Gateshead Health NHS Foundation Trust have become the first hospital in the NENC to share the maternity data that they record within the GNCR platform. It also makes them the first Trust to share maternity data outside of their organisation in the UK. Northumbria Healthcare NHS Foundation Trust, North Cumbria Integrated Care NHS Foundation Trust, South Tyneside and Sunderland NHS Foundation Trust and Newcastle Hospital NHS Foundation Trust are also all live. The three remaining Trusts (County Durham and Darlington NHS Foundation Trust, North Tees and Hartlepool Foundation Trust and South Tees Hospitals NHS Foundation Trust) are all due to go live on 16 April 2025.

Maternity And Neonatal Independent Senior Advocacy Service

The NENC ICB is part of a national pilot where Maternity and Neonatal Independent Senior Advocates (MNISA) to support people to have their voice heard throughout investigations and complaints into care received in maternity and neonatal services.

The MNISA's have received 19 referrals to date and are currently working with 16 families. All communication materials are translated into Arabic, Bengali, Kurdish Sorani, Polish, Romanian and Easy Read. Translation into other languages are available on request. The LMNS has recently commissioned a video which explains all about the MNISA service and contains quotes from families who are currently using the service and is aimed at both staff and families. Once finalised, the video will also be translated into different languages.

Perinatal Pelvic Health Services

A key objective of both the Three Year Plan and the current NHS Long Term Plan is to sustainably commission Perinatal Pelvic Health Services (PPHS) by ensuring that pregnant women and mothers have access to pelvic health services, to identify, prevent and treat common pelvic floor problems.

The NENC LMNS launched a PPHS in 2024 which is accessible in all 8 Provider Trusts, in line with the national service specification. This service has been co-developed with service users with lived experience and specialist clinical staff from midwifery, physiotherapy, urogynaecology and primary care.

There is a dedicated PPHS single point of access within each Trust geographical area, and there are standardised resources for women, birthing people and professionals. A range of communication materials have been translated into different languages and easy read including different videos which include stories from women with lived experience

Pregnancy In Diabetes

The LMNS facilitated a Diabetes Summit which took place in December 2024 with great success bringing together key stakeholders from across the NENC. As part of the next steps outlined at this summit the LMNS have set up a diabetes leads meeting whose purpose is to design, agree and develop a new NENC diabetes guideline ensuring an equity of service across the North East and North Cumbria. This work started in Q4 of 2024/25 so will continue into 2025/26.

Saving Babies Lives

The LMNS facilitated a collaborative planning workshop for all trusts to develop a plan for audit targets and parameters. This ensured all trusts were auditing based upon the same information allowing for further assurance of achievement of that element of the care bundle. This was successful and 7 out of 8 Trusts in the NENC declared compliance with the saving babies lives care bundle v3 as part of their MIS year 6 declarations.

Birth Rights Training

The LMNS commissioned this training so that maternity staff in the North East and North Cumbria have a better understanding of where they come from and how they apply to maternity

care. 56 delegates attended the initial training courses including midwives, obstetric consults, LMNS PMO team and MNVP reps. The course content included:

- How can we deliver safe and personalised care?
- Supporting women and birthing people to have an informed choice
- What really is informed consent?
- How can we reduce litigation and complaints in maternity care?
- Could we do more to prevent birth trauma rather than treating it

Further courses have been commissioned specifically for student midwives.

Gender Inclusion Training

NENC LMNS was successful in applying for national funding to commission CPD accredited Gender Inclusion training to help staff to better support transgender and non-binary service users navigating maternity. We partnered with Transmission PR to provide eight training sessions, with 20 spaces available per session with courses running during January and February 2025**.** These sessions have all been completed with good feedback from attendees.

MNVP – Governance, assurance and improving quality and safety training

The NENC LMNS hosted a MNVP course to support MNVP leads, trust and ICB representatives in ensuring that service user voices are effectively embedded in decision-making within maternity and neonatal services. Aligned with NHS England's MNVP guidance, the course covered key areas such as governance, assurance, and quality improvement, using a mix of formal talks, workshops, and interactive discussions. Delegates explored the national context of service user involvement, strategic influence at trust and LMNS levels, benchmarking against national reports and audits and approaches to problem-solving and action planning. Practical sessions focused on best-practice examples, governance processes, and presenting insights to boards to drive meaningful improvements in maternity and neonatal care.

Children and Young People

This year has seen an exciting new development to support the children and young people across our region as the NENC Child Health and Wellbeing Network, who have been delivering improvements as part of the NHS England Transformation programme since 2021, formally joined our organisation.

The Network demonstrates a proactive system approach to their work with children and young people, with a broad membership of over 2,000, and a central theme of youth voice which has brought them four Apprentice roles, the young advisors' Know Our Impact (KOI) group, and many youth engagement groups.

Examples of some of their innovative work include:

Building and Strengthening Governance and Youth Voice – A new Strategic Oversight Group for Children and Young People has been developed which brings together the multiple workstreams and system partners giving work relating to children and young people a system view, collective voice and higher prominence. Reflecting the importance of integration, it is co-chaired between our ICB Executive Lead for Children (Levi Buckley) and a Local Authority Representative (Audrey Kingham). The voice of children and young people is central to that meeting, and during the October half term, the Network held their inaugural 'Joint Meeting'

between our Know Our Impact (KOI) Young People's Group and their Child Health and Wellbeing Strategic Oversight Group counterparts, facilitated by Investing in Children. This event brought together senior members of the Network's Executive and Leadership teams with young people to discuss critical issues such as bullying, poverty, and mental health.
The session was a platform for the young people to highlight their Manifesto, raising their key concerns and recommendations. In response, the professionals demonstrated their commitment to these issues by signing a pledge to incorporate the young people's asks into their daily leadership roles across the system. To hear more from the young people on their manifesto please click here - Young Advisors Manifesto and Theory of Change artwork. This collaborative effort underscores the Network's dedication to listening to and acting on the voices of young people, ensuring their perspectives shape our policies and practices.

Healthier Together (HT) – The Healthier Together website and mobile app provides the region with a NHS trusted digital resource to support, educate and empower parents and carers to make informed decisions about their child's health and wellbeing, along with a safety-netting tool to support professional across the region, and reduce pressures across Urgent and Emergency Care (UEC) and primary care. There have been over 350,000 website users since it launched and over 10,000 children are registered on the app.

Healthier Together Champions – HT Champions is a Health Service Journal Digital Award-winning programme, training over 300 Healthier Together Community Champions across the region in over 100 health, VCSE and education organisations. Champions are trained to support the most vulnerable families within under-served communities to access and utilise Healthier Together. Continuation of this approach will further support pressures across UEC and primary care and ensure that the most vulnerable families can be reached and health inequalities can be addressed.

Creative Health – the Network has had a cross-cutting theme of Arts and Creativity since its inception in 2019 and has engaged a Creative Health Advisor to drive this work forward. This year has included two great opportunities for young people in the region to thrive with creative health benefits through the Network's Student Achievement in Reading and Local Energy Advice Partnership initiatives. A review that is being conducted highlights how our region is a vanguard of creative health adoption.

NENC Core20PLUS5 – The Network has carried out comprehensive development work around the national Core20PLUS5 model to create a regional framework for NENC that enables cross-system use, to address health inequalities in different settings. This work has enabled a range of exciting projects across the priority areas including epilepsy, oral health, and mental wellbeing. Creation of a practical toolkit to implement the framework is being developed into online learning content for the Boost platform. Continuation of this work will enable roll-out of the new learning resources across the system to maximise impact on key priority areas of inequality.

Asthma – The CHWN ALG has led a range of education-based initiatives and has collaboratively developed, piloted and launched the Beat Asthma Friendly Schools Accreditation Scheme (BAFS) which is an innovative whole school approach to improving asthma care in the community. Alongside this we have also developed a Beat Asthma Friendly Clubs (BAFC) accreditation scheme which seeks to promote good asthma management in extra-curricular settings. We are currently working with Housing Providers and the North East Public Protection Partnership on the development of a Beat Asthma Friendly Housing (BAFH) pledge and NENC Regional approach which seeks to identify and mitigate risks of indoor air

quality and the impact of built environment on health and other outcomes for CYP with asthma. *(There are many photos of the schools on HT which we have permission for wider sharing of)*

Diabetes – The Diabetes Transition and Young Adult pilot (NHSE Funded pilot) was awarded the Nursing Times Kings Award for Integrated Approaches to Care in October 2024. The initiative addresses barriers to successful transition by tackling social deprivation, improving transition support and expanding access through flexible clinic options. The results speak for themselves for more information see here.

Epilepsy – Work has progressed since October 2023 to evaluate and baseline the 8 paediatric epilepsy services across the NENC footprint against the National Epilepsy Care Bundle which has resulted in the collaborative development of localised Service Improvement Action Plans for each of the 8 secondary care services. Which identified tangible local actions, timescales and measures of performance. This process, outcomes and findings has been showcased at OPENUK in November 2024 and also British Paediatric Neurology Association in January 2025. In addition to this a range of educational webinars have been recorded and published for multi-agency professionals and others available here on our HT website.

Successful Integration and learning: There have been many projects focusing on integration as a core focus of CHWN workstreams. There are 25 activities and outputs of the network that are currently being reviewed against the 5 principles for integration across the system (defined by Q community, NHS Confederation and the Health Foundation)

1) Defining scope and goals together
2) Building relationships and trust
3) Diverse expertise as an asset
4) Developing shared system leadership
5) Use an improvement mindset

Initial findings have highlighted work into all 5 areas but most evidence for Defining scope and goals together and using Diverse expertise as an asset.

Testimonial quotes – collaborating with the Network and experiences of integration from that review include:

"The Child Health and Wellbeing Network has been a great source of advice, comfort, guidance and wisdom and it has enabled the 'education sector' to bridge the 'healthcare' system. The team have been welcoming, friendly, always approachable and value project work to help overcome notable problems in the system. There is power in community cohesion and the Network has an ability to help connect colleagues, who may not have ordinarily come into contact with one another, produce great results, resources, packages and evidence-based research.

“I have had such a wonderful and unique experience working cross-sector with the CHWN; enabling me to connect to professionals and organisations who ordinarily we wouldn't come into contact with." ***– Executive Headteacher and former Education Advisor to CHWN***

"The Network has really helped bring together children's leaders from across all sectors that work with them, whether this is health, education, social services or the voluntary sector. The Network leadership truly values all sectors and this I believe has really helped create a stronger and more coherent voice for children's services. Underpinning this is a strong commitment to listening to children and young people as well as co-production wherever possible. There is a constant drive to ask, 'what do our CYP think, what do they want from us...' which is starting to

change the way we think and work." ***– Dr Mike McKean, Consultant in Respiratory Paediatrics and Policy Advisor for CHWN***

"The cross-sector approach from the Child Health and Wellbeing Network has been brilliant. Whilst the ICB has provided the impetus and administration, it has felt genuinely equal in terms of power and influence. ***– Network member***

"It has been very positive in that we are working together more closely with shared aims and objectives in mind. Hopefully this means that families are receiving clearer and more consistent messages too." ***– Katie Clarke, Strategic Lead for Early years, Cumberland Council***

Digital and Infrastructure

Following the ICB's internal organisational change programme, the Digital and Infrastructure (D&I) directorate was created and came into operation from April 2024.

The D&I directorate comprises the following functional areas:

- Estates; ICB Corporate and GP/Primary Care.
- Digital Data and Technology (DDaT); ICB corporate, GPIT and Integrated Care System (ICS) digital care programme oversight and delivery.
- Sustainability/Net Zero; Internal ICB and ICS coordination.
- Health and Safety; *Internal ICB*.

D&I strategic Leadership

Throughout the past year, there have been a significant number of digital and infrastructure strategic developments, most notably, the ICB provided system coordination and supported the development of the ICS ten-year Infrastructure Strategy, bringing together a wide range of essential infrastructure elements, that aims to transform the North East and North Cumbria (NENC) healthcare system, in terms of its Estate, Capital equipment, Sustainability/Net Zero and Digital service investments.

The ten-year Infrastructure strategy is a national requirement set out by NHS England (NHSE) for all Integrated Care Systems to develop and implement. The NENC Integrated Care Board approved the draft Infrastructure Strategy in July of 2024, prior to submission and consideration by NHSE. Following review NHSE provided some high-level feedback on a small number of areas.

The final and updated version of the infrastructure strategy was submitted to NHSE at the end of February 2025, in addition, an update was tabled at the ICB's Financial Performance and Investment Committee (FPIC), and ICB public board meeting in March 2025.

ICB Estate

A great deal of work and progress has taken place over the past twelve months from an ICB Estates perspective, both within the ICB corporate, and wider General Practice (GP) and Primary Care Estate.

It is worth noting that the key objectives of the ICB's Estates team are:

- Supporting GP Practices by ensuring we are meeting the statutory requirements of the Premises Cost Directions 2024. The ICB budget for Primary Care Estate supports approximately, 347 GP Practices across 6 Local Delivery Teams (LDT's)
- Allocation of Premises Improvement Grants, ensuring a fair share of the capital allocation the ICB receives for both Estates and GPIT
- Access to Section 106 funding from 14 Local Authorities across NENC to support the impact of housing developments on health services
- Maximising the utilisation of the community estate and sessional space and proactively managing void estate costs
- Provision and rationalisation of corporate estate to meet the working requirements of the ICB
- Working with partner organisations with a *'One Public Estate*' ethos to maximise the opportunities through integrated working

In terms of the ICB corporate Estate, the team have been developing a Corporate Estate strategy, to ensure the physical environment we occupy as a large and diverse organisation supports our values and ways of working. It is anticipated that the ICB Corporate Estate strategy will be approved during Q1 2025/26.

Furthermore, from a GP/Primary Care Estate perspective, some examples of GP/Primary Care Estate initiatives over the past year include:

- New GP building for Middleton and Dinsdale Medical Practice taking them from their temporary building into a purpose-built facility
- Creation of 12 additional clinical rooms within the current footprint of GP Practice buildings to enable the delivery of circa 85k appointments annually
- Completion of Community Diagnostic Centre in Redcar Primary Care Hospital utilising previously void space
- Reduction in Void estate releasing circa £950K full year effect
- Hand back of the Monkton Hall premises, reducing ICB running costs by approximately £250K annually
- Successful allocation of Section 106 funding with Durham County Council, with further work taking place with other Local Authorities to agree a uniformed approach to Section 106 funding formula going forward

Digital Data and Technology (DDaT)

The Digital and Infrastructure Directorate has continued to make good progress against both strategic and operational priorities throughout the year.

Within General Practice, national funding was secured to refresh the ageing Community of Interest Network (CoIN) and replace this with a modern network infrastructure known as a software-defined wide area network (SD-WAN). The national award offered for the Future Connectivity programme funding was matched funded by the ICB to complete this work.

The outcome will be a new network provision for Gigabit bandwidth capability supporting the ‘analogue to digital shift’ and new news of working for our GP customers. In addition, the programme is providing the opportunity to explore new digital infrastructure technologies, that will provide rural communities' faster connections using satellite links.

Work on Cyber security has continued throughout the period given the heightened threat level and various incidents across the health and care sector. Within NENC we successfully secured

significant national investments in order to bolster Information and Communication Technology (ICT) products, services and networks within our secondary care organisations. Funds will be used to invest in nationally recognised capabilities aligned to the Cyber Assessment Framework (CAF). These improved security measures will be implemented by the end of the financial year 2024/25.

From an Information Governance (IG) and Data Protection perspective, the ICB retained the Data Security and Protection Toolkit (DSPT) status of *'Standards Met'* during the past year.

Within the ICB, we have maintained hardware standards and improved operational performance through the implementation of a single "corporate domain" and a refresh of equipment at the end of the productive life cycle. Consolidation of corporate mobile contracts into a single pooled data contract has contributed to operating cost efficiency which also supports onboarding of additional staff/functions into the ICB.

A focus on improving corporate ICT support with our delivery partner has resulted in significantly streamlined support processes with a standard for provision consistently applied across the organisation.

The ICB Technology team have worked over the last year to develop and produce a "*GP IT Prospectus*", this document will be hosted on the GP TeamNet portal and will provide a useful electronic resource describing the GP IT services the ICB commissions for constituent GP practices and Primary Care Networks, and how to access or request those services.

The prospectus was developed in close collaboration with support of the Regional Local Medical Committee (LMC), the ICB's Chief/Associate Chief Clinical Information Officers (CCIOs/ACCIOs), the ICB's Heads of Digital and Infrastructure, and the ICB's commissioned GP IT service providers. The primary objectives of the GP IT Prospectus are to provide clarity to constituent GP practices and Primary Care Networks (PCN's) on the commissioned GP IT services and infrastructure they are provided with under the terms of the v6 draft GP IT Operating Model 2023-25, and how to access/request those services.

This was needed to provide equity and clarity across the larger footprint of the NENC ICS, addressing the variation in the way the GP IT services were previously funded, commissioned and delivered by the eight legacy Clinical Commission Groups (CCGs).

NENC ICS DDaT Strategy and Governance

The NENC ICS Digital, Data and Technology Strategy 2023-26 is essentially about delivery and transformation, and as such, this requires all parts of our health and care system to be fully aligned and in agreement. The delivery of our strategy is led and managed via our governance and accountability arrangements, which have been refined and streamlined throughout 2024/25 and supported by the ICB Digital and Infrastructure Directorate:

NENC ICS Digital Partnership Council

- The NENC ICS Digital Partnership Council (DPC) meets bi-monthly and has been established to provide leadership, actively advocating partnership working and engagement of member organisations; to oversee activities required in delivery of our strategy
- The chair arrangements for the DPC are a shared responsibilities between health and care, comprising a Chief Executive Officer from an NENC NHS organisation together

with an executive level officer from the North East Branch of the Association of Directors of Adult Social Services (ADASS)
- The DPC receives updates from the NENC ICS Digital Delivery Group and NENC ICS Digital Strategy and Innovation Group, including escalations of risks and issues for consideration, resolution and/or upward escalation, as deemed necessary and appropriate

NENC ICS Digital Delivery Group

- The NENC ICS Digital Delivery Group (DDG) meets monthly to oversee the delivery of a range of agreed, pan-regional, digital transformational programmes and projects, including initiatives such as the Great North Care Record, Digital Diagnostics and Digitising Social Care
- The Group provides strategic thought leadership, recommendations, assurance and oversight, engaging, challenging and encouraging sharing of knowledge, experience and innovation
- The DDG aims to ensure collaboration across stakeholder organisations, sharing best practice to avoid duplication and inefficiencies across the system

NENC ICS Digital Strategy and Innovation Group

- The NENC ICS Digital Strategy and Innovation Group (DSIG) meets bi-monthly and has responsibility for contributing to development, delivery and iterations of the NENC ICS DDaT Strategy
- The DSIG provides a forum for insight, exploring new and emergent opportunities and threats. The Group acts as a guiding coalition, providing strategic thought leadership, coordinating a horizon-scanning function and makes recommendations to embrace strategic innovations

Secure Data Environment

Significant progress continued to be made within the NENC ICS Secure Data Environment (SDE) programme, several notable achievements include the establishment of new SDE governance arrangements with the creation of a Data Access Committee (DAC) along with a new Public Engagement Group (PEG). This will be further enhanced with additional ICB level governance arrangements during the early part of 2025.

