Board Meeting (in Public)

MEETING
31 January 2023 08:45 GMT

PUBLISHED
30 January 2023

Agenda

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The Durham Centre, Belmont Industrial Estate, Durham, DH1 1TN	31 Jan 2023	08:45

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10	Questions from the Public on Items on the Agenda	Chair	13:30	—
11	Any Other Business from Members	Chair	13:35	—
12	Close	Chair		—

North East and North Cumbria Integrated Care Board
Minutes of the meeting held on 29 November 2022 at 09.30am,
City Hall, Sunderland City Council

DRAFT

Present:	Professor Sir Liam Donaldson, Chair Samantha Allen, Chief Executive Nicola Bailey, Interim Executive Director of Place Based Delivery (North and North Cumbria) Ken Bremner, Foundation Trust Partner Member David Chandler, Interim Executive Director of Finance Professor Graham Evans, Executive Chief Digital and Information Officer David Gallagher, Executive Director of Place Based Delivery (Central and South) Tom Hall, Local Authority Partner Member Professor Eileen Kaner, Independent Non-Executive Member David Stout, Independent Non-Executive Member Jacqueline Myers, Executive Director of Strategy and System Oversight Rajesh Nadkarni, Foundation Trust Partner Member Dr Neil O'Brien, Executive Medical Director Cath McEvoy-Carr, Local Authority Partner Member Claire Riley, Executive Director of Corporate Governance, Communications and Involvement John Rush, Independent Non-Executive Member Dr Hannah Bows, Independent Non-Executive Member Dr Mike Smith, Primary Medical Services Partner Member Ann Workman, Local Authority Partner Member Aejaz Zahid, Executive Director of Innovation
In Attendance:	Jane Hartley, Voluntary Organisations' Network North East (VONNE) David Thompson, North East and North Cumbria Healthwatch Network Representative Deborah Cornell, Director of Corporate Governance and Involvement Toni Taylor, Governance Officer (minutes) Jan Thwaites, Executive Assistant (minutes support)

B/2022/43 Welcome and Introductions

The Chair welcomed members to the third meeting of North East and North Cumbria Integrated Care Board (the ICB).

The following individuals were in attendance under public access rules:

- Cllr Shane Moore, Leader, Hartlepool Borough Council
- Alistair Walker, Graduate Management Trainee
- Adam Brown, Head of NHS Business Development, GPDQ
- Katy Mitchell, NHS Supply Chain
- Joleen Grainger, NHS Supply Chain
- Jay Hare and colleagues, Twisting Ducks

B/2022/44 Apologies for Absence

Apologies were received from Annie Laverty, Executive Chief People Officer and Dr Saira Malik, Primary Medical Services Partner Member.

B/2022/45 Declarations of Interest

It was noted that members had submitted their declarations prior to the meeting.

Jane Hartley, VONNE representative, raised a declaration of interest with regards to agenda item 9.7 (allocation of finance). VONNE is currently leading on the healthy communities in social prescribing.

B/202246 Minutes of the previous meeting held on 27 September 2022

These were agreed as a true record.

B/2022/47 Matters arising from the minutes

There were no matters arising.

B/2022/48 Notification of items of any other business

There were no additional items of business raised.

B/2022/49 Learning Disabilities and Autism: Building the Right Support

The report provided an overview of the challenges and opportunities for the North Cumbria and North East Integrated Care System (ICS) to deliver the Council's transforming care for autistic people, people with learning disabilities and people with both in partnership.

There were a number of television programmes that highlighted people with autism and a focus, particularly from the Care Quality Commission, on how individuals were treated within care settings and the community.

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The Board noted that the numbers of children identified as having special educational needs and disabilities was increasing across North East and North Cumbria (NENC), however the support services available to support and assist parents in the care of those children had not particularly increased.

The report highlighted the challenges faced by the service and referenced engagement with patients, families and carers.
It was noted several responses to the report had been received from Healthwatch colleagues across NENC and these included:

- Difficulty in accessing information in some healthcare services and the accessible information standard being maintained
- Improving the working and communication between the learning disability and mental health teams
- Extended use of personal budgets to make more person friendly
- Hospital discharge and the issues that had been raised
- Improved training and education for families.

It was acknowledged that the ICB had committed to look at discharge pathways and getting patients back home to their communities whilst providing support to individuals to help maintain independence. It was suggested that regular updates were provided to the Board to demonstrate progress being made.

It was noted the report did not include workforce implications and it was important to recognise the highly skilled specialist workforce. The wider system workforce also needed to flexible to adapt to the multiple requirements of the community, including more disadvantaged communities, by upskilling the workforce on issues such as learning disabilities and autism.

It was explained that waiting times for a diagnosis were currently unacceptable and measures would be looked at to ensure improvements were being made.

Work was being piloted across North East and North Cumbria to look at nursing associates working as part of social care to learning disabilities and autism.

It was noted the Lawnmowers Independent Theatre Company in Gateshead provided training through theatre to the wider workforce particularly to GPs, practice nurses, and academic trainees. The Company was run by and for people with learning difficulties and details would be shared following the meeting to enable the ICB to explore a more creative commissioning environment.

ACTION:

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The Board to receive quarterly updates on the transforming care key performance indicators and progress on delivery of the ambitions of building the right support.
Contact details of the Lawnmowers Independent Theatre Company to be shared with the Executive Director of Place (North and North Cumbria) following the meeting.

RESOLVED:
The Board **RECEIVED** the report and supported the recommendations outlined in the paper.

B/2022/50 **The Twisting Ducks Video**

The Executive Chief Nurse introduced colleagues from the Twisting Ducks Theatre Company.

The Twisting Ducks Theatre Company had produced a series of films since 2007 to raise awareness and improve the lives of people with learning disabilities and autism. The Company had made health information accessible in several ways including easy to read and film-based resources and offer training to health and social care professionals.

The Board watched a short film called '24 years' worth living', produced to support a recent learning disabilities mortality review event. The video showed that, despite all the years of completing reviews, there was still 24 years difference in life expectancy for people with learning disabilities and autism.

The Board thanked colleagues from 'The Twisting Ducks Theatre Company' for joining the meeting and for providing a deep insight into the challenges faced.

B/2022/51 **Chief Executive's Report**

The report provided an overview of recent activity carried out by the Chief Executive and Executive Directors, as well as some key national policy updates.

Tees Esk and Wear Valley NHS Foundation Trust
Heartfelt condolences were conveyed to the families following the deaths of three individuals whilst in the care of Tees Esk and Wear Valley NHS Foundation Trust (TEWV). The ICB was committed to supporting TEWV to improve services and ensure care pathways for people who have mental health needs were met.

East Kent Report
A report had recently been published following an investigation led by Dr Bill Kirkup, CBE on maternity and neonatal services in East

Kent. The report highlighted issues reported in the media, specifically 'Dispatches' and 'Panorama', around the culture of maternity and neonatal services. Dr Kirkup had been invited to attend the January 2023 meeting to explore the learning for maternity services and highlight the opportunity to make connections around culture, openness and transparency and working with families.

North East and North Cumbria Learning and Improvement Network
The recent learning and improvement system event had looked at seven areas of priority. Work was underway on the first priority area 'waiting times and crisis support for child and adolescent mental health services' between the two mental health providers in the NENC. The next learning and improvement system event was scheduled for mid-December. It was suggested parent and carer forums in the region be included to help support the children and young people's summit.

Covid and Flu Vaccine Campaign
The Covid and flu vaccinations programmes were continuing. In particular, health and social workers were being encouraged to take up their vaccinations as well as eligible members of the public yet to be vaccinated. The overall rate of uptake for the flu vaccinations in schools visited to date was 57% which was benchmarked above the national average.

Flu admissions were currently higher than expected compared with previous seasons and expected to increase further. There were still significant numbers of people in hospital with Covid and were being monitored daily. A surge in flu cases, which on the backdrop of Covid, could put significant pressure on health services. The first outbreaks of flu in care homes had been reported and it was noted flu cases were rising in the community. Planning continued in relation to the increase of vaccination rates.

The ICB would be participating participate in an emergency planning exercise looking at a scenario of industrial action and elevated admission levels to identify learning and build this into plans.

RESOLVED:
The Board **RECEIVED** the report for information and assurance.

B/2022/52 **Integrated Delivery Report**

The report provided an overview from of quality, performance and finance. The report had been structured around 2022/23 planning priorities and linked to the NHS Oversight Framework. Key points were highlighted as follows:

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Quality

- Following a recent Care Quality Commission (CQC) inspection, published September 2022, North Tees and Hartlepool NHS Foundation Trust were given an overall rating of 'requires improvement', compared to a previous rating of 'good'. The Trust was now on the national maternity improvement programme. Ockenden and East Kent learning reports were being combined into an improvement plan due to be published February 2023 with a planning meeting scheduled for March to look at this and take the work forward.

- The CQC recently inspected the learning disability and autism wards of Cumbria, Northumberland and Tyne and Wear NHS Foundation Trust (CNTW) and Tees, Esk and Wear Valleys NHS Foundation Trusts (TEWV). In both trusts the ratings for these wards had deteriorated to 'requires improvement' for CNTW and 'inadequate' for TEWV. This did not impact their overall trust ratings.

- South Tyneside and Sunderland NHS Foundation Trust Maternity Services had been removed from the enhanced surveillance process and quality assurance would resume through the place-based quality review group meetings.

- There had been 14 never events to date which included invasive procedures. A review was underway to look at local and national safety standards and also compliance of checklists to identify learning across the organisation.

Performance

- South Tees NHS Foundation Trust had moved out of Tier 2 escalation for cancer due to improved performance. Learning had been shared with other foundation trusts across the patch
- North Tees and Hartlepool NHS Foundation Trust had moved into Tier 2 escalation for cancer waiting times
- Notable progress had been made by North Cumbria Integrated Care NHS Foundation Trust in reducing the cancer 62-day backlog
- Newcastle Hospitals NHS Foundation Trust remained in Tier 2.

Key Performance measures:
The following standards had shown a significant deterioration this month:
- The North East Ambulance Service NHS Foundation Trust (NEAS) category two response times had deteriorated from 40:45 to 57:34 (although compared favourably to the national at 1:01:19)
- The average hours lost per day had deteriorated significantly across the NENC, 106 compared to a target of 61.4

- 12-hour accident and emergency (A&E) breaches: Patients waiting in A&E more than 12 hours following decision to treat had increased significantly from 909 in September 2022 in NENC, to 1106 in October 2022.

The Board noted that the key areas of focus were supporting timely ambulance response times and reducing handover delays.

Primary Care

There was a significant increase in the number of general practitioner (GP) appointments being delivered compared to pre-pandemic levels. Approximately 5% of these appointments were not being attended, which was currently below the national rate. Face to face appointments were currently being offered which exceeded the level nationally.

Elective Care

The longest wait patients had experienced was two years from referral to treatment with a key pressure being the spinal service at Newcastle Hospitals NHS Foundation Trust. The Trust continued to manage patients and seek additional capacity through mutual aid to reduce backlogs. There were currently 3,344 patients in the region waiting for elective treatment and work was ongoing to review elective services for productivity and new ways of working.

Two rapid improvement events had taken place since September. The events focussed on managing the safety of individuals waiting for an ambulance, enhanced clinical triage for appropriate prioritisation and ambulance handover delays. Issues such as flow through hospitals, processes within emergency departments, and processes around community response to discharge were highlighted. A proposal was being developed to recommend a 'redline' in the system at 59 minutes on handover delays to ensure no handover exceeds one hour. It was felt the greatest risk was to unseen patients at home, waiting a long time for an ambulance.

A review had taken place of all acute providers against the 10 high impact interventions for affected discharge. Work was underway with Association of Directors of Adult Social Services colleagues to look at how the £500m discharge funding would be utilised at place level. It was noted that discussion was required with local health and wellbeing boards to agree the areas for funding. An indepth review into the work of the discharge funding would be received at the next Board meeting in public in January 2023.

Primary care had felt the pressure of ambulance and emergency care delays. Patients often visited primary care where they feared a long wait in A&E departments. If the GP decision was hospital treatment was required, a long wait for an ambulance

consequently required significant primary care resource. This demonstrated the high level of demand and system issues.

Reference was made to the Urgent and Emergency Care Network Board and the significant level of engagement and commitment from provider chief executives, medical director teams, nursing director teams and A&E Delivery Boards to focus on short term interventions to ensure patient safety whilst being mindful of a longer-term plan.

A significant issue within the care sector was patients being discharged from hospital requiring additional support. More patients were needing 2:1 care and support, specifically older people with multiple long-term conditions. Joint working, ownership and shared responsibility within the care sector was very strong.

The Board noted the significant pressures within mental health providers with 100% occupancy rates and long waiting lists for those requiring detainment under the Mental Health Act.

Work was ongoing with the regions 11 independent hospice providers, virtual wards and the home first approach, most of which were solutions that relied upon place-based resources. Working in partnership at place to address systemic issues was key whilst balancing urgent actions to address winter and long-term actions. There was a commitment to move beyond the metrics mandated nationally and identify measures that were important.

A system control centre had been established which would go live shortly. It was noted that there were no mental health measures currently defined nationally but a commitment had been made locally to develop a dashboard around mental health emergency pressures. Assurance was given assurance that the control centre was focus on the whole system and not just acute settings.

Healthwatch continued to receive feedback in relation to primary care and delayed access to timely appointments.

