

NORTH EAST AND NORTH CUMBRIA INTEGRATED CARE BOARD Board Development Session — Note of Proceedings

Part 1: Strategic Commissioning and Quality Management

Date of session: 26 August 2026 | Chair: Sir Liam Donaldson

Presenters: Louise Mason-Lodge (Director of Nursing, Quality)

1. Purpose and context

- 1.1 This was the second in the Board's new series of development sessions, introduced to give members an in-depth grounding in policy areas before they reach the Public Board. The first session, on neighbourhood health and strategic commissioning in general terms, was judged to have worked well. This session applied the same approach to quality within the strategic commissioning role: a subject on which the Board retains a wide statutory responsibility, even as delivery increasingly sits with providers and formal oversight sits with NHS England.
- 1.2 This session was the first of three held during the same development day; the other two - a session on statutory safeguarding training and a briefing on all-age continuing healthcare - are the subjects of the two companion notes in this set.

2. Policy and statutory context

- 2.1 The Chief Nurse opened by setting the changed landscape since ICB reorganisation: NHS England's role in quality is understood to be oversight; the ICB's role is monitoring and surveillance; providers are responsible for quality delivery. Members noted that the practical distinction between "oversight" and "monitoring and surveillance" is not yet well defined nationally, and that the ICB has had to work this through for itself in the absence of a national blueprint.
- 2.2 The Director of Nursing for Quality and Secondary Care set out the existing Quality Strategy 2024–2029, developed before ICB reorganisation but still in force, with a review likely over the next 12–18 months once the successor National Quality Board strategy is published. She framed the core message of the session as: quality should be the organising principle for commissioning, not an adjunct to it - meaning the ICB should be making evidence-based commissioning decisions using early-warning intelligence and evidence of unwarranted variation, not simply reacting once something has gone wrong.

3. The Quality Management Framework

- 3.1 The Quality Management Framework (QMF) was presented as to describe "how" the ICB discharges its quality duty: a single, coherent framework across North East and North Cumbria that sets out governance and escalation arrangements, roles and responsibilities, and alignment with the ICB's operating model and quality strategy. It is built around four linked processes - quality planning, quality control, quality improvement and quality assurance - which one member likened to the classic quality-management "trilogy" of planning, control and improvement. The QMF is due to be formally signed off at the Quality and Safety Committee shortly; a fuller supporting paper will follow this session.
- 3.2 Members were told the framework is designed to be compliant with the CQC Single Assessment Framework, aligned with the NHS 10-Year Health Plan and the emerging NHS England model ICB blueprint, and to apply not only to the acute foundation trusts but across primary care, neighbourhoods and independent-sector providers — a point several members returned to during discussion (see section 4.2).

4. Discussion themes

The discussion ranged widely; the themes below draw together points made across the session rather than following the order in which they arose.

4.1 What should the ICB actually ask of providers?

- 4.1.1 The Chair opened with a first-principles question: in return for the money the ICB hands over in a broadly predictable way, what should it require of providers on quality - generic assurance about their systems, culture and use of data, or scrutiny of specific clinical conditions and pathways, or both? #
- 4.1.2 Members generally favoured working through the levers the ICB already has rather than inventing new ones: the NHS Standard Contract already sets mandatory quality markers and standards and separately allows the ICB to name two or three improvement areas it expects a given provider to address. There was recognition that the ICB cannot specify, still less monitor, every clinical condition, and that some compromise on scope is unavoidable.

4.2 Beyond the foundation trusts: scope, trust and "the compact"

- 4.2.1 Several members cautioned against the Board's discussion of quality becoming dominated by its relationship with the acute foundation trusts, noting this is only part of a much wider commissioning footprint that includes primary care, the independent sector and direct payments - collectively a large share of ICB spend.
- 4.2.2 A recurring proposal was a "compact" with providers: a clear, mutually understood statement of what the ICB will scrutinise directly, what remains the provider's own governance responsibility (tested through their own audit, clinical effectiveness and quality committees rather than duplicated by the ICB), and where the ICB reserves the right to look regardless. Members felt this would reduce both the risk of the ICB drifting into a provider's operational role, and the opposite risk of disengagement once a relationship is established.