The ICB, as the SDE data controller, also submitted application to the Confidentiality Advisory Group (CAG) for section 251 approval for both research and non-research purposes. Both applications were approved during the year.

Digitising Social Care

In 2024/25, the Digitising Social Care programme, which aims to transform adult social care through digital innovation by transitioning providers from paper to digital records, has successfully completed its final year of a three-year transformation initiative.

Over the past three years, the North East and North Cumbria ICB has achieved significant progress, with 80% of adult social care providers now utilising digital social care records. Key accomplishments of the three-year programme include:

- Funding and supporting 306 adult social care providers in their transition from paper to digital records
- Positively impacting over 12,000 service users and their families
- Extending support to adult social care providers across all local authority areas within the Northeast and North Cumbria region
- Observing savings in the time taken on administrative tasks, resulting in more time being available for staff to spend on care
- Enabling cost reductions within adult social care settings through decreased paper and printing expenses

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.

Task force on climate-related financial disclosures (TCFD)

The DHSC GAM has adopted a phased approach to incorporating the recommended Taskforce on Climate-related Financial Disclosures (TCFD), as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports.

Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally, by NHS England.

TCFD recommended disclosures, as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025-26 financial year.

For 2024/25, the phased approach incorporates the disclosure requirements of the following 'pillars': Governance, Risk management, and Metrics and targets.

These disclosures are provided below:

- The ICB's governance around climate related risks and opportunities.
- The actual and potential impacts of climate-related risks and opportunities on the ICB's business.
- How the ICB identifies, assesses and managed climate-related risks.
- The metrics and targets used to manage risks and opportunities

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 ICS 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 ICS Green Plan 2022-25.

Sustainability/NetZero

NHSE stated that ICB's should embed sustainability goals within their broader strategic and operational plans. By aligning sustainability with core healthcare objectives such as improving population health, tackling health inequalities, and enhancing productivity, ICB's can ensure that sustainability is not seen as a separate or secondary concern but as an integral part of their mission.

There is a direct link between NHSE Greener objectives and the ICB's key healthcare objectives:

- Improving population health and healthcare outcomes
- Tackling inequalities in outcomes, experience, and access
- Enhancing productivity and value for money
- Supporting broader social and economic development

NHSE expects ICB's to use its leadership role and lead the healthcare community in reducing the NHS's impact on factors that influence climate change in line with the published NHSE guidance in the following key areas:

- Reducing the environmental impact of medicines (esp. anaesthetic gases and inhalers)
- Improving digitally enabled working
- Ensure sustainability is built into clinical transformation
- Using the 10-year infrastructure strategy to decarbonise all NHS buildings and maximise energy efficiency, support modal shift and transform waste management

The NENC ICS Green Plan

The ICB approved the ICS Green Plan 2022-25 at the inaugural board meeting in July 2022, a regional Green Plan refresh is scheduled for June 2025. In order to inform the refresh process, the regional provider collaborative "sustainability leads" and associated subgroups participated in a series of workshops facilitated by Health Innovation North East and North Cumbria (HI NENC) in order to establish the regional 'Golden Threads' within the exiting ICS Regional Green Plan.

The objectives were set to maximise resource, shorten implementation cycles and concentrate efforts on regional solutions that will positively affect the individual trust Green Plans which are also due for refresh in June 2025.

Thirteen workshops were undertaken with six of the groups with seventy priority areas initially being identified, these were subsequently reduced to thirty-five as part of the overall engagement through the workshops. A timeline was established for the thirty-five priorities areas based on priority and achievable timelines grouped in three key priority themes: *Data Collation, Policy and Education*.

Workshop findings:

- Further stakeholder engagement is required to implement the priority areas being cognisant of the pressures on resource, funding and the working environment, this should be recognised in the Green Plan refresh in 2025
- It is key to deliver the regional 'Golden Threads' aligned to Data, Education and Policy to maximise resource and shorten implementation cycles
- Providing regional subgroup frameworks via SMART objectives will enable a common set of working parameters and agreement of the relevant baseline data collection needed
- A close working relationship between NHS England (NHSE), the ICB, the Provider Collaborative Sustainability Leadership group, including relevant sub-groups, and key partners is critical for delivery

The ICB NENC 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 Net Zero considerations when moving from cure to prevention, hospital to home, and analogue to digital.

This is categorised in three strategic objectives:

1. Improved Engagement and Education
    - Underpinned by:

- Delivering a centralised information point to make best practice and new policies more readily available.
- Sharing best practice, encouraging the ‘spread and adoption’ of improved processes

2. Baseline Data collation - Establishment of regional guidance Frameworks
    - Underpinned by:
        - Regional Baseline Reporting and agreeing data metrics and ensuring this is shared with SRO’s

3. Influence Plans and Policy - Work with the regions Health Care System to influence Regional and Trust Green Plans and policy.
    - Underpinned by:
        - Contextualising the issues faced by the NHS in reducing scope 1-3 emissions and showcasing potential solutions

Workforce Programme

Workforce remains a priority for the North East and North Cumbria. The NENC People and Culture strategy aims to outline a shared vision and move towards a ‘one workforce’ model across health and care. It focuses on greater integration, building on existing strong foundations, and committing to making North East and North Cumbria a better place to live and work. This approach supports our ambition to be the employer of choice.

The image below sets out the six pillars of the strategy: supply, retention, health and wellbeing, health equity and inclusion, system leadership and talent and reform.

One of the enablers of the strategy is the ICS People Partnership Forum, a system wide workforce group which meets regularly to support collaborative working, identify priorities, opportunities and innovation; and share good practice.

Pillar 1 – Supply

Attracting potential staff to the health and care sector continues to be a key focus. We have a number of initiatives aimed at creating a workforce that reflects the communities we serve and inspiring the next generation of the health and care professionals.

Apprenticeships are important in both health and care and are a key component of the NHS Long Term Workforce Plan and Adult Social Care Workforce Strategy offering career progression, maintain entry-level career routes, and are crucial for widening participation and ensuring workforce diversity. NHS trusts across the region continue to welcome T Level students aged 16-18 for practical experience. Our Mini Scrubs programme for primary school children is helping to raise awareness of health and care careers such as care assistant, social worker, and nursing home manager. A 'Lesson in a box' is currently being developed to further support the programme.

The NHS Finance Insights Placement programme offers 12-month paid work experience for individuals from lower socio-economic backgrounds. The NHS Universal Family Programme supports young people aged 16-25 who have been in care to enter education, employment, or training.

Pillar 2 – Retention

A key ambition of the NHS Long Term Workforce Plan and Adult Social Care Workforce Strategy is to increase the retention of staff, in part by making the NHS a better place to work. Nationally, evidence has shown a reduction in leavers for NHS trusts who participated in the first People Promise Exemplar Programme. Results from the current programme, which spans NHS trusts, primary care and the North East Ambulance Service, is showing a reduction in sickness absence, staff turnover and an increase in flexible working requests and approvals, which supports to maintain a healthy work life balance and avoid burnout. Work is ongoing to embed the People Promise across the system including trailblazing pilot projects in social care settings including domiciliary care, learning disabilities, and care homes, further across primary care, and the development of regional resources for system partners to access best practice across the programme.

The NENC System Retention Network Group, which includes local authorities, primary care, mental health and acute NHS trusts representation, have developed a fertility policy, line manager training and resources to support staff in the workplace. A system menopause policy has been developed with dedicated workforce menopause clinics currently being rolled out across NENC NHS organisations to support staff on their menopause journey.

Pillar 3 – Health and Wellbeing

We remain committed to supporting the health and wellbeing of our staff through the Employee Assistance Programme and the Staff Wellbeing Hub, which provide access to appointments with experienced mental health professionals, as well as other guidance and support services.

The Staff Wellbeing hub is available to all staff who work in NENC in a health or care role. We are reviewing our workplace adjustments to create a standardised approach for all ICB staff and collaborating with our NHS system partners to create a Health and Care Workplace Passport for NENC.

Pillar 4 – Leadership and Talent

A well-supported, engaged, and skilled workforce is at the heart of our ambition to improve health and care outcomes. In 2024/25, the focus has been on embedding a leadership culture that empowers staff, fosters innovation, and promotes continuous improvement.

The Boost Learning and Improvement Community has played a crucial role in professional development, with 13,000 members participating in leadership initiatives, and knowledge-sharing events centred on driving improvement as a system. Boost has facilitated learning through 52 improvement events and provided leadership training and coaching to over 1000 delegates. This investment in system-wide leadership has been recognised nationally. Boost now hosts a formal learning academy to enhance system leadership on health equity and population health management, increasing our capability to act on our biggest strategic priorities.

Pillar 5 – Health equity and inclusion

We continue to collaborate across NENC, forging strong connections with partner organisations. Executive Champions have been designated for each protected characteristic, with equity, diversity, and inclusion (EDI) objectives assigned to each ICB Executive Team member. To meet our public sector equality duty, the ICB Executive Team has completed Equality Impact Assessment (EIA) training, and policy leads have been established with a supporting toolkit.

We have published mandatory information on the NHS Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap, and the Disability and Ethnicity Pay Gap. Our calendar features EDI events and communication campaigns celebrating festivals and awareness days, including International Women's Day, Disability History Month, Black History Month, Pride, and LGBTQ+ History Month.

The rollout of the Oliver McGowan Mandatory Learning Disability and Autism Training for all NHS staff across NENC is ongoing. The Healthier and Fairer Learning Academy, launched in 2024 on the Boost Platform, focuses on addressing Health Inequalities in our region. It offers free access to training programs for all health and care staff and the public. Over 13,000 people are registered, with more than 5,000 signing up for a module or learning event between September 2024 and March 2025. Newcastle University is conducting evaluative research to understand workforce behaviours and learning culture.

Pillar 6 – Reform

Our reform agenda is underpinned by a commitment to integration, efficiency, and responsiveness, ensuring that services are designed around the needs of our communities.

Recognising the critical role that digital transformation plays in health and care, we have focussed on opportunities on developing and supporting Digital, Data, and Technology (DDaT) roles across the system. The NENC Digital Skills Development Network (DSDN) has been key in aligning DDaT strategy, infrastructure planning, and workforce capability development.

Regional training programmes, cross-sector collaboration platforms and digital leadership pathways have been established to ensure that our workforce is equipped to meet the demands of an increasingly technology-driven health and care environment.

The Boost Learning and Improvement Community has been a central pillar of our reform efforts, providing an inclusive approach for change. The Boost platform has enabled the development of structured networks, learning opportunities and peer collaboration, strengthening the region's capacity for continuous improvement. The NENC Improvement Conference and the Healthy Weight and Treating Obesity Conference are key examples of how we are fostering cross-sector collaboration and evidence-based improvement.

Research and Innovation

Key Achievements

A Research and Innovation (R&I) Blueprint is in development utilising feedback from key research and innovation players, aligned across the NENC ICB footprint. This was aligned to the statutory duties for ICBs which includes;

Each integrated care board must, in the exercise of its functions, facilitate or otherwise promote:

a) research on matters relevant to the health service, and
b) the use in the health service of evidence obtained from research.

Further engagement activities are being planned to support collaboration across the system and to position the North East and North Cumbria as open for business for research. In addition, we will continue to work closely with regional and national partners to ensure alignment of research activity to the priorities of the ICB. As part of this the NIHR aligned some regional research funding to the ICBs Clinical Conditions Strategy which is welcomed and supports the future development of research opportunities.

Research and Evidence

The Research and Evidence Team at the North of England Commissioning Support (NECS) is commissioned and overseen by the ICB to deliver a range of research support services, including research governance, research training, the hosting and management of NIHR research grants, developing research with stakeholders, aligned to ICB and national priorities, knowledge mobilisation, and service evaluations.

The head of the Team is strategically linked in nationally to influence policy in research with national stakeholders e.g., NHSE, National Institute for Health and Care Research (NIHR), and Department of Health and Social Care (DHSC) etc. to ensure the voice of NENC research ecosystem and population, are represented, and the national research ecosystem and ICB interface, are connected and add value. A particular focus on connecting ICS research leaders through NHSE led meetings has allowed sharing and learning as ICB mature in research and evidence, as well as piloting and developing research and evidence metrics for ICBs for their statutory duties. Most welcome was the engagement with National Institute for Health and Care Research (NIHR), William Rosenberg et al, to scope and advise on the "one NIHR offer to ICB", this produced recommendations for the NIHR strategy board and which have been accepted

Research governance

Processes provide assurance to the ICB that research is conducted in line with Health Research Authority requirements and national policy and guidance. As well as Capacity and Capability assessment for non-portfolio projects, 25 letters of access have been issued.

NIHR research capability funding (RCF) for ICB was aligned to 2 key areas

- Supporting GPs to enhance their research career with time to develop research bids for future awards and move the growth of research into community settings. This is part of a ICB supported long-term vision to bring together leading experts within primary and community care systems in a single virtual unit to build academic primary care within NENC
- Exploring and developing a NENC Deep End Community Researcher Link Worker Workforce to build on the research engagement network (REN) funded work, public health links to deprived areas and align to the direction of travel and expertise in academic in primary care and public health to grow research in areas of disadvantaged population

Knowledge mobilisation of research into the ICB has been achieved through a number of activities -

- Evidence and evaluation is one workstream of the ICB Mental Health Programme, bringing together practitioners, ICB leads, academics, librarians, HI NENC, the voluntary sector, and those with lived experience together to share outcomes of research to inform decision makers and advise on developing new research
- Aligning the Applied Research Collaborations (ARC) knowledge mobilisation bid with ICB and system priorities e.g. inequalities, mental health, women's health to successfully get funding for knowledge mobilisation fellows working across the ICB
- ARC evidence hub is now available on BOOST ;ICB learning and development site https://boost.org.uk/looking-for-research-evidence-thats-easy-to-understand/.
- Training in evidence finding and appraising, ensures staff have the tools and skills to support finding and using the evidence from research, in decision making.
- Routine use of social media, webinars, attending research events, NENC ICB bulletins, and targeted messaging

Research activity: commercial and non-commercial

The NIHR Clinical Research Network (CRN)/Research Delivery Network (RDN) NENC annual recruitment numbers, as of 31 March 2025, shows a total of 67461 recruits across all specialties, all trusts, primary care and non NHS sites. 1239 recruits were from non NHS sites supporting the spread of research to community settings where now more health and care is undertaken. Commercial research recruitment was a total of 6048, of which 4135 were recruited in primary care. Added to this great recruitment achievement, primary care has 34% of practices research active and 43 practices signed the National Contract Value Review, the highest of any ICB.

Research partnerships

ICB has been working collectively across the numerous NIHR funded units in NENC. This has included strategic work to consider joint ways of working, how to influence bids and work of, for example Policy Units, and collaborations for successful funding awards. This helps the

research ecosystem understand the ICB priorities and where and how to "push and pull" new research findings and answer research questions. The ICB director of comms has connected with all the NIHR funded comms leads to consider how best to share information and research successes efficiently.

The CRN/RDN put out a call for their strategic funding aligned to the ICB priorities with ICB as part of the funding panel decision making. With the RDN remit changing there is joint working with ICB to consider how ICB and RDN could share/align the stakeholder board that will have similar membership and some joint priorities to be an effective strategic group of influence to bring more research to NENC.

The NIHR ARC NENC is intertwined with many aspects of ICB priority work as its themes were collectively agreed across the system at its inception. ARC NENC researchers are members of several ICB workstreams particularly across the Healthier and Fairer Programme, Frailty, and Mental Health, bringing new evidence and evaluating key workstreams. The ARC NENC Evidence Hub contains research outputs of relevance to ICB, and is linked and shared and available on BOOST, the ICB learning and improvement platform ICB leaders contributed, supported and are named partners and leads in the recent ARC NENC bid to continue the excellent work already delivered. Of the 4 themes proposed in the new ARC bid they all align with the ICB priority areas.

Shared Data Environment

The NENC region has been funded as a Sub National Shared Data Environment (SNSDE) for research with ICB leadership across Digital, Data and Research, shaping this to enhance the research and commercial opportunities. The ICB is now the data controller for all primary care data and IG agreements are underway to add data flows from all trusts and primary care. Confidentiality Advisory Group 251 for both research and non-research purposes has been granted. A wide array of engagement across public, patients and professionals has been undertaken and a national pricing model agreed. A Data Access Committee (DAC) has been established. The SDE is now live with several pilot projects and a pipeline being established.

Improving Diversity of Representation in Research

Research Engagement network

The NENC ICB successfully secured ongoing funding from NHSE to continue the work of the Research Engagement Network (REN), focussed upon areas of unmet need in research in underserved communities which was determined to be Mental Health Services for Children and Young People (CYP) as a key priority.

This was cross organisational working with ICB, NIHR ARC NENC, NIHR CRN/RRDN NENC and for this year both Mental Health Trusts – Cumbria, Northumberland, Tyne and Wear Foundation Trust and Tees, Esk and Wear Valley Foundation Trust and, NECS, with key partnership with North East and North Cumbria Voluntary Organisations Network North East (VONNE). Funds were allocated to Voluntary, Community and Social Enterprise (VCSE) organisations, across all parts of NENC, and initiated a range of innovative, community developed, engagement strategies to connect and understand more about research in health and care.

