Item: 9.1

NHS
North East and
North Cumbria

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

BOARD 3 JUNE 2025	
Report Title:	**2025/26 Financial and Operational Plans**

Purpose of report

This paper presents the final financial and operational plan for both the ICB and wider ICS for 2025/26.

Key points

The full NHS Operational Plan submissions were made on 27 March 2025 and include the full suite of finance, workforce and performance information and documents including a checklist narrative and board assurance checklist. A further resubmission by exception was made on 30 April 2025 which reflects the final position with agreed changes after the ICB Plan review with NHS England on the 9 April 2025. This included improved performance in two key metrics and the correction of some minor data quality issues on performance. Finance submissions reflected the final ICS financial positions for the ICB and each Trust.

In line with the government's mandate, the 2025/26 priorities and operational planning guidance sets out a focused, smaller number of planning priorities for 2025/26 with an emphasis on improving access to timely care for patients, increasing productivity and living within allocated budgets, and driving reform. To support this, systems will have greater control and flexibility over how they use local funding to best meet the needs of their local population.

Given the level of risk in our plans, work is underway to de-risk the plan and ensure that robust impact assessments are in place for key efficiency and difficult decision schemes. At the time of full submission of our plans, the board assurance checklist was only partially assured due to the requirement for the Board to have a full understanding of all quality risks (with mitigations) linked to ICB efficiency schemes.

Financial Plan:

The 2025/26 financial allocations are summarised in the paper. As in the prior year, the NENC ICB receives lower than average net growth funding, including the convergence adjustment (reduction in funding as part of a move towards 'fair share' funding) as NENC is deemed by NHSE to be overfunded against a fair shares target allocation.

Although a balanced financial position has been delivered across the ICS for 2024/25, this included a significant level of non-recurring efficiencies and other one-off benefits, together with additional non-recurring funding allocations from NHS England (including £50m to offset the planned system deficit).

The significant underlying recurrent deficit across the system and lower than average net growth (after convergence adjustment) for North East and North Cumbria mean 2025/26 is expected to be an even more challenging year financially.

Part A of the paper summarises the final 2025/26 financial plan figures submitted on 30 April 2025, showing an overall breakeven revenue position for the ICS, after receiving deficit support funding of £33.3m from NHSE.

The agreed ICS financial plan for 2024/25 was a deficit of £49.9m with equivalent deficit support funding then received from NHSE to allow a breakeven position to be delivered. Effectively this reduction in deficit support funding requires an improvement in the position of £16.6m compared to 2024/25.

At the initial headline plan submission in February, there was a financial gap of c£180m across the ICS (to achieve a breakeven position). That financial gap assumed efficiencies of 5% on average across providers, with an average of 7% efficiencies being required to close the gap.

Significant work has been undertaken across the system to reduce the gap, involving stretching efficiency targets and review of 'difficult decisions'.

The planned system position includes a planned ICB surplus of £11.8m offsetting an equal net deficit position across provider trusts.

This position assumes delivery of efficiencies substantially in excess of those delivered in 2024/25 (the majority of which were non-recurrent in nature), with provider efficiencies expected to be around 5-8% of turnover. This will be extremely challenging to deliver, has involved significant work around potentially difficult decisions, and presents a huge risk to delivery of the 2025/26 plan.

Relevant equality and quality impact assessments will take place on all efficiency plans.

There are a large number of material financial risks to delivery of the 2025/26 plans, together with a substantial underlying recurrent deficit across the system. Total net unmitigated risk of £244m across the ICS was identified within the financial plan for 2025/26. This is a significant increase on the level of unmitigated risk identified within the 2024/25 financial plan, which was £160m.

Work will continue on the Medium-Term Financial Plan and system recovery workstreams, along with progressing service reform and 'difficult decisions' to identify further potential mitigations to support the 2025/26 position as well as recurrent recovery of the system position.

Activity and Performance:

The North East and North Cumbria operational plan submission demonstrates a planned position for 2025/26 to meet all the national priorities at ICB and ICS level where applicable. Compliance against the national priorities and all other activity and performance metrics are included in Section B. This also includes any variation across providers and key points by exception for the key performance requirements.

Several discussions have taken place in various forums between providers and the ICB, and in some instances NHS England to review plans and support in the development and submission of further improvements throughout March and April 2025.

In some areas, plans are ambitious and not without risk given the resources available to the system in 2025/26.

Workforce:

The North East and North Cumbria operational workforce plan submission shows all providers are forecasting to reduce their workforce, with the exception of one provider. Reductions range from 1.8% to 5.7% across providers.

North East Ambulance Service, as part of a three-year investment and growth programme plans to increase their workforce (by 3%).

All providers except NEAS are planning for a reduction in their substantive workforce and are committing to achievement of ambitious plans for bank and agency reduction.

The majority of providers have committed through their plans to reduce sickness absence rates during 25/26 with the exception of North Cumbria Integrated Care and Tees, Esk & Wear Valley who are not planning any change to 24/25.

Some providers are reporting no change from their 24/25 planned turnover rates; however some are planning a reduction with the exception of South Tyneside and Sunderland who are planning an increase of 0.96% and Newcastle Upon Tyne Hospitals who are planning an increase of 2.4%.

Workforce across Primary Care is planned to remain in line with the previous year.

Risks and issues

- Several providers have submitted plans to meet the national ambitions for RTT which will be difficult to deliver given the reduced ERF allocations and overall reduced level of resources available across the ICS.
- Delivery of the system workforce plan is reliant upon some ambitious bank and agency reduction initiatives.
- Workforce KPI plans were agreed prior to additional national guidance which increased the reduction required in corporate services spend. As a result of the additional ask, and uncertainty for staff during transition there is a risk that sickness and turnover may increase.
- Given the level of efficiencies required for the ICB, a robust EQIA process has been established which is monitored weekly. This allows full visibility across the ICB to track progress around EQIA and delivery of efficiency schemes. Due to the volume of schemes in place, the time required to undertaken and sign off EQIAs will take some time. Until EQIAs are completed, the level of risk is still unknown for some schemes so the submission was only partially assured on one of the assurance statements around EQIA completion. This is reflected in the final board assurance statements that were submitted in May'25.

Assurances and supporting documentation

- The ICB Executive Committee agreed to implement the ICB Planning Framework in October 2024. The framework sets out an inclusive planning process which has facilitated the development of plans with engagement from ICB teams.
- To support the planning process, a planning infrastructure was implemented which included internal ICB and external ICS governance. This includes a weekly Executive ICS reference group, weekly Chief Executive Officer group and ICS wide weekly planning update call. Support from the wider ICS was also in place via established Chief Finance Officer, Performance and Planning forums and infrastructure via the Medium-Term Financial Plan.
- Regular updates have been provided to the Finance, Performance and Investment Committee and a dedicated board development session was carried out in February 2025.
- The ICB led a peer review process with each provider to review and challenge assumptions between headline and full submission. This has led to several positive changes from the headline to full submission and a reflection on the deliverability of some of the ambitions in the headline submissions.
- The development of trajectories has been an inclusive process which considers the transformation agenda. Where appropriate, ICB teams including Local Delivery Teams have been engaged in the development and agreement of trajectories.
- Plans have been tested using tools released by NHS England such as the triangulation tool and activity and performance validation tool. These tools have been used to assess plans and pick up with trusts any issues which led to the final resubmission on 30th April.
- The board assurance framework has been completed by all providers across NENC. All providers have given assurances that plans have been triangulated and where relevant, deliver the national priorities with appropriate risk mitigation. The only exception to this is around the need to undertake further relevant impact assessments linked to difficult decisions.
- For ICB efficiencies, EQIA trackers are in place with full visibility across the ICB. EQIAs are being carried out in-line with the ICB policy and the outcome will be reported as part of ICB governance.