A query was raised in relation to social care issues and whether these would be concentrated on at place. It was suggested that more detail on workforce and delayed discharge data would be useful. It was clarified that the ICB's statutory responsibility was not to regulate or oversee social care but to look at some of the key indicators system wide. It was agreed this would be fed back to the next directors of adult social care meeting and an update received by the Board in due course.

ACTION:
An indepth review into the work of the discharge funding to be presented at the next Board meeting in January 2023.

RESOLVED:
The Board **RECEIVED** the comprehensive report for information and assurance.

B/2022/53 Finance Report

The report provided an update on the financial performance of the ICB and ICS for the period to 30 September 2022.

Some key points were noted as follows:

- The ICB had a duty to live within its allocated resources of £6.5b. The ICB was reporting a forecast surplus against plan of £5.6m, an increase of £3m

- The ICB was reporting pressure on independent acute activity and on packages of care. These were currently being offset through underspends on prescribing budgets and use of programme reserves

- Since the previous report, one foundation trust provider had reported a deterioration in forecast outturn of £5.6m (from surplus to break-even). This had been offset by a combination of additional surplus in the ICB as reported above. Another local foundation trust provider had improved its forecast outturn position by £2.6m.

- In respect of the national pay award, an allocation of £86.6m had been received for NHS organisations within the ICS to fund the additional costs of the Agenda for Change pay award, based on a national average pay impact of 1.66%. Each provider trust had calculated the impact for their organisation and identified a potential net shortfall in funding to support the full pay award of up to £20m. This represented a risk in the delivery of a balanced financial position for the ICS

- In relation to capital, there was an expectation that the ICB did not overspend the capital resource limit. However, there was a planned overspend at the beginning of the year and the latest forecast was that the ICB would break-even by year end.

- In terms of running costs, a forecast underspend of £1m was expected largely due to the impact of vacancies in the current year.

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Attention was drawn to some high-level indications following the Autumn statement:

- An additional £3.3 billion pound expected
- An additional £2.8 billion for social care, £4.7 billion the following after
- An expected 3% cost reduction target for NHS England on top of any unachieved cost reduction plans from this financial year. It was expected that 2023/24 would be a challenging year in terms of NHS budgets.

A new NHS England underspend protocol had been published and would be reviewed in detail at the Finance, Performance and Investment Committee.

RESOLVED:
The Board **RECEIVED** the report for assurance and **NOTED** there were potential financial risks across the ICS still to be mitigated.

B/2022/54 **ICB Oversight framework**

The framework was presented to the Board for information and assurance purposes.

The framework had been approved by the Executive Committee in November 2022. Responsibility for maintaining effective oversight arrangements would sit with the Committee.

Work was underway to launch the framework and ensure it operated effectively. The framework would primarily deliver assurance but also act as a tool ensure objectives were being delivered and ensure learning opportunities were taken from across the system.

It was expected that the NHS England arrangements would continue to evolve and further responsibilities may devolve to the ICB in 2023/24.

It was recognised that there was opportunity to simplify the system. A mapping exercise was underway of all interactions in the system to have a single source of issues and incidents. The aim was for an integrated approach to governance.

The Board wished to record thanks to the provider collaborative for their engagement in become a learning and improvement system. It was recognised that transparency and openness was key as well as adapting behaviours.

RESOLVED:
The Board **NOTED** the oversight arrangements set out within the report.

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B/2022/55 ICB Operational Resilience – Winter Plan Delivery

The report highlighted progress made against the key ICB priorities, supporting winter planning and enhanced operational resilience.

Further winter guidance had been published by NHS England and a comprehensive review of this had reported the ICB to be in a positive position.

The ICB priority areas for winter in response to the guidance were:
1. Increased clinical triage and use of non-emergency department pathways
2. Increased access to urgent primary care
3. Improved discharge and patient flow.

Progress was noted in the following key areas:
- Increased provision for high intensity users – opportunities for services to be reshaped
- Community in practice – opportunities to learn from each other from pilots and new ways of working
- Maximising recruitment for new staff in primary care – recruitment and deployment of staff to best use capacity to support the urgent care need.

NHS England had identified the following six specific metrics for the provision of safe and effective urgent and emergency care that would be used to monitor performance in each system through the winter board assurance framework:
- 111 call abandonment
- Mean 999 call answering times
- Category 2 ambulance response times
- Average hours lost to ambulance handover delays per day
- Adult general and acute type 1 bed occupancy
- Percentage of beds occupied by patients who no longer meet the criteria to reside but require further support

From a local perspective, three metrics had also been identified:
- 111 and 999 calls clinical triage rates
- 111 and 999 call disposals by pathway
- Vaccination rates

The report highlighted the impact of an intervention that went live on 1 November to support the priority of increased clinical triage. The core clinical triage service, within the North East Ambulance NHS Foundation Trust, was reserved for the more complex cases through 999 route. Early indications showed this to be working effectively.

The report highlighted a steady increase in the number of patients accessing the 2-hour urgent emergency response.

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All 13 local authorities in the ICS provided a 24-hour urgent response to patients who did not require clinical assessment at hospital and were better managed in the community. The most common 999 call for this type of response were patient falls and work was underway to look at how standards could best be met.

It was noted there had been some rapid improvement work done by Northumbria Specialist Emergency Care Hospital (NSECH) and North East Ambulance Service (NEAS) to navigate patients appropriately and avoid unnecessary conveyances to the emergency department and with the community matrons in Tees Valley to review patients waiting for ambulances to identify those who could be treated in the community more appropriately.

The recently published winter guidance set out the requirement for a strategic system coordination centre to support the system in responding to surges in demand and challenges. The centre would operate physically and virtually between 8am – 8pm, 7 days a week and would survey a wide range of metrics including waits for ambulances, ambulance handover times and peaks in delayed discharges causing flow problems. Detailed work with providers was underway with regards to system response plans. The Board thanked partners for assistance regarding the mobilisation of the centre.

The impact of these interventions (funded non-recurrently) was to be measured to make a considered judgement whether to roll these out more widely.

The role of pharmacies in the initiative was raised, noting that the data intelligence they captured was not always utilised. Responsibility for the commissioning of pharmacies would be delegated to ICBs in April 2023 which will provide opportunity to work with them more closely.

Healthwatch drew attention to communications regarding vaccinations which had caused some confusion initially, specifically children with health issues were not always being directed to most appropriate place for their vaccinations. This had now been addressed.

Workforce resilience hubs established during Covid remained critical as the NHS continued to recover from the pandemic. It was noted that national funding for the hubs was being withdrawn from 1 April 2023. Discussions had taken place as a system and a business case would be put forward in relation to need, learning and maintenance of support for the hubs.

A query was raised in relation to the difference between an emergency control room and a strategic coordination centre. It was clarified that emergency rooms could be stood up at any time

to respond to an emergency. Strategic coordination centres had been mandated nationally as previously mentioned and set up specifically to managing risk over the challenging winter period operationally.

RESOLVED:
The Board **RECEIVED** the report for assurance and **NOTED** the risks associated with delivery.

B/2022/56 NHS England Commissioning Delegations – Primary Care and Specialised Commissioning

The report presented provided an update on the status of the proposed delegation from NHS England to ICBs in respect of community pharmacy, optometry and dental (POD) services and the ICB's approach, progress and next steps.

The ICB already had delegated authority from NHS England for primary medical services since its establishment and would assume responsibility POD services, subject to completion of the due diligence process. The Board noted there would be an opportunity to re-integrate services at a local level.

Completion of the pre-delegation assessment framework had highlighted some risks which were being managed. The safe delegation checklist was to be completed, looking at due diligence, highlighting risks and how these would be mitigated moving forward. A further paper would be brought to the Board in March prior to the proposed delegation on 1 April 2023.

In relation to specialised commissioning, the Executive Committee had supported the recommendation to establish a joint commissioning arrangement with NHS England from April 2023 and full delegation from April 2024. This would enable the ICB to better understand the specialised commissioning responsibilities and implications and carry out the required due diligence.

NHS England had proposed a joint committee be established for specialised commissioning to enable the ICB to be involved in key decisions during the shadow period 2023/24. Discussions were underway regarding the responsibilities of the committee however accountability would remain with NHS England until full delegation on 1 April 2024.

There were currently 65 services expected to be suitable for delegation. Further work was to be conducted over the coming months with a final list to be confirmed later in the year. The services totalled £501m specialist commissioning spend.

The proposed delegation of specialised commissioning responsibilities to the ICB had identified the following risks:

- Financial risk – there was the intention to change the allocation approach to be needs based. This would need to be clarification during transition period and due diligence work
- The inheritance of responsibility - momentum needed to be maintained as addressing issues of sustainability and new ways of working.

There were examples of specialities across services which provided an opportunity of a holistic review of these services to ensure the best arrangement for the NENC population.

Healthwatch noted in terms of issues raised by the public, dentistry was by far the most significant. Across the NENC areas, there were some areas in the region where access to dental services deserts was having a serious impact on the population, particularly those who are already disadvantaged.

ACTION:
A further update to brought to the Board in March on the delegation of POD services prior to the proposed delegation on 1 April 2023 and on progress for the proposed delegation of specialised services to the ICB.

RESOLVED:
The Board **NOTED** the update in relation to the proposed delegation of both POD and specialised service commissioning and **APPROVED** the Executive Committee recommendation to form a joint committee with NHS England from April 2023.

The Board **DELEGATED** responsibility for approval of the pre-delegation assessment framework submission to the Executive Director of System Oversight.

B/2022/57 Establishing the Integrated Care Partnership

An updated was provided on the formation of the Strategic Integrated Care Partnership (ICP) and four Area ICPs, and to seek views on their terms of reference and membership.

The strategic ICP had met for the first time in September, with the next meeting scheduled for December. The aim was to improve health outcomes for people across NENC with a focus on developing an integrated care strategy, a draft of which was currently out for comments and feedback.

Members of the Board gave their views on the terms of reference and membership for the Strategic ICP and Area ICPs.
RESOLVED:
The Board **RECEIVED** the update for information.

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B/2022/58 **Constitution of the NHS North East and North Cumbria Integrated Care Board – technical amendments**

An updated Constitution for the ICB was presented which set out some proposed technical amendments requested by NHS England.

RESOLVED:
The Board **APPROVED** the proposed amendments and **RECOMMENDED** submission of the revised Constitution to NHS England for formal approval.

B/2022/59 **Highlight Report from the Executive Committee 13 September and 11 October**

An overview of the discussions and decisions at the Executive Committee meetings held on 13 September and 11 October was provided.

A risk had been identified and added to the risk register in relation to cyber security following a national cyber event which had impacted on some urgent and emergency care services.

A chair's action was highlighted in relation to an urgent decision needed for the GP IT futures procurement of clinical information systems.

RESOLVED:
The Board **RECEIVED** the highlight report and minutes for assurance and formally **NOTED** the chair's action.

B/2022/60 **Highlight Report from the Quality and Safety Committee meeting held on 20 October 2022**

An overview of the discussions at the first meeting of the Committee held on 20 October 2022 was presented.

The Committee reviewed its terms of reference including the membership, cycle of business and risks.

The Committee also received and reviewed a report concerning the risks aligned to the quality and safety portfolio. Additional risks were suggested along with updates to existing risks including workforce, children and adult mental health services and prescribing.

RESOLVED:
The Board **RECEIVED** the highlight report and minutes for assurance.

B/2022/61 **Highlight Report from the Finance, Performance and Investment Committee and minutes of 1 September and 6 October 2022**

An overview of the discussions and decisions at the Finance, Performance and Investment Committee meetings held on 1 September and 6 October was presented.

The Committee reviewed its terms of reference, with a final draft to be discussed at the next meeting on 1 December. The proposed amendments to the terms of reference would be presented at the Board meeting in January 2023 for approval.

The Committee would also be discussing historical clinical commissioning group services allocation and coding at its meeting in December.

RESOLVED:
The Board **RECEIVED** the highlight report and minutes for assurance.

B/2022/62 **Recommended Addendum to the Scheme of Reservation and Delegation in relation to Individual Funding Requests**

A review of the individual funding request process had been undertaken and it was highlighted that an addendum to the Scheme of Reservation and Delegation (SoRD) was required to ensure appropriate and timely decision-making could be maintained for patients.

The Board was requested to approved this retrospectively from 1 July 2022.

RESOLVED:
The Board **APPROVED** the retrospective addendum to the SoRD.

B/2022/63 **Towards a Healthier and Fairer North East and North Cumbria: Review of our Strategic Approach to Tackling Health Inequalities**

The report provided an update on the formation of a Healthier and Fairer Advisory Group (as a formal subcommittee of the Executive Committee) to provide assurance on the work undertaken by the ICB to progress health inequalities.

The initial meeting of the Group had discussed its terms of reference, in particular the membership and governance arrangements. Membership of the Group would include

representatives from director of public health networks and voluntary sector partners.

The subcommittee would focus on three broad headings; prevention, Core20plus5 (to include children) and NHS economic disparities. Core20plus5 was a national initiative looking at individuals who live in the 20% most deprived areas, along with five groups with specific health indicators.

The ICB had been allocated £13,604,000 recurrent funding to support targeted reductions in health inequalities for this financial year and the next two years. Going forward, the Group would play a key role in recommending to the Executive Committee how this funding was allocated, based on robust analysis and evaluation of what would have the biggest impact on public health and health inequalities.

The intention was to take an evidenced-based approach and how the ICS could best support the most vulnerable and marginalised individuals across NENC. There were currently six universities and 60 health and care organisations included in this work.

The Board noted it would receive further updates on the work of the Group as it reviewed existing work programmes and agreed its priorities for the year ahead.