This Network provided a shared space for knowledge exchange, access to training, learning and development opportunities and also opportunities for VCSE organisations to inform,

develop and participate in research that reflects the needs and priorities of the CYP communities. This is linked with NIHR ARC NENC Children and Young Peoples' Research Partnership, which focusses on identifying research priorities with young advisors and has succeeded in being awarded a NIHR programme development award.

This work has resulted in several co-produced events, shared learning, materials and a" matching tool " for researchers to access the community for research development and recruitment. In addition, training material and top tips for roll out to early career researchers to understand CYP needs and approaches for success are being finalised. In addition, BOOST hosts the outcomes, tools etc for open access to all.

Deep End GP practice's involvement in research

CRN/RRDN provided a research facilitator and support to GP practices in Deep End following North of England Commissioning Support/CRN work undertaken to show they were less likely to recruit to research and to understand the barriers. This has been shared in many national fora and a paper is due to be published soon. The 2024/25 recruitment data now shows that 31% of the 51 GP practices in the Deep End are now research active meaning a more inclusive population is taking part in the research and with all the benefits that ensues.

Innovation

The ICB has formerly appointed Health Innovation North East and North Cumbria (HI NENC) formerly the Academic Health Science Network for the North East and North Cumbria, as its regional innovation partner, and a Memorandum of Understanding has been executed between the two organisations. Further, the CEO of HI NENC has been appointed as a strategic advisor to the ICB with regard to innovation, and the CEO of the ICB attends HI NENC Board Meetings. Collectively, these links ensures that our regional innovation portfolio is focussed upon the priority areas defined within the Better Health and Wellbeing for All Strategy.

During the course of 2022/23, the ICB and HI NENC have jointly supported the following initiatives:

Health and Life Sciences Pledge

There is a growing and vibrant Health and Life Sciences sector in the North East and North Cumbria, and accordingly the Pledge aims to bring together this ecosystem to:

- Collectively address regional health and social care challenges, supporting the reduction in health inequalities
- Gain recognition for our unique infrastructure and assets, on both a national and international stage
- Work cohesively to identify opportunities and attract investment to the region
- Collectively celebrate our collective success within the innovation arena

Launched in March 2023, as a joint initiative between HI NENC and the ICB, the Pledge continues to grow, and now has 136 Pledgees, which span academia, NHS, social care, voluntary sector, industry, and charities. For further details, www.hlspledge.org.uk

Bright Ideas in Health Awards

In late March 2023, HI NENC hosted its Bright Ideas in Health Awards (BIHA) Ceremony and the ICB was the headline sponsor, alongside several other research and innovation-based organisations. The BIHA celebrate the achievements of individuals and teams working within the NHS, social care, industry, and academia, who have risen to the challenge of telling us how, and where, they believe that the services provided to patients can be improved, either through a technical innovation or through better service delivery.

The Awards have a long history within the region and were first launch in 2003 as the Innovation at Work Awards and renamed in 2006. More than 200 new ideas were submitted across seven categories to the Awards and many of these have been triaged and are currently being developed along the Innovation Pathway.

April 2024 sees the launch of the Bright Ideas in Health Awards for the nineteenth time with two new categories being added: (i) Innovative Women's Health, and (ii) Innovation and Improvement in Reducing Health Inequalities. These new categories demonstrate further alignment with ICB priorities. Other categories will include: MedTech Award, Outstanding NHS Industry Collaboration, Innovation in Clinical Education, Demonstrating an impact in Patient Safety, Towards a Net Zero Award, and Research for Local Need. Further details can be found here.

The Innovation Pathway

Back in 2012, HI NENC developed The Innovation Pathway, which has now become a regional, and national mechanism for supporting new ideas, as well as innovators (from both the NHS and industry) with bespoke advice.

During the last year, the ICB has adopted the Innovation Pathway approach across several programmes of work, with a particular focus upon real world evaluation and working with industry. The outputs of the Innovation Pathway include new, and improved products and services for the NHS, the creation and safeguarding of jobs, as well as the securing of investment following the bespoke intervention provided. For further details, please see here.

Innovation for Health Inequalities Programme (InHIP)

The InHIP aims to address local healthcare inequalities experienced by deprived and other under-served populations. This is a national initiative and in the North East and North Cumbria region, the Programme has focussed upon addressing health inequalities relating to cardiovascular disease prevention, within the Middlesbrough area.

The Programme has been delivered by the ICB, HI NENC and the NIHR ARC NENC, where we have delivered a series of behavioural insight focus groups with minority and marginalised communities, to understand their experiences of and barriers to accessing cardiovascular disease (CVD) health checks. The views of local communities are key to this work, and insights into their experiences has helped to co-design sustainable, and effective CVD prevention interventions, aimed at reducing avoidable premature CVD deaths and narrowing health inequalities within the local population. Please see here.

Driving Digital Transformation

HI NENC is supporting the ICB to drive inclusive digital transformation across the North East and North Cumbria, with the goal of improving outcomes for patients. The HI NENC Digital Transformation Director is embedded within the ICB Digital Team, and together we are working across the health and care system, to identify, support, and facilitate opportunities to use digital health initiatives to transform pathways of care.

Some of the Programmes of work include: -

- Digital Pioneers - facilitates collaboration, exchange of ideas to support scale and spread of digital innovations across Primary Care
- Digital Champions - a CPD accredited, 12-month education programme to support Primary Care staff looking to embrace digital technology
- Health and Tech Adoption and Accelerator Fund (HTAAF) – in October 2023, the ICB successfully secured £700k from the Department of Health and Social Care. This national Fund aims to support the adoption and spread of health technology, and within the NENC region has focussed upon the creation of a regional Virtual Ward Solution. The ICB is working in partnership with HI NENC, a digital based SME, and five provider organisations as part of this project
- Sub National Secure Data Environment – the ICB is leading this programme, in partnership with other regional organisations. From the perspective of research and innovation, the relevant organisations comprising this ecosystem are all involved in shaping this agenda. Moreover, two clinical academics leads have just been appointed to help oversee the programme supported by several research and innovation-based advocates. For further details regarding these digital programmes, please see here.

2024 Programme of Work

The ICB is working with HI NENC to finalise the 2024/25 innovation portfolio. The successes of the above programmes of work will be built upon, as well as supporting other priority areas such as Women's Health, Children and Young People, and Respiratory. In addition, we will continue our work to raise the profile of the North East and North Cumbria in terms of its unique assets, infrastructure, and relationships, as well as developing our international links.

Quality Governance

The ICB published the Quality Strategy in October 2024, which recognises that by working together across our region, we have an opportunity to do even more to make care safer and set the highest ambition for quality and safety standards for our communities. Our region-wide quality strategy is key to this. Our strategy supports and builds on the work already underway across health and care organisations in the North East and North Cumbria to develop a positive culture of safety, openness and learning. While individual organisations have actions in place, we strongly believe there is added value in having common standards applied consistently across our region. Our 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 has established quality structures to support oversight from place-to-board, based on National Quality Board guidance. We have Integrated Place reports, with a standardised quality

agenda to ensure a consistent approach. Learning and areas for escalation feed into the quality groups, co-chaired by a Director of Nursing and Medical Director, focused on patient experience, patient safety, and clinical effectiveness. Key learning from these four meetings and areas for escalation are discussed at the ICB Quality and Safety Committee.

Following the transition into our new structures we are reviewing our quality governance arrangements to ensure they remain suitable and appropriate to support the ICB and the delivery of the quality strategy through the development of our quality management systems and safety management systems.

In addition to this we have an ICB System Quality Group. Based on best practice guidance from the National Quality Board, this group reviews a wider than health-focused review of quality across the system. This meeting includes regulators and colleagues from Health Education England (HEE) and reviews quality concerns across all health and social care providers, escalated from place level discussions. Items for learning or onward escalation are discussed at the Regional Quality Group, 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 has continued to discharge its statutory safeguarding duties throughout 2024/25 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) 2022.

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 and expertise and specialist advice both within the ICB and with partner agencies.

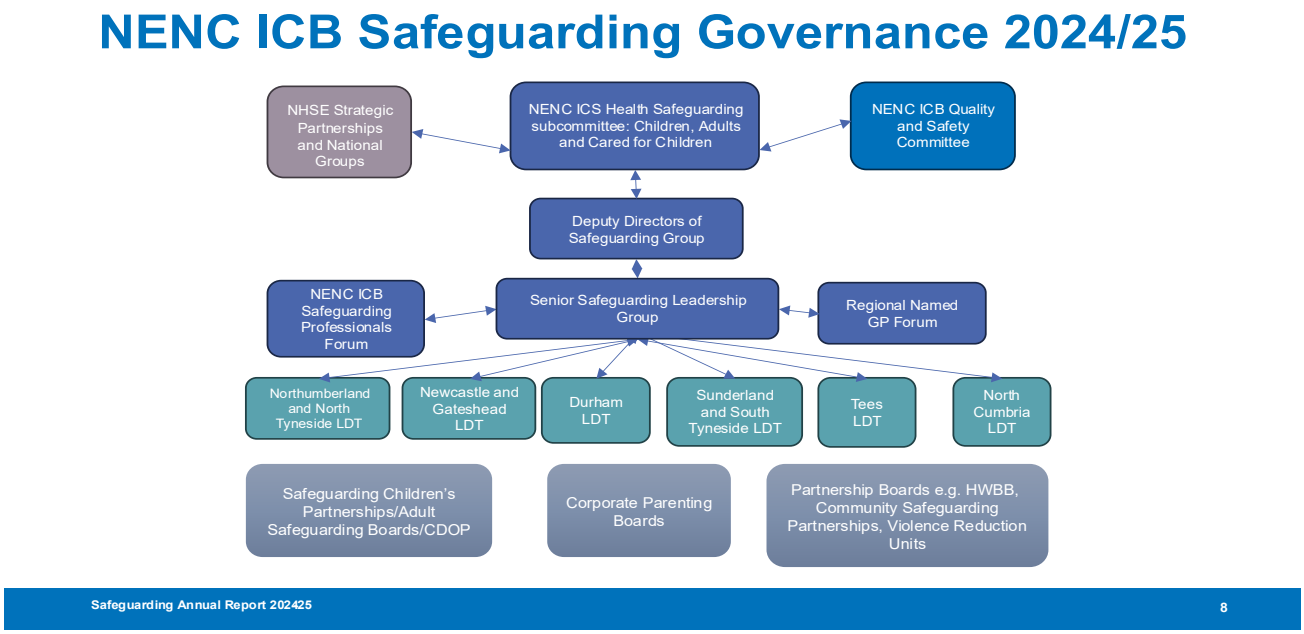
Processes were in place to monitor the safeguarding arrangements of our commissioned health services and to provide assurance that children and adults at risk of abuse were safeguarded in all NHS settings as well as individual homes, independent hospitals, and in care sector provision. The Designated 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 or 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 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.



Partnership Working

The ICB worked seamlessly across the Integrated Care System (ICS) to safeguard children, young people, and adults at risk, working with statutory and responsible partners and agencies to effectively safeguard our population. This included meeting all the statutory ICB duties relating to domestic abuse, sexual violence, and serious violence, with each relevant area undertaking a strategic needs' assessment and co-producing a plan to tackle serious violence. In relation to serious violence the ICB as members of the Community Safety Partnerships (CSP) and Violence Reduction Units (VRU) have contributed to and agreed a Strategic Needs Assessment (SNA) as per its duty (Police, Crime, Sentencing and Courts Act

2022) and the resulting strategies. Working with partners to prevent and reduce serious violence is highlighted as one of our strategic priorities.

Safeguarding Partnerships and Boards Annual Reports

ICB Local Delivery Team	**Children's Safeguarding Partnerships Annual Report**	**Safeguarding Adult Boards Annual Reports**
Newcastle Gateshead	Newcastle NSCP Annual Report 2023-2024 Gateshead GSCP Annual Report 2023-2024	Newcastle NSAB Annual Report 2023-2024 Gateshead GSAB Annual Report 2023-2024
Sunderland South Tyneside	Sunderland SSCP Annual Report 2023-2024 South Tyneside STCP Annual Report 2023-2024	Sunderland SSAB Annual Report 2023-2024 South Tyneside SAB Annual Report 2023-2024
Northumberland North Tyneside	NCASP Annual Report 2023-2024 North Tyneside NTSCP Annual Report 2023-2024	North Tyneside NTSAB Annual Report 2023-2024
Cumbria	Cumbria CSCP Annual Report 2023-2024	Cumbria CSAB Annual Report 2023-2024
Durham	Durham DSCP Annual Report 2023-2024	Durham DSAP Annual Report 2023-2024
Tees	South Tees STSCP Annual Report 2023-2024 Darlington DSP Annual Report 2023-2024 HSSCP Annual Report 2023-2024	Tees Wide TSAB Annual Report 2023-2024

Working Together

During 2024/25 the ICB worked across all of our 11 Childrens' Safeguarding Partnerships (CSPs) to meet the published requirements of the Working Together to Safeguard Children Guidance (updated and published in December 2023). This included assurance that the strategic leadership arrangements from the ICB Chief Executive as the nominated Lead Safeguarding Partner (LSP) were in place with the delegated responsibility to each partnership being led by the Directors of Nursing (DSPs). The terms of reference of the NENC ICS Health Safeguarding Executive subcommittee were updated to reflect these revisions and ensure attendance of LSP and DSPs.

In relation to the Working Together requirements for the two Child Death Review Partners (CDR) as the local authority and the ICB, work was commenced across the four Child Death Overview Panels (CDOP) to scope our current arrangements.

ICB Strategic Priorities

The ICBs strategic safeguarding priorities remain as highlighted in the ICS Integrated Care Strategy and the complementary Joint Forward Plan as:

- Collaborating with local authorities to improve health outcomes and service access for cared-for children and those transitioning from child to adult mental health services
- Implementing a trauma-informed approach in all health services
- Following the Domestic Abuse Act 2021 for multi-agency support to victims
- Supporting people with self-neglect and those needing treatment
- Working with partners to prevent and reduce serious violence

A particular focus during 2024/25 has been the specialist advice and expertise in support of the ICBs work in delivering the Women's Health Strategy for England in relation to Violence Against Women and Girls (VAWG). This has included linking partnerships in the needs assessments work and aligning priorities in support of learning from Domestic Homicide Reviews (DHRs)

Cared for and Care Experienced

NHS North East North Cumbria (NENC) ICB is the Responsible Commissioner for health services provided to NENC Children in Care whether they are resident within our footprint or outside. The ICB is required to meet the health needs of Children in Care and Care Leavers as illustrated in the Statutory Guidance Promoting the Health and Well-being of Looked-after Children, (DoH, DfE, 2015).

Systems of quality assurance and performance monitoring were in place with health and social care partners during 2024/25. The ICB maintained its statutory duty to cooperate with Local Authorities to ensure health assessments were undertaken and that support and services were provided to Children in Care without undue delay.

For cared for and care experienced the Designated teams maintained oversight of the commissioned services compliance with Children in Care requirements via the provider safeguarding contractual standards to ensure system oversight and assurance. Designated Nurses continued to represent and contribute to local Corporate Parenting Boards and attend the North East Care Leavers Board comprising 12 of the 14 regulatory Local Authorities.

Mental Capacity Act

Mental Capacity Act remained a key element of the ICB Safeguarding Governance arrangements:

- Designated teams maintained oversight of the commissioned services compliance with MCA requirements via the provider safeguarding contractual standards to ensure system oversight and assurance
- The designated team provided MCA support on complex safeguarding cases
- Designated teams worked closely with Safeguarding Adults Boards and other strategic partners to drive forward the development of MCA related practice and learning

Implementation of national and local safeguarding reviews

Learning and emerging themes from reviews and incidents were shared from each LDT area through the Designated Professional Forum whose membership is made up of the designated, deputies and lead professionals for adults, children, children looked after, primary care and the Mental Capacity Act.

Joint and collaborative work continued with partners and cross referenced and took account of high profile local and national reviews to ensure local safeguarding arrangements were safe and effective. The ICB safeguarding learning and development group have designed and developed the 2025/26 ICB learning offer based on the key findings of local and national reviews including the National Safeguarding Practice Review.

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.

Main deliverables for the workstream

Fully developed and implemented during 2024/25, the 'NENC One Way of Doing LeDeR' is now fully operational. A NENC LeDeR Reviewing Team is operational undertaking all reviews on behalf of the ICB. In addition, the NENC LeDeR Panel is operational chaired by Dr. Kathy Petersen, Strategic Clinical Lead for Mental Health, Learning Disability, Neurodivergence and the NENC Learning into Action Group is also operational chaired by Judith Thompson, North East and North Cumbria Learning Disability and Autism Network Manager and LeDeR strategic lead. The NENC LeDeR Governance and Assurance Group has been fully refreshed, is operational and chaired by Ann Fox, Deputy Chief Nurse. The LeDeR programme is accountable to the ICB Quality and Safety Committee.

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 2024/25

Key accomplishments during the report period include:

- Implementation of LeDeR 'new ways of working' with a one-system approach across NENC.
- Publication of LeDeR Annual Report 2023 a copy of which can be found here
- Publication of LeDeR Annual Report 2023 Easy Read Summary which can be found here
- Publication of Learning into Action Report 2023 which can be found here

Special education needs and disabilities (SEND)

The SEND Designated Clinical Officer function has been reviewed and identified variation as these roles all emerged and developed differently when first introduced. A consultation process has been undertaken which has reduced that variation and set out a way forward for this key role, to both works locally with LDT's as well as remain focused on their clinical leadership role.

The ICB has participated in a national trial of the development of a SEND Quality Assurance Framework which has strengthened understanding of SEND arrangements. More robust monitoring and oversight are being developed to support the assurance and delivery of support to children and young people with SEND and their families.

Durham and Darlington local area SEND Partnerships have been inspected by Care Quality Commission 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 with local SEND arrangements. The outcome for the SEND inspection of Westmoreland and Furness Council who were inspected in January 2025 is awaiting publication.