Recommendation/action required

The Board is asked to:

- Approve the final ICB and ICS financial and operational plan submissions
- Note the requirement for robust EQIAs to be carried out for key efficiency and difficult decision schemes in-line with the approved ICB policy.
- Approve the updated ICB revenue budgets for 2025/26 (as per Part A table 2) including those contracts which are above £30m as per appendix 1.
- Approve the ICS capital plan figures (as per Part A table 6).

Acronyms and abbreviations explained

BCF – Better Care Fund
EQIA – Equality and Quality Impact Assessments
ERF – Elective Recovery Fund
CNST – Clinical Negligence Scheme for Trusts
CUF – Cost Uplift Factor
CYP – Children and young people
FT – NHS Provider Foundation Trust
IFRS – International Financial Reporting Standard
LLP – Limited Liability Partnerships
MHIS – Mental Health Investment Standard
MTFP – Medium Term Financial Plan
NENC – North East and North Cumbria
NHSE – NHS England
PDC – Public Dividend Capital
PFI – Private Finance Initiative
PIFU – Patient Initiated Follow Up
POD – Pharmacy, Ophthalmic and Dental services
QIA – Quality Impact Assessment
SDF – Service Development Funding
SECB – Strategic Elective Care Board
UEC – Urgent and Emergency Care

Sponsor/Approving Executive Director	Jacqueline Myers, Chief Strategy Officer David Chandler, Chief Finance Officer Kelly Angus, Chief People Officer
Date approved by Executive Director	23 May 2025
Report author	Richard Henderson, Director of Finance (Corporate) Matt Thubron, Deputy Director of Planning and Performance Jayne Aitken, Strategic Head of People, Strategy and Workforce Planning

Link to ICP strategy priorities (please tick all that apply)

Longer and Healthier Lives	✓
Fairer Outcomes for All	✓
Better Health and Care Services	✓
Giving Children and Young People the Best Start in Life	

Relevant legal/statutory issues

Note any relevant Acts, regulations, national guidelines etc

Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**	✓	**No**		**N/A**	

A number of Board members are conflicted with the proposals, the governance team have worked through the conflicts of interest. The affected Board members will receive the papers but abstain from any decision making on conflicted contracts.

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

Essential considerations (must be completed)	
Financial implications and considerations	Financial plan position for 2025/26 is summarised in the paper and has been reviewed and coordinated by ICB Directors of Finance and agreed by Chief Finance Officer. Final plan submission approved by each organisation Director of Finance.
Contracting and Procurement	The contracting and procurement directorate have been involved throughout the development of the plans including work around efficiency planning.
Local Delivery Team	Yes, Local Delivery Teams have been involved in various aspects of the planning process including the development of trajectories for key performance metrics and workforce returns.
Digital implications	N/A
Clinical involvement	The Chief Medical Officer has led the difficult decisions process and clinical leads have been involved in Local Delivery Team discussions. Quality impact assessment to be concluded on identified efficiency schemes. Further clinical engagement required on plans across the system, as part of development and delivery of final plans.
Health inequalities	N/A
Patient and public involvement	Not at this stage.
Partner and/or other stakeholder engagement	Through established internal and external governance, all relevant stakeholders have been engaged in the planning process through providers and SROs of key ICS workstreams.
Other resources	N/A

NHS North East and North Cumbria Integrated Care Board
Financial and Operational Plan 2025/26

1. Purpose of paper

This paper provides a summary of the final financial and operational plan (including activity and performance and workforce) for both the ICB and wider ICS for 2025/26.

This final plan reflects a final resubmission by exception on the 30th April 2025 which takes into account the outcome of the ICB Full Plan review meeting between NHS England and the ICB on 12th April 2025.

The structure of the paper is as follows:

- PART A – Financial Plans
- PART B – Activity and Performance
- PART C – Workforce
- PART D – Board assurance framework
- PART E – Recommendations

2. Operational planning submission requirements

The 2025/26 NHS Operational planning round sees a different approach to previous years with the NHS mandate setting out a reduced number of essential objectives for the NHS. Consistent with these objectives, NHS England has reduced the number of national priorities for 2025/26, giving local systems greater control and flexibility over how local funding is deployed to best meet the needs of their local population.

Formal submissions have also been reduced in numbers with a single headline submission which was made in February 2025 and then a full submission on March 27th. A further resubmission by exception was made on April 30th to take into account revised ICS financial positions, improved performance in key cancer and ED metrics and also improved workforce positions for two trusts.

The national priorities to improve patient outcomes in 2025/26 are:

- Reduce the time people wait for elective care
- Improve A&E waiting times and ambulance response times
- Improve patients access to general practice and to urgent dental care
- Improve patient flow through mental health crisis and acute pathways and improve access to children and young people's (CYP) mental health services.

In delivering on these priorities for patients and service users, ICBs and providers must work together, with support from NHS England to:

- Drive the reform that will support delivery of our immediate priorities and ensure the NHS is fit for the future
- Live within the budget allocated, reducing waste and improving productivity
- Maintain our collective focus on the overall quality and safety of our services.

The following documents have been collated for submission:

- Full ICS finance plan

- Full activity and performance plan
- Separate ambulance activity and performance plan
- Full ICS workforce plan including non-FT mental health and general practice
- Planning checklist narrative including a productivity plan for the ICB and each provider
- ICB and provider board assurance framework

A separate narrative for workforce was requested locally to ensure that the relevant level of detail is visible which underpins the workforce submissions. This also ensure that submissions are aligned to the principles and agreements via the MTFP.

PART A – FINANCIAL PLANS

Introduction and context

Final planning guidance for 2025/26 was published by NHS England on 30 January 2025. Given the delays in publication and extremely short timescales to develop plans, we are continuing to review the guidance and update draft plans at the time of writing this report. Further updates will be provided in the meeting as required.

Work undertaken on the ICS Medium Term Financial Plan (MTFP) has provided the starting point for the 2025/26 financial plan, refreshed as required to reflect the planning guidance.

As previously highlighted to Board, the MTFP identified an underlying recurrent deficit across the system of over £400m. Whilst a breakeven financial position across the system is forecast in 2024/25 (after receipt of £50m deficit support funding), delivery of this position is heavily reliant on substantial levels of non-recurrent efficiency and one-off technical benefits.

The significant underlying recurrent deficit across the system and lower than average net growth (after convergence adjustment) for North East and North Cumbria mean 2025/26 is expected to be an even more challenging year financially.

As part of the MTFP work we have developed an ICS financial strategy model that is consistent with what we believe would be acceptable by NHSE which is a demonstrated improvement over 3 years - a deficit of £50m, £25m and then break-even, in each of the 3 years modelled (assuming no deficit support funding).

It is not deemed possible to produce a balanced plan sooner than the 3rd year of the plan – indeed achieving by then will be a significant challenge due to the scale of the underlying deficit which has been reduced in year each year by significant non-recurrent measures a number of which are not sustainable.

This model currently suggests the ICS would need to achieve a 7**%** level of efficiency in 25/26 reducing to 3.5%/2% in later years respectively.

Work on financial plans has progressed alongside and aligned as far as possible to work on supporting performance trajectories and workforce plans. It is recognised however that due to the timescales involved and level of iterative changes to respective plans, further work will be required to ensure full alignment and consistency of plans across the system.

Revenue allocations

The majority of the NHS revenue allocations for ICBs for 2025/26 have been published. Whilst there are a number of complexities within the funding allocations, the intent in this paper is to summarise the main points so that Board members are sufficiently briefed.

Table 1 below summarises total confirmed ICB revenue allocations for 2025/26.