- 4.2.3 For the high volume of smaller contracts — cited in relation to mental health, disability and neurodevelopmental services — a proportionate "dip-test" or sampling approach was suggested rather than attempting comprehensive coverage.

4.3 Culture, early warning and learning from experience

- 4.3.1 Members discussed how cultural and interface problems within a provider can persist for years before surfacing formally, drawing on a live example at one acute trust. Two possible early-warning indicators were proposed for the Quality Management Groups (QMGs) to build in: systematic use of patient-reported and staff-reported outcome measures, and closer attention to cases where a provider persistently outsources capacity to the independent sector — potentially benign for routine elective work, but a marker warranting deeper scrutiny where it involves more complex or higher-risk services.

4.4 Strengthening quality intelligence, including "soft" intelligence

- 4.4.1 There was broad agreement that the ICB holds a great deal of data but under-uses it and currently relies too heavily on providers' own reporting - quality accounts and national audit returns - without independently triangulating this against patient experience and informal intelligence.
- 4.4.2 A range of ways of generating the ICB's own intelligence, rather than relying solely on provider self-reporting, were discussed:
- direct patient and citizen engagement - surveys, focus groups and open-ended questions about lived experience, not only satisfaction scores, with particular attention to seldom-heard patients who are reluctant to raise concerns with the clinicians treating them;
 - a new Patient Experience Assurance Group, reporting to the Quality and Safety Committee and including external partners, to triangulate complaints, MP inquiries and other intelligence and track what changes as a result;
 - fuller use of existing national data sources, including the national patient survey programme and the Friends and Family Test, extracted at ICB level;
 - social media and community sentiment analysis, drawing on examples where informal online feedback surfaced service changes before formal channels did;
 - structured "mystery shopping" and commissioner assurance visits, of the kind previously used in a dentistry review, alongside a critical-friend style of provider visit that has lapsed in recent years.

4.5 System-wide focus versus individual-provider intervention

- 4.5.1 A counterpoint raised most directly by the Quality and Safety Committee chair was that the ICB has limited direct levers over an individual trust's clinical decisions, and that Board time is better spent on system-wide goals - shifting care to more appropriate, less acute settings; ensuring pathways are coordinated rather than fragmented across providers; and consistent safety standards system-wide - than on case-by-case intervention where the ICB has little practical power to act.
- 4.5.2 Others argued the ICB has under-used levers of its own, notably linking a proportion of provider payment to specific, named outcome measures, citing the

earlier national reduction in venous thromboembolism as a precedent and suggesting sepsis, and the forthcoming national service frameworks, as candidates.

- 4.5.3 Members also noted that national improvement programmes already carry more leverage with providers on system-level change than ICB-level conversation alone and suggested aligning ICB priorities with these programmes rather than duplicating them.

4.6 Prioritisation and accountability

- 4.6.1 Members were clear that the ICB cannot cover every condition, pathway or provider, and must consciously choose a small number of priorities each year - retaining some capacity for sustainability and service-configuration decisions alongside day-to-day quality monitoring - rather than attempting comprehensive coverage and inevitably failing at parts of it.
- 4.6.2 Doubts were also raised about whether accountability and escalation are genuinely clear across the ICB, despite extensive reporting into the System Quality Group: the volume of reporting was not felt to translate reliably into demonstrable impact on contracting and commissioning decisions.

5. Actions and next steps

- The full Quality Management Framework paper - deliberately not circulated in advance, to keep this session focused on members' own views rather than a pre-written document - will be shared after the session; members are asked to comment on what it should include, omit or strengthen.
- A report of this session will go to the Public Board, at minimum as a background paper.
- The Chair asked for a short, accessible public statement of the ICB's quality commitment, in preference to a lengthy document, so that providers and the public can readily engage with it.
- Members agreed that the quality work must be developed alongside, not separately from, performance and finance discussions, so that quality is not traded off against financial pressure.

6. Flagged for future sessions

- Patient safety - as a distinct paradigm from quality improvement, though related to it - was not covered in this session and will be the subject of separate future work.
- The developing multi-professional leadership model linking quality, contracting and commissioning is still at an early stage; its progress should be tracked at a future session.