Engaging people and communities

The ICB is committed to listening to views from a range of residents, including patients, the public, carers, and stakeholders from across the region. This includes listening to views from people from protected characteristic groups.

The ICB identifies different ways of working, involving, communicating, engaging, and listening to a range of stakeholders. This is to ensure that community voices are included in the services we provide. We have evolved the ways we involve people, through learning lessons of what has worked well and ensuring a mix of engagement and communication methods are used.

The ICB has an involvement and engagement team that supports commissioners to assess the need for involvement activity as well as practically supporting, advising, planning, project managing and commissioning activity as appropriate. Each project has a specific bespoke involvement plan which sets out objectives, tactics and resources required.

We have a robust process in place to ensure that patients' views are considered for the services we commission, to help evaluate current service delivery and to help shape how future services will work. This includes a toolkit for staff to use when undertaking service change, and guidance on mechanisms and techniques that can be used to ensure patient views are

captured. Advice and guidance are also available from ICB involvement leads, who support involvement across the whole region.

The team build and facilitate networks with the public, with public sector partners and with VCSE partners in local areas. This supports promotion and co-ordination of activity as well as best practice sharing. Local networks also create vehicles for listening to local communities in an organic way, as opposed to being project driven.

The ICB monitors this through regular reports and updates through its governance structures, including Patient Voice Group, Quality and Safety Committee and Board meetings. The updates set out our commitment to working with the public, patients, carers and communities and their representatives, to ensure health and social care services are shaped around what people need.

Overview of how we work:

Shaping services through listening

- The ICB is committed to working with system partners, patients, carers and the public to improve patient safety, patient experience, health outcomes and, in doing so, support people to optimise their health and wellbeing. Our Annual Involvement Report details examples of the work we have supported.

Collaborative listening

- Being part of an integrated care system means we work with partners and other stakeholders, some of which may discharge our statutory responsibilities to involve, on our behalf. We work closely together to receive updates and provide assurance, which goes through the ICB Governance arrangements.

Working with our communities

- Working with our partners is important in how we involve people. We work closely with Healthwatch and the Voluntary sector. We share feedback with different NHS and other organisations. This happens in local areas across North East and North Cumbria. We will keep developing how we work with people and partners.

Supporting people to involve

- The ICB have developed a range of materials to support meaningful listening. This includes our Involvement strategy, processes, training documents, toolkits, and proformas.

Shaping services through listening:

Annual involvement and engagement report

The ICB is committed to working with system partners, patients, carers and the public to improve patient safety, patient experience, health outcomes and, in doing so, support people to optimise their health and wellbeing.

Our vision demonstrates our commitment to make the best use of public resources. Important decisions that affect patients are made in partnership with key stakeholders. At the heart of this process are local people. To ensure that we have person-centred, sustainable services, we work with partners and the public towards to enable the public to influence decision-making in relation to service change and development.

We undertake demographic monitoring in relation to the nine protected characteristics of the Equality Act 2010 and beyond, where appropriate. This helps us to understand who is participating in activity and where targeted work is needed. It also enables analysis of responses by different demographics, where data allows, to support duties in relation to equalities and health inequalities. The ICB's annual involvement and engagement report details all the ways we work with local people to improve access, service delivery and quality. It also includes evidence of local people acting as a catalyst for innovation and change.

Now more than ever, we need to ensure we capture feedback to help identify health inequalities by working closely with partners, to provide agile services in an ever-changing landscape. The ICB has developed stronger links with the community, through working in partnership with Healthwatch and the voluntary sector, to ensure consistency of listening and sharing health messages, which partners can support across their groups and platforms.

The annual involvement and engagement report provides a summary and demonstrates the range of some of the key patient and community engagement activities during 2024/25. This report demonstrates how the involvement of patients and public has influenced decisions the ICB has made.

You can read more about the work we have supported over the past year in our Annual Involvement Report.

The Big Conversation

The ICB wants to have honest conversations with patients and public. We want to learn more about the things that are important to people. We want to learn more about the things which are priorities for the ICB. We will do this by going out to our local communities. We will talk to people about one topic at a time. We will have lots of ways people can share their thoughts.

Women's health

The Big Conversation on women's health was launched at a Women's Health Conference in July 2024 and ran until September. This was done in partnership with the North East and North Cumbria Healthwatch Network.

The Big Conversation involved a regionwide survey and six focus groups. These were targeted at women who were identified as seldom heard where 35 people were involved from the following groups:

- Women with learning disabilities in Cumberland
- Women who are refugees and asylum seekers in Stockton
- Women who are unpaid carers in Northumberland
- Women from ethnic minority backgrounds in South Tyneside
- Women with lived experience of maternal mental health issues in Westmorland and Furness
- Staff who work with women who have experienced sexual abuse in Darlington

Around 4,500 people responded to a survey. Participants were asked:

- Where would you go for women's health related information?
- How confident do you feel about telling healthcare professionals about your women's health concerns?
- What is important to you when using women's healthcare services?
- What matters to you in terms of your health and well-being?
- What are your top five health priorities?

Overall, the top five priorities selected by the survey respondents were:

1. Mental health and well-being
2. Healthy ageing and long-term conditions including bone, joint and muscle health
3. Menopause, perimenopause and hormone replacement therapy
4. Screening services including cervical, breast, bowel and cancers
5. Menstrual and gynaecological health.

Headline findings:

- 61% of women said they feel confident to speak with a healthcare professional about women's health issues. However, many went on to say they aren't confident they will be heard or get the help they need
- Women said they aren't listened to, they are dismissed and not taken seriously when seeking support from healthcare professionals
- GPs have a critical role as the 'gatekeepers to support' for most women. We heard that many women are concerned that their GP does not listen to them, act on what they are told or doesn't have up to date knowledge about many women's health issues. Improving experiences in primary care will significantly improve confidence in women's health care
- Women want the choice to have a female healthcare professional. This is a strong message from our general engagement. However, it was very important in our targeted focus group work

- The GP (75%) and NHS website (75%) were selected as the most common place to find information on women's health. Focus groups highlighted the need for targeted accessible communications. Also, the importance of peers in their communities and community support organisations
- It is important to women that their health records are easily accessible by healthcare professionals. Also, that health records are kept up to date
- Women would like more research into women's health concerns
- Focus groups gave extra insight specific to their cohort. E.g. women with learning disabilities thought there was a lack of knowledge about the impact of neurodivergence on women's health. Confidentiality was a concern for the focus group which included women who had experienced sexual assault

The report outlined a number of recommendations. You can read more about the Women's Health programme and Big Conversation.

LOC in the Lakes: The weight is over – revolutionising health and wellbeing for all

Working in partnership with Boost and Health Innovation North East and North Cumbria (HINENC), LOC in the Lakes 2024 focused on tackling obesity in the North East and North Cumbria. The challenges we face in health and care in our region are immense, and one of the most significant of these issues is the rising level of obesity. Currently, nearly a third of our children are either overweight or obese before they reach the age of 15. This will impact our future communities, in terms of the risks to physical, mental, and social health, and the pressure on NHS services.

Obesity is mostly preventable. To revolutionise health and wellbeing for all, as a system, we need to:

- take a whole family approach to health and wellbeing;
- think beyond what's possible; and
- turn our minds to the groundbreaking and radical solutions.

The event brought people together to learn from local innovations, create fresh ideas for change. We spoke with people who work and volunteer in health and care services. As a result of LOC, a community of practice has been established and a programme of training and engagement opportunities are available through the Boost Learning Academy.

You can read more about the LOC in the Lakes 2024

Working well

Sometimes people can't work, or stay in work, because of poor health. The ICB want to help people to stay well enough to work. They will deliver a new programme to support people to do this. It's called Working Well. The Working Well service will offer support tailored to people's own needs. We will first learn more about why people can't work or are struggling to stay in work. That way, we can support people in the right way.

We needed help to shape this programme. We wanted to learn from:

- People who are in work, but who have a health problem
- People who are not currently in work because of a health problem
- People whose job it is to support people to stay in work

We held six online focus groups in February 2025. The focus groups aimed to explore the initial perceptions of the service, the impact the service may have, challenges and solutions, and how best to deliver the programme.

In total, 41 people joined these discussions. Attendees included people currently in full or part time work who have a health condition, people currently employed but on sick leave, those out of work due to a health concern, and people whose job role it was to support people to remain in work.

What we learned

People felt the main benefits of the programme would be to support people with long-term health conditions to return or remain in work, and increasing the support capacity for these individuals. It was also felt that the service would provide reassurance to employers and offer advocacy between employers and employees.

Some key concerns were identified, including a lack of awareness and understanding of health conditions by managers. There were also some concerns about employers' motivations for signposting someone into the service. People also had concerns about using GP information to contact people, feeling the information was not accurate, and it may not capture people who would benefit from the service (e.g., someone who did not speak with their GP regularly). There were also concerns around data sharing and safety.

People felt employers were more likely to have a better understanding of employees' sickness and absence reasons, so they would be best placed to make a referral. Or for individuals to be able to self-refer to the service. However, it was felt that engagement should be voluntary and at a time which is suitable for the member of staff. People felt that there should be some pre-information or conversations which take place before a person is invited to take part in the programme, perhaps through conversations with GPs, Allied Health Professionals, and other clinicians, as well as signposting and referral by charities and Job Centre Plus.

For the programme to be effective, there needs to be buy-in from employers, including for the consideration and implementation of reasonable adjustments. Feedback was also received about working collaboratively alongside the other services operating in the employability sector and not duplicating service provision

Plans for listening in 2025-26

We heard that people with lived experience should be involved in the service design and evaluation of the programme. This has been incorporated into the next listening activities. Coproduction workshops with people with lived experience will be held across the region. These will include collaborative design of the service model, and conversations to refine and validate the model. And the development of metrics to measure what success would look like from a patient and public perspective.

We will work with Healthwatch and our voluntary sector to have conversations with our local communities. These conversations will focus on support for people with health conditions or carers, to help get a range of views.

We will deliver a system wide workshop to help shape how the service could work, including in collaboration with the existing services which support people. People will be invited to share their thoughts on the principles which will underpin the programme.

Building upon what we learn, we will have conversations with key stakeholders from across the region. This will include clinical leads, commissioning staff, DWP, Job Centre, Health coaches, for example. Through these conversations, we will be able to sense-check what we had learned so far and identify any further areas to consider.

Collaborative listening

While the ICB holds the statutory duty to involve and the involvement strategy around working with people and communities, we take a distributed leadership approach to leading on involvement.

Being part of an integrated care system means we work with partners and other stakeholders, some of which may discharge our statutory responsibilities to involve, on our behalf. We work closely together to receive updates and provide assurance, which goes through the ICB governance arrangements.

The ICB has several programmes of work across the system, where Involvement is embedded. Secure Data Environment.

In 2023 NHS England created a network of ‘Secure Data Environments' (SDE). It looks at how research can use patients’ health and care records. This is to help create new treatments and services. SDEs supports the work the Government talked about in their strategy: Data Saves Lives: Reshaping health and social care with data**.**

SDEs can link together as part of a national network. There are 11 SDEs set up across England. There is one in the North East and North Cumbria and HINENC host the SDE for our region on behalf of the ICB.

There is a strong commitment to public and patient involvement in the SDE programme. An extensive strategy has been developed that actively involves, listens to and engages with the population of the North East and North Cumbria.

The approach builds upon the successful public engagement work as part of the Great North Care Record programme. We continue to work closely with the public, engaging them in discussions about how we manage and make information from their health and care records accessible to researchers and planners. Together, we are developing clear principles to ensure transparency and trust in how data is made accessible.

There are 16 public members who guide and advise the programme team. They are included in the meetings where key decisions are made. They have shaped communication materials, provided guidance in setting up the Data Access Committee and take on a key role in reviewing whether applications to access data are in the public interest. You can read more about how people are embedded into the SDE governance arrangements.

In 2024, an impact assessment was carried out on people who have already opted out of data sharing which provided useful insights into which groups of people are most likely to opt out.

In August to September 2024, a street survey was undertaken to explore perception of the SDE. In total, 1,149 individuals from across North East and North Cumbria participated in the survey. The sample was population representative based on age, sex and ethnic group.

The results from the survey will be used by the SDE programme steering group to respond to queries raised by the Confidentiality Advisory Group (CAG) about whether patients, service users or members of the public have been asked about the acceptability of processing identifiable patient data without consent to create anonymised and pseudonymised data sets. They will also be used to inform future communication and engagement activities with members of the public.

You can read more about the SDE programme, and the survey feedback.

Northern Cancer Alliance

We are supporting public involvement in a review of oncology services across the North East and North Cumbria by the Northern Cancer Alliance. The Alliance includes representation from all trusts. The aim of the review is to develop a sustainable clinical model for oncology services which aims to address the current issues being experienced within the existing service delivery model: a national shortage of oncology workforce and increasing demands on oncology services.

While this oncology service review has been taking place, and due to a shortage of oncologists within the service provided by Newcastle Hospitals NHS Foundation Trust the rapid implementation of temporary changes was needed within the north of the Integrated Care System region.

In July 2023, a range of listening activities were held to understand the impact that these temporary changes have had on patients accessing the oncology service. This included a survey, focus groups, and phone interviews.

Building on from this, in 2024, the ICB commissioned additional conversations with Black, Asian and minority ethnic individuals that are patients or caregivers of patients using the oncology service. The final interview was with a patient of the oncology service that has learning difficulties. In total, we spoke with 12 people who provided additional valuable insight.

Participants reported significant challenges with language barriers for those whose first language is not English, that need to be addressed. For example, with the provision of appropriate translators and for information about their patient care to be translated into an appropriate language. The main feedback received was around making sure information was clearer.

Other organisations which discharge our statutory duties to involve:

Maternity Voices - The North East and North Cumbria has a Local Maternity and Neonatal System (LMNS). A LMNS is a partnership of people involved in maternity and neonatal services. People work together to make services better. They want services to be safer, more personal, and kinder to people who use them.

Child Health and Wellbeing network - The child health and wellbeing network brings people from different sectors together to work with children, young people and their families.

Learning disability network - The North East and Cumbria Learning Disability Network includes people with learning disabilities and families as well as people from health and social care, education, and the voluntary and community sector. The network has a range of work programmes that focus on people with a learning disability.

Working with our communities

The ICB is committed to listening to local communities, and to work with community-based organisations to support these two-way conversations.

One of the ways we do this is through close partnership with Healthwatch. Healthwatch organisations play an important role in representing the views of patients and are present at many forums and groups. Funding has been secured to work alongside Healthwatch, to embed engagement and involvement in everything we do.

You can read more about how we work with Healthwatch.

We also work with a wide range of other local voluntary sector organisations across the region to support these two-way conversations. This helps us to reach and involve our wide and diverse populations in shaping local health services.

You can read more about how we work with the Voluntary, Community and Social Enterprise sector (VCSE).

Working with Haref

We work closely with the Haref Network in Newcastle. The Network help us make sure our health conversations are accessible to all members of the community including ethnically marginalised groups.

This year, through Haref Network, we have been able to share health information and surveys to a wide range of community organisations led by people from ethnically marginalised communities.

The Network has also meant we have been able to connect with organisations that provide services for ethnically marginalised groups. These groups include asylum-seeker and refugee groups. We meet with them throughout the year to look at current health issues and share information.

Listening Forums

We want to have meaningful conversations with our local communities. To help us do this, we attend community groups and meetings across the region. Examples of some of the groups we attend include:

- County Durham - County-Wide Patient Reference Group
- County Durham Health and Care Engagement Forum
- County Durham Community Involvement Group
- ADASS Lived Experience Network
- County Durham - Learning Disability commissioning involvement - Inclusion North Partnership
- South Tyneside and Sunderland Involvement Partnership

- A Better U network in South Tyneside
- HealthNet in South Tyneside
- Area Voluntary and Community Sector Networks in Sunderland
- North Tyneside Patient Forum
- North Tyneside - Think Differently: Support for neurodiverse children and young people, to reduce pressure on CAMHS
- Living Well North Tyneside
- Northumberland Strategic Carers Partnership Board
- North Tyneside Carers Partnership Board
- Gateshead and Newcastle - Patient and Public Engagement and Community Forum
- Connected Voices – Gateshead and Newcastle
- North Cumbria - primary care involvement with primary care networks
- North Cumbria – Healthwatch community forums for Cumberland and Westmorland and Furness

We share information through these meetings about the things we are working on. We also to listen to feedback about things which are important to people. The people who attend these meetings can shape them based on what they are interested in or what they want to learn more about.

In 2024, conversations through these groups have helped us:

- Develop our Involvement strategy
- Shape the ICB 'Tell us what you think' questions
- Shape our standardised equality questions
- Develop an approach to health literacy
- Shaped information leaflets.

Example of how we shared information

The North Tyneside Patient Forum communications working group worked closely with our Health Literacy Programme. They fed back on the ease of reading of bowel screening leaflets. The author said:

"I incorporated some of the suggestions from the group members into the final version...I took all of the queries about what they thought we should and shouldn't include to the clinical team, and incorporated whatever they felt was accurate/appropriate.... All patient feedback is really valuable, whether we end up acting on it or not, because it gives us things to think about and points out places where information might be missing."

We have had conversations to help us shape services. Such as:

- Change NHS engagement
- Urgent and emergency care services
- Social prescribing
- Mental health crisis services
- Virtual wards

Example of how we listened to feedback

Work took place across the region to support the national Change NHS involvement. Sunderland and South Tyneside Involvement Partnership took part in a Change NHS 'workshop in a box'. The group wanted the NHS to be:

- Easy to access
- Efficient
- Cost effective
- Equitable
- To have simpler communication
- Services that listen

The group discussed areas for improvement and the importance of:

- The NHS being a free public service
- Consistent and improved technology, whilst retaining choice and human contact
- Funding, staffing and tailoring care into communities
- The importance of prevention in relation to mental health
- Tailored and holistic approaches
- Barriers to healthy lifestyles

A full write up of discussions was fed back via the Change NHS portal.

We have listened to updates on things that are important to people. For example:

- Community champions
- Women's Health services
- Navigating to the right health services
- ICB pharmacists helping people manage medicines at home

Example of how we listened to what's important to people

As part of our commitment to women's health hubs, we wanted to know from women themselves what the barriers were to them accessing services. We also worked closely with our partners in Gateshead Health NHS Foundation Trust, Newcastle GP Services, as well as other health and social care providers.