RESOLVED:
The Board **APPROVED** the formation of the Healthier and Fairer Advisory Group as a formal subcommittee of the Executive Committee.

B/2022/64 Board Assurance Framework

The Board was presented with the first edition of the ICB's Board Assurance Framework (BAF) for 2022/23. The framework was to be used to provide assurance on the management of key risks to the delivery of the ICB's strategic aims and objectives.

RESOLVED:
The Board **RECEIVED** the Board Assurance Framework for assurance.

B/2022/65 Questions from the Public on Items on the Agenda

Item 9.7 - Towards a Health and Fairer North East and North Cumbria: Review of Our Strategic Approach to Tackling Health Inequalities.

A question was received from a member of the public as follows:

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'I note that the membership of the proposed Healthier and Fairer Advisory Group does not seem to have a role for a Patient Representative. I would suggest it should and I would like to put my name forward for the post. I will be happy to give full details of my background at an appropriate time'.

In response, it was noted that work was currently underway with Healthwatch around patient representation and those with lived experience as detailed in the Involving People and Communities Strategy which had been approved by the Board at its first meeting in July. An update on delivery of the strategy was scheduled for the Board in the new year.

B/2022/66 Any other business

There were no other items of business.

The meeting closed at 12:43.

DRAFT

Item: 7.1
Enclosure:

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

NORTH EAST & NORTH CUMBRIA ICB BOARD MEETING

31 January 2023

Report Title:	**Chief Executive Report**

Purpose of report

The purpose of this report is to provide an overview of recent activity carried out by the ICB Chief Executive and Executive Directors, as well as some key national policy updates.

Key points

The report includes items on:

- National Planning Guidance
- System Resilience
- Emergency Preparedness, Resilience and Response Framework
- The Hewitt Review
- Primary Care, Pharmacy, Optometry and Dentistry Delegation
- Priority Services Campaign
- Learning and Improvement Community
- Care Leaver Covenant
- ICP Update

Risks and issues

1. Note the risks related to the EPRR Framework.
2. Note the assurance required on the POD delegation given the delay in transfer of staff from NHS England and completion of due diligence.

Assurances

The report provides assurance to the board of recent business activity and development carried out by the ICB Chief Executive and Executive Directors.

Item: 7.1
Enclosure:

Recommendation/action required
The Board is asked to: • Review and note the North East and North Cumbria Integrated Care Board assurance process and ICB compliance rating as well as the provider organisations compliance ratings with regard to EPRR. • Endorse the submission to NHS England as part of the NHSE EPRR annual assurance process for 2022-23. • Receive the ICB CEO report for assurance.

Acronyms and abbreviations explained						
A&E – Accident and emergency NENC – North East and North Cumbria ICB – Integrated Care Board UTC - Urgent Treatment Centre EPRR - Emergency Preparedness, Resilience and Response Framework POD - Pharmacy, Optometry and Dentistry						
Sponsor/approving director	Sir Liam Donaldson, Chair					
Report author	Samantha Allen, Chief Executive					
Link to ICB corporate aims (please tick all that apply)						
CA1: Improve outcomes in population health and healthcare						✓
CA2: tackle inequalities in outcomes, experience and access						✓
CA3: Enhance productivity and value for money						✓
CA4: Help the NHS support broader social and economic development						✓
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**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality	**Yes**		**No**		**N/A**	✓

impact assessment been undertaken? (please tick)						
Key implications						
Are additional resources required?	None noted.					
Has there been/does there need to be appropriate clinical involvement?	Not applicable – for information and assurance only.					
Has there been/does there need to be any patient and public involvement?	Not applicable – for information and assurance only.					
Has there been/does there need to be partner and/or other stakeholder engagement?	Engagement has taken place throughout the assurance process with NHS England and provider organisations.					

Item: 7.1
Enclosure:

Chief Executive Report

1. Introduction

The purpose of this report is to provide an overview of work across the Integrated Care Board (ICB) and key national policy updates and reports.

2. National

On 23 December 2022 NHS England published the national planning guidance[1] for both the 2023/24 Operational Plan and the Joint Forward Plan. On 12 January NHS England issued further guidance for the Operational Plan, including the technical guidance and a series of documents for engagement relating to the financial framework for 2023/24.

The 2023/24 Operational Plan takes the form of a series of templates addressing activity and performance, workforce, and finance, at an ICB level. This will be collated from individual NHS Trust templates. Additionally, the local system, coordinated by the ICB, will be required to produce a recovery narrative document, describing how the local system will towards delivering the national objectives.

The national objectives are based around three key areas:

1. Immediate priority to recover core services and productivity

    - improve ambulance response and A&E waiting times
    - reduce elective long waits and cancer backlogs, and improve performance against the core diagnostic standard
    - easier for people to access primary care, particularly general practice.

2. Make progress in delivering the key ambitions in the NHS Long Term Plan

3. Continue transforming the NHS for the future

The Joint Forward Plan will be a narrative document covering the period 2023/24 – 2028/29 and will effectively be the delivery plan for the Integrated Care Strategy published in December 2022 and on the Board's agenda today. The Joint Forward Plan is a shared responsibility between the ICB and partner NHS Trusts, with a strong requirement for engagement with a broad range of partners including Health and Wellbeing Boards and the Integrated care partnership (ICP). The national guidance is not prescriptive about either content or form and does leave room for local determination.

[1] NHS England » 2023/24 priorities and operational planning guidance

Item: 7.1
Enclosure:

The ICB intends to include 14 Local Authority Place plans, and thematic plans for each of the Integrated Care Strategy goals and enablers as part of the Joint Forward Plan documents.

The key timelines are:

- 23 February: draft submission for the 2023/24 operational plan templates and recovery narrative.
- 30 March: final submission for the 2023/24 operational plan templates and recovery narrative.
- 31 March: contracts agreed and signed for 2023/24.
- 31 March: draft joint forward plan.
- 30 June: final joint forward plan.

The ICB will work closely with NHS England, NHS Trusts and broader partners to meet the requirements of both the Operational Plan and the Joint Forward Plan. The ICB Executive Chief Strategy and Operating Officer and Executive Director of Finance will ensure coordination planning and financial submissions, aligned to quality expectations. Oversight will be provided by both the Executive Committee and Finance, Performance and Investment Committee.

I anticipate the ICB Board will be required to approve the final Operational Plan for 2023/24, or arrange for appropriate delegations for approval, and for the final Joint Forward plan in June.

3. **North East and North Cumbria**

3.1 System Resilience

The urgent and emergency care system across the country and North East and North Cumbria (NENC) is no exception and has been the most challenged it has ever been due to a combination of demand, capacity in urgent and emergency care, flow and discharge, staff absences and vacancies and industrial action. The whole system is working tirelessly to meet demand across a wide range of service delivery and new initiatives.

The rise in infection rates has resulted in increased admissions and staff absences and these peaked over the Christmas holiday and New Year period.

High numbers of acute respiratory infection outbreaks in care homes continue to be reported. Between the 23 December 2022 and 06 January 2023 there were eight community outbreaks of influenza the North East for which the antiviral pathway was activated. The North East activity in secondary care remains at high levels with similar rates of hospitalisations (23.1 admissions per 100,000) and intensive care unit/high dependency unit admissions (1.49 per 100,000) when compared with the previous week.

The current vaccination rate for covid at 08 January 2023 is 63% and for flu almost 62%. Concerted efforts to vaccinate more people and those from vulnerable groups continue.

Working with leaders across our system we remain focused on the key urgent and emergency care priorities we have set. This includes ambulance handovers and the NENC system has agreed across all providers to implement no handover delays over 59 minutes with a start date of 01 February 2023.

Implementation plans and funding bids are now prepared and being enacted to achieve this. There are a wide range of actions underway to alleviate pressures on handovers and flow across the system including:

- Review of discharge profiles and actions with daily calls with Place and Local Authorities.
- Schemes submitted for the £500m discharge monies and close working with Local Authority colleagues to progress discharges and a further £200m to come.
- Acute Respiratory Infection Hub business case submissions supporting alternative pathway to ED for respiratory conditions easing demand and capacity upon ED.
- Urgent Treatment Centres (UTC) support offer to extend operational hours of the UTCs
- Same Day Emergency Care review to allow direct access to the Units.
- Work in progress on discharge and repatriation standard operating procedures working with the Provider Collaborative.
- Exploration of temporary structures to create estate and space for treatment.

The mitigating actions are being progressed through the Urgent Emergency Care Network Strategic Board's delivery plan working closely with the Local A&E Delivery Boards and provider collaborative.

Urgent and emergency care performance continues to be pressurised with adult general and acute bed occupancy rates stand at 94.46% (against a target of 87.75%) while patients not meeting the criteria to reside was 9.19% at 01 January 2023.

From a handover delay perspective the average hours per day lost to handovers was 190 minutes at 01 January 2023 and the category 2 average response time was at 51 mins 43 seconds against a target of 18 minutes.

The mean 999 call answering time stands at 12.8 seconds which is a huge improvement and the lowest on record for months. The percentage of 111 calls abandoned was 22.91% against a target of 3%.

3.2 Emergency Preparedness, Resilience and Response

As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS-funded services must show they can effectively respond to major, critical and business continuity incidents while maintaining services to patients.

A detailed paper is appended for assurance.

The ICB has completed the annual assurance process over recent months which included:

- Undertaking a review of all key areas to inform the completion of the self-assessment against the 2022 updated core standards. The ICB has declared an overall assurance rating of partially compliant for the organisation to NSH England with several key areas for development. These key areas and subsequent actions have been included in the ICB EPRR action plan and will be addressed and enacted.
- Undertaking a review of all provider self- assessment submissions prior to submission to NHSE. This has enabled a system plan to be developed in order to ensure the ICS is able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care.

As part of this process, the ICB worked with all Local Health Resilience and Local Resilience Forum partners to promote integrated ways of working and the sharing of learning and good practice.

The areas of forward planning include development of a place-based health and care system EPRR assurance process to ensure the minimum requirements for NHS funded services (including primary care) are met and to ensure a resilient and functioning system is in place and can respond to any critical/major incidents effectively. 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.

3.3 The Hewitt Review

The Rt Hon Patricia Hewitt has been asked by the Chancellor of the Exchequer and the Secretary of State for Health and Social Care to lead an independent review into how the oversight and governance of Integrated Care Systems can best enable them to success. Appended is a letter received on the 18 January 2023 regarding the review and detailing the workstreams and draft principles. As Co-Chair of the digital and data workstream I am contributing to the review and the ICB submitted evidence in the national call for evidence to inform the review. It is hoped the review will provide the opportunity to influence the development of Integrated Care Systems.

3.4 Primary Care POD Delegation

ICBs have delegated responsibility for commissioning general medical services from NHS England and these were transferred from CCGs to the ICB in July 2022. NHS England now plan to transfer responsibility of the commissioning of the other three primary care services, Pharmacy, Optometry and Dentistry (POD) to ICBs with effect from April 2023. Secondary care dental commissioning and clinical waste is also planned to transfer at that point.

Due diligence needs to be completed to fully assess the risks and mitigate these. Whilst there are risks there are also significant opportunities. However, it is crucial for the ICB to be enabled through national and local frameworks to be above to seize the opportunities.

There is a POD Delegation task and finish group in place with input from relevant ICB and NHSE colleagues chaired by the Executive Area Director (Tees Valley and Central).

The group meets fortnightly and is working through a safe delegation checklist to undertake the necessary due diligence for the delegation of responsibilities, including the compilation of any risks and the necessary mitigating actions. The safe delegation checklist needs to be signed off by ICBs by March 2023.

In addition to transferring the functions, NHS England is looking to transfer their staff that fulfil those functions to ICBs by July 2023. The difference in transfer dates is partly due to the need to formally consult with staff who would transfer.

ICB colleagues are members of North East and Yorkshire wide groups looking at the delegation of functions and transfer of staff, where issues, learning and good practice is shared across the ICBs.

There is an NHS England team in North East and Yorkshire dedicated to GP and POD commissioning functions for the NENC, who will transfer to the ICB.

The ICB's director of primary care transformation is working with NHS England's local head of primary care and human resource colleagues form both organisations to deliver a workshop with the team who will transfer in Durham 23 January 2023. At this session, which is not part of the NHS England formal consultation process with staff who are subject to the transfer, there will be an opportunity to share the aims, objectives and ways of working in the ICB, raise any issues or concerns and help formulate the way of working for primary care commissioning from 2023/4 onwards. Outputs form the meeting will help inform the ICB's developing approach to commissioning primary care.

3.5 Priority Services Campaign

The ICB has joined forces across health and care organisations in the North East and North Cumbria to raise further awareness of the priority services register. A free support service provided by energy suppliers.

A service we know will be vital to thousands of people in our region who may need extra support from their energy supplier not just this winter but all year round.

All energy suppliers have a priority services register. By signing it up it allows an energy supplier to identify people who may need extra support such as those with health conditions, those who need a power supply for medical equipment as well as other groups such as pensioners, pregnant women and many more. The full criteria can be found on the Ofgem website[2].

With winter upon us and the current cost of living crisis this has never been more important. Many colleagues in local authorities, the NHS and the voluntary sector are doing great things to support households through this difficult period, and we hope that by working together we can build on this with this new campaign.

[2] Get help from your supplier - Priority Services Register | Ofgem

Our concerns have already been expressed in the open publication of two letters issued to Ofgem[3] by the ICB - these have warned of the grave issues linked to any disruption of energy supply and the impact this will have on the health of our most vulnerable communities. Information about the campaign can be found on our website.