Table 1:

Recurrent allocations	**£m**
Core Programme	6,664.8
Primary Medical Care	705.2
Delegated Primary Care (POD)	378.9
Running Costs	48.6
Other recurrent allocations (OCT and Corneal tissue transfer)	-0.7
Recurrent allocation	**7,796.8**

Non-recurrent allocations	**£m**
Elective Recovery Funding (ERF) (core)	162.3
Elective Recovery Funding (ERF) (additional) - *indicative*	107.0
Service Development Fund (SDF)	35.8
Transfers from SDF	93.8
COVID Testing Allocation	5.0
Other POD allocations	1.2
Discharge funding	28.4
Community Diagnostic Centre funding	45.3
Activity growth funding for emergency ambulance services - *indicative*	6.1
Pay: other income support	5.7
Depreciation / amortisation – additional ringfenced funding	10.4
Charge exempt overseas visitor (CEOV) and UK cross border adjustment	-3.0
Microsoft Licences	-1.8
Total Non Recurrent allocation	**496.0**

Deficit support funding	33.3

Total NENC ICB Allocation	**8,326.1**

Key points to note:

Growth

- Base allocation growth has been set at 4.4%. This reflects the cost uplift factor (CUF) of 4.15%, including 2.8% pay assumption and the impact of Employers National Insurance Contribution (ENIC) increases etc.

Convergence

- A convergence adjustment continues to be applied to ICBs based on distance from target allocation. The adjustment for NENC is 0.5% (£33.5m) which is the maximum adjustment.

Baseline adjustments

- Recurrent adjustments have been made to allocations to include pay award funding issued in 2024/25, together with virtual and physical capacity funding, ambulance capacity funding and adult long Covid services.

Delegated Primary Care Allocations

- Separate funding allocations are received for delegated primary medical care and other primary care (pharmacy, ophthalmic and dental services, or 'POD').
- The utilisation of POD allocations remains subject to the additional rule that dental budgets are ringfenced.
- For 2025/26, NHSE may agree to relax the dental ringfence (so that any underspends are retained locally) for ICBs which i) deliver additional urgent care in line with the manifesto commitment and ii) improve dental access more broadly. Additional guidance is awaited on this.

ICB Running Costs

- As previously highlighted, ICB running cost allocations are being reduced by 30% on a real terms basis over the two years to 2025/26 (25% reduction in 'cash terms'). The running cost allowance reduced by 18% in 2024/25 with a further reduction of almost 9% (over £4m) in 2025/26, excluding an increase in funding allocations to reflect increased ENIC costs. The work of the ICB 2.0 programme has allowed savings to be delivered which will meet this reduced running cost allocation in 2025/26.
- The ICB running cost allocations shown here are the current published values. Subsequently NHSE have announced an expected 50% reduction in ICB running costs / staffing, further details are awaited on the exact requirements and timescales involved. At the current time, no impact of this is reflected in the ICB financial plan for 2025/26.

Service Development Funding (SDF)

- For 2025/26 most SDF bundles have been transferred to ICB core programme allocations, with a reduction applied by NHSE. For NENC this amounts to £93.5m funding in total as shown in Table 1.
- Where funding has been transferred into ICB core programme allocations this is no longer ringfenced.
- The main areas of funding remaining in the SDF for 2025/26 are Cancer Alliances, IT and technology, funding issued on a drawdown or reimbursement basis, funding allocated for a specific purpose by government departments
- Work is currently ongoing to assess the impact of the reduction in SDF allocations (including amounts transferred to core programme allocations) and consider any commitments already made.

Elective Activity and Elective Recovery Fund (ERF)

- Elective recovery funding has been separately identified in ICB allocations (see Table 1). Core funding has been distributed on a fair shares basis with additional ERF being distributed to systems on a target basis, based on 2024/25 (M8) forecast outturn. For NENC the system allocation has been reduced from 2024/25 levels by £18m.
- Unlike in 2024/25, there is no additional funding available for elective activity beyond that in ICB allocations.
- NHSE will set target elective activity relative to 2023/24 for each system, with a requirement to improve RTT (Referral to Treatment) performance by 5% minimum.
- Whilst there is no longer an expectation that providers and commissioners will agree a payment limit for elective services, there is an overall agreement that the system must remain within financial allocations. Guidance now requires Indicative Activity Plans to be developed that align to system affordability – this includes both NHS and non-NHS providers.

Finance Business Rules

The ICB and System finance business rules for 2025/26 are largely unchanged from the previous year and summarised in the table below:

Rule	ICB	System
Capital resource use		Collective duty to act with a view to ensuring that the capital resource use limit set by NHS England is not exceeded
Revenue resource use	Duty to meet the resource use requirement set by NHS England	Collective duty to act with a view to ensuring that the revenue resource use limit set by NHS England is not exceeded
Breakeven duties	Duty to act with a view to ensuring expenditure does not exceed the funding received	Collective objective for system partners to work together to seek to achieve system financial balance
Financial apportionment	Revenue and capital resources of all trusts apportioned exclusively to a principal ICB	
ICB administration costs	Duty not to exceed the ICB running cost allowance limit set by NHS England	N/A
Risk management	Local contingency decision required to show how financial risks will be managed	
Prior years' under and overspends	N/A	Maintain as a cumulative position
Repayment of prior years' overspends	N/A	Overspends are subject to the repayment policy
Mental Health Investment Standard	Comply with standard as set out in relevant planning guidance	N/A
Better Care Fund	Comply with minimum contribution as set out in relevant planning guidance	N/A

As in 2024/25, there is a key requirement for the ICB to deliver at least a breakeven position, and collectively for the system to break even. The ICB is also required not to exceed the running cost allowance limit.

For 2025/26, NHSE will set a plan limit for each system, reflecting the improvement required from 2024/25. For those systems in deficit, non-recurrent support funding will be issued equal to the size of the limit. Systems are required to prepare 2025/26 plans that achieve the plan limit position.

For NENC this plan limit is a deficit of £33.3m (compared to £50m in 2024/25) with non-recurrent deficit support funding provided at that value, as noted in Table 1, with an expectation that a breakeven position is then delivered for the system.

Planning approach and key assumptions

Contracts

NHS Provider trust contract baselines have been rolled forward from 2024/25 adjusted for non-recurring funding and the impact of any in-year recurrent changes agreed in 2024/25 (including the pay award) to produce a recurrent 2025/26 opening contract baseline. This has then been

adjusted for 2025/26 additions, including for example net inflation uplifts, convergence adjustments, ERF and growth on drugs and devices.

Contracts will continue to be largely a fixed, block amount, but with a variable element for activity within the scope of elective recovery funding (elective ordinary and day case, outpatient procedures, outpatient first attendances). The variable element will be transacted in-year with activity paid for at 100% of the NHSPS unit price, maintained within affordability through Indicative Activity Plans and Activity Management where required.

Contract Uplifts

The cost uplift factor (CUF) for 2025/26 is 4.15%, with a general efficiency requirement of 2.0%, leaving a net uplift of 2.15%.

The breakdown of the CUF is shown below, this is predominantly driven by pay growth, including estimated pay increases plus expected ENIC impact.

Cost	Estimate	Cost weight	Weighted estimate
Pay	4.72%	70.45%	3.33%
Drugs	0.83%	2.34%	0.02%
Capital	2.39%	7.35%	0.18%
Unallocated CNST	0.31%	2.09%	0.01%
Other	3.51%	17.76%	0.62%
Total			**4.15%**

Note: calculations are done unrounded – only two decimal places displayed.

Efficiency Requirement

The national efficiency 'ask' for 2025/26 built into the national tariff calculation is 2.0%, a significant increase on the 1.1% in 2024/25 (and previous years). In addition, a convergence adjustment (allocation reduction) has been applied to the system of 0.5%.

This, combined with the significant underlying financial pressures facing the ICS, result in a true efficiency ask which is far in excess of the 2% included in tariff.

The ICS financial strategy model indicated the ICS would need to achieve a 7**%** level of efficiency in 25/26 in order to deliver a deficit position of £50m (consistent with 2024/25).

Total efficiencies of around 6% are expected to be delivered in 2024/25 across the ICS, although the much of this is currently non-recurrent in nature.