Women in Gateshead told us that a key priority was that they would like women's health services to be more easily accessible. They told us, through our forums, as well as an extensive independently run survey, and focus groups, that they wanted more flexible locations and times to access these services.

On the back of this listening exercise, a new community health bus was introduced in Gateshead, to deliver women's health services. As a result of the listening, services did not require any appointments - women could simply drop in when it was convenient to them. This made it easier for them to access the care they need at a time that suits them. We also worked with women in local communities, to identify a wide range of different locations that the bus could attend, as well as different times to access the services, to make the services as accessible as possible.

You can read more about the introduction of the new community health bus (nicknamed 'Monty') which has been a huge success.

Supporting people to involve

The ICB has developed a range of materials to help staff listen in a way that is meaningful. This includes our Involvement strategy, processes, training documents, toolkits, and proformas.

Involvement strategy

In 2022, we published the ICB's first 'People and Communities Involvement and Engagement Framework'. This strategy was developed through extensive engagement with stakeholders across the North East and North Cumbria.

In 2024, we asked Healthwatch to review the strategy. Healthwatch held conversations with local communities and provided feedback to the ICB. This feedback was incorporated into a 'draft Involving People and Communities Strategy 2024-28'.

In the updated strategy we describe how the ICB will continue to involve people and communities. We heard from our communities that people want to get involved and make a difference. We recognise the excellent work that already takes place across our region. We need to be open and have ongoing conversations so we can keep building trust.

In response to the feedback from Healthwatch we also changed our principles to:

- Meaningful involvement
- Removing barriers
- Listening to feedback

We shared the draft strategy wider for further comment, and used the feedback finalise the Involvement strategy for the ICB. In response to the feedback received we made several changes, including:

- Made the document easier to read
- Made the strategy shorter
- Developed a workplan – this work plan includes how we will measure success

Hearing lived experience

We are committed to listening to people's experiences of local health services, both good and bad, to help us shape future services.

We collect examples of people's experiences from patients, carers, staff, and wider stakeholders to learn about the needs of people accessing health services and put patients at the heart of service development and decision making. This allows us to identify where systems and processes may need to be improved, as well as sharing areas of good practice, to improve people’s experiences and access to health care.

We developed a protocol to support us to collect these examples. In 2024, we updated this protocol based on what people told us about it. We made it easier to read and understand. We changed some words to make sense to more people. We made the consent forms clearer and

easier to complete. We listened to people and changed the name of the protocol to something clearer.

The "Hearing Lived Experience Protocol" helps the public and patients understand how we listen to and learn from their experiences. It explains how we collect and record their experiences. It also gives different ways to share these stories. The protocol also gives staff a simple guide to follow. This helps make sure we do things the right way to keep patients safe and well.

These lived experiences are shared with the Quality and Safety Committee, with the Board, and at events such as the Big Conversations. We only share people's examples when we have permission to do so.

We developed an animation to help us collect examples of people's experiences with healthcare services. This has been shared with Healthwatch and wider stakeholders and promoted through social media.

You can read more about how we collect lived experience.

Valuing Public Involvement Policy for the ICB

We wanted to make it easier for people to get involved with the ICB. We want people to feel valued. One part of this is how we pay people back any expenses. Or give people an 'involvement payment'. We had lots of different practices in place. Each team worked out their own process. We wanted to have one process for the whole ICB. We needed a process that works well for:

- People who get involved
- Staff
- With tax office (HMRC) guidelines
- The benefits system.

We found out about what the different practices were across the system. We then developed a draft policy that would work for the ICB. We presented the draft policy to our Patient Voice Group. This includes people from:

- Healthwatch
- The voluntary sector
- Our Child and Wellbeing Network
- The Learning Disability Network
- The Northern Cancer Alliance.

The draft policy was well received. We are now writing procedures to support the policy. We will test the policy and procedures with workstream leads and local delivery teams and then seek approval through the ICB governance structure.

The policy will make it easier to involve people. We will be able to pay people their expenses back more quickly. This has been a barrier to involvement. We will be clearer about when we can pay an involvement payment. We will have better practice around tax and benefits. This will be better for both people who get involved and for the organisation.

Financial review

Two distinct funding streams are provided to ICBs:

- Programme Budget Allocation – this funding relates to direct health care expenditure. This includes delegated primary care 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	7,538,166	50,313	7,588,479
Additional in-year allocation adjustments	532,796	4,630	537,426
Total ICB funding for the year	**8,070,962**	**54,943**	**8,125,905**

Reflecting the significant financial challenges facing the system, an overall deficit financial plan of £49.95m for the ICS for 2024/25 was agreed at the start of the year. This included an initial planned surplus of £53.6m within the ICB, which partially offset planned deficits across provider trusts. The overall ICS deficit financial plan position was offset by deficit support funding received from NHS England allowing a breakeven plan position for the ICS.

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 19 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 2024/25:

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 2024/25, the ICB delivered an overall surplus of £12.19m.	✓
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 £48.95m, which was within the running cost allowance of £54.94m.	✓
Capital resource use does not exceed the amount specified in Directions The ICB is required to manage capital spending within the capital resource limit. The ICB received no direct capital resource during the year and incurred no capital expenditure.	✓

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 preparation for further reductions in ICB running cost allocations to be received in 2025/26.

The overall ICB surplus of £12.19m was planned in order to offset deficits in NHS provider trusts within the system. The original planned ICB surplus was £53.6m. In January 2025, the ICB Board approved a reduction to the ICB surplus of £50m to support specific financial pressures within a number of provider trusts within the ICS, with a corresponding improvement in provider deficit position agreed, ensuring no net impact on the overall ICS position. This resulted in a revised ICB planned surplus of £3.6m. The improvement in the ICBs actual surplus position compared to plan was agreed to offset a deterioration in the overall provider position within the ICS.

Efficiencies totaling £120.67m (compared to a plan of £117.71m) 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 has a shared responsibility for achievement of financial balance at an ICS level. 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 2024/25, an overall deficit financial plan of £49.95m for the ICS was agreed with NHS

England at the start of the year. An additional funding allocation of £49.95m was subsequently received from NHS England during the year which has allowed the ICS to report an overall break-even position for the year. The final outturn position for the ICS is a slight surplus of £0.38m in total.

The ICB agreed a joint capital resource use plan for the year along with partner NHS Foundation Trusts. Although the ICB received no direct capital resource, overall capital expenditure across the ICS for 2024/25 was managed within the agreed ICS capital allocation.

Compliance with Better Payment Practice Code

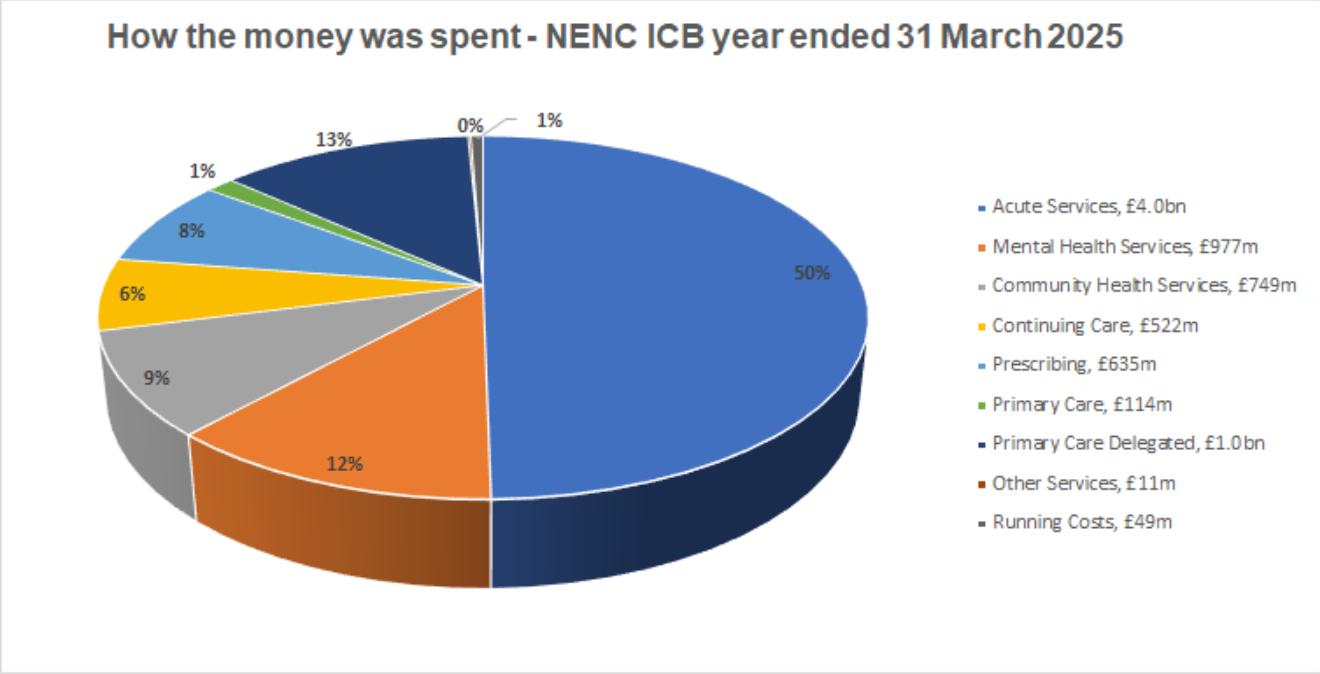
In addition to the above statutory duties, ICBs have similar responsibilities to other NHS organisations in respect of the Better Payment Practice Code (BPPC). The BPPC requires the payment of all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

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 2024/25:



Looking ahead

2025/26 is expected to be a hugely challenging year financially, both for the ICB and wider ICS. A deficit financial plan for the wider ICS was agreed in 2024/25 (prior to support funding received from NHS England) recognising the substantial financial pressures facing the system. This position included significant non-recurring efficiencies and benefits across both the ICB and wider ICS.

The high level of non-recurring benefits which are being used to support the ICS financial position in 2024/25, combined with low levels of recurrent efficiencies delivered in previous years and lower than average net growth for 2025/26 mean it will be extremely difficult to deliver a balanced financial plan without taking unpalatable decisions.

Considerable work has been undertaken over the past year, across both the ICB and in collaboration with NHS Provider Trusts across the ICS, to develop a medium-term financial plan for the system with a range of priority workstreams to support the ICS to live within its means going forward.

The financial plan for 2025/26, submitted in March 2025, showed an overall breakeven position across the ICS, after receipt of deficit support funding of £33.3m. This includes a planned surplus for the ICB of £11.8m. This position includes extremely challenging efficiency plans and significant additional risks compared to 2024/25, with total net risk of over £240m across the ICS. Work continues as a priority across the system to manage the position and seek to mitigate risks and deliver the transformation required to address underlying recurrent financial pressures.

Accountability Report

Samantha Allen
Chief Executive of North East and North Cumbria Integrated Care Board

Accountable Officer
19 June 2025

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 2024 to 31 March 2025 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** brings 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

Directors' Report

Director's profiles

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 2024 to 31 March 2025 is shown in table 1 below.

Table 1 - Membership of NHS the ICB's Board.

All members were in post on 1 April 2024 until 31 March 2025, unless shown.

Position	Name	Gender	Status
Chair	Professor Sir Liam Donaldson	Male	Voting
Chief Executive	Mrs Sam Allen	Female	Voting
Interim Chief People Officer	Mrs Kelly Angus from 28/10/2024 ongoing until recruitment process is complete	Female	Voting
Chief Delivery Officer	Mr Levi Buckley	Male	Voting
Chief Finance Officer	Mr David Chandler	Male	Voting

Position	Name	Gender	Status
Chief Digital and Infrastructure Officer	Professor Graham Evans	Male	Voting
Interim Chief Nurse and AHP Officer	Mrs Ann Fox 1 November 2024 – 2 February 2025	Female	Voting
Chief Procurement and Contracting Officer	Mr Dave Gallagher	Male	Voting
Chief Nurse and AHP Officer	Dr Hilary Lloyd from 3 February 2025	Female	Voting
Chief Strategy Officer	Ms Jacqueline Myers	Female	Voting
Chief Medical Director	Dr Neil O'Brien	Male	Voting
Chief Nurse, AHP and People Officer	Mr David Purdue until 31 October 2024	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 Patient and Public Involvement (PPI)	Dr Hannah Bows until 30 June 2024	Female	Voting
Independent Non-Executive Member	Professor Eileen Kaner	Female	Voting
Independent Non-Executive Member	Mr Jon Rush	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	Mrs Catherine McEvoy-Carr Until 30 June 2024	Female	Voting
Local Authority Partner Member	Mr John Pearce from 1 July 2024	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

Position	Name	Gender	Status
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 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 will agree an annual programme of business; however, this will be flexible to new and emerging priorities and risks.

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	Female
Independent Non-Executive Director	Mr Jon Rush	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
Interim Chief People Officer	Mrs Kelly Angus from 28/10/2024 ongoing until recruitment process is complete	Female
Chief Delivery Officer	Mr Levi Buckley	Male
Chief Finance Officer	Mr David Chandler	Male
Chief Digital and Infrastructure Officer	Professor Graham Evans	Male
Chief Contracting and Procurement Officer	Mr Dave Gallagher	Male
Interim Chief Nurse and AHP Officer	Mrs Ann Fox 1 November 2024 – 2 February 2025	Female
Chief Nurse and AHP Officer	Dr Hilary Lloyd from 3 February 2025	Female
Chief Strategy Officer	Ms Jacqueline Myers	Female
Chief Medical Director (Vice Chair)	Dr Neil O'Brien	Male
Chief Nurse, AHP and People Officer	Mr David Purdue until 31 October 2024	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
Independent Non-Executive Director (PPI)	Dr Hannah Bows Until 30 June 2024	Female
Independent Non-Executive Director	Professor Pali Hungin From July 2024	Male
Independent Non-Executive Director (Chair)	Professor Eileen Kaner	Female
Independent Non-Executive Director (Vice Chair)	Mr Jon Rush	Male

Membership of the Finance, Performance, and Investment Committee
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.

Table 5: Membership of the ICB Finance, Performance, and Investment Committee

Position	Name	Gender
Chief Finance Officer	Mr David Chandler	Male
Chief Delivery Officer	Mr Levi Buckley	Male
Independent Non-Executive Member (Vice Chair)	Professor Eileen Kaner	Female
Chief Strategy Officer	Ms Jacqueline Myers	Female
Chief Medical Officer	Dr Neil O'Brien	Male
Independent Non-Executive Director (Chair)	Mr Jon Rush	Male
Foundation Trust Partner Member	Mr Ken Bremner	Male
Foundation Trust Partner Member	Mr Rajesh Nadkarni	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 Eileen Kaner until July 2024 Professor Sir Pali Hungin from July 2024	Female Male

Position	Name	Gender
Independent Non-Executive Director (Vice Chair)	Professor Hannah Bows Until 30 June 2024	Female
Chief Medical Officer	Dr Neil O'Brien	Male
Chief Nurse, AHP and People Officer	Mr David Purdue until 31 October 2025	Male
Chief Nurse and AHP Officer	Dr Hilary Lloyd from 3 February 2025	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 from June 2024)	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
Clinical Director of Medicines Optimisation and Pharmacy	Professor Ewan Maule	Male
Director of Nursing (North)	Mr Richard Scott	Male
Director of Nursing (South)	Mr Chris Piercy / Ms Jeanette Scott (job share)	Male / Female
Director of Safeguarding	Ms Louise Mason-Lodge	Female
Deputy Chief Nurse	Mrs Ann Fox	Female
Interim Chief Nurse and AHP Officer	Mrs Ann Fox 3 October 2024 – 3 February 2025	Female

More details about the work of the ICB, its Board and its committees are given in the Governance Statement.

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 is available here. The register of interests for Board members is also publicly available here.

Personal data related incidents

There were no personal data related incidents reported to the Information Commissioner's Office in the period 1 April 2024 to 31 March 2025.

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 in particular 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, in particular, 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 2024 and 31 March 2025, the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the 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 Boards 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 Boards 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 and 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 2024 to 31 March 2025. The main items of business were:

- Chief Executive Report
- Integrated Delivery
- Finance reports
- Board Assurance Framework
- Committee Highlight Reports and Minutes
- 2024/25 Financial and Operational Plan
- Quality Strategic Plan
- ICB Annual Report and Accounts 2023/24
- Committee Annual Reviews
- Chairs Report
- North East Ambulance Service (NEAS) Independent Investigation Report – one year on
- ICB Financial Delegations and Financial Limits Update 2024/25

- NENC ICS Infrastructure Strategy 2024-2034
- Equality, Diversity and Inclusion Implementation Plan
- NENC ICB Safeguarding Annual Report
- NENC People and Culture Strategy
- Lord Darzi's Independent Investigation of the NHS in England
- Approval of Constitution and Standing Orders
- Approval of Governance Handbook
- Primary Care Access Recovery Plan update
- NENC Quality Strategy
- Our ambition to improve population health
- Menta Health, Learning Disability and Neurodiversity Improvement Plan
- Review of intensive and assertive community mental health care
- Learning Disabilities Mortality Review (LeDeR) Annual Report
- North East Child Poverty Commission "No Time to Wait"
- Complaints Annual Report
- Standards of Business Conduct and Declarations of Interest Policy
- Voluntary, Community and Social Enterprise update
- Involving People and Communities Strategy 2024-28
- Healthcare Associated Infections
- Emergency Preparedness, Resilience and Response Self-Assessment
- Tees, Esk and Wear Valleys NHS Foundation Trust – improvement journey
- Quality and Safety – urgent emergency care
- Elective Care Reform Package

The Board also receives a report from the Chief Executive and highlight reports from its committees at each meeting.

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 annual appraisal process and future development of all board members supports 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 2024 to 31 March 2025. The main items of business were:

- Quality Strategy
- Patient Safety
- Safeguarding
- Insight vision and strategic workplan
- Difficult decisions and service change

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 2024 to 31 March 2025.

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 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 2024 to 31 March 2025.