[3] Health chief welcomes Ofgem report but concerns remain for the most vulnerable | North East and North Cumbria NHS (northeastnorthcumbria.nhs.uk)

3.6 Learning and Improvement Community

The North East and North Cumbria Learning and Improvement community has doubled in size to now include 487 members. This growing network of people, from all parts of the region, is united in its desire to be *'the best at getting better'* - utilising an improvement mindset and methods to tackle some of our biggest challenges facing our communities.

The team held a Christmas and Improvement themed engagement event on the 14 December. This webinar brought together a wide range of participants, including NHS and local authority staff, representatives from the voluntary and community sector and members of the public. The participation of service advocates and people with learning difficulties, a reminder of the importance of inclusion and the challenges of how best to authentically respond in 2023 to the diverse needs within our learning system.

Following a successful bid, the ICB has received an award of £250,000 from the Health Foundation to continue the development and evaluation of our Learning & Improvement system. Over the next 18 months, the team have planned a programme of activities aligned with the original system priorities identified at the launch event in September. Immediate deliverables over the next few months include a 'Discharge Breakthrough' event in February and a virtual learning and improvement summit on Mental Health.

Aligned with the children and young person's mental health priority, the ICB also successfully bid for a Research England grant of almost £100k to help fund the development of new models of public engagement to improve diversity in research participation in this area. Work on this has now begun in collaboration with the NENC VCSE partnership.

From a learning and improvement perspective, we submitted evidence, on behalf of the ICB, to the Hewitt review - citing the North East and North Cumbria improvement and learning system as an example of an ICS aiming to create a future where every partner organisation is focused on common purpose and joint determination to drive improvements in health, wealth, and wellbeing.

3.7 Care Leaver Covenant

The Care Leaver Covenant is a national inclusion programme that supports care leavers aged 16-25 to live independently. NHS Chief Executive Amanda Pritchard has signed the Care Leaver Covenant on behalf of all NHS organisations which introduces the concept of society becoming a 'universal family' with roles for public, private and voluntary organisations supporting young people with care experience.

Item: 7.1
Enclosure:

NHS England invited all ICBs to express an interest in becoming one of ten national pathfinders to design and deliver new opportunities to enable young people leaving care to access career opportunities across the system and harness the talent and potential that lies within this community. Given the North East region continues to see the highest levels of demand of any region across children's social care and, in every year since 2016 has had the highest rates of children looked after (CLA), child protection and children in need it was clear we had both a responsibility and willingness as an ICB to grasp this opportunity.

Following a robust application process, we are delighted that North East and North Cumbria ICB has been selected as one of the ten national pathfinders to move at pace with this work and share learning nationally with peers and across our system. Given the size of our geography, the pilot will focus on Newcastle, North Tyneside and Northumberland building on a strong foundation of partnership working to support those with care experience.

Enshrined within our values is a focus on reducing health inequity dealing with the root causes of inequality and tackling social injustice. We know that those with experience of care often have worse health and socio-economic outcomes than peers and this initiative provides us with an opportunity to live these values playing our part in the universal family while also growing our workforce. Nationally the project will result in 250 care leavers accessing employment, education and training opportunities in service by 2024. Support will be provided by Spectra, an organisation with experience of working with young people leaving care, who has partnered with NHS England to deliver the programme.

Thanks to the Workforce Programme Team sitting within the People Directorate, to responding to the request in a very short timeframe, working with colleagues both within and outside of the ICB.

3.8 <u>ICP Update</u>

In the North East and North Cumbria we have 33 Members of Parliament. Since the ICB was established on 01 July 2022 we have received over 200 enquiries. Topics varied widely however a common theme has been the availability of covid vaccination appointments and how patients can access non-standard vaccine types. This is particularly prevalent in the more remote areas of the North East and North Cumbria, where the rurality can have a significant impact on service accessibility, and the availability of covid vaccination clinics. We have also seen a range of enquiries on the waiting times for certain services, including childhood autism and ADHD assessments. Through our regular analysis of MP correspondence, we are now able to identify trend that we need to address as a system, triangulating this with other feedback including freedom of information requests, complaints and compliments.

MPs receive a fortnightly bulletin on key ICB priorities and initiatives, as well as wider NHS issues affecting the region. In addition, Sir Liam and I lead bi-monthly meetings with MPs and these are a great opportunity to engage with MPs on topics and update on ongoing issues across the region. The next update sessions will be held on Monday 20 February.

Item: 7.1
Enclosure:

The Strategic ICP met for the second time on 15 December. At the meeting we were able to consider the wide range of feedback we received on our draft Integrated Care Strategy which was developed by a multi-sectoral steering group comprising NHS and local authority colleagues from across our system was approved.

At the Strategic ICP meeting we also considered and agreed a Terms of Reference for our Strategic ICP and four Area ICPs, with a recommendation to commence a new cycle of six-monthly Strategic ICP meetings alongside quarterly Area ICP meetings.

These Area ICPs are based on geographical groupings that created valuable forums to think through how we better coordinate care and create new opportunities for wider access to services. NHS chairs and local authority leaders, as well as their chief executives and senior officers, have already been meeting together informally in this way for several years, building the relationships and trust that are helping to deliver increasing levels of integration and joint planning. Our Area ICPs are based on these existing geographies within our ICS:

- **North**: Gateshead, Newcastle upon Tyne, North Tyneside, and Northumberland.
- **Central**: County Durham, South Tyneside, and Sunderland.
- **Tees Valley**: Darlington, Hartlepool, Middlesbrough, Redcar & Cleveland, and Stockton-on-Tees.
- **North Cumbria**: Cumberland, and Westmorland & Furness (given part of the latter authority is within the North East and North Cumbria ICS area).

With the recent devolution arrangement announced for seven of the local authorities in the North East we may want to consider the arrangements for the North and Central Areas.

The Strategic ICP will facilitate joint action to improve health and care outcomes and work together to influence the wider determinants of health as well as the broader social and economic development of the North East and North Cumbria. Whilst there is a legislative basis for Integrated Care Partnerships, and extensive national guidance on the formation of Integrated Care Systems, there is, in addition, considerable flexibility for the Integrated Care Partnership's members to determine its operating model. Therefore, the statutory members of the ICP have agreed a "one plus four" model, with one Strategic ICP (with a core membership of the ICB and all the local authorities in the ICS) which will be built up from the four existing and well-established partnership forums within North East and North Cumbria.

The Strategic ICP will:

- Oversee and approve the ICS-wide Integrated Care Strategy, built up from an analysis of need from the four Area ICPs led by the Joint Strategy Development Group.
- Promote a multi-agency approach to improving population health and wellbeing and tackling the wider social and economic determinants of health for our population of over 3 million people.
- Consider and suggest ways forward to tackle health inequalities, and improve experiences and access to health services at this same population level.
- Champion initiatives involving the contribution of the NHS and wider health and care organisations to large scale social and economic development.

The Area ICPs will:

- Develop and strengthen relationships between professional, clinical, political and community leaders.
- Analyse needs from each of the constituent places within that Area (based on the HWBB-led Joint Strategic Needs Assessment process) to feed into the Integrated Care Strategy setting process.
- Agree how to deliver the priorities set out in the Integrated Care Strategy within their Area.
- Provide a regular forum for system partners to share intelligence, identify common challenges, agree joint objectives and share learning.
- Ensure the evolving needs of their local population are well understood.

Agreeing our ICP arrangements and approving our Integrated Care Strategy is a key milestone for us in the North East and North Cumbria and I commend the staff and partners who have worked so hard to get us to this point in our journey as a system.

4. Recommendations

The Board is asked to:

- Review and note the North East and North Cumbria Integrated Care Board assurance process and ICB compliance rating as well as the provider organisations compliance ratings with regard to EPRR.
- Endorse the submission to NHS England as part of the NHSE EPRR annual assurance process for 2022-23.
- Receive the ICB CEO report for assurance.

Name of Author: Samantha Allen

Name of Sponsoring Director: Sir Liam Donaldson

Date: 18 January 2023

Item: 7.1

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

NORTH EAST & NORTH CUMBRIA ICB BOARD MEETING

31 January 2023

Report Title:	**Emergency Preparedness, Resilience and Response (EPRR) Core Standards Annual Assurance Process**

Purpose of report

The purpose of this paper is to provide the ICB Board with an update with regards to the outcome of the annual NHS England EPRR Core Standards Annual Self-Assessment for 2022-23 for the NENC ICB and process undertaken with provider organisations.

Key points

- All NHS organisations are required to undertake a self-assessment against the 2022 updated core standards relevant to their organisation which should then be taken to a public board or, for organisations that do not hold public boards, be published in their annual report.
- The ICB has worked with organisations and LHRP partners to agree a process to gain confidence with organisational ratings and provide an environment that promotes the sharing of learning and good practice. This process has been agreed with the NHS England Regional Head of EPRR.
- The areas which are currently assessed as partially compliant will be monitored and maintained as part of an action plan and continuously assessed by the Local Health Resilience Partnership (LHRP) as well as during the monthly meetings with EPRR Leads chaired by the ICB. An action plan will be developed by the ICB to oversee progress which will be shared and discussed by the LHRP to ensure system oversight
- The NENC ICB has undertaken a self-assessment against the 2022 updated core standards as per the NHS England EPRR Core Standards guidance. An overall assurance rating has been assigned based on the percentage of NHS Core Standards for EPRR which the organisation has assessed itself as being partially compliant

Risks and issues

- Evacuation and Shelter – A system wide evacuation process is required. All Trusts have plans in place to evacuate wards however there are no plans in place for a full evacuation which will include system partners such as social care.
- A full review of business continuity management arrangements within NE&NC ICB is to take place and the risks that fall out of that as an organisation. The ICB needs to determine what the ICB approach will be and undertake Business Impact Analysis of all services and teams.

Assurances

- For the forthcoming year, the ICB will ensure that there is a regional approach to develop a policy in relation to evacuation and shelter with local standard operating procedures as well as considering patient triage systems and patient tracking systems.
- The areas which are currently assessed as partially compliant for provider organisations will be monitored and maintained as part of an action plan and continuously assessed by the Local Health Resilience Partnership (LHRP) as well as during the monthly meetings with EPRR Leads chaired by the ICB. An action plan will be developed by each Trust and the ICB to oversee progress which will be shared and discussed by the LHRP to ensure system oversight.
- The areas which are currently assessed as partially compliant (as well as those fully compliant) for the NENC ICB will be monitored regularly and enhanced and improved as part of an action plan and continuously overseen within the NENC ICB Emergency Preparedness, Resilience and Response Steering Group
- Whilst the NENC ICB have an incident response plan, governance and support in place, business continuity management and risks identified as a commissioner of healthcare services needs to be reviewed and considered

Recommendation/action required

- Members of the ICB Board are asked to review and note the North East and North Cumbria Integrated Care Board assurance process and ICB compliance rating as well as the provider organisations compliance ratings.
- ICB Board are asked to endorse the submission to NHS England as part of the NHSE EPRR annual assurance process for 2022-23.

Acronyms and abbreviations explained	
EPRR – Emergency Preparedness, Resilience and Response LHRP - Local Health Resilience Partnership	
Sponsor/approving director	Jacqueline Myers, Executive Chief of Strategy and Operations
Report author	Pippa Morley, ICS EPRR Operational Delivery Manager & Marc Hopkinson, Associate Director of Transformation, System Resilience and EPRR

Link to ICB corporate aims (please tick all that apply)	
CA1: Improve outcomes in population health and healthcare	✓
CA2: tackle inequalities in outcomes, experience and access	
CA3: Enhance productivity and value for money	✓
CA4: Help the NHS support broader social and economic development	✓

Relevant legal/statutory issues

Health Care Act 2022
NHS England EPRR Framework
Civil Contingencies Act 2004
NHS England EPRR Core Standards 2022-23

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

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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**	✓

Key implications	
Are additional resources required?	N/A
Has there been/does there need to be appropriate clinical involvement?	N/A
Has there been/does there need to be any patient and public involvement?	N/A
Has there been/does there need to be partner and/or other stakeholder engagement?	Engagement has taken place throughout the assurance process with NHS England and provider organisations.

Item: 7.1

ICB Board

Title	**Emergency Preparedness, Resilience and Response (EPRR) Core Standards Self-Assessment for NENC ICB**		
Author of the Report	ICS EPRR Operational Delivery Manager/Associate Director of Transformation, System Resilience and EPRR		
Name of the person presenting at the meeting	TBC		
Date of the report	November 2022		
Purpose of Paper	The purpose of this paper is to provide the ICB Board with an update with regards to the North East and North Cumbria Integrated Care Board's self-assessment against the NHS England EPRR core standards for 2022-23.		
Is this report confidential?	No		
Summary	• The NENC ICB has undertaken a self-assessment against the 2022 updated core standards as per the NHS England EPRR Core Standards guidance. An overall assurance rating has been assigned based on the percentage of NHS Core Standards for EPRR which the organisation has assessed itself as being partially compliant. • The areas which are currently assessed as partially compliant will be monitored and maintained as part of an action plan and continuously assessed within the Emergency Preparedness, Resilience and Response Steering Group.		
Recommendation(s)	The ICB Board are asked to approve the NENC ICB EPRR core standards self-assessment declaration prior to submission to NHS England Regional team		
Consultation / Discussion Route *Please detail any consultation and other approval routes*	**Meeting**	**Date**	**Outcome**
Risks			

Item: 7.1

North East and North Cumbria Integrated Care Board
ICB Board

NENC ICB Emergency Preparedness, Resilience and Response Annual Assurance 2022-23

1. Introduction

1.1. The purpose of this report is to provide the NENC ICB Board with the submission from NENC ICB against the NHS England EPRR core standards annual self-assessment for 2022-23.