Key planning assumptions

The following key planning assumptions have been applied in the draft ICB and wider ICS financial plan:

- NHS provider contract values are based on:
  - Rolled forward 2024/25 values adjusted for non-recurring funding and any agreed in-year recurrent changes including impact of 2024/25 pay award,
  - Convergence adjustment applied across all baseline contracts, with cap and collar arrangement to limit impact on individual organisations,
  - 2024/25 inflationary uplift of 4.15% net of efficiencies of 2.0% (see above),
  - Additional growth applied for excluded drugs and devices based on average of last 3 years,

- Funding provided to support excess pay award pressure relating to 2024/25.

- Spend on mental health is planned to increase in line with the Mental Health Investment Standard (MHIS), which has a requirement to grow at the minimum of the overall ICB core allocation increase. The MHIS target has also been increased to take account of relevant mental health SDF transferred into core programme allocations.

- Better Care Fund growth of 1.7% has been included in line with planning guidance, with the full amount of growth expected to be used to increase the minimum contribution to adult social care of 3.9%.

- Remaining Service Development Funding included within the financial allocations (not transferred to core programme allocations) has been protected and is planned to be spent.

- £2.6m continues to be allocated as an uplift to Middlesbrough place (to be split across relevant acute, mental health and other place budgets) as part of a 3 year pace of change towards fair share funding agreed in 2024/25, following analysis at the Resource Allocation Group.

- 3.3% increase in prescribing costs has been assumed in line with national planning assumptions, prior to efficiency assumptions.

- A total of 8.4% growth has been included in respect of individual packages of care (continuing healthcare and s117 packages) to reflect expected price inflation. Any potential growth in package numbers will need to be managed within overall budgets or offset by efficiencies.

- Total ICB efficiencies of £126m are included in the plan, together with further assumed non-recurring technical benefits of around £20m (compared to the latest total forecast efficiencies for 2024/25 of £120m). Total planned efficiencies across provider trusts within the ICS are between 5-8% of provider turnover overall (compared to around 5.1% forecast to be delivered in 2024/25).

Draft ICB financial plan and budgets

The final financial plan shows a surplus position for the ICB of £11.8m.

A summary of the latest draft ICB financial plan and proposed budgets for 2025/26 is shown in Table 2 below:

Table 2

ICB Financial Plan and Budgets 2025/26	Annual Plan 2025/26 £'000
ICB Allocation	**8,326,133**
ICB Expenditure:	
Acute Service Expenditure	(4,108,403)
Mental Health Service Expenditure	(982,705)
Community Health Service Expenditure	(745,247)
All-age Continuing Care Service Expenditure	(548,183)
Primary Care Service Expenditure	(742,329)
Other Programme Service Expenditure	(28,448)
Other Commissioned Service Expenditure	(16,749)
Primary Medical Services Expenditure	(705,153)
Delegated Primary Care Expenditure	(380,098)
Total ICB Commissioning Service Expenditure	**(8,257,315)**
Running Costs	(48,637)
Reserves/Contingencies	(8,340)
Total ICB Expenditure	**(8,314,292)**
Total ICB Net Position Surplus / (Deficit)	**11,841**

Whilst the ICB has delivered a surplus (subject to audit) of £12.2m in 2024/25, this included a number of significant recurring financial pressures which have been mitigated on a non-recurring basis in-year. The underlying financial position of the ICB remains a substantial recurring deficit and delivery of the planned 2025/26 position will require increased efficiencies and other non-recurring benefits.

Delivery of the planned surplus for 2025/26 includes the following assumptions:

- Delivery of efficiencies totalling £126m, approximately 8% of relevant budgets,
- Assumed non-recurrent technical benefits and budget slippage of almost £20m,
- Financial risks around elective activity growth can be managed.

The level of total efficiencies (including non-recurrent technical benefits) required presents a potential risk to delivery of the plan and as in 2024/25 includes a significant amount of non-recurrent opportunities.

Efficiencies included in the ICB plan reflect the following:

Efficiency Schemes	£000's Recurrent	£000's Non-Recurrent	£000's Total
Prescribing & MO efficiencies	18,765		18,765
Continuing Healthcare & Packages of Care	30,886		30,886
ICB Running Costs	4.273		4,273
Estates	1,000		1,000
Local Delivery Team Programme	9,488	5,513	15,000
Transformation Programme efficiencies		15,000	15,000
Service Reform initiatives		7,200	7,200
Internal flexibilities		33,990	33,990
Total Efficiency	**64,412**	**61,703**	**126,114**

Latest forecast efficiencies 2024/25			120,669
Increase required (4%)			*5,445*

Note – further non-recurrent technical benefits of almost £20m are also assumed within the financial plan but are not reported as efficiencies in 2025/26 in line with NHSE guidance. On a comparable basis, the increase from 2024/25 is therefore around £25m (20%).

NHSE have been very clear to all ICBs and systems that it is imperative that the NHS lives within its resources, that it maximises productivity opportunities (cash and non-cash) and makes the difficult decisions to ensure the ICB and ICS can live within means. More detail on this is included in a separate part of the report and for the ICB it should be noted that £30m of difficult decisions are assumed as required and following work to date deemed as achievable within this years plan.

Despite this being the most challenging financial plan to produce we have been able to ring-fence £5m of recurrent funds from the growth allocation which will used to fund left shift and prevention initiatives in line with the expectations of the NHS Long Term Plan narrative. Business cases have been reviewed and ranked by the ICB and a limited number of very high priority cases will be able to be funded from this funding – Spirometry and Acute Respiratory Hubs being the two that ranked highest.

Included within the ICB plan are a number of contracts/agreements with values in excess of £30m. These comprise contracts with local NHS Foundation Trusts (within the ICS), together with certain section 75 agreements with local authorities which are above £30m.

Appendix 1 highlights those contracts above £30m where formal approval is sought by Board in line with delegated financial limits. The Board is asked to approve the revised values in appendix 1 as part of the approval of the financial plan and budgets. This includes final NHS Foundation Trust contract values along with Better Care Fund agreements and relevant other Local Authority section agreements. It should be noted the other Local Authority section agreements predominantly relate to individual packages of care and the values included in appendix 1 are estimates of expected costs. Actual costs will be reconciled and agreed in year based on actual packages agreed.

Relevant Better Care Fund (BCF) final values and other high value section agreements with local authorities are being pulled together and will be included in the final report for Board. Draft BCF values were already approved by Board previously to support initial payments on account being made. As in 2024/25, it is requested that the ICB approval of the BCF is delegated to the Chief Delivery Officer based on recommendations from place sub-committees, with formal approval of

BCF agreements required to be via relevant Health and Wellbeing Board, within the budgets set by ICB Board.

ICS financial plan

The agreed ICS financial plan for 2024/25 was a deficit of £49.9m with equivalent deficit support funding then received from NHSE to allow a breakeven position to be delivered. For 2025/26, deficit support funding of £33.3m has been confirmed by NHSE, with a breakeven position then expected for the ICS as a whole. Effectively this requires an improvement in the position of £16.6m compared to 2024/25.

An element of growth funding has been used to 'top up' the confirmed deficit support funding back up to £50m, allowing 'target' surplus/deficit values to be set at the same levels as 2024/25. This deficit support funding has then been allocated to organisations in the same way as previous years, based on proportionate deficit values.

At the initial headline plan submission in February, there was a financial gap of c£180m across the ICS (to achieve a breakeven position). That financial gap assumed efficiencies of 5% on average across providers, with an average of 7% efficiencies being required to close the gap.

Significant work has been undertaken across the system to reduce the gap, involving stretching efficiency targets and review of 'difficult decisions'. Peer review sessions have been held with all organisations to agree relevant actions to improve plans.

The latest expected position is shown in Table 4 below.