The main items of business were:

- Terms of Reference including:
  - Clinical Effectiveness and Governance Subcommittee
  - Pharmaceutical Services Regulatory Subcommittee
  - Contracting Subcommittee
  - Value Based Clinical Commissioning Steering Group
  - Women's health Steering Group
  - Improvement Steering Group
- Integrated Delivery Reports
- Financial Sustainability
- Medium Term Financial Plan
- Policy Reviews including:
  - Corporate Policies
  - HR Policies
  - Health and Safety Policies
  - Investment Business Case Policy

  - Menopause Policy
  - Standards of Business and Declarations of Interest Policy
- Priority Areas
- Placed Based Delivery
- Business Cases
- Procurement Exercises and Strategies
- Information Asset Register
- Risk Management and Corporate Risk Register
- Board Assurance Framework 2024/25
- Northern Cancer Alliance Workplan 2024/25
- Winter Planning
- Safeguarding is Everyone's Responsibility
- Planning Framework and Business Cycle 2025/26
- System Development Funding
- Voluntary, Community, and Social Enterprise Engagement and Infrastructure Review
- ICB 2.0 closedown report
- Primary Care Dental Access Crisis Plan
- Women's Health Development
- Primary Care Access Recovery Plan
- Acute Respiratory Infection Hub Funding
- North East Ambulance Service and Northumbria Healthcare Foundation Trust Peer Support Evaluation
- Emergency Preparedness Resilience Response Self-Assessment
- Health and Growth Accelerator Delivery Plan
- Primary Care Priority Pathways
- Weight Management Drugs
- Future connectivity programme
- Equality, Diversity and Inclusion Implementation Plan
- 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 2024 to 31 March 2025.

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 five times in the period 1 April 2024 to 31 March 2025. The main items of business were:

- Compulsory Redundancies
- Recruitment to Executive Director Posts
- South Tyneside Car Allowance
- Interim Chief People Officer Arrangements
- Succession planning for the Executive team
- Agenda for Change Pay Award 2024/25
- VSM Leadership Pay Award 2024/25
- Clinical Leadership Pay Award 2024/25
- Board Dental Partner Renumeration
- Acting up Payments
- Terms of Reference amendments
- Application of South Tyneside PCT Pay Protection Policy

Finance, Performance, and Investment Committee (FPI)

The FPI Committee is a committee of the ICB. It was in operation throughout the twelve-month period from 1 April 2024 to 31 March 2025.

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 FPI Committee was established by the ICB Board on 1 July 2022 and has met ten times during 2024/25.

The Finance, Performance and Investment Committee is undergoing its annual self-assessment checklist survey, to gain views from members on the Committee's effectiveness and performance during 2024/25. The survey results will suggest improvements and enable planning new objectives for 2025/26.

- Financial group reporting audit recommendation
- Monthly ICB financial performance update
- Resource Allocation Group (RAG) update
- 2024/25 Planning Process Update
- Integrated Delivery Report
- Committee Terms of Reference revisions
- Integrated Delivery Report (inc. Dental Update)
- Infrastructure Board update
- Committee effectiveness review
- Risk Management Report
- Infrastructure Strategy Update
- Dental Access Recovery
- Oversight Arrangements of Independent Sector – Patient Choice

- Mental Health, Learning Disability and Neurodiversity Update
- Finance Sustainability Group Update
- System Recovery Group Update
- Medium Term Financial Plan 25-26 update
- North Cumbria Integrated NHS Foundation Trust electronic patient record business-case letter of support for ratification
- Prevention Programme
- Deep dive: Elective, Cancer and Diagnosis
- Finance and Performance 25-26 operational planning update
- Weight loss drugs risk presentation
- Deep dive: Virtual Wards
- Risk Register and Board Assurance Framework

Audit Committee

The Audit Committee is a committee of the ICB. It was in operation throughout the twelve-month period from 1 April 2024 to March 2025.

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 comprised of three independent non-executive directors:

- Mr David Stout, Audit Committee Chair
- Professor Eileen Kaner
- Mr Jon Rush

All three have been members of the Audit Committee since its establishment on 1 July 2022.

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.

The Committee reviewed its annual effectiveness self-assessment checklist of processes to provide assurance that the Committee has met its terms of reference and have been effective in achieving its overall purpose.

The HFMA checklist focussed on processes with a number of themes and questions completed by the Chair and Board secretary to provide assurance to the Board on delivery of its delegated functions.

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 five times in the period 1 April 2024 to 31 March 2025. 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
- Annual Review of ICB Seal Report
- ICB Finance Update Report
- Internal Audit Progress Report
- Internal Audit Strategic / Annual Plan and Detailed Programme of Work
- Head of Internal Audit Opinion
- Audit Strategy Memorandum
- Counter Fraud Progress Report
- Counter Fraud, Bribery and Corruption policy
- Counter Fraud Annual Report and Self-Review Assessment
- Audit Completion Report
- Assurance over Outsourced Services
- Audit Committee Effectiveness Survey Checklist
- Audit Committee Self-Assessment Improvement Plan
- Fit and Proper Person Test
- Freedom to Speak Up (FSTU)
- External Audit Progress Report
- Review of External and Internal Annual Review of Effectiveness
- Annual Review of Audit Committee Terms of Reference
- Mental Health Investment Standard
- All Age Continuing Care (AACC) – Standing Financial Instructions (SFIs) Scheme of Delegation Report
- Interim Baseline Submission Cyber Assurance Framework (CAF) – Aligned DSP Toolkit 2025-26 Report
- ICS Financial Grip and Control Review Report
- Annual Report 2024/25: Provisional Timeline

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 2024 July to 31 March 2025.

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 were 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 within the year to refine the quality exception reports which had improved.

The Quality and Safety Committee met six times in the period 1 April 2024 to 31 March 2025. The main items of business were:

- Area Quality Reports
- Patient Involvement and Experience update
- Complaints
- Board Assurance Framework and Risk Register
- Subcommittee Terms of Reference
- Integrated Quality, Performance and Finance Report
- Patient Stories
- Maternity and Neonatal Services Report
- Fuller Report into Mortuary Compliance
- Equality Impact Assessment
- Medicines Optimisation Annual Report
- Green Plus Drugs and GP Collective Action Update
- Closedown of Serious Incident Panels
- Patient Safety Centre
- Involving People and Communities' Strategy 2024-28
- LeDeR annual report
- Neurorehabilitation
- Infection Prevention and Control
- Complex Care Incident Management
- Special Education Needs and Disabilities (SEND)
- Transforming Care

- Paediatric Hearing Services
- Patient Safety Incident Response Framework
- Subcommittee Minutes
- Publication of the Williams MOU

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 on the basis of 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 2023/24.

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 Subcommittees exist to scrutinise the robustness of; 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 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 2024 – 31 March 2025

			BOARD		EXECUTIVE COMMITTEE		REMUNERATION COMMITTEE		FINANCE, PERFORMANCE and INVESTMENT COMMITTEE		AUDIT COMMITTEE		QUALITY AND SAFETY 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**
Donaldson	Sir Liam	Chair	8	8										
Allen	Sam	Chief Executive	8	7	12	10								
Avantaggiato -Quinn	Maria	Director of Allied Health Professionals											6	4
Angus	Kelly	Interim Chief People Officer **Board and Exec Member from Oct 24**	8	2	12	4								
Bows	Dr Hannah	Independent Non-Executive Member Patient and Public Involvement (PPI) **Until 30 June 2024**	8	0			5	0						
Buckley	Levi	Chief Delivery Officer	8	7	12	11 1 x deputy			10	5				
Bremner	Ken	Foundation Trust Partner Member	8	4					10	5			6	2
Chandler	David	Chief Finance Officer	8	6 2 x deputy	12	9 3 x deputy			10	7 3 x deputy				
Dronsfield	Sarah	Director of Quality											6	5
Evans	Professor Graham	Chief Digital and Infrastructure Officer	8	6	12	11								
Fox	Ann	Interim Chief Nurse and AHP Officer	8	2	12	3							6	6
Gallagher	Dave	Chief Contracting and Procurement Officer	8	8	12	10 2 x deputy							6	4 1 x deputy
Hall	Tom	Local Authority Partner Member	8	6										
Hungin	Professor Pali	Independent Non-Executive Member	8	7			5	3					6	6

			BOARD		EXECUTIVE COMMITTEE		REMUNERATION COMMITTEE		FINANCE, PERFORMANCE and INVESTMENT COMMITTEE		AUDIT COMMITTEE		QUALITY AND SAFETY 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**
		Rem Com Member from Sept 24												
Kaner	Professor Eileen	Independent Non-Executive Member	8	7			5	5	10	7	5	2		
Lloyd	Hilary	Chief Nurse and AHP Officer **Board, Exec and QSC member from Feb 25**	8	1	12	2							6	2
Malik	Dr Saira	Primary Medical Services Partner Member	8	7									6	6
Mason-Lodge	Louise	Director of Nursing											6	1
Maule	Ewan	Director of Medicines											6	3
Myers	Jacqueline	Chief Strategy Officer	8	7 1 x deputy	12	11 1 x deputy			10	7 3 x deputy				
Nadkarni	Rajesh	Foundation Trust Partner Member	8	7					10	7			6	3
O'Brien	Dr Neil	Chief Medical Officer	8	6 1 x deputy	12	10 2 x deputy			10	7			6	4 1 x deputy
Pearce	John	Local Authority Partner Member **From 1 July 2024**	8	2										
Piercy	Chris	Director of Nursing											6	4
Purdue	David	Chief Nurse and AHP Officer **Left ICB Oct 24**	8	5	12	5 1 x deputy							6	2
Riley	Claire	Chief Corporate Services Officer	8	7 1 x deputy	12	12							6	4
Rush	Jon	Independent Non-Executive Member	8	7			5	4	10	9	5	5		
Scott	Jeanette	Director of Nursing											6	2
Scott	Richard	Director of Nursing											6	4
Smith	Dr Mike	Primary Medical Services Partner Member	8	8					10	9				
Stout	David	Independent Non-Executive Member (Audit)	8	7							5	5		

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 North East and North Cumbria Integrated Care Board 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 (BAF), 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 to 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 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 with regards to risks relating to services being commissioned as well as risks to the organisation's strategic and operational plans and also

takes into account any extreme (red) or high (amber) risks 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 also 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 reviews 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 ensure 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 leads have a responsibility to incorporate risk management within all aspects of their work and are responsible for ensuring the implementation of this strategy.

Throughout 2024/25, 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 the 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 2024 to 31 March 2025:

- 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 witing 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 mitigation plans in place to reduce risks to the target level 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 2024/25. Its systems have been in place for the year under review and up to the date of approval of the annual report and accounts. As of 31 March 2025, the ICB carried one extreme (red) risk and 18 high (amber) 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 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
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 in December 2023 and is being reviewed in April 2025 and will be confirmed by the Board following the latest review.

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 that 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, and ICB committee structures to ensure the Board is fully informed and sighted its statutory decision making and effective stewardship of NHS spending for all the residents of the ICB
- 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 which 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 Office 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 Executive Medical Officer is the Caldicott Guardian 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 lead and staff are advised and reminded of the ICB's polices. Polices 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.

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 place 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 an information governance toolkit 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 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 2023/24. The ICB will submit its Cyber Security Framework aligned Data Security and Protection toolkit for 2024/25 will be published by 30 June 2025.

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.

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.

The ICBs 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 through the use of an integrated financial ledger system
- The provision of a wide 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 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 2025, 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 are reported to the Audit Committee.

A small number of control exceptions have been identified from these auditor reports which have been reviewed and are not considered to have a significant impact or present a significant risk to the ICB.

A number of financial and governance controls exist within the ICB which mitigate any risk arising from the control exceptions.

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.

Pressures have continued to be evident in certain standards across the ICB, particularly in respect of:
- Healthcare associated infections
- Category 2 ambulance response times
- Accident and emergency 4 hour waiting times
- Elective waiting times and pressures in some specialties
- Units of dental activity
- Cancer 62 performance in some providers
- Access to talking therapies,

- Increase in need for mental health, learning disability and neurodiversity pathways and long waits in some pathways.
- Mental health support for children and young people

In addition, the system continues to face recruitment challenges in the clinical and social care workforce, and a workforce working group continues to monitor and action as required.

Any failure to deliver the objectives has the potential to adversely impact on patient care, as well as posing a reputational harm.

Monitoring has continued through the contract management processes to manage the delivery of objectives. An ICB facilitated performance improvement process remains in place to support relevant strategic programmes and providers. Performance is a key element of oversight meetings with our trusts involving the Executive teams from both the ICB and trust. The frequency of these are dependent on the NHS Oversight Framework (OF) segmentation of each trust. A segmentation decision indicates the scale and general nature of support needs (ranging from no specific support needs in segment one to a requirement for mandated intensive support in segment four) and influences the oversight arrangements that are established. NHS England holds the responsibility to review and change segmentation.

The North East and North Cumbria Performance Improvement and Oversight Group continues with Chief Operating Officers from the acute trusts in attendance. Monitoring and review also continues through the Finance Performance and Investment Committee and Quality and Safety Committee and Audit Committee (via the corporate risk register). Exception reports are also highlighted to the Executive Committee.

Throughout 2024/25 NENC ICB has established a Mental Health System Performance Overview Group, a collaborative forum with key partners and stakeholders to understand system challenges and transformation opportunities, and which facilitates the reduction in variation across localities and providers through the sharing of best practice and deep dives into key priority areas. In addition, the group supports systemwide data and information improvement work including the development of dashboards to ensure consistency of data reporting and definitions amongst partners to facilitate improvement.

During 2024/25, NHS England continued a process introduced in 2022/23 by which trusts were allocated to tiers in relation to their elective and cancer performance. In 2024/25 the focus for cancer moved from backlog to consider Cancer Faster Diagnosis Standard (FDS) and 62 day cancer waiting times positions throughout 2024/25. In addition, NHSE has introduced tiering escalation for Diagnostics in 2024/25.

The ICB continues to closely monitor Category 2 ambulance response times and delayed ambulance handovers. Mitigations include the ICB's winter plan and surge plan which are in place; monitoring takes place through the local delivery boards at Place; daily, weekly, and monthly system situation reports (SitReps) are used during surge periods; a system wide surge planning exercise has been undertaken and a targeted transformation and improvement programme has taken place with colleagues from across the system during Q3/4 2024/25 with a focus on reducing ambulance handover delays. Specific performance management interventions have also taken place with some of our most challenged providers to identify issues, share best practice, and support improvement initiatives.

Accident and Emergency 4 hour wait times are also closely monitored through regular SitReps and an ongoing dialogue with hospital trust colleagues to identify and mitigate areas of underperformance and deliver sustainable improvements to patient flow through emergency departments. Regular oversight conversations take place with NHS England regional colleagues to focus on breach reduction, identifying opportunities for improvement, and learning from best practice examples elsewhere in the wider system.

During 2024/25 Place Subcommittees have been established to ensure that providers come together to work in an integrated way to support the delivery of the ICB's objectives and many have introduced work streams to support more integrated working especially around hospital discharges, pathways etc.

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 2024 to 31 March 2025.

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 2024 to 31 March 2025 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 2 audits, 'good assurance' for 8 audits, 'reasonable assurance ' for 4 audits from 14 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 is an agreed staffing structure, and ICB staff are organised into 9 directorates, each led by an executive director.

During the period 1 April 2024 to 31 March 2025, the ICB delivered a substantial efficiency programme, realising total efficiencies of around £120m.

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 specialised services

The North East and North Cumbria Integrated Care Board have not signed a delegation agreement (DA) with NHS England for delegated specialised services during the 2024/25 reporting period. However, the North East and North Cumbria ICB will assume full commissioning responsibilities for delegated specialised services from 1 April 2025.

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 2024 to 31 March 2025, 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 2024 and 31 March 2025 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 2024 to 31 March 2025 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 and that controls are generally being applied consistently."

During the period, Internal Audit issued the following audit reports:

Table 8 - Summary of internal audit assurance work undertaken

Audit area	Assurance			
	Substantial	Good	Reasonable	Limited
Core Assurance Areas				
Governance, Risk and Performance				
Risk Management and Board Assurance Framework		✓		
Ethical Governance				
Fit and Proper Persons Test		✓		
Finance, Contracting and Capital				
Primary Care Assurance Framework – Follow up of recommendations from report Primary Care Delegated Commissioning Governance (Ref: NENC 2023-24/09)		✓		
Key Financial Controls	✓			
Human Resources and Workforce				
Staff Survey			✓	
Digital Systems, Processes, and Information Governance				

Audit area	Assurance			
	Substantial	Good	Reasonable	Limited
Data Security Protection Toolkit (2024 Final Assessment)	✓	DSPT is categorized as 'Advisory' due to NHS Digital (NHSD) ratings being used, rather than the standard AuditOne assurance and findings' prioritization definitions. Substantial: Overall risk assessment across all 10 National Data Guardian Standards. All of the standards are rated as Substantial. Substantial: Confidence level of the Independent Assessor in the veracity of the self-assessment. Low level of deviation – the organisation's self-assessment against the Toolkit does not differ/deviates only minimally from the Independent Assessment.		
Cyber Assessment Framework (CAF) Supply Chain		✓		
Quality and Clinical Governance				
Patient Safety Incident Response Framework (PSIRF)			✓	
Additional Assurance and Advisory: Governance, Risk and Performance				
Conflicts of Interest (carried forward from 2023/24)		✓		
Workstreams and Transformation		✓		
Additional Assurance and Advisory: Finance, Commissioning and Contracting				
Continuing Healthcare – Governance Arrangements (carried forward from 2023/24)			✓	
Additional Assurance and Advisory: Human Resources and Workforce				
Annual Leave			✓	
System Workforce Planning and Management (carried forward from 2023/24)		✓		
Additional Assurance and Advisory: Quality and Clinical Governance				
Medicines Optimisation (carried forward from 2023/24)		✓		
Totals	2	8	4	0

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.

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 annual audit letter 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 is 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 2024 to 31 March 2025 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 Report

Remuneration Committee

The Remuneration Committee is a committee of NENC ICB. It was in operation throughout the twelve-month period from 1 April 2024 to 31 March 2025.