2. Executive Summary

2.1. The NENC ICB undertook a self-assessment process against the NHS England EPRR core standards for 2022-23. The EPRR Steering Group has overseen this assurance process.

2.2. Following completion of this process the ICB then participated in a peer review workshop with other ICB's within North East & Yorkshire. The North East and Yorkshire ICBs met to review their self-assessment against the core standards. All ICBs had identified similar areas as being partially compliant against the standards, however the level of compliance will change as ICBs, including NENC ICB, continually review and develop internal systems, processes and plans.

2.3. As NENC ICB matures as an organisation, as well as the EPRR team, the EPRR core standards will form part of the core EPRR work plan to ensure that the organisation is monitoring and maintaining the standards to achieve a higher compliance next year with appropriate action plans and reports feeding into the EPRR steering group and Executive Committee.

2.4. It is important to note that whilst the ICB has declared itself as being partially compliant, the organisation has rigorous and robust plans in place to manage any incident in line with its category 1 responsibilities.

3. Areas for Development

3.1. Two key areas were identified as requiring further action to move the organisation to its desired position.

3.2. ***Business Continuity Management – Overall***

3.2.1. A full review of business continuity management arrangements within NE&NC ICB is to take place and the risks that fall out of that as an organisation. The ICB needs to determine what the ICB approach will be and undertake Business Impact Analysis of all services and teams.

3.2.2. Whilst the ICB have an incident response plan, governance and support in place, business continuity management and risks identified as a commissioner of healthcare services needs to be reviewed and considered.

3.3. ***The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.***

3.3.1. As with provider organisations, the ICB is currently enrolling individuals who participate in the on-call rota in the national programme for principles of health command training. The ICB is also awaiting the receipt of on-call commander portfolio's from NHS England to enable training needs analysis to take place in line with the newly published minimum occupational standards for commanders.

3.3.2. This will also include a programme to ensure the organisation has Loggists available and trained to support any incident.

4. Assurances

4.1. As per the NHS England EPRR Core Standards guidance, an overall assurance rating has been assigned based on the percentage of NHS Core Standards for EPRR which the organisation has assessed itself as being partially compliant.

4.2. The areas which are currently assessed as partially compliant (as well as those fully compliant) will be monitored regularly and enhanced and improved as part of an action plan and continuously overseen within the Emergency Preparedness, Resilience and Response Steering Group.

5. Risks

5.1. The following risks have been identified following this process:

- Business Continuity Management

6. Recommendations

6.1. Members of the ICB Board are asked to review and note the North East and North Cumbria Integrated Care Board assurance process and ICB compliance rating.

6.2. Members of the ICB Board are asked to endorse the submission to NHS England as part of the NHSE EPRR annual assurance process for 2022-23.

Appendix A – NENC ICB EPRR Core Standards Self-Assessment 2022-23

Please choose your organisation type: Integrated Care Board

Percentage Compliance	81%
Overall Assessment	Partially Compliant

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Not Compliant	Not Applicable
Governance	6	5	1	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	8	8	0	0	3
Command and control	2	2	0	0	0
Training and exercising	4	2	2	0	0
Response	5	5	0	0	2
Warning and informing	4	4	0	0	0
Cooperation	6	6	0	0	1
Business continuity	10	4	6	0	1
CBRN	0	0	0	0	14
Total	47	38	9	0	21

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Evacuation and Shelter	8	8	0	0	0
Total	8	8	0	0	0

Assurance Rating Thresholds
- Fully Compliant = 100%
- Substantially Compliant =99-89%
- Partially Compliant = 88-77%
- Non-Compliant = 76%or less

Calculated using the number of FULLY compliant standards

Notes
Please do not delete rows or columns from any sheet as this will stop the calculations
Please ensure you have the correct Organisation Type selected
The Overall Assessment excludes the Deep Dive questions
Please do not copy and paste into the Self Assessment Column (*Column T*)

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Standard Detail	Integrated Care Board	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead
The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	The Accountable Emergency Officer is the Executive Director of Strategy and System Oversight. Evidence: AEO Job Description	Fully Compliant		

The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	The ICB EPRR Policy sets out the organisations response and roles of individual staff to increase the resilience of the ICBs response to a business continuity, critical or major incident. The document is available via the Surge/Incident Management website which is accessible to all on-call health commanders and key individuals. The ICB dedicates a section of its annual report to EPRR in which a statement of commitment and summary of previous years activity is provided. The document is refreshed an on annual basis or after any business continuity, critical or major incident to reflect any learning and outcomes with key policies and procedures adapted to ensure resilient response. Evidence: NENC ICB EPRR Policy	Fully Compliant

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The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activitites.	The ICB Emergency Preparedness Resilience & Response (EPRR) Steering Group oversees the implementation of EPRR with reports for key areas taken to the Executive Committee when appropriate. The Accountable Emergency Officer is a standing member of the EPRRSG which takes place on a monthly basis. The Executive Committee is regularly updated about EPRR, surge management and risks either real or potential to the organisation. The annual EPRR core standards self-assessment submission is presented to EPRRSG and Executive Committee for approval. The EPRR Core standards will be published via the ICB Public Board in 2022. Reports on business continuity, critical and major incidents and poor performance/patient outcomes caused by surges and sustained levels of demand are also regularly discussed with appropriate mitigation discussed and put in place. Evidence: Minutes of EPRRSG	Fully Compliant		
The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	Further work is required to develop a work plan which will include regular testing and exercising of plans and individuals. There is a well established process for reviewing the management and outcomes of any incident. A debrief and report will be produced after each incident - a 'Hot' debrief 24 hours after the event and a 'Cold' debrief 7 days after the event. A report will also be produced and shared with all key staff members following participation in any exercise or scenario testing.	Partially Compliant	EPRR work programme to be established and embedded into the organisation	Strategic Head of EPRR

The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	An EPRR team structure has been developed and is currently being established from current ICB staff. New roles will also be recruited to including an EPRR lead. This team will be in place to provide strategic direction, oversight, coordination and subject matter expertise to support local systems (Area/Place) in order to ensure whole system integration, collaborative working, operational delivery and resilience. This team is/will be made up of skilled and experienced staff with specific experience in EPRR. The team will not only provide strategic direction and develop the workplan it will also develop ICB policies and plans in line with the CCA, 2004 which would be difficult for single 'Place/Area based' systems to address in isolation. e.g. Mass Casualty Plan Executive Directors have undergone legal training during May 2022 in relation to health strategic command as per the CCA 2004. Directors are booked to complete the Principles of Health Command course throughout 2022. As of 1st July 2022, the ICB has a 1st on call (Tactical) and a 2nd on call (Strategic) rota which is able to receive notifications and effectively respond to surge/escalation and/or critical/major incidents.	Fully Compliant

The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	There is a well established process for reviewing the management and outcomes of any incident. A debrief and report will be produced after each incident - a 'Hot' debrief 24 hours after the event and a 'Cold' debrief 7 days after the event. A report will also be produced and shared with all key staff members following participation in any exercise or scenario testing. The ICB EPRR policy is refreshed an on annual basis or after any business continuity, critical or major incident and/or training/exercising to reflect any learning and outcomes with key policies and procedures adapted to ensure resilient response. The NENC ICB participates in region wide exercises in collaboaration with LRF partners and share learning to be embedded into processes Evidence: NENC ICB EPRR Policy	Fully Compliant
The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	The ICB will be represented at LRF Risk Groups to review and consider community risk registers and identify either real or potential risks against the organisation. The ICB also attends other regional groups such as the LHRP whereby regional and national risk registers are considered and mitigating actions identified.	Fully Compliant

The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	The ICB have a EPRR register in place which is monitored as part of the EPRR Steering Group to ensure appropriate mitigation is implemented for each risk identified. The ICB will work together with Local Resilience Forums and their associated community risk registers to ensure any concerns highlighted are reported via the internal risk process and managed accordingly.	Fully Compliant
Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	The ICB Corporate EPRR Team will provide strategic direction, oversight, coordination and subject matter expertise to support local systems (Place/Area) in order to ensure whole system integration and collaborative working. This team will also develop regional policies and plans in line with the CCA, 2004 which would be difficult for single 'Place/Area based' systems to address in isolation. e.g. Mass Casualty Plan. A key function of the EPRR Team is that it works closely across the evolving EPRR landscape to: - ensure the delivery of effective EPRR is maintained; - develop, manage and maintain key relationships with stakeholders; - ensure that the ICB EPRR strategy is understood by all stakeholders and is efficiently and effectively delivered ; and - proactively identify and manage key emerging or increasing risks. Workshops have taking place with stakeholders to ensure partners fully understand the roles and responsibilities of the NENCICB. The LHRP is the forum in which partner organisations work and collaborate with the ICB to ensure appropriate plans are in place for any incident/eventuality. These plans will	Fully Compliant

continue to be reviewed annually as well as post any incident following a rigorous debrief.

In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	An incident response plan for the NENC ICB has been produced and details the key principles of responding to an incident or emergency. The IRP includes action cards detailing the processes to follow for specific incident i.e. outbreaks, adverse weather etc. It also clearly identify the arrangements, mitigating actions and response that will be implemented should the BCP ever be invoked or implemented by the ICB. This includes the governance structure which details who and how they will integrate into any resilience arrangements including across multiple LRF footprints. Evidence: NENC ICB Incident Response Plan, EPRRSG Papers	Fully Compliant
In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	An incident response plan for the NENC ICB has been produced and details the key principles of responding to an incident or emergency. The IRP includes action cards detailing the processes to follow for specific incident i.e. outbreaks, adverse weather etc. It also clearly identify the arrangements, mitigating actions and response that will be implemented should the BCP ever be invoked or implemented by the ICB. Evidence: NENC ICB Incident Response Plan	Fully Compliant

In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles.	Anti-viral and outbreak management pathways are in place and have been reviewed across the North East and North Cumbria to ensure that there is a streamlined process in place in collaboration with UKSHA. UKSHA is a member of the LHRP, whilst ICB staff are a core part of UKSHA incident planning and response arrangements. Evidence: Anti-viral pathways via Surge/Incident Management Website	Fully Compliant
In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	An incident response plan for the NENC ICB has been produced and details the key principles of responding to an incident or emergency. The IRP includes action cards detailing the processes to follow for specific incident i.e. outbreaks, adverse weather etc. It also clearly identify the arrangements, mitigating actions and response that will be implemented should the BCP ever be invoked or implemented by the ICB Evidence: NENC ICB Incident Response Plan & Action Cards	Fully Compliant

In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	The ICB has staff members who are represented on regional steering and planning groups. The ICB has plans in place to be able to respond to any incident, be part of any incident management team and provide support, resource and staff (where required) to support the roll out of any countermeasures. Pathways have been agreed for seasonal influenza and avian influenza outbreaks whilst arrangements are in place with local health care providers to provide health care support as and when necessary.	Fully Compliant

In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	The NENC ICB will work in line with the Mass Casualty Framework for Cumbria and the North East of England which brings together the work undertaken by both Local Health Resilience Partnerships across Cumbria and the North East and key individuals who have led this imperative work stream. The Mass Casualty Framework will act as an overarching document for health and local authority social care in Cumbria and the North East of England and will support all mass casualty plans across the various health economies. All local stakeholders have plans in place to support any mass casualty incidents (health and care). These plans will be regularly reviewed to ensure suitability/appropriateness.	Fully Compliant
In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The ICB as part of its incident response plan will provide coordination and support should it be necessary to evacuate patients and visitors from any local health care facilities and/or local buildings (i.e. high rise).	Fully Compliant
In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.		Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required		

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In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.		Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	
The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.		Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	

The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	NENC ICB is responsible for leading the mobilisation of the NHS in the event of an incident or emergency in the North East and North Cumbria. In addition, the ICB is responsible for ensuring that it has the capability for NHS command, control, communication and co-ordination of commissioners and providers of NHS funded care, during incidents, emergencies, or periods of significant operational challenge. This is achieved via a two-tier on-call system, consisting of a first and second on-call. NENC ICB works in partnership with other agencies within North East and North Cumbria Health and Care Partnership and North East Local Resilience Forums: Northumbria, Cleveland, and County Durham and Darlington and the on-call system provides a single point of access for these partners The NENC ICB has established a 24/7 on-call rota which is able to receive notifications and effectively respond to surge/escalation and/or critical/major incidents. This rota is made up of staff who are experienced and competent and who are able to undertake Strategic and Tactical roles. - Rota Frequency: 24/7, 1 week, Tuesday 08:00hrs to Tuesday 08:00hrs. - Incident Mailbox: ngccg.NENCICBincident@nhs.net - Contact no: 0191 2697733 The NENC ICB on-call policy sets out the arrangements for individuals on-call for NENC ICB. It confirms the competencies and minimum standards expected of NENC ICB on-call staff, in line with the requirements of the following legislation and statutory duties	Fully Compliant

Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	Executive Directors have undergone legal training during May 2022 in relation to health strategic command as per the CCA 2004. Directors are booked to complete the Principles of Health Command course throughout 2022. As of 1st July 2022, the ICB has a 1st on call (Tactical) and a 2nd on call (Strategic) rota which is able to receive notifications and effectively respond to surge/escalation and/or critical/major incidents. All staff who support this rota are trained and will be able to effectively ensure that the ICBs category 1 requirements are fulfilled. A structured workplan to monitor and maintain on-call commander competencies is to be established and training needs analysis undertaken as necessary.	Fully Compliant	All remaining Strategic and Tactical Commanders will complete the required mandatory training by the end of 2022 and commanders portfolios produced to monitor and maintain competence	Head of EPRR