Table 4

ICS Financial Plan 2025/26	**Final 25/26 Plan Surplus / (Deficit) £m**
ICB net surplus / (deficit)	11.8
Total provider net surplus / (deficit)	(11.8)
Total ICS surplus / (deficit)	**0.0**

Total efficiencies included within provider plans at headline plan submission amounted to £415m (5%). This was already higher than the totals achieved in 2024/25 (latest estimate c£399m) and final efficiency plans have increased further up to almost £468m across all providers.

This equates to almost 6% of provider turnover on average, ranging from between 5-8% across individual organisations. 69% of total efficiency plans relate to recurrent schemes, with 31% being non-recurrent.

This represents a huge potential risk to delivery of plans, particularly as the majority of efficiencies in 2024/25 were delivered on a non-recurring basis.

Key financial risks

There are a number of potential financial risks associated with both the ICB financial plan and wider ICS plan.

The 2024/25 plan submission included total unmitigated net risk of over £160m across the ICS, including £26m within the ICB.

That net risk has been managed during 2024/25 but largely via non-recurring measures and one-off benefits which are not expected to be available at the same level in 2025/26. This will lead to an increased financial risk in 2025/26.

Total net risk identified within the 2025/26 financial plan amounts to £244m across the ICS, including almost £34m within the ICB.

Within the ICB, the main risks relate to potential growth in prescribing costs as well as growth in continuing healthcare costs, both of which saw significant budget pressures in 2024/25. For prescribing this includes potential risk around weight management drugs. There is also a risk of continued activity growth on acute independent sector contracts, above available elective recovery funding cap, along with similar risks around ADHD and ASD assessments at non-NHS providers.

Across the wider ICS there are a number of risks relating to cost growth and inflationary pressures together with additional costs associated with capacity pressures. There is also a significant risk around the delivery of required efficiency savings included within the plan, which are higher than efficiencies delivered in 2024/25 (and previous years) which included substantial non-recurring benefits.

NENC Capital Plan

In total, confirmed and indicative capital allocations amount to £277.3m across the ICS.

- Core baseline provider capital allocation. For 2025/26, there is no longer a separate IFRS 16 CDEL budget, and the overall provider operational capital budget includes CDEL cover for IFRS 16 requirements. For 2025/26 this core allocation has also been adjusted to repay the £30m brokerage to West Yorkshire ICB as agreed, that was received in 2024/25.

- Capital retention for high performing providers. Where providers are in Tier 1 or Tier 2 and delivered a surplus in 24/25 they have the flexibility to invest capital equivalent to that surplus in 25/26, in addition to the core CDEL.
- Indicative baseline allocations in respect of national programmes including
    - Constitutional Standards recovery in secondary care across Diagnostics, Electives and UEC schemes.
    - Estates Safety Funding to address critical infrastructure and safety risks.
    - Mental Health reducing Out of Area Placements funding.

- Core ICB capital allocation for Primary Care digital and Estates
- Additional ICB allocation for better utilisation of Primary Care Estate across NHS systems.

Table 5

Capital Allocations	2025/26 £'000
Providers:	
Baseline allocation (incl IFRS16)	166,679
High Performing Providers Capital retention	15,896
Indicative Estates Safety Fund	33,291
Indicative Constitutional Standards Funding	48,750
Indicative Mental Health: Reducing OoAP	0
Total provider capital allocation	**264,616**
ICB capital allocation	6,924
Primary Care Utilisation Fund	5,789
Total ICB capital allocation	**12,713**
Total ICS capital allocation 2025/26	**277,329**

As in 2024/25 systems have an allowable over-programming tolerance of 5% of operational capital allocations at plan stage, however this has not been utilised in submitted plans for 2025/26.

NHSE will once again be operating an Urgent and Emergency Care Incentive Scheme for 2025/26, that provides additional capital for the best performing trusts, which will be in addition to the allocations above.

As in 2024/25, the provider capital allocation is effectively delegated to the Provider Collaborative to manage, with assurance over delivery of capital plans provided via the Finance, Performance and Investment Committee. The allocation of funding included in the final financial plan submission is shown below, including the level of additional expenditure expected through national programmes.

Table 6

Capital Funding Plans:	2025/26 £'000
Providers:	
South Tyneside and Sunderland NHS Foundation Trust	23,927
North Cumbria Integrated Care NHS Foundation Trust	27,138
Gateshead Health NHS Foundation Trust	20,076
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	43,182
Northumbria Healthcare NHS Foundation Trust	61,349
South Tees Hospitals NHS Foundation Trust	16,095
North Tees and Hartlepool NHS Foundation Trust	21,771
Tees, Esk and Wear Valleys NHS Foundation Trust	13,800
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	11,503
North East Ambulance Service NHS Foundation Trust	10,956
County Durham and Darlington NHS Foundation Trust	13,671
Total provider capital	**263,468**
ICB:	
GPIT & Improvement Grants	6,924
Transfer from Provider Allocation	526
Primary Care Utilisation Fund	5,789
Total ICB capital plans	**13,239**
Total ICS capital funding plans 2025/26	**276,707**
Total ICS capital allocation (indicative)	**277,329**
Variance to allocation	**-622**

In addition to the above provider capital plans include expenditure on a range of other national programmes in plan submissions – e.g. RAAC, TIF, Diagnostics, UEC Capacity etc. These are not included in the above system allocation but feature in individual provider plan submissions and total £102.5m across NENC.

PART B – ACTIVITY AND PERFORMANCE

Introduction

This section provides an overview of the 2025/26 operational plan submission to NHS England in relation to activity and performance on 27th March 2025 and then a further resubmission on the 30th April 2025.

The 2025/26 priorities and operational planning guidance was published on 30th January 2025 and this sets out the national ambitions for the NHS England as set out in section 2. The full submission includes a significant number of additional metrics which the system is required to submit.

The North East and North Cumbria submission demonstrates a planned position for 2025/26 to meet all national ambitions and priorities at an ICB or aggregated provider ICS position.

National priorities

A summary position for ll against the key national priorities covering headline RTT compliance, Cancer, ED and Ambulance Performance (Cat2) along with Reliance on Mental Health Inpatient Care, is as follows:

Reduce the time people wait for elective care

		Provider Aggregate		Commissioner	
Priority	Success measure	NENC Final Plan Resubmission		NENC Final Plan Resubmission	
Reduce the time people wait for elective care	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	✓	**73.6% Planned (Mar-26)**	✓	**74.01% Planned (Mar-26)**
	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	✓	**80.1% Planned (Mar-26)**	✓	**80.6% Planned (Mar-26)**
	Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026	✓	**0.5% Planned (Mar-26)**	✓	**0.5% Planned (Mar-26)**
	Improve performance against the headline 62-day cancer standard to 75% by March 2026	✓	**76.4% Planned (Mar-26)**	✓	**76.8% Planned (Mar-26)**
	Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026	✓	**81.3% Planned (Mar-26)**	✓	**82.9% Planned (Mar-26)**

Improve A&E waiting times and ambulance response times

		Provider Aggregate	
Priority	Success measure	NENC Final Plan Resubmission	
Improve A&E waiting times and ambulance response times	Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25	✓	**82.1% Planned (Mar-26)**

Success measure	NEAS final
Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26	✓

Improve mental health and learning disability care

Priority	Success measure	NENC 25/26 Final Plan Resubmission	
Improve mental health and learning disability care	Reduce average length of stay in adult acute mental health beds	✓	**2% Reduction planned (Apr25-Mar26)**
	Increase the number of CYP accessing services to achieve the national ambition for 345,000 additional CYP aged 0–25 compared to 2019	✓	**60,897 Planned (Mar-26)**
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, delivering a minimum 10% reduction	✓	**20% Reduction planned (Mar-26)**

The summary position for each metric which was submitted as part of the plans including the baseline and March 2026 position is as follows:

Elective and Diagnostics				
Ref	**Metric**	**NENC Plan**	**Baseline / Target**	**Meets National Ambition**
E.B.40	Proportion of patients waiting less than 18 weeks on an incomplete pathway - NENC Provider Aggregate	73.6%	68.4%	Yes
E.M.42	Time to first attendance, waiting for first event and of those waiting less than 18 weeks - NENC Provider Aggregate	80.1%	72.6%	Yes
E.B.18	Proportion of the RTT Waiting List Waiting 52w or more - NENC Provider Aggregate	0.5%	1.3%	Yes
E.B.3a	The number of incomplete Referral to Treatment (RTT) pathways (waiting list size) - NENC Provider Aggregate	338,152	360,320	No national ambition Reduction
E.M.34	PIFU as percentage of total outpatient attendances - NENC Provider Aggregate	5.0%	3.0%	No national ambition (Historic ambition 5%)
E.B.26a to K	Increase the percentage of patients that receive a diagnostic test within 6 weeks in line with the March 2025 ambition of 95% NENC Provider Aggregate	5.1%	11.7%	No national ambition Recovery close to 5%

Although RTT performance for NENC remains one of the best nationally, there is a nationally set ambition for a 5% improvement to be delivered for the 18w RTT standard and a new 18w time to first appointment metric. At ICS (provider aggregate) and ICB level, all three key national RTT priorities have plans set to deliver the national ambitions of a 5% improvement in the two key RTT metrics as well as deliver the proportion of patients waiting in excess of 52w. All providers have submitted a compliant plan apart from Northumbria Healthcare NHS FT who have not submitted a compliant plan against the time to first attendance metric (E.M.42).

Other key metrics in this area are showing improvements on the baseline period includes an overall reduction in the incomplete waiting list (down 22,168 on the November 2024 baseline), increased patient initiated follow ups (PIFU) rates and improved 6 weeks diagnostics performance. For diagnostics, all providers and modalities are showing a marked improvement with most now at or close to the historical 5% national target. MRI, CT, echocardiography and audiology are the areas above the 5% but showing improvements in 2025/26. Likewise, NCIC, South Tees and STSFT are above the 5% but again showing improvements.

Urgent and Emergency Care				
Ref	**Metric**	**NENC Plan**	**Baseline / Target**	**Meets National Ambition**
E.M.13	Improve Accident and Emergency Performance to a minimum of 78% of patients seen within 4 hours by March 2026 - NENC Provider Aggregate	82.1%	74.1%	Yes (All providers)
E.M.13d	Number of attendances at type 1 A&E departments where the patient spent more than 12 hours - NENC Provider Aggregate	4.3%	9.6%	Yes (Reduction)
E.B.23c	Improve ambulance category 2 average response times to no more than 30 minutes across 2024/25 - NEAS	00:28:29	00:28:48	Yes
E.B.42	Average handover time - NENC Provider Aggregate	00:20:45	00:30:22	No national ambition Reduction
E.M.30	Average number of overnight G&A beds occupancy - NENC Provider Aggregate	6,687	6,883	No national ambition Increase
E.B.43	NEL Average length of stay - acute trusts - NENC Provider Aggregate	7.4	7.9	No national ambition
E.B.44	NEL Average length of stay - community trusts - ICB	21.5	21.9	No national ambition

All providers have submitted plans to deliver the national ambition of 78% of patients being seen within 4 hours by March 2026. There is still some variation in performance across trusts with Northumbria Healthcare planning on 91.2% compared to NCIC, CDDFT, STSFT and South Tees planning on 78%. NCIC have submitted an ambitious plan of improvement linked to the implementation of their co-located UTC and wider UEC transformation plan.

The overall number of patients spending more than 12 hours in A&E is expected to reduce over the coming year with the proportion reducing from around 10% to 4.3% in March 2026. The main planned improvements can be seen in Gateshead Health and CDDFT who have focused improvement plans in this area.

NEAS submitted a compliant baseline plan for category two ambulance response times with performance of 28 minutes and 29 seconds. This includes building in improvement trajectories submitted by each trust for ambulance handovers which remains a risk to delivery for NEAS. On submission of a compliant plan, subject to delivery, NEAS can access additional in-year growth funding to deliver further improvements. NEAS have built a stretched plan to deliver a 5 minute improvement which would take them to 24 minutes and 28 seconds if the funding is released to deliver the improvements and ambulance handovers continue to improve as planned.

Primary and Community Care				
Ref	**Metric**	**NENC Plan**	**Baseline / Target**	**Meets National Ambition**
E.D.19	Appointments in General Practice - ICB	1,793,127	1,571,161	No national ambition Increase
E.D.22	Number of unique patients seen by an NHS dentist - adult - ICB	41.7%	41.8%	No national ambition
E.D.23	Number of unique patients seen by an NHS dentist - child - ICB	60.7%	59.8%	No national ambition Increase
E.D.24	Units of dental activity delivered - ICB	73.2%	71.1%	No national ambition Increase
E.D.26	Pharmacy First Consultations - ICB	24,357	23,821	No national ambition Increase
E.T.5	Virtual ward capacity - ICB	69.3%	56.7%	No national ambition Increase
E.T.8	Urgent Community Response (UCR) referrals - ICB	12,297	12,355	No national ambition Reduction
E.B.45	Number of patients discharged on discharge ready date - NENC Provider Aggregate	87.6%	87.1%	No national ambition Improvement
E.T.9	Community services waiting list over 52 weeks - Adults - ICB	354	412	No national ambition Reduction
	Community services waiting list over 52 weeks - Children - ICB	668	734	No national ambition Reduction
E.T.10	Community care contacts - ICB	585,914	606,475	No national ambition Reduction

There are no national targets for primary and community care and 2025/26 has seen an increased number of performance metrics that required submission. After discussions with key ICB teams and ICS stakeholders, trajectories have been developed to reflect our key priorities across NENC.

A separate urgent dental plan was submitted which has been constructed to meet the national requirements set out in the government's pledge to provide an additional 700,000 urgent and emergency dental appointments nationally. After a detailed assessment of the NENC share of the national requirements, although a plan has been developed to meet the expectations, it is not without significant challenge. This is due to the proactive work that NENC have undertaken as part of our Dental Recovery Planning which has already seen increased activity in this area.

In other key areas, plans have also been developed which will see increased appointments in general practice and for the pharmacy first scheme and further reductions in the adult and children's community waiting list. Virtual ward occupancy is set to see some further improvements but this will need to consider the efficiency work in this area.

Cancer				
Ref	**Metric**	**NENC Plan**	**Baseline / Target**	**Meets National Ambition**
E.B.27	Cancer 28 day waits (faster diagnosis standard) - ICB	82.9%	81.8%	Yes
E.B.34	Percentage of Lower GI Suspected Cancer referrals with an accompanying FIT result - ICB	81.0%	81.0%	No national ambition
E.B.35	Cancer 62-day pathways. Total patients seen, and of which those seen within 62 days - ICB	76.4%	72.3%	Yes
E.B.38	Cancer 31 day performance - ICB	93.3%	86.2%	No national ambition (historic target of 96%)

Cancer performance remains strong in NENC with plans to further improve in 2025/26. The ICS (provider aggregate) and ICB has submitted plans to deliver the national priorities for 28 day FDS and the 62 day target with only NCIC (28 day FDS and 62 day), South Tees (62 day) not planning to deliver the standards. South Tees have submitted a much improved 62 day position linked to improvement plans which are being monitored as part of tiering conversations. NCIC have submitted a reduction in performance on their current baseline due to the reduction in financial support linked to tiering. As part of the ongoing dialogue with NCIC in the tier 2 meetings, NCIC submitted an improved position for the 62 day metric due to the improvements we are expecting to be locked in as part of the ongoing improvement plan. The ICB with support from NHS England will continue to review and support the improvements via the tier 2 conversation with NCIC.