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 2024 to 31 March 2025 was £275-280k (2023/24: £265-270k).

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
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
2023/24:			
Total remuneration (£)	38,901	50,952	81,138
Salary component of total remuneration (£)	37,350	50,952	81,138
Pay ratio information	6.9:1	5.3:1	3.3:1

During the reporting period 2024/25, no employees received remuneration in excess of that of the highest paid director (2023/24: none). Excluding the highest paid director, banded remuneration ranged from £20-25k up to £190-195k (2023/24: £10-15k up to £180-185k).

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 154-157.

There have been no significant changes to the ratio of highest paid director remuneration to the rest of the ICB's workforce during the year. The increase in remuneration levels of both the highest paid director and other ICB staff reflects the 5.5% pay award agreed for 2024/25 as well as changes to Agenda for Change pay scales.

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	3.74%	Not applicable
The average percentage change from the previous financial period in respect of employees of the ICB, taken as a whole	3.07%	Not applicable

The increase in the highest paid director remuneration reflects a nationally agreed 5.5% 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 5.5% pay award under Agenda for Change arrangements. The average percentage change for ICB employees as a whole was impacted by staff turnover during the period. This included the departure of a number of individuals following a restructure of the ICB in response to a national requirement to reduce ICB running costs.

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.

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 2024/25 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 2023/24.

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 - 2024/25 [subject to audit]:

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*

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 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*
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.

NENC ICB senior officers' salaries and allowances comparative figures for 2023/24:

Name	Position	1 April 2023 to 31 March 2024						
		(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	260 - 265	4,700	-	-	50 - 52.5	315 - 320	*260 - 265*
David Chandler	Executive Director of Finance	175 - 180	1,100	-	-	420 - 422.5	595 - 600	*175 - 180*
Dr Neil O'Brien	Executive Medical Director	180 - 185	-	-	-	-	180 - 185	*180 - 185*
David Purdue	Executive Chief Nurse and People Officer	180 - 185	1,000	-	-	95 - 97.5	280 - 285	*180 - 185*
Claire Riley	Executive Director of Corporate Governance, Communications and Involvement	170 - 175	2,500	-	-	-	170 - 175	*170 - 175*
Professor Graham Evans	Executive Chief Digital and Information Officer	170 - 175	-	-	-	105 - 107.5	275 - 280	*170 - 175*
Aejaz Zahid	Executive Director of Innovation *Until 15/08/2023*	45 - 50	200	-	-	12.5 - 15	60 - 65	*120 - 125*
Annie Laverty	Executive Director of Improvement and Experience	170 - 175	1,100	-	-	40 - 42.5	210 - 215	*170 - 175*
Jacqueline Myers	Executive Chief of Strategy and Operations	170 - 175	1,500	-	-	-	170 - 175	*170 - 175*
Dave Gallagher	Executive Area Director (Central and South)	170 - 175	-	-	-	492.5 - 495	660 - 665	*170 - 175*
Levi Buckley	Executive Area Director (North and North Cumbria) *From 02/05/2023*	150 - 155	-	-	-	-	150 - 155	*165 - 170*

Name	Position	1 April 2023 to 31 March 2024						
		(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 Hannah Bows	Independent Non-Executive Member	10 - 15	-	-	-	-	10 - 15	*10 - 15*
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 *From 01/03/2024*	0 - 5	-	-	-	-	0 - 5	*15 - 20*
Dr Saira Malik	Primary Medical Services Partner Member	20 - 25	-	-	-	-	20 - 25	*20 - 25*
Dr Mike Smith	Primary Medical Services Partner Member	20 - 25	-	-	-	2.5 - 5	30 - 35	*20 - 25*

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), car allowance (where relevant) and a VAT refund relating to a lease car.

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, with the exception of Kelly Angus, interim Chief People Officer who was on secondment to the ICB from NHS England with remuneration processed via NHS England'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
Catherine McEvoy-Carr	Local Authority Partner Member (until 30/06/2024)
Tom Hall	Local Authority Partner Member
John Pearce	Local Authority Partner Member (from 01/07/2024)

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 2024/25 is shown below:

Name	Position	2024/25		
		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	80 - 85	-	80 - 85
Dr Mike Smith	Primary Medical Services Partner Member	50 - 55	-	50 - 55
Jon Rush	Independent Non-Executive Member	15 - 20	-	15 - 20

NENC ICB senior officers' pension benefits - 2024/25 [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 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	-

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 2023/24:

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 2024 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2023	(f) Real increase in Cash Equivalent Transfer value	(g) Cash Equivalent Transfer Value at 31 March 2024	(h) Employer's contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Sam Allen Chief Executive	0 - 2.5	60 - 62.5	75 - 80	200 - 205	1,253	363	1,651	-
David Chandler Executive Director of Finance	17.5 - 20	90 - 92.5	65 - 70	180 - 185	878	632	1,533	-
Dr Neil O'Brien Executive Medical Director	-	37.5 - 40	25 - 30	55 - 60	459	77	561	-
David Purdue Executive Chief Nurse and People Officer	2.5 - 5	55 - 57.5	80 - 85	225 - 230	1,583	378	1,985	-
Claire Riley Executive Director of Corporate Governance, Communications and Involvement	-	20 - 22.5	25 - 30	65 - 70	525	76	622	-
Professor Graham Evans Executive Chief Digital and Information Officer	5 - 7.5	7.5 - 10	40 - 45	110 - 115	17	27	67	-
Aejaz Zahid Executive Director of Innovation *Until 15/08/2023*	0 - 2.5	-	10 - 15	20 - 25	194	9	233	-
Annie Laverty Executive Director of Improvement and Experience	2.5 - 5	-	30 - 35	-	379	80	480	-
Jacqueline Myers Executive Chief of Strategy and Operations	-	37.5 - 40	50 - 55	135 - 140	943	210	1,174	-

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 2024 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2023	(f) Real increase in Cash Equivalent Transfer value	(g) Cash Equivalent Transfer Value at 31 March 2024	(h) Employer's contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Dave Gallagher Executive Area Director (Central and South)	20 - 22.5	87.5 - 90	80 - 85	230 - 235	1,423	-	108	-
Levi Buckley Executive Area Director (North and North Cumbria) *From 02/05/2023*	-	-	55 - 60	60 - 65	893	81	1,003	-
Dr Mike Smith Primary Medical Services Partner Member	0 - 2.5	-	15 - 20	0	149	45	199	-
Dr Saira Malik Primary Medical Services Partner Member	-	-	15 - 20	40 - 45	305	17	331	-

Note – Dave Gallagher is affected by the public service pensions remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995 to 2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

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

No compensation has been paid by the ICB during the year for early retirement (2023/24: none).

No exit packages for senior officers were agreed during the year. In 2023/24, one exit package was agreed for compulsory redundancy of the following senior officer:

Name	Position	Cost of compulsory redundancy (£)
Annie Laverty	Executive Director of Improvement and Experience (up to 31 March 2024)	160,000

This exit package was agreed during 2023/24 but was not expected to be paid until the individual's employment ended in 2024/25. The actual amount paid in 2024/25 amounted to £19,250.

Payments to past directors

No payments have been made by the ICB to past directors (2023/24: none).

Staff Report

Number of senior managers
The ICB had 25 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.

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	10	15
Total employees – headcount	562	149

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 5.00%.

Staff turnover percentages
The staff turnover for the ICB was 12.71%

Staff engagement percentages
The ICB staff survey has been undertaken in this reporting period with a 66% 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
NENC ICB HR02	Health at Work
NENC ICB HR02a	Supporting Attendance

Policy number	Policy / Version
NENC ICB HR02b	Addiction and Dependency
NENC ICB HR02c	Mental Wellbeing and the Workplace
NENC ICB HR02d	Menopause Policy
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 HR07	Recruitment
NENC ICB HR07A	Recruitment and Retention Premium
NENC ICB HR08	Volunteers
NENC ICB HR09	Working Time Directive Policy
NENC ICB HR10	Induction and Probation
NENC ICB HR11	Special Leave Policy
NENC ICB HR11A	Compassionate Leave
NENC ICB HR11B	Carers Leave
NENC ICB HR12	Secondment Policy
NENC ICB HR13	Freedom to Speak Up
NENC ICB HR14	Travel and Expenses
NENC ICB HR15	Managing Conduct and Concerns
NENC ICB HR16	Managing Allegations Against Staff

Policy number	Policy / Version
NENC ICB HR17	Managing Work Performance
NENC ICB HR18	Respect at Work Policy
NENC ICB HR19	Grievance and Resolution Policy
NENC ICB HR20	Professional Registration Policy
NENC ICB HR21	Job Evaluation
NENC ICB HR22	Organisational Change
NENC ICB HR2A	Redeployment Policy
NENC ICB HR23	Domestic Abuse and the Workplace
NENC ICB HR24	Retirement Policy
NENC ICB HR25	Armed Forces, Reserves and Cadets
NENC ICB HR52	Pay Protection
HR10	Further Education, Training and Development Policy
HR18	Appraisal/Ongoing review and objectives policy
HR45	Work Experience

Trade Union Facility Time Reporting Requirements

As set out in the Trade Union (TU) (Facility Time Publication Requirements) Regulations 2017, the ICB is required to publish the number of employees who were trade union officials during this period and any information about paid facility time and trade union activities.

0.01% TU facility time was recorded for ICB employed staff for the reporting period in 2024/25 (2023/24: none).

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 2024/25, the value of consultancy services expenditure is £387k (2023/24: £365k).

Off-payroll engagements

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as at 31 March 2025 for more than £245 per day:

	Number
Number of existing engagements as of 31 March 2025	12
Of which, the number that have existed:	
for less than one year at the time of reporting	-
for between one and two years at the time of reporting	3
for between 2 and 3 years at the time of reporting	6
for between 3 and 4 years at the time of reporting	-
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 2024 and 31 March 2025, for more than £245 per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2024 and 31 March 2025	12
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)]	12
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 2024 and 31 March 2025:

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.	25

Exit packages, including special (non-contractual) payments [subject to audit]

No exit packages were agreed in the financial year.

Table 1 below details exit packages agreed in the previous financial year ended 31 March 2024.

Table 1: Exit Packages for the year ended 31 March 2024

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	4,867	1	4,867	-	-
£10,000 - £25,000	-	-	6	86,843	6	86,843	-	-
£25,001 - £50,000	3	112,611	12	422,833	15	535,444	-	-
£50,001 - £100,000	-	-	12	855,291	12	855,291	-	-
£100,001 - £150,000	1	106,667	6	698,364	7	805,031	-	-
£150,001 –£200,000	1	160,000	5	793,333	6	953,333	-	-
>£200,000	-	-	-	-	-		-	-
TOTALS	**5**	**379,278**	**42**	**2,861,531**	**47**	**3,240,809**	**-**	**-**

This table reports the number and value of exit packages agreed in the financial year ended 31 March 2024. All exit packages shown above related to the restructure of the ICB in response to the national requirement to reduce ICB running costs by 30% in real terms by 2025/26.

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 2024

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	42	2,862
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	**42**	**2,862**

All 'other departures' relate to voluntary redundancies agreed during the year ended 31 March 2024 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 on remote contingent liabilities, gifts and fees and charges. Relevant disclosure on losses and special payments can be found in note 18 of the financial statements.

An audit report is also included in this annual report on page 197 onwards.

ANNUAL ACCOUNTS

NHS North East and North Cumbria ICB Financial Statements for the year ended 31 March 2025

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The Primary Statements:

NHS North East and North Cumbria ICB - Financial Statements for the year ended 31 March 2025

Statement of Comprehensive Net Expenditure for the year ended 31 March 2025

	Note	2024/25 £000	2023/24 £000
Income from sale of goods and services	2	(103,655)	(99,661)
Other operating revenue	2	(2,365)	(1,643)
Total operating income		**(106,020)**	**(101,304)**
Employee benefits	3.1	47,594	48,697
Purchase of goods and services	4	8,171,018	7,682,901
Depreciation	4	569	653
Other operating expenses	4	522	806
Total operating expenditure		**8,219,703**	**7,733,057**
Finance costs	6	33	39
Net operating costs for the financial year		**8,113,716**	**7,631,792**
Comprehensive net expenditure for the year		**8,113,716**	**7,631,792**

Statement of Financial Position as at 31 March 2025

	Note	31 March 2025 £000	31 March 2024 £000
Non-current assets			
Right of use assets	7	3,219	3,788
Total non-current assets		**3,219**	**3,788**
Current assets			
Contract and other receivables	8	47,751	19,049
Cash	9	779	1,430
Total current assets		**48,530**	**20,479**
Total assets		**51,749**	**24,267**
Current liabilities			
Trade and other payables	10	(493,069)	(533,412)
Lease liabilities	7	(437)	(602)
Total current liabilities		**(493,506)**	**(534,014)**
Total assets less current liabilities		**(441,757)**	**(509,747)**
Non-current liabilities			
Lease liabilities	7	(2,841)	(3,250)
Total non-current liabilities		**(2,841)**	**(3,250)**
Assets less Liabilities		**(444,598)**	**(512,997)**
Financed by taxpayers' equity			
General fund		(444,598)	(512,997)
Total taxpayers' equity		**(444,598)**	**(512,997)**

The notes on pages 177 to 196 of the Annual Report form part of this statement.

The financial statements on pages 173 to 176 were approved and authorised for issue by the Board on 16 June 2025 and signed on its behalf by:

Samantha Allen
Chief Executive of North East and North Cumbria Integrated Care Board

Accountable Officer
19 June 2025

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2025

	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)**

	General fund £000	Total reserves £000
Changes in taxpayers' equity for the year to 31 March 2024:		
Balance at 1 April 2023	(455,278)	(455,278)
Changes in ICB taxpayers' equity for the year to 31 March 2024		
Net operating costs for the financial year	(7,631,792)	(7,631,792)
Net recognised ICB expenditure for the financial year	**(7,631,792)**	**(7,631,792)**
Net funding	7,574,073	7,574,073
Balance at 31 March 2024	**(512,997)**	**(512,997)**

Statement of Cash Flows for the year ended 31 March 2025

	Note	2024/25 £000	2023/24 £000
Cash flows from operating activities			
Net operating costs for the financial year		(8,113,716)	(7,631,792)
Depreciation	4	569	653
Interest paid	6	33	39
(Increase) in contract and other receivables	8	(28,702)	(4,348)
(Decrease) / increase in trade and other payables	10	(40,343)	61,848
Net cash outflow from operating activities		**(8,182,159)**	**(7,573,600)**
Net cash outflow before financing		**(8,182,159)**	**(7,573,600)**
Cash flows from financing activities			
Net funding received		8,182,115	7,574,073
Repayment of lease liabilities	7	(607)	(667)
Net cash inflow from financing activities		**8,181,508**	**7,573,406**
Net (decrease) in cash	9	**(651)**	**(194)**
Cash at the beginning of the financial year		1,430	1,624
Cash at the end of the financial year		**779**	**1,430**

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 2024 to 2025. 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. For right of use assets, the depreciated historical cost is considered to give an appropriate proxy of current value in existing use or fair value.

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 15 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

Under IFRS16, the distinction between finance leases and operating leases is only applicable where the ICB is the lessor. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

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.

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 17: Insurance Contracts (application from 1 January 2021). Standard is not yet adopted by the FReM which is expected to be April 2025, early adoption is not therefore permitted.
- 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 2024/25, were they applied in that year.

Notes to the financial statements (continued)

2. Operating Income

	2024/25 Total £'000	2023/24 Total £'000
Income from sale of goods and services (contracts)		
Prescription fees and charges	53,504	50,361
Dental fees and charges	50,138	48,768
Other contract income	13	532
Total Income from sale of goods and services	**103,655**	**99,661**
Other operating revenue		
Other non contract revenue	2,365	1,643
Total other operating revenue	**2,365**	**1,643**
Total operating Income	**106,020**	**101,304**

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

	2024/25			2023/24		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£000	£000	£000	£000	£000	£000
Employee benefits:						
Salaries and wages	36,028	35,151	877	34,828	34,297	531
Social security costs	3,926	3,926	-	4,050	4,048	2
Employer contributions to NHS Pension scheme	7,477	7,477	-	6,312	6,308	4
Other pension costs	8	8	-	17	17	-
Apprenticeship levy	155	155	-	155	155	-
Termination benefits	-	-	-	3,335	3,335	-
Gross employee benefits expenditure	**47,594**	**46,717**	**877**	**48,697**	**48,160**	**537**

No amounts were recovered in respect of employee benefits and no employee benefits were capitalised during the year (2023/24: none).

3.2 Average number of people employed

	2024/25			2023/24		
	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Total	**560**	**551**	**9**	**575**	566	9

None of the above people were engaged on capital projects (2023/24: none).

3.3 Exit packages agreed in the financial year

No exit packages have been agreed during 2024/25.

2023/24 Comparative figures

	2023/24 Compulsory redundancies		2023/24 Other agreed departures		2023/24 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	1	4,867	1	4,867
£10,001 to £25,000	-	-	6	86,843	6	86,843
£25,001 to £50,000	3	112,611	12	422,833	15	535,444
£50,001 to £100,000	-	-	12	855,291	12	855,291
£100,001 to £150,000	1	106,667	6	698,364	7	805,031
£150,001 to £200,000	1	160,000	5	793,333	6	953,333
Total	**5**	**379,278**	**42**	**2,861,531**	**47**	**3,240,809**

3.4 Analysis of Other Agreed Departures

	2024/25		2023/24	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	42	2,861,531
Total	**-**	**-**	**42**	**2,861,531**

All exit packages agreed during 2023/24 related to the restructure of the ICB in response to the national requirement to reduce ICB running costs by 30% in real terms by 2025/26.

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 3 ill health retirements during 2024/25, with a total cost of £537,285 (2023/24: None).

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 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 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 £10.7m (2023/24: £7.2m).