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The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	The ICB will detail all training available internally, externally and via multi-agency partners as well as exercises scheduled for the year in the annual EPRR training and exercise calendar. This calendar will contain a mixture of formal and informal training session to ensure it remains flexible and able to adapt to the changing risks, priorities and needs of the organisation. Competent individuals will carry out all EPRR training. The ICB will also provide bespoke training and exercises upon request and advertise all relevant training available to appropriate teams and individuals. The ICB EPRR team will retain records of training and delegates and will ensure that they attend meetings or individual briefings to explain the ICB's EPRR arrangements (compulsory for all new members to the on-call rota	Partially Compliant	Training and Exercise calendar established for the next financial year	EPRR Team

In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	Staff who fulfil the on-call rota and/or strategic/tactical commander roles are fully experienced, capable and knowledgable in the field of EPRR. They have significant experience of managing incidents (major/critical/serious operational difficulties), however as a result of a recent reorganisation and significant sustained operational pressures, participation in training and exercising has been severely limited. This has also been recognised by other agencies/stakeholders within the field of EPRR. The ICB will develop a plan and detail all training available internally, externally and via multi-agency partners as well as exercises scheduled in the annual EPRR training and exercise calendar which will be developed during the remainder of 2022/23. This calendar will contain a mixture of formal and informal training session to ensure it remains flexible and able to adapt to the changing risks, priorities and needs of the organisation. Competent individuals will carry out all EPRR training. The ICB will also provide bespoke training and exercises upon request and advertise all relevant training available to appropriate teams and individuals. The ICB EPRR team will retain records of training and delegates and will ensure that they attend meetings or individual briefings to explain the ICB's EPRR arrangements (compulsory for all new members to the on-call rota	Partially Compliant	Training and Exercise calendar established for the next financial year	EPRR Team

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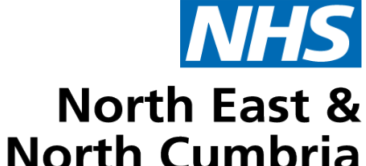
The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	The NENC ICB hold records for on-call commanders training and exercising attendance, we are awaiting guidance with regards to the development of CPD portfolios in line with national expectations. The on-call policy does however set out the competencies and minimum standards expected of NENC ICB on-call staff,	Fully Compliant	Commander CPD Portfolios to be produced to ensure commander competency can be monitored and maintained throughout the ICB	Strategic Head of EPRR
There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	As part of mandatory training Exercise and Training attendance records reported to Board	Within the Surge/Incident Management website hosted by NECSU there is a EPRR/Incident Managemenet section which holds information to support commanders in their response to a major incident and provides background information on the civil protection duties for a Category 1 responder and acts as a repository for key information. Workshops have taken place with on-call commanders to provide them with an overview of the website and where documentation can be accessed for their role and responsibilities. The EPRR steering group has been established by the ICB executive team and is the organisations formal group which oversees EPRR. This board provides regular updates to the ICB executive team.	Fully Compliant		

The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	The NENC ICB Incident Coordination Centre (ICC) is to provide a place where the ICB can implement and co-ordinate the organisation-wide initial response and recovery operations; to provide a single point of contact for requests for assistance allowing the Incident Management Team an immediate overview of the organisation-wide response and to provide an area for information collation and preparation of any briefings. Depending on the nature of the incident the ICC might be a physical location or virtual. All ICC arrangements and locations are detailed within the Incident Response Plan.	Fully Compliant	Regular reviews of ICC's to take place to ensure fit for purpose.	Head of EPRR
Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and local copies	Within the Surge/Incident Management website hosted by NECSU there is a EPRR/Incident Managemenet section which holds information to support commanders in their response to a major incident and provides background information on the civil protection duties for a Category 1 responder and acts as a repository for key information. Workshops have taken place with on-call commanders to provide them with an overview of the website and where documentation can be accessed for their role and responsibilities. Physical on-call grab bags have also been produced for on-call commanders with clear guidance provided to commanders that the inforamtion held on the website is the current response and they are	Fully Compliant		



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			responsible for ensuring local copies made are kept up to date.			
In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	Business Continuity Plans (BCP) describes how North East and North Cumbria Integrated Care Board (NENC ICB) will discharge its functions in the event of any incident that might disrupt its normal business or business operations. The plan details the prioritisation of recovery of critical activities together with the resources and technical requirements needed to support recovery. It has been developed to retain the flexibility required by a large multi-faceted organisation whilst also being tailored to meet the specific needs of the NENC ICB area	Fully Compliant	Business impact assessments to be undertaken by all teams and services.	Head of EPRR

To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	• Documented processes for accessing and utilising loggists • Training records	The NENC ICB incident response plan clearly explains the requirements for recording decisions. Those on-call must keep a log of each time they are contacted or make contact in relation to their on-call activities. A new log must be started for each staff member on-call so that it is clear who is writing the log and what on-call position they hold. In addition to the incident response plan are action cards for the incident managemen team which include actions for commanders to maintain a log. Whilst there is access to trained loggists who will be able to provide support during any incident, there is work is required to increase the number of trained loggists as well as provide refresher training.	Fully Compliant	Increase number of loggists available and identify availability to ensure there is 24/7 cover	Head of EPRR
The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	As part of the incident response plan action cards there is a process in place for commanders to complete situation reports as and when required utilising a standard sitrep template.	Fully Compliant		
Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.		Guidance is available to appropriate staff either electronically or hard copies				
Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)		Guidance is available to appropriate staff either electronically or hard copies				

The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	An incident response plan for the NENC ICB has been produced and details the key principles of responding to an incident or emergency. The IRP includes action cards detailing the processes to follow for specific incident i.e. outbreaks, adverse weather etc. It also clearly identify the arrangements, mitigating actions and response that will be implemented should the BCP ever be invoked or implemented by the ICB. This includes the governance structure which details who and how they will integrate into any resilience arrangements including across multiple LRF footprints. There is a out of hours comms rota in place as well as incident declaration process in place to notify the ICB of an incident.	Fully Compliant
The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	The Incident Coordination Centre Coordinator will liaise with the communications lead as needed to ensure effective, on-going communications. Clear and consistent communication is an essential part of incident response. This involves internal ICB and health sector communication as well as with multi-agency partners and the public. The ICB communications team will be involved in Incident response from the outset. They will work with the Strategic and Tactical Commander(s) to agree communications internally and externally	Fully Compliant

The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	The ICB has a well established mechanism and systems in place to communicate effectively internally and externally. NECS provide this support and would liaise with NHSE depending upon the incident and type of response required.	Fully Compliant

The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	There is an on call agreement in place with NECS to support the ICB 24/7. Previous incidents and exercises - lessons learned - have influenced this strategy and approach. There are a number of staff who have undergone media training and therefore have the skills, capability and confidence to speak and deal with the media.	Fully Compliant
The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	A North East and North Cumbria LHRP has been established to oversee the health Emergency Preparedness, Resilience and Response (EPRR) arrangements across the North East and North Cumbria footprint which is traditional coterminous with an Integrated Care Board (ICB). The LHRP will form a strategic fora to bring together senior decision makers responsible for EPRR within each organisation in order to support the delivery of the NHS wide objectives for EPRR, undertake a planning and preparedness function albeit not the responsibility to respond to an emergency or incident and remain responsible and accountable for its effective response in line with its statutory duties and obligations. A terms of reference is in place with minutes of meetings held and cascaded to members	Fully Compliant
The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	The NENC ICB is currently formalising arrangements for attendance at each LRF however should there be a major incident the ICB is able to provide appropriate representation at any given time (as evidenced during operation london bridge). The NENC ICB is currently completing briefings for LRF members to enhance	Fully Compliant

			awareness and knowledge of the ICB arrangements as a category 1 responder	
The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	The NENC ICB has pre-agreed mutual aid between a number of local stakeholders, particularly for the use of buildings, should the ICB offices space become comprimised.	Fully Compliant
The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	Y	• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs • Where an organisation sits across boundaries the reporting route should be clearly identified and known to all	The ICB strategic and tactical structure x 4 will ensure that all LRF's can be supported during any incident as evidenced by operation london bridge.	Fully Compliant
Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.		• Detailed documentation on the process for managing the national health aspects of an emergency		

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The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.	Y	• LHRP terms of reference • Meeting minutes • Meeting agendas	A North East and North Cumbria LHRP has been established to oversee the health Emergency Preparedness, Resilience and Response (EPRR) arrangements across the North East and North Cumbria footprint which is traditional coterminous with an Integrated Care Board (ICB). The LHRP will form a strategic fora to bring together senior decision makers responsible for EPRR within each organisation in order to support the delivery of the NHS wide objectives for EPRR, undertake a planning and preparedness function albeit not the responsibility to respond to an emergency or incident and remain responsible and accountable for its effective response in line with its statutory duties and obligations. A terms of reference is in place with minutes of meetings held and cascaded to members	Fully Compliant		
The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	The organisation has agreed protocols for sharing information. ResilienceDirect is the platform which will be used by ICB members during any incident as well as the ICB incident coordination centre email. As this is NHS mail, during any incident patient identifiable information may be shared (subject to relevant guidance consideration).	Fully Compliant		
The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a	The ICB has a business continuity policy in place. Work will be undertaken with each Director and their teams to undertake business impact assessments in order that up to date plans are developed and in place to ensure that critical services can be maintained.	Fully Compliant	Business impact assessments to be undertaken and/or refreshed and business continuity plan reviewed.	Strategic Head of EPRR

		benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning			
The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	NENC ICB needs to be able to plan for and respond to, a wide range of incidents and emergencies that could affect health or patient care. This plan documents a coordinated and managed resumption of the ICB's business operations within acceptable recovery timeframes. The plan details the prioritisation of recovery of critical activities together with the resources and technical requirements needed to support recovery. It has been developed to retain the flexibility required by a large multi-faceted organisation whilst also being tailored to meet the specific needs of the NENC ICB area. This plan will be activated in response to an incident causing significant disruption to normal service delivery, particularly the delivery of key critical services/functions.	Partially Compliant	A full review of business continuity management arrangements within NENC ICB is to take place

The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	The ICB has a business continuity policy in place. Work will be undertaken with each Director and their teams to undertake business impact assessments in order that up to date plans are developed and in place to ensure that critical services can be maintained.	Partially Compliant	Business impact assessments to be undertaken and/or refreshed and business continuity plan reviewed.	Strategic Head of EPRR

The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	The ICB has a business continuity plan in place however this needs refreshing and reviewing.	Partially Compliant	BCP to be reviewed.	Strategic Head of EPRR
The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	As part of the support and training for key staff, a series of exercises are being planned to ensure that staff are able to participate and develop competencies whilst also to test the ICB's BCP. Learning from these exercises will inform and enhance/improve the BCP and action cards and roles. The ICB has already participated in several exercises which has informed incident response plan and business continuity plan.	Fully Compliant	a range of scenarios and exercises will be undertaken throughout 2022-23. This includes participation in LRF/LHRP organised events.	Strategic Head of EPRR

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Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	The DSP Toolkit is completed on an annual basis as part of ongoing assurance of information governace and data security requirements.	Fully Compliant		
The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• Business continuity policy • BCMS • performance reporting • Board papers	As part of the ICB's business continuity policy, business continuity plans are tested and exercised with corrective actions identified and monitored. Regular reports are provided to the EPRR committee and a 6 monthly report provided to the Board.	Partially Compliant		
The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	The audit of EPRR and BCP/incident response plans are a part of the annual audit cycle.	Partially Compliant	EPRR team will support completion of audit	Strategic Head of EPRR

There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	The BCP will be consistently reviewed and updated following declaration and management of incidents; the lessons learned and debrief/evaluation have subsequently inform practice and plans/responses.	Partially Compliant	The business continuity plan will be reviewed and revised following every business continuity test (including real time exercises or incidents). The lessons learned and debrief/evaluation will then inform future practice and plans/responses.	Strategic Head of EPRR
The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set	The NENC ICB's contracting process ensures that all suppliers have rigourous and robust processes and procedures in place to ensure the delivery of services. There has been recent examples where local suppliers have failed and have required mitigating plans to be repidly developed to ensure continuity of service provision.	Fully Compliant		

		intervals for critical and/or high value suppliers

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Standard	Deep Dive question	Further information	Integrated Care Boards	Organisational Evidence - Please provide details of arrangements in order to capture areas of good practice or further development. (Use comment column if required)	Self assessment RAG Red (not compliant) = Not evidenced in evacuation and shelter plans or EPRR arrangements. Amber (partially compliant) = Evidenced in evacuation and shelter plans or EPRR arrangements but requires further development or not tested/exercised. Green (fully compliant) = Evidenced in plans or EPRR arrangements and are tested/exercised as effective.
Up to date plans	The organisation has updated its evacuation and shelter arrangements since October 2021, to reflect the latest guidance.	https://www.england.nhs.uk/publication/shelter-and-evacuation-guidance-for-the-nhs-in-england/	Y	The NENC ICB Incident Response Plan clearly identifies the arrangements, mitigating actions and response that will be implemented should the plan ever be invoked or implemented. Each site used by the ICB has its own evacuation procedures and policies which are reviewed and tested regularly by the landlord. The ICB will liaise and/or provide coordination to system providers during any incident which requires evacuation. This includes local authorities e.g. high rise buildings, civic offices etc.	Fully Compliant

Activation	The organisation has defined evacuation activation arrangements, including the decision to evacuate and/or shelter by a nominated individual with the authority of the organisation’s chief executive officer.		Y	see above	Fully Compliant
Incremental planning	The organisation's evacuation and shelter plan clearly defines the incremental stages of an evacuation, including in situ sheltering, horizontal, vertical , full building, full site and off-site evacuation.		Y	see above	Fully Compliant
Evacuation patient triage	The organisation has a process in place to triage patients in the event of an incident requiring evacuation and/or shelter of patients.				
Patient movement	The organisation's arrangements, equipment and training includes the onsite movement of patients required to evacuate and/or shelter.				
Patient transportation	The organisation's arrangements, equipment and training includes offsite transportation of patients required to be transferred to another hospital or site.				
Patient dispersal and tracking	The organisation has an interoperable patient tracking process in place to safely account for all patients as part of patient dispersal arrangements.				
Patient receiving	The organisation has arrangements in place to safely receive patients and staff from the evacuation of another organisations inpatient facility. This could with little advanced notice.				

Community Evacuation	The organisation has effective arrangements in place to support partners in a community evacuation, where the population of a large area may need to be displaced.	Y	see above	Fully Compliant
Partnership working	The organisation's arrangements include effective plans to support partner organisations during incidents requiring their evacuation.	Y	see above	Fully Compliant
Communications- Warning and informing	The organisation's evacuation and shelter arrangements include resilient mechanisms to communicate with staff, patients, their families and the public, pre, peri and post evacuation.	Y	see above	Fully Compliant
Equality and Health Inequalities	The organisation has undertaken an Equality and Health Inequalities Impact Assessment of plans to identify the potential impact evacuation and shelter arrangements may have on protected characteristic groups and groups who face health inequalities.	Y	An EIA and HIA has been undertaken which has informed the ICB hybrid working policy which would ensure that all protected characteristic groups have been considered and are supported in order to effectively undertake their duties.	Fully Compliant
Exercising	The evacuation and shelter arrangements have been exercised in the last 3 year. Where this isn't the case this will be included as part of the organisations EPRR exercise programme for the coming year. Please specify.	Y	The landlord regularly undertakes tests of the evacuation and shelter arrangements for the ICB estates.	Fully Compliant

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ICB Board

Title	**Emergency Preparedness, Resilience and Response (EPRR) Core Standards Self-Assessment**		
Author of the Report	ICS EPRR Operational Delivery Manager/Associate Director of Transformation, System Resilience and EPRR		
Name of the person presenting at the meeting			
Date of the report	November 2022		
Purpose of Paper	The purpose of this paper is to provide the ICB Board with an update with regards to the outcome of the annual NHS England EPRR Core Standards Annual Self-Assessment for 2022-23 and process undertaken with provider organisations.		
Is this report confidential?	No		
Summary	• All NHS organisations are required to undertake a self-assessment against the 2022 updated core standards relevant to their organisation which should then be taken to a public board or, for organisations that do not hold public boards, be published in their annual report. • The ICB has worked with organisations and LHRP partners to agree a process to gain confidence with organisational ratings and provide an environment that promotes the sharing of learning and good practice. This process has been agreed with the NHS England Regional Head of EPRR. • The areas which are currently assessed as partially compliant will be monitored and maintained as part of an action plan and continuously assessed by the Local Health Resilience Partnership (LHRP) as well as during the monthly meetings with EPRR Leads chaired by the ICB. An action plan will be developed by the ICB to oversee progress which will be shared and discussed by the LHRP to ensure system oversight		
Recommendation(s)	ICB Board members are asked to note the outcome of the provider organisations annual NHS England EPRR core standards self-assessment for 2022-23.		
Consultation / Discussion Route *Please detail any consultation and other approval routes*	**Meeting**	**Date**	**Outcome**
Risks	Evacuation & Shelter. Focus will be placed upon this area of work for 2023-24.		

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North East and North Cumbria Integrated Care Board
ICB Board
Provider Organisations Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance 2022-23

1. Introduction

1.1. The purpose of this report is to provide the North East and North Cumbria Integrated Care Board with the outcome of the annual NHS England EPRR Core Standards Annual Self-Assessment for 2022-23.

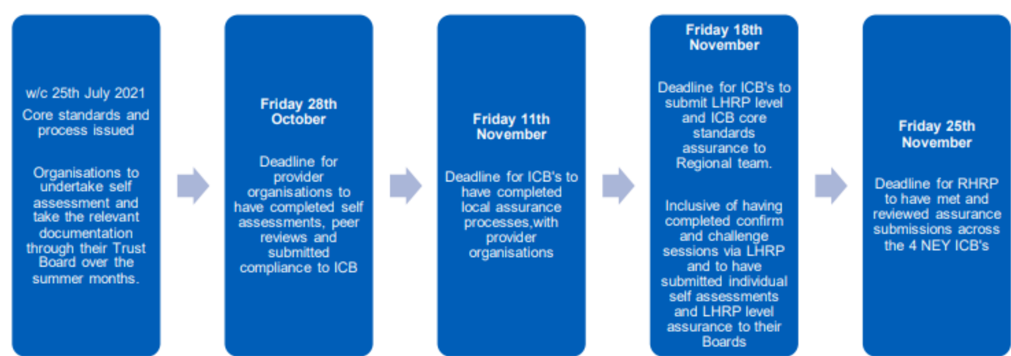
1.2. This paper describes the process undertaken with Provider Trusts.

2. Executive Summary

2.1. As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS-funded services must show they can effectively respond to major, critical and business continuity incidents while maintaining services to patients. To do this, NHS England asks commissioners and providers of NHS-funded care to complete an EPRR annual assurance process, self-assessing their compliance against core standards. The outcome of this process is used to inform the organisation's overall EPRR annual assurance rating.

2.2. With the introduction of the Health and Care Act in 2022 and Integrated Care Boards taking on the role of Category 1 responders and taking over responsibility from NHSE for local EPRR leadership, the 2022/2023 assurance process was co-ordinated by NENC ICB.

2.3. The timeline for submission of this year's standards within the North East & Yorkshire region was as follows:



2.4. Local organisations were required to complete their self-assessment, undertake a peer review with a similarly sized/type of organisation prior to submitting their completed self-assessment to the NENC ICB. The ICB then held a 'check and challenge' session with all providers which took place in October 2022 to discuss each Trusts declaration of

compliance and to identify any areas for further support/development either at a Trust level, local system or ICB.

2.5 North East and North Cumbria Integrated Care Board will now confirm with NHSE that they have successfully completed the annual assurance process with their system partners and will include Trust declarations in their submission.

3. Areas for Development

3.1. The following core standards have been identified by NENC ICB as requiring further development/enhancement during 2022/2023 with actions put in place to move organisations and the region to its desired position. NENC ICB will therefore work with stakeholders, through the Local Health Resilience Partnership to ensure progression.

- **Evacuation and Shelter –** A system wide evacuation process is required. All Trusts have plans in place to evacuate wards however there are no plans in place for a full evacuation which will include system partners such as social care. For the forthcoming year, the ICB will ensure that there is a regional approach to develop a policy with local standard operating procedures as well as considering patient triage systems and patient tracking systems.

- **Training and Exercising –** Due to national roll out of the Principles of Health Command training, all providers confirmed that they still required individuals to attend/complete this course and are awaiting the receipt of the commander portfolio's to enable them to undertake training needs analysis and monitor compliance against the minimum occupational standards for commanders.

- **Business Continuity** – A rigorous and robust process is needed to gain assurance from key suppliers on their business continuity arrangements.

4. Assurance Declaration

4.1. As per the NHS England EPRR Core Standards guidance, an overall assurance rating has been assigned based on the percentage of NHS Core Standards met by each organisation. The table below details the levels of compliance declared by each organisation. The collated submissions can be found in Appendix A.

Provider Organisation	Compliance Declaration
County Durham & Darlington NHS Foundation Trust	Substantially Compliant 91%
Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust	Substantially Compliant 89%
Gateshead Health NHS Foundation Trust	Partially Compliant 83%
North Cumbria Integrated Care NHS Foundation Trust	Substantially Compliant 92%
North East Ambulance Service NHS Foundation Trust	Partially Compliant 86%
Northumbria Healthcare NHS Foundation Trust	Substantially Compliant 98%
North Tees & Hartlepool NHS Foundation Trust	Substantially Compliant 91%

Newcastle Upon Tyne Hospitals NHS Foundation Trust	Partially Compliant 84%
South Tees Hospital NHS Foundation Trust	Partially Compliant 81%
South Tyneside & Sunderland NHS Foundation Trust	Partially Compliant 86%
Tees, Esk and Wear Valleys NHS Foundation Trust	Substantially Compliant 89%

4.2. The areas which are currently assessed as partially compliant will be monitored and maintained as part of an action plan and continuously assessed by the Local Health Resilience Partnership (LHRP) as well as during the monthly meetings with EPRR Leads chaired by the ICB. An action plan will be developed by each Trust and the ICB to oversee progress which will be shared and discussed by the LHRP to ensure system oversight.

5. Recommendations

5.1. Members of the ICB Board are asked to review and note the North East and North Cumbria Integrated Care Board assurance process and provider organisations compliance ratings.

5.2. The ICB Board are asked to endorse the submission to NHS England as part of the NHSE EPRR annual assurance process for 2022-23.

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Provider Organisation Submissions Collated

Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	CDDFT	CNTW	GHFT	NCIC	NEAS	NHCT	NTEES	NUTH	STHFT	STSFT	TEWV
				Substantially Compliant 91%	Substantially Compliant 89%	Partially Compliant 83%	Substantially Compliant 92%	Partially Compliant 86%	Substantially Compliant 98%	Substantially Compliant 91%	Partially Compliant 84%	Partially Compliant 81%	Partially Compliant 86%	Substantially Compliant 89%
Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant
Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant

Governance	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. <u>Evidence</u> • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activitites.	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant
Governance	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	<u>Evidence</u> • Reporting process explicitly described within the EPRR policy statement • Annual work plan	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant
Governance	**EPRR Resource**	.	<u>Evidence</u> • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant

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Governance	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant
Duty to risk assess	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant
Duty to risk assess	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant
Duty to maintain plans	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant
Duty to maintain plans	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant

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Duty to maintain plans	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant
Duty to maintain plans	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles.	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant
Duty to maintain plans	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant	Fully Compliant

Duty to maintain plans	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant
Duty to maintain plans	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant

			casualty incident where necessary.											
Duty to maintain plans	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Partially Compliant	Partially Compliant	Partially Compliant	Fully Compliant
Duty to maintain plans	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant
Duty to maintain plans	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant

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Duty to maintain plans	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant
Command and control	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant
Command and control	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	Partially Compliant	Partially Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Partially Compliant	Partially Compliant	Partially Compliant	Partially Compliant	Partially Compliant

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Training and exercising	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	<u>Evidence</u> • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Partially Compliant	Partially Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Partially Compliant	Partially Compliant	Partially Compliant	Partially Compliant
Training and exercising	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. <u>Evidence</u> • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant
Training and exercising	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	<u>Evidence</u> • Training records • Evidence of personal training and exercising portfolios for key staff	Partially Compliant	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Partially Compliant	Partially Compliant	Partially Compliant	Partially Compliant
Training and exercising	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant

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Response	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant
Response	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Planning arrangements are easily accessible - both electronically and local copies	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant
Response	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant
Response	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant
Response	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant

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Response	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Guidance is available to appropriate staff either electronically or hard copies	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant		Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	
Response	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Guidance is available to appropriate staff either electronically or hard copies	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant		Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	
Warning and informing	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant
Warning and informing	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant

			for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).											
Warning and informing	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant

North East &
North Cumbria

			activities in annual reports within the organisations own regulatory reporting requirements											
Warning and informing	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant
Cooperation	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant
Cooperation	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant

Cooperation	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant
Cooperation	**Arrangements for multi area response**	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs • Where an organisation sits across boundaries the reporting route should be clearly identified and known to all		Fully Compliant	Fully Compliant		Fully Compliant						
Cooperation	**Health tripartite working**	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.	• Detailed documentation on the process for managing the national health aspects of an emergency		Fully Compliant	Fully Compliant								
Cooperation	**LHRP Secretariat**	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.	• LHRP terms of reference • Meeting minutes • Meeting agendas		Fully Compliant	Fully Compliant								
Cooperation	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant
Business Continuity	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation.	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant

			• Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning											
Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant

Business Continuity	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Partially Compliant

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Business Continuity	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant
Business Continuity	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief <u>Evidence</u> Post exercise/ testing reports and action plans	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant
Business Continuity	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	<u>Evidence</u> • Statement of compliance • Action plan to obtain compliance if not achieved	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant
Business Continuity	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant

Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant
Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant

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Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Not Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Partially Compliant
Business Continuity	Computer Aided Dispatch	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon	• Exercising Schedule • Evidence of post exercise reports and embedding learning		Fully Compliant	Fully Compliant		Fully Compliant						
CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant		Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant
CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Fully Compliant		Fully Compliant	Fully Compliant		Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant
CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	• Impact assessment of CBRN decontamination on other key facilities	Fully Compliant		Fully Compliant	Fully Compliant		Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant

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CBRN	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Rotas of appropriately trained staff availability 24 /7	Fully Compliant		Partially Compliant	Fully Compliant		Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	
CBRN	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Completed equipment inventories; including completion date	Fully Compliant		Fully Compliant	Fully Compliant		Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant
CBRN	**PRPS availability**	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Completed equipment inventories; including completion date	Fully Compliant		Fully Compliant	Fully Compliant		Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	
CBRN	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Record of equipment checks, including date completed and by whom.	Fully Compliant		Fully Compliant	Partially Compliant		Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	
CBRN	**Equipment Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Completed PPM, including date completed, and by whom	Fully Compliant		Fully Compliant	Fully Compliant		Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	
CBRN	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Organisational policy	Fully Compliant		Fully Compliant	Fully Compliant		Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	
CBRN	**HAZMAT / CBRN training lead**	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Maintenance of CPD records	Fully Compliant		Fully Compliant	Partially Compliant		Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	

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CB RN	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	Fully Compliant		Partially Compliant	Fully Compliant		Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant
CB RN	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Maintenance of CPD records	Fully Compliant		Fully Compliant	Fully Compliant		Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	
CB RN	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique	Fully Compliant		Partially Compliant	Fully Compliant		Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant
CB RN	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.		Fully Compliant		Fully Compliant	Fully Compliant		Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant

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Domain	Standard	Deep Dive question	CDDFT	CNTW	GHFT	NCIC	NEAS	NHCT	NTEES	NUTH	STHFT	STSFT	TEWV
Evacuation and Shelter	**Up to date plans**	The organisation has updated its evacuation and shelter arrangements since October 2021, to reflect the latest guidance.	Fully Compliant	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant	Not Compliant	Partially Compliant	Partially Compliant	Partially Compliant	Partially Compliant	Partially Compliant
Evacuation and Shelter	**Activation**	The organisation has defined evacuation activation arrangements, including the decision to evacuate and/or shelter by a nominated individual with the authority of the organisation's chief executive officer.	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Not Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant
Evacuation and Shelter	**Incremental planning**	The organisation's evacuation and shelter plan clearly defines the incremental stages of an evacuation, including in situ sheltering, horizontal, vertical , full building, full site and off-site evacuation.	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	N/A	Not Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant
Evacuation and Shelter	**Evacuation patient triage**	The organisation has a process in place to triage patients	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Not Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant

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		in the event of an incident requiring evacuation and/or shelter of patients.											
Evacuation and Shelter	**Patient movement**	The organisation's arrangements, equipment and training includes the onsite movement of patients required to evacuate and/or shelter.	Partially Compliant	Fully Compliant	Partially Compliant	Fully Compliant	N/A	Not Compliant	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant	Fully Compliant
Evacuation and Shelter	**Patient transportation**	The organisation's arrangements, equipment and training includes offsite transportation of patients required to be transferred to another hospital or site.	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	N/A	Not Compliant	Fully Compliant	Partially Compliant	Not Compliant	Partially Compliant	Fully Compliant
Evacuation and Shelter	**Patient dispersal and tracking**	The organisation has an interoperable patient tracking process in place to safely account for all patients as part of patient dispersal arrangements.	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	N/A	Not Compliant	Fully Compliant	Partially Compliant	Not Compliant	Partially Compliant	Fully Compliant
Evacuation and Shelter	**Patient receiving**	The organisation has arrangements in place to safely receive patients and staff from the evacuation of another organisations inpatient facility. This could with little advanced notice.	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant	N/A	Not Compliant	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant	Fully Compliant
Evacuation and Shelter	**Community Evacuation**	The organisation has effective arrangements in place to support partners in a community evacuation, where the population of a large area may need to be displaced.	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Not Compliant	Fully Compliant	Fully Compliant	Partially Compliant	N.A	Fully Compliant
Evacuation and Shelter	**Partnership working**	The organisation's arrangements include effective plans to support partner organisations during incidents requiring their evacuation.	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Not Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant

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Evacuation and Shelter	**Communications-Warning and informing**	The organisation's evacuation and shelter arrangements include resilient mechanisms to communicate with staff, patients, their families and the public, pre, peri and post evacuation.	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Not Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant
Evacuation and Shelter	**Equality and Health Inequalities**	The organisation has undertaken an Equality and Health Inequalities Impact Assessment of plans to identify the potential impact evacuation and shelter arrangements may have on protected characteristic groups and groups who face health inequalities.	Partially Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Not Compliant	Partially Compliant	Not Compliant	Partially Compliant	Fully Compliant	Partially Compliant
Evacuation and Shelter	**Exercising**	The evacuation and shelter arrangements have been exercised in the last 3 year. Where this isn't the case this will be included as part of the organisations EPRR exercise programme for the coming year. Please specify.	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant	Not Compliant	Partially Compliant	Partially Compliant	Fully Compliant	Not Compliant	Fully Compliant

The Hewitt Review: an independent review of integrated care systems

Letter from Rt Hon Patricia Hewitt to ICB Chairs, ICP Chairs and ICB CEOs

18th January 2023

Dear Colleague,

As you know, the Chancellor of the Exchequer and the Secretary of State for Health and Social Care asked me to lead an Independent Review into how the oversight and governance of Integrated Care Systems (ICSs) can best enable them to succeed. The review covers ICSs in England and the NHS targets and priorities for which ICBs are accountable, including those set out in the Government's mandate to NHS England.

Since the Terms of Reference were published, I have had the opportunity to discuss the issues with over 300 ICB and ICP leaders, as well as other leaders from local government, NHS Trusts and Foundation Trusts, social care providers, VCSE groups, academics and others with an interest in the success of ICSs. I'm also delighted to say that I've received around 400 submissions from organisations and individuals in response to the Call for Evidence.

If you have been involved already in discussions or evidence, thank you very much. If you haven't yet been involved, I look forward very much to hearing from you in the coming weeks. As well as the Confed networks that many of you belong to, if diaries permit I would also welcome the opportunity to join you at any regional meeting you may already hold of ICS chairs or CEOs.

As several of you have pointed out, this Review covers a very wide range of issues and the timescale is very tight indeed (my final report is due by 15 March) And as some of you have stressed, it will be essential to distinguish between short-term recommendations that can be implemented within weeks or a few months, and those that need consistent action over the medium or longer term.

Fortunately the Review isn't starting from a blank sheet of paper. As well as the excellent evidence that has been submitted, the Review will build on a great deal of prior work, including the Messenger Review, the Fuller Stocktake of Primary Care, Sir Chris Ham's recent report on ICSs, the Integration White Paper and so on. And we can already see welcome change taking place, particularly in the way NHSE involved many ICS leaders in the recent Planning Guidance and the nature of that Guidance itself.

But fundamentally, this Review is an opportunity for all of us with a stake in ICSs to shape our future. As I've said to many of you, I certainly don't claim to have all the answers. But through this Review, I hope I can be a catalyst for crowd-sourcing! So the impact of the Review depends upon your contribution, personally as well as organisationally.

The next stage: five work streams

The next stage of the review will focus on five work streams, led by colleagues from across the health and care system. These will cover:

- **Prevention and population health management**, co-chaired by Patricia Miller (CEO, Dorset Integrated Care Board) and Joe Rafferty (CEO, Mersey Care FT);
- **Integration and place**, co-chaired by Felicity Cox (CEO, Bedfordshire, Luton and Milton Keynes Integrated Care Board) and Cllr Tim Oliver (Chair, Surrey Heartlands Integrated Care Partnership and Leader, Surrey County Council);
- **Autonomy, accountability and regulation**, co-chaired by Dr Kathy McLean (Chair, Nottingham and Nottinghamshire Integrated Care Board) and Rt Hon Paul Burstow (Chair, Hertfordshire and West Essex Integrated Care Board and Chair, SCIE);
- **Productivity and finance**, co-chaired by Dr Penny Dash (Chair, North West London Integrated Care Board) and Sir Richard Leese (Chair, Greater Manchester Integrated Care Board);
- **Digital and data**, co-chaired by Sam Allen (CEO, North East and North Cumbria Integrated Care Board) and Adam Doyle (CEO, Sussex Integrated Care Board).

Colleagues from patient and service user groups, local government, the voluntary community faith and social enterprise sector and the social care provider sector, as well as the NHS, are all being included in the work streams, reflecting the partnerships that constitute ICSs. There will also be opportunities to join 'town hall' style meetings in February. If you would particularly like to be involved in one of these work streams, could you please contact the co-chairs and the secretariat at the Department of Health and Social Care, via **hewittreview@dhsc.gov.uk.**

Draft Principles

Six principles have emerged repeatedly from the discussions so far as well as from an initial reading of the evidence. They are set out, in draft, below. I'm grateful to everyone who has contributed to them, including the authors of the many documents I've drawn on.

These principles are not set in stone, although they will help provide a framework for the work streams. As discussions develop, so will the principles. But I intend my final report to set out principles that will, I hope, command as close to universal agreement as possible, and will therefore provide a touchstone for all of us, whether partners within ICSs or working at national and regional level, about how we should act in future.

Collaboration: within each system as well as between systems and national bodies. Rather than thinking about the centre, regions, systems, and places as a hierarchy, we should view each other as real partners with complementary and interdependent roles and work accordingly. This means recognising the importance of collaboration between partners from the NHS, local government, social care providers and the VCSE in neighbourhoods, places and systems. Because different local partners have different accountability and funding arrangements, only ICSs can create mutual accountability between all partners around jointly agreed outcomes and targets (for both the long-term health of the population and for immediate issues such as discharge and tackling the backlog). On the other hand, it is also essential to recognise that, while the role of the centre should change, some things can only be done effectively and efficiently by them. NHS England's new operating framework and its emphasis on aligned support and collaboration managed by or with the ICS rather than direct to provider organisations is therefore very helpful and should be followed by more joining up between DHSC, DLUHC, NHSE and other national bodies to mirror the integration within ICSs.

A limited number of shared priorities: the public's immediate priorities – access to primary care, urgent and emergency care, elective care and mental health services - are priorities for all of us, Ministers, NHSE and ICBs. The level of interest in these matters rightly makes them a central part of accountability for all ICBs – and their partners in the wider ICS. Evidence-based guidance and best practice examples are, of course, invaluable to local leaders; but it is essential that those local leaders have flexibility about how they apply those lessons to their particular local circumstances.

Give local leaders space and time to lead: Effective change in any system - particularly one as complex as health and care - needs consistent policy, finances, support and regulation over several years. Adding new targets and initiatives, providing small funding pots (often with complex rules and reporting requirements), or non-recurrent funding makes it impossible to plan or even recruit, wastes money and time, and weakens impact and accountability. Multi-year funding horizons, with proportionate reporting requirements, are essential.

Systems need the right support: ICSs require bespoke support geared to the whole system and the partners within it, rather than to individual providers or sectors. But support also needs to be proportionate: less intervention for mature

systems delivering results within budget; more intervention and support for systems facing greater challenges.

Balancing freedom with accountability: It is right that with greater freedom comes robust accountability, including for financial spending and ensuring value for money. That accountability includes the local accountability that is hard-wired into ICSs - through ICPs, HealthWatch, Foundation Trust governors and many other forms of patient and public involvement. Peer review, widely used in local government, may also have a role. This local accountability is complemented by NHSE's role to support and provide oversight for ICBs in line with the statutory framework including NHSE's support for NHS organisations within the ICS with greater challenges. The role of CQC as the independent inspector has itself been strengthened by the 2022 Act. The CQC's remit now includes inspecting ICSs as a system, regulating local authorities in relation to their adult social care functions, as well as their existing functions in relation to social care, NHS and other healthcare providers. CQC is transforming its own working methods to meet these new responsibilities. It will also be essential to consider the vital, but different, role of supporting ICSs, ICBs and providers with great challenges to improve, particularly where there are major failings in care. This will need to be done hand in hand with NHSE's role in overseeing systems.

Enabling timely, relevant, high-quality and transparent data: we recognize that timely, relevant, high-quality and transparent data is essential for integration, improvement, innovation and accountability. As high performing ICSs are already showing, high quality, integrated data collection and interoperable digital systems can initiate real change. Good data, used well, can generate actionable insights into outcomes and the drivers of inequalities, as well as productivity, quality and safety. ICSs should focus on enabling data sharing and digital innovation that supports real-time service improvement, Of course, effective data can also enable greater accountability, a learning culture and research, although simply doing this through uncoordinated data requests can create unnecessary administrative burdens rather than improvements. NHS England, working in collaboration with DHSC and local government (including through DLUHC, the LGA and CCN) have a key role to play. By defining standards on data taxonomy and services' interoperability, and coordinating data request to the system, they can create the conditions for wider transformation.

Do please let me know if you have any questions about the Review, any immediate comments on the draft principles or particular issues you would like to draw to the attention of the work streams that weren't included in the evidence you've already submitted.

Yours sincerely,

Rt Hon Patricia Hewitt

Chair of the independent review of Integrated Care Systems

Item: 7.2

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

NORTH EAST & NORTH CUMBRIA ICB BOARD MEETING

31 January 2023

Report Title:	**North East & North Cumbria (NENC) ICB Integrated Delivery Report**

Purpose of report

The NENC Integrated Delivery Report provides an ICS overview of Quality, Performance and Finance. The performance and finance elements of the report are discussed in detail at the Finance Performance and Investment Committee, and the Quality elements at the Quality and Safety Committee. The report is also received by the ICB Executive Committee. Due to the data publication dates and the sequence of meeting dates sometimes the reports in the same cycle have included different data. Going forward the Board will always receive report content that has been to the Finance and Performance Committee.

Key points

The integrated delivery report is structured around the 2022/23 planning priorities and linked to the NHS Oversight framework (NHS OF) which applies to all Integrated Care Systems (ICSs), NHS Trusts and Foundation Trusts to provide oversight of our delivery of the NHS Long Term