Mental Health				
Ref	**Metric**	**NENC Plan**	**Baseline / Target**	**Meets National Ambition**
E.A.4a	Access to NHS talking therapies for anxiety and depression - reliable recovery - ICB	48.5%	48.00%	No national ambition (historic target 48%)
E.A.4b	Access to NHS talking therapies for anxiety and depression - reliable improvement - ICB	68.0%	67.00%	No national ambition (historic target 67%)
E.A.5	Active inappropriate adult acute mental health out of areas placements (OAPs) - ICB	0	0	No national ambition Maintain
E.H.15	People Accessing Specialist Community Perinatal Mental Health Services - ICB	2,355	2,310	No national ambition Maintain
E.H.34	Individual Placement Support access - ICB	2,429	1,720	No national ambition Improvement
E.H.37	Average length of stay for adult acute beds - ICB	53.1	63.0	Yes

E.H.9	Access to Children and Young People Mental Health Services - ICB	60,897	58,840	Yes

The ICB is compliant against the 2 key mental health national priorities to increase access to CYP mental health services and reduce the average length of stay for adults in acute mental health beds. For other key metrics without national ambitions, the ICB submitted plans which show improvements or sustained positive performance in all areas. For IPS, the plan is to see a further expansion, increasing from 1,720 people accessing support to 2,429 throughout 2025/26. The ICS also submitted an ambition plan to significantly reduce the number of out of area placements in 2025/26, striving for a zero tolerance.

Plans are in place to sustain performance in talking therapies and the number of people accessing specialist community perinatal mental health services.

Learning Disabilities and Neurodevelopmental				
Ref	**Metric**	**NENC Plan**	**Baseline / Target**	**Meets National Ambition**
E.H.32	Reliance on mental health inpatient care for adults with a learning disability - ICB	114	91	Yes (10% reduction)
E.H.33	Reliance on mental health inpatient care for autistic adults - ICB	74	59	Yes (10% reduction)
E.K.3	Learning disability registers and annual health checks delivered by GPs - ICB	76.0%	30.0%	No national ambition (historic target 70%)

NENC continue to be in a positive position for key learning disabilities and neurodevelopmental metrics, meeting the national ambition to reduce reliance on inpatient care for adults with a learning disability and/or autism. Plans are in place to reduce both areas by >10% which meets the requirement set by NHS England.

Secondary Care Activity			
Ref	**Metric**	**NENC Plan (Growth on 24/25)**	**Trust Range**
E.M.10a	Total number of specific acute elective day case spells in the period - ICB	-1.3%	-0.7% to +10.4%
E.M.10b	Total number of specific acute elective ordinary spells in the period - ICB	2.5%	-5.5% to +9.1%
E.M.10	Total Elective Spells - ICB	-0.8%	-0.1% to +10.0%
E.M.8	Consultant-led first outpatient attendances (Spec acute) - ICB	1.3%	-1.9% to +39.3%
E.M.9	Consultant-led follow-up outpatient attendances (Spec acute) - ICB	-3.5%	-10.7% to +10.0%
E.M.13	Total Number of A&E Attendances (All Types) - NENC Provider Aggregate	3.2%	+0.7% to +5.5%
E.M.11	Non-elective spells - NENC Provider Aggregate	-5.0%	-12.2% to +3.8%
E.M.15	Same day emergency care (SDEC) - NENC Provider Aggregate	37.9%	+4.23% to +28.3%

Providers have submitted activity plans which underpin their performance ambitions. Overall activity comparisons to the 2024/25 calculated forecast out turn are included in the above table alongside the variation across Trusts.

PART C – WORKFORCE

Introduction

Workforce planning and system recovery work undertaken throughout 24/25 has resulted in the NENC system being in a strong position entering into the challenging 25/26 planning round. The System Recovery Programme infrastructure and governance has successfully enabled a true collaborative system approach across the Provider Collaborative and the ICB resulting in the creation of a robust strategic workforce programme that has fostered constructive peer challenge, the spread of good practice, reduced duplication, increasing consistency and shared accountability.

Strategic Workforce Planning & Grip and Control

In June 2024, the System Recovery Programme Workforce Board approved a Workforce Programme that will support Trusts to achieve their financial plans and collectively return the system to financial balance within 3 years. The System Recovery Workforce Programme (SRWP) is led by one of the system Chief Executives as Senior Responsible Officer (SRO), and the Workforce Programme Board which comprises of multi-disciplinary representatives from across the system. 13 initiatives are being delivered spanning three themes - substantive staff; temporary staff; and workforce planning, which collectively aim to address workforce challenges and improve productivity. They include programmes such as job planning and sickness review; exploring e-rostering and a collaborative bank; and job evaluation and others.

A significant development to support the System Recovery Workforce Programme (SRWP) and strategic planning is the creation of a central workforce data dashboard which staff across providers, ICB and the programme have access to. This enables a review of all Trust plans across professions and highlights variation that may warrant further understanding or action. In developing the dashboard, greater consistency in workforce data reporting has also been achieved and in-year tracking of progress against plan.

In December 2024, all Trusts undertook a self-assessment of their workforce planning and control assurance arrangements using a framework developed by NHS England. A dedicated session with Chief People Officers is to take place to share the outcomes of this and consideration will be given as to where collaboration and system wide work could deliver the greatest impact.

The People Promise programme has gained traction during 24/25 the results of which the system will continue to realise in 25/26 based on the experience of first wave sites. Nationally, evidence has pointed to a reduction in leavers and turnover for NHS trusts who participated in the first People Promise Exemplar Programme, with the main impact at around the 12-month stage. Local results from the current programme, which spans Foundations Trusts, primary care settings and the North East Ambulance Service is showing a reduction in sickness absence, staff turnover and agency use. Key element of the programme focus on flexibility and wellbeing which have the positively to impact positively on retention. This will support the bank and agency reliance across the trusts.

Following the headline submission key lines of enquiry from NHS England were shared with each trust which were addressed as part of the local narrative template submission. The narrative describes the actions/initiatives Trusts plan to implement over and above the system supported initiatives and enhances understanding of the context surrounding the workforce numbers. This

includes assurance on grip and control, bank and agency reduction, risks, and supporting programmes such as the People Promise.

NHS England invited systems to submit any final changes to plans by exception. In the North East and North Cumbria, South Tees Hospitals NHS Foundation Trust corrected some data quality matters however this did not change the overall position. Newcastle Hospitals NHS Foundation Trust following further local triangulation, requested to submit a revised plan showing further reduction and alignment with financial plans.

Final submission

The North East and North Cumbria operational workforce plan submission shows all providers are forecasting to reduce their workforce, with the exception of one Trust. Reductions range from 1.8% to 5.7% across providers. North East Ambulance Service, as part of a three-year investment and growth programme plans to increase the workforce (by 3%), however remains committed to agency reduction.

Most providers are planning for a reduction in their substantive workforce ranging from 0.28% to 4.98%, with NCIC planning for the largest reduction. All providers are committing to achievement of ambitious plans for bank and agency reduction.

All providers have committed to reducing bank staff in line with or over and above the national planning ask of 10% reduction, with the exception of NEAS where their bank staff is only 19 WTE. CNTW (235 WTE; 69%) and Gateshead (44 WTE; 36%) plans reflect the most ambitious reductions.

Similarly, there is continued focus on reduction of agency use with most providers in line with or exceeding the 30% target. CDDFT plan 76% reduction and CNTW are planning 69%. However South Tees Hospitals NHS Foundation Trust are planning an 18% reduction although numbers are small, reducing from 19 WTE to 16 WTE.

The majority of providers have committed through their plans to reduce sickness absence rates during 25/26 with the exception of North Cumbria Integrated Care and Tees, Esk & Wear Valley who are not planning any change to their 24/25 position. Most Trusts are committing to a 1% reduction.

A number of providers are reporting no changes from their 24/25 planned turnover rates. Gateshead, North Tees and Hartlepool, NCIC and NEAS are planning a reduction, and it is worth noting these are all People Promise sites. South Tyneside and Sunderland and Newcastle Upon Tyne Hospitals are both planning an increase.

Workforce across Primary Care is planned to remain in line with the previous year, reflecting no growth or reductions.

The non-NHS mental health provider workforce is growing by 4%. The overall ICS mental health position will be updated when full data submissions from Northumbria Healthcare FT and Newcastle hospitals FT.

PART D – BOARD ASSURANCE FRAMEWORK

ICBs are required to respond to several statements that are set out within the board assurance framework. For NENC, we have asked all providers to complete the board assurance framework and this will be submitted as part of the full submission.

The purpose of the board assurance statements is to provide assurance that all considerations around finance, workforce and activity have been addressed whilst ensuring that the ambitions for 2025/26 can be met and that quality of patient care is prioritised.

As a result of the significant work ongoing across the ICB around efficiencies and difficult decisions, the following position was submitted with further work throughout May 2025 particularly the requirement to undertake robust relevant impact assessments on these areas. Work has started on the production of robust EQIAs for each applicable scheme in-line with the approved ICB policy.

ICB Teams are now working through each scheme to assess the level of EQIA required which is recorded on a tracker. This is available to view by key ICB teams to ensure that there is full visibility of the schemes which will be reported to SRB. The quality team will have full visibility of the "pipeline" of EQIAs that will be submitted which will require sign off by relevant ICB governance and then formal assurance to relevant committees and/or the Board.

Assurance statement	**Confirmed (Yes / No)**
Governance	
The Board has assured the plans for 2025/26 that form the basis of the system's (ICB and partner trusts) submissions to NHS England. This included review of the partner trusts Board Assurance returns.	Yes
The Board has reviewed its quality and finance governance arrangements, and put in place a clinically led process to support prioritisation decisions.	Yes
Prioritisation decisions were reviewed by the Board, including explicit consideration of the principles set out in planning guidance.	Yes
A robust quality and equality impact assessment (QEIA) informed development of the ICB's and wider system's plans and these have been reviewed by the Board.	PARTIAL
The system's plan was developed with appropriate input from and engagement with system partners.	Yes
Plan content and delivery	
The Board is assured that the system's plans address the key opportunities to meet the national priorities for the NHS in 2025/26. This includes the actions against the national delivery plan 'checklists' and the use of benchmarking to identify unwarranted variation / improvement opportunities.	Yes
The Board is assured that all possible realistic in-year productivity and efficiency opportunities have been considered across the system and are reflected in the plans of each system partner organisation.	Yes
The Board is assured that any key risks to quality linked to the system's plan have been identified and appropriate mitigations are in place.	Yes
The Board is assured of the deliverability of the system's operational, workforce and financial plans. This includes appropriate profiling and triangulation of plan delivery, and mitigations against key delivery challenges and risks.	Yes

PART E - RECOMMENDATIONS

The Board is asked to:

- Approve the final ICB and ICS financial and operational plan submissions
- Note the requirement for robust EQIAs to be carried out for key efficiency and difficult decision schemes in-line with the approved ICB policy.
- Approve the updated ICB revenue budgets for 2025/26 (as per Part A table 2) including those contracts which are above £30m as per appendix 1;
- Approve the ICS capital plan figures (as per Part A table 6); and

Appendix 1 – contracts with an annual value of £30m or above

NHS Foundation Trusts

Provider Name	Service Description	2025/26 Annual Contract Value (£000s)				
		Acute and Community	Secondary Dental	Secondary Dental - ERF	Community Dental	Total
County Durham and Darlington NHS FT	Acute & Community	£608,391	£1,223	£268	£3,307	£613,188
Gateshead Health NHS FT	Acute	£272,227	£0	£0	£0	£272,227
Gateshead Health NHS FT	Community	£26,326	£0	£0	£0	£26,326
The Newcastle Upon Tyne Hospitals NHS FT	Acute & Community	£686,259	£17,221	£2,848	£2,772	£709,099
Northumbria Healthcare NHS FT	Acute & Community	£552,763	£1,335	£223	£1,566	£555,887
South Tyneside and Sunderland NHS FT	Acute & Community	£629,384	£9,172	£949	£5,577	£645,081
North Tees and Hartlepool NHS FT	Acute & Community	£379,245	£0	£60	£2,606	£381,911
South Tees Hospitals NHS FT	Acute & Community	£469,484	£6,624	£959	£0	£477,067
North Cumbria Integrated Care NHS FT	Acute & Community	£452,771	£4,293	£528	£3,941	£461,533
Tees, Esk and Wear Valleys NHS FT	Acute & Community	£278,411	£0	£0	£0	£278,411
Cumbria, Northumberland, Tyne and Wear NHS FT	Acute & Community	£379,761	£0	£0	£0	£379,761
North East Ambulance Service NHS FT	Ambulance	£229,525	£0	£0	£0	£229,525

Specialised Commissioning Contracts - NHS Foundation Trusts

Provider Name	Service Description	2025/26 Annual Contract Value (£000s)
County Durham and Darlington NHS FT	Specialised Commissioning	£9,887
Gateshead Health NHS FT	Specialised Commissioning	£12,590
The Newcastle Upon Tyne Hospitals NHS FT	Specialised Commissioning	£367,437
Northumbria Healthcare NHS FT	Specialised Commissioning	£11,457
South Tyneside and Sunderland NHS FT	Specialised Commissioning	£38,744
North Tees and Hartlepool NHS FT	Specialised Commissioning	£7,283
South Tees Hospitals NHS FT	Specialised Commissioning	£166,737
North Cumbria Integrated Care NHS FT	Specialised Commissioning	£9,413
Cumbria, Northumberland, Tyne and Wear NHS FT	Specialised Commissioning	£130,141

Contract values agreed by NHS England in 2024/25 as part of agreed specialised commissioning financial plan, but responsibility transfers to the ICB with effect from 1 April 2025.

Better Care Fund (BCF) Agreements with Local Authorities:

Provider	Place/Area	Service / Agreement	Expected 2025/26 Annual Value/Budget £000s
Better Care Fund agreements:			
Hartlepool Borough Council	Tees Valley	BCF	£10,740
Middlesbrough Borough Council	Tees Valley	BCF	£16,899
Redcar and Cleveland Borough Council	Tees Valley	BCF	£16,077
Stockton-on-Tees Borough Council	Tees Valley	BCF	£20,246
Darlington Borough Council	Tees Valley	BCF	£11,135
Durham County Council	Durham	BCF	£62,595
Northumberland County Council	Northumberland	BCF	£34,525
Cumberland Council	North Cumbria	BCF	£31,037
Westmorland and Furness Council	North Cumbria	BCF	£5,443
Newcastle City Council	Newcastle	BCF	£33,573
North Tyneside Council	North Tyneside	BCF	£23,840
South Tyneside Council	South Tyneside	BCF	£19,648
Sunderland City Council	Sunderland	BCF	£34,531
Gateshead Council	Gateshead	BCF	£23,267
Other Local Authority section agreements:			
Durham County Council	Durham	S245/ & 75 (CHC, S117, JP)	£36,250
Gateshead Council	Gateshead	S256 Adult CHC/ FNC	£24,000
Newcastle City Council	Newcastle	Adults/ S117/ FNC/ CCC	£53,000
Newcastle City Council	Newcastle	S256 Adult CHC/ FNC	£42,000
Northumberland County Council	Northumberland	CHC	£61,619
South Tyneside Council	South Tyneside	S256 - CHC/ S117/ FNC/ Children's	£32,700
Sunderland City Council	Sunderland	CHC/ S117/ FNC	£55,000

**Note, BCF funding may not universally go to Local Authorities (LAs) to spend, as they are pooled budgets and funding is used differently by Places. A significant proportion of BCF funding is instructed to be transferred for use by the LAs however.*
The majority of other Local Authority section agreements relate to individual packages of care. Actual costs will be reconciled and agreed during the year based on actual packages agreed.