Notes to the financial statements (continued)

4. Operating expenses

	2024/25 £000	2023/24 £000
Purchase of goods and services		
Purchase of healthcare from NHS and DHSC bodies:		
· other ICBs and NHS England	37,892	42,589
· foundation trusts	5,125,142	4,845,169
· other NHS trusts	34,192	31,236
· other WGA bodies	2	2
Purchase of healthcare from non-NHS bodies	1,071,245	922,314
Purchase of social care	158,430	156,078
General dental services and personal dental services	216,045	209,622
Prescribing costs	634,949	623,712
Pharmaceutical services	147,383	146,123
General ophthalmic services	32,442	31,996
Primary Medical Services Costs (GPMS/APMS and PCTMS)	663,543	630,879
Supplies and services – clinical	12,078	11,426
Supplies and services – general	2,911	1,561
Consultancy services	388	365
Establishment	6,954	5,702
Transport	90	50
Premises	21,997	18,701
Audit fees	244	297
Other non statutory audit expenditure		
· Other services	42	12
Internal audit expenditure	303	371
Other professional fees	1,941	2,163
Legal fees	1,865	1,558
Education and training	940	975
Total Purchase of goods and services	**8,171,018**	**7,682,901**
Depreciation and impairment charges		
Depreciation	569	653
Total Depreciation and impairment charges	**569**	**653**
Other operating expenses		
Chair and Non Executive Members	217	215
Clinical negligence	14	19
Expected credit loss on receivables	291	551
Other expenditure	-	21
Total other operating expenses	**522**	**806**
Total operating expenses	**8,172,109**	**7,684,360**

The total of £244k under Audit Fees consists of:
- Forvis Mazars LLP's Audit Fee of £239k (including VAT at 20%) for the ICB's 24/25 External Audit.
- Additional Forvis Mazars LLP Audit Fees of £5k (including VAT at 20%) in respect of additional audit work carried out on the 2023/24 accounts.

The total of £42k under Non-Statutory Audit Expenditure consists of:
- Mental Health Investment Standard (MHIS) fee of £42k (including VAT at 20%) for work to be completed by Forvis Mazars LLP for 2024/25.

Notes to the financial statements (continued)

5. Better Payment Practice Code

Measure of compliance	2024/25 Number	2024/25 £000	2023/24 Number	2023/24 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the year	163,038	2,061,888	159,190	1,850,268
Total Non-NHS Trade invoices paid within target	161,262	2,047,254	158,215	1,834,151
Percentage of Non-NHS Trade invoices paid within target	**98.91%**	**99.29%**	**99.39%**	**99.13%**
NHS Payables				
Total NHS Trade invoices paid in the year	4,321	5,240,732	4,884	4,869,327
Total NHS Trade invoices paid within target	4,306	5,240,570	4,847	4,868,655
Percentage of NHS Trade invoices paid within target	**99.65%**	**100.00%**	**99.24%**	**99.99%**

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

	2024/25 £000	2023/24 £000
Interest		
Interest on lease liabilities	33	39

Notes to the financial statements (continued)

7. Leases

7.1 Right of use assets

	2024/25 Buildings Total £000	2023/24 Buildings Total £000
Cost or valuation at 1 April	5,130	5,130
Cost/Valuation at 31 March	**5,130**	**5,130**
Depreciation at 1 April	(1,342)	(689)
Charged during the year	(569)	(653)
Depreciation at 31 March	**(1,911)**	**(1,342)**
Net Book Value at 31 March	**3,219**	**3,788**
Net Book Value by Counterparty:		
Leased from other group bodies	**3,219**	**3,788**

7.2 Lease liabilities

	2024/25 £000	2023/24 £000
Lease liabilities at 1 April	(3,852)	(4,480)
Interest expense relating to lease liabilities	(33)	(39)
Repayment of lease liabilities (including interest)	607	667
Lease liabilities at 31 March	**(3,278)**	**(3,852)**

7.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	31 March 2025 £000	31 March 2024 £000
Within one year	(442)	(607)
Between one and five years	(1,497)	(1,570)
After five years	(1,505)	(1,873)
Balance at 31 March	**(3,444)**	**(4,050)**
Effect of discounting	166	198
Included in:		
Current lease liabilities	(437)	(602)
Non-current lease liabilities	(2,841)	(3,250)
Balance at 31 March	**(3,278)**	**(3,852)**

7.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	2024/25 £000	2023/24 £000
Depreciation expense on right-of-use assets	569	653
Interest expense on lease liabilities	33	39
Expense relating to short-term leases	254	94

7.5 Amounts recognised in Statement of Cashflows

	2024/25 £000	2023/24 £000
Total cash outflow on leases under IFRS 16	(607)	(667)

Notes to the financial statements (continued)

8. Contract and other receivables

	Current 31 March 2025 £000	Current 31 March 2024 £000
NHS receivables: Revenue	18,748	8,813
NHS accrued income	33	756
Non-NHS and Other WGA receivables: Revenue	13,746	7,299
Non-NHS and Other WGA prepayments	3,795	3,071
Non-NHS and Other WGA accrued income	11,885	78
Expected credit loss allowance - receivables	(1,331)	(1,072)
VAT	853	92
Other receivables	22	12
Total contract and other receivables	**47,751**	**19,049**
Total current and non current	**47,751**	**19,049**

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.

8.1 Receivables past their due date but not impaired

	31 March 2025 £000	31 March 2024 £000
By up to three months	1,456	2,949
By three to six months	62	909
By more than six months	957	142
Total	**2,475**	**4,000**

£861k 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 2025 (31 March 2024: none).

8.2 Expected credit losses on financial assets

	2024/25 Contract and other receivables - Non DHSC Group Bodies £000	2024/25 Total £000	2023/24 Total £000
Balance at 1 April	(1,072)	(1,072)	(631)
Lifetime expected credit losses on contract and other receivables-Stage 2	(291)	(291)	(551)
Amounts written off	32	32	110
Allowance for credit losses at 31 March	**(1,331)**	**(1,331)**	**(1,072)**

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.

Notes to the financial statements (continued)

9. Cash

	2024/25 £000	2023/24 £000
Balance at 1 April	1,430	1,624
Net change in period	(651)	(194)
Balance at 31 March	**779**	**1,430**
Made up of:		
Cash with the Government Banking Service	779	1,430
Cash as in Statement of Financial Position	**779**	**1,430**

The ICB held £nil cash at 31 March 2025 on behalf of patients (31 March 2024: none).

10. Trade and other payables

	Current 31 March 2025 £000	Current 31 March 2024 £000
NHS payables: revenue	5,651	918
NHS accruals	49,485	82,084
Non-NHS and Other WGA payables: Revenue	44,682	65,437
Non-NHS and Other WGA accruals	374,446	366,394
Social security costs	475	582
Tax	570	815
Other payables	17,760	17,182
Total trade and other payables	**493,069**	**533,412**
Total current and non-current	**493,069**	**533,412**

At 31 March 2025, the ICB had no liabilities due in future years under arrangements to buy out the liability for early retirement over 5 years (31 March 2024: none).

Other payables include £5,074k in respect of outstanding pension contributions at 31 March 2025 (31 March 2024: £5,210k).

11. Contingencies

During 2024 a joint procurement [the Procurement] was undertaken with 23 other ICBs for a Primary Care Clinical Waste Collection and Disposal contract, for a period of 5 years with the option to extend for a further 4 years. Each ICB procured an individual Lot.

In December 2024, 9 of the ICBs, including 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 [the Claim] challenging the contract award decisions were commenced by one of the unsuccessful bidders [the Claimant], naming all 22 of the ICBs which remained involved in the Procurement (2 ICBs having decided not to proceed) as Defendants.

At this early stage of the Claim, it is not possible to sensibly nor accurately determine the probability of success by the Claimant, nor is it possible to estimate the financial impact of a successful Claim with any level of certainty. Given this uncertainty of both of these key components, the ICB is therefore classifying this challenge as a contingent liability.

Notes to the financial statements (continued)

12. Commitments

There were no contracted or non-cancellable contracts entered into by the ICB at 31 March 2025 which are not otherwise included in these financial statements (31 March 2024: none).

13. Financial instruments

13.1 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.

13.1.1 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.

13.1.2 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.

13.1.3 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.

13.1.4 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.

13.1.5 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)

13. Financial instruments (continued)

13.2 Financial assets

	Financial Assets measured at amortised cost Total 31 March 2025 £000	Financial Assets measured at amortised cost Total 31 March 2024 £000
Contract and other receivables:		
· NHSE bodies	625	1,608
· Other DHSC group bodies	18,188	8,122
· External bodies	24,290	6,156
Cash	779	1,430
Total Financial assets	**43,882**	**17,316**

13.3 Financial liabilities

	Other Total 31 March 2025 £000	Other Total 31 March 2024 £000
Trade and other payables:		
· NHSE bodies	3,468	2,272
· Other DHSC group bodies	61,195	90,107
· External bodies	426,747	442,849
Lease liabilities	3,278	-
Total Financial liabilities	**494,688**	**535,228**

14. 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)

15. 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 2024/25, 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 2024/25		Amount recognised in entity's books only 2023/24	
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	-	61,647	-	55,888
Better Care Fund	NENC ICB - Northumberland County Council	See note (1) below on Better Care Fund	-	33,754	-	30,943
Better Care Fund	NENC ICB / South Tyneside Council	See note (1) below on Better Care Fund	-	27,806	-	25,710
Better Care Fund	NENC ICB / Sunderland City Council	See note (1) below on Better Care Fund	-	34,464	-	32,789
Better Care Fund	NENC ICB / Lancashire & South Cumbria ICB / Cumbria County Council	See note (1) below on Better Care Fund		36,138	-	32,518
Better Care Fund	NENC ICB / Newcastle Local Authority	See note (1) below on Better Care Fund		33,036	-	29,912
Better Care Fund	NENC ICB / Gateshead Local Authority	See note (1) below on Better Care Fund		22,945	-	20,802
Better Care Fund	NENC ICB / Darlington Borough Council	See note (1) below on Better Care Fund		11,006	-	10,057
Better Care Fund	NENC ICB / Stockton Council	See note (1) below on Better Care Fund		19,866	-	18,227
Better Care Fund	NENC ICB / Hartlepool Council	See note (1) below on Better Care Fund		10,447	-	9,457
Better Care Fund	NENC ICB / Redcar & Cleveland Council	See note (1) below on Better Care Fund		15,739	-	14,340
Better Care Fund	NENC ICB / Middlesbrough Council	See note (1) below on Better Care Fund		16,570	-	14,989
Better Care Fund	NENC ICB / North Tyneside MBC	See note (1) below on Better Care Fund		23,301	-	21,284
Gateshead Carers	NENC ICB / Gateshead Local Authority	Carers Service		510	-	510
Section 75	NENC ICB / South Tyneside Council	Care of Learning Disability Clients		13,126	-	11,426
Section 75	NENC ICB / South Tyneside Council	Delivery of legal advice in respect to CHC, Joint packages and S117		30	-	25
Section 75	NENC ICB / South Tyneside Council	Equipment Store		1,082	-	761
Section 76	NENC ICB / South Tyneside Council	Joint Commissioning Unit		410	-	612
Children's Preventative Care	NENC ICB / Sunderland City Council	Children's Preventative Care and improving commissioning initiatives		2,882	-	2,272
Gateshead Equipment Service	NENC ICB / Gateshead Local Authority	Purchase of home loans equipment for Gateshead residents		1,906	-	1,822
Tees Community Equipment Service	NENC ICB / Middlesbrough Council / Hartlepool Council / Stockton Council / Redcar & Cleveland Council	Tees Community Equipment Service		1,377	-	1,328

(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)

16. Related party transactions

During 2024/25, the ICB has undertaken transactions with the following Integrated Care Board members or members of the key management staff, or parties related to any of them:

Integrated Care Board Members	Declaration	Related Party	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
S Allen Chief Executive	Board Member	Health Innovations NENC (formerly Academic Health Sciences Network)	4,059	-	1,071	-
D Chandler Chief Finance Officer	Trustee of HFMA and Northern Branch chair	HFMA	6	-	2	(6)
Dr N O'Brien Chief Medical Officer	GP Partner	Cestria Health Centre	2,441	-	63	-
	Practice is a member	Chester-le-Street Primary Care Network	2,520	-	314	-
	Practice is a member	Chester-le-Street Health Ltd	1	-	1	-
	GP Partner	Coxhoe Medical Practice	1,335	-	30	-
	Practice is a member	Central Durham GP Providers Ltd	2,866	-	572	-
L Buckley Chief Delivery Officer	Partner is Chief Executive of Healthworks	Healthworks	392	-	-	-
Professor G Evans Chief Digital and Infrastructure Officer	Wife is a Trustee	Butterwick Hospice Trust	1,428	-	46	-
C Riley Chief Corporate Services Officer	Trustee of Helpforce	Helpforce Charity	40	-	-	-
Dr M Smith Partner Member - PMS	GP Partner and PCN Clinical Director	Claypath & University Medical Group	4,941	-	276	-
	Practice is member	Central Durham GP Providers Ltd	2,866	-	572	-
J Rush Partner Member - NHS	Trustee for Cumbria CVS	Cumbria CVS	511	-	-	-
J Pearce Local Authority Partner Member	LA Partner Member	Durham County Council	77,982	-	3,870	-
T Hall Local Authority Partner Member	LA Partner Member	South Tyneside Council	39,189	-	16,258	(14)
C McEvoy-Carr Local Authority Partner Member	LA Partner Member	Newcastle City Council	69,778	-	12,183	-
K Bremner Foundation Trust Partner Member	Board member	Health Innovations NENC (formerly Academic Health Sciences Network)	4,059	-	1,071	-

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)

16. Related party transactions (continued)

2023/24 comparative figures:

During 2023/24, the ICB undertook 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	4,000	(60)	1,989	-
D Chandler Executive Director of Finance	Chair of Northern Branch	HFMA	20	-	15	-
Dr N O'Brien Executive Medical Director	GP Partner	Cestria Health Centre	2,521	-	119	-
	Practice is a member	Chester-le-Street Primary Care Netwo	2,209	-	90	-
	Practice is a member	Chester-le-Street Health Ltd	252	-	51	-
	Practice is member of Central Durham GP Providers Ltd	Coxhoe Medical Practice	1,250	-	37	-
	Practice is a member	Central Durham GP Providers Ltd	1,927	-	65	-
L Buckley Executive Area Director (North Cumbria and North)	Partner is Chief Executive of Healthworks	Healthworks	508	-	52	-
Professor G Evans Executive Chief Digital & Information Officer	Wife is a Trustee	Butterwick Hospice Trust	534	-	-	-
D Gallagher Executive Area Director (Central and South)	Non-Executive Director (until 17	Health Innovations NENC (formerly	4,000	(60)	1,989	-
Dr M Smith Partner Member - PMS	GP Partner and PCN Clinical Director	Claypath & University Medical Group	4,822	-	285	-
	Practice is member of Central Durham GP Providers Ltd	Central Durham GP Providers Ltd	1,927	-	65	-
J Rush Partner Member - NHS	Trustee for Cumbria CVS	Cumbria CVS	519	-	-	-
A Workman Local Authority Partner Member	LA Partner Member (until 31 July	Stockton Borough Council	30,976	-	10,397	(70)
T Hall Local Authority Partner Member	LA Partner Member	South Tyneside Council	28,920	-	12,259	(56)
S Moore Local Authority Partner Member	LA Partner Member (until 25 May	Hartlepool Borough Council	17,142	-	4,509	(9)
C McEvoy-Carr Local Authority Partner Member	LA Partner Member	Newcastle City Council	61,931	-	18,937	(743)
K Bremner Foundation Trust Partner Member	Board member	Academic Health Sciences Network)	4,000	(60)	1,989	-

Notes to the financial statements (continued)

17. Events after the end of the reporting period

From 1 April 2025, NHS England has delegated responsibility for specialised commissioning to the ICB, with a total delegated funding allocation in the region of £779m. Acute, Mental Health and Independent Sector hospitals that provide specialised commissioning services will receive income directly from the ICB rather than NHS England. Therefore, expenditure in 2025/2026 is likely to increase by £779m due to the delegation of commissioning responsibility.

18. Losses and special payments

There have been a total of six losses recorded during the year for the total value of £32k, in relation to administrative write offs of six aged debts. In 2023/24 there were eighteen losses recorded for the total value of £110k, in relation to administrative write offs of seventeen aged debts and one salary overpayment. These amounts are reported on an accruals basis but excluding provisions for future losses.

19. 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:

	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**
Additional directions on resource use: funding for agenda for change pay offer	-	-	**Yes**

Prior year comparatives:	2023/24 Target £000	2023/24 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	7,636,281	7,631,792	**Yes**
Revenue administration resource use does not exceed the amount specified in Directions	62,371	60,811	**Yes**
Additional directions on resource use: funding for agenda for change pay offer	-	-	**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 no capital resource during 2024/2025 and incurred no capital expenditure (2023/24: none).

Performance against the revenue expenditure duties is further analysed below:

	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.

Prior period comparatives:	2023/24 Programme Resource £000	2023/24 Administration Resource £000	2023/24 Total £000
Revenue resource	7,573,910	62,371	**7,636,281**
Net operating cost for the financial year	7,570,981	60,811	**7,631,792**
Underspend against revenue resource	**2,929**	**1,560**	**4,489**

The ICB delivered an in-year surplus of £4,489k for 2023/24. 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 2025, 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 2024/25 as contained in the Department of Health and Social Care Group Accounting Manual 2024/25, 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 2025 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 2024/25; 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 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 2024/25 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 identified that the principal risks of non-compliance with laws and regulations related to the National Health Service Act 2006 (as amended by the Health Care Act 2022) and we considered the extent to which non-compliance might have a material effect on the financial statements.

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:

- 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 from NHS England;
- 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 the Accountable Officer's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, significant one-off or unusual transactions and the risk of fraud in financial reporting relating to expenditure recognition due to the potential to inappropriately record expenditure in the wrong period.

Our audit procedures in relation to fraud included but were not limited to:

- making enquiries of management, internal audit 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;
- addressing the risks of fraud through management override of controls by performing journal entry testing; and
- addressing the risk of fraud in expenditure recognition in relation to year-end accruals through substantive 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 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, 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 2025.

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 November 2024.

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 Governing Body 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
Key Audit Partner
For and on behalf of Forvis Mazars LLP

Forvis Mazars
5th Floor, 3 Wellington Place
Leeds LS1 4AP

19 June 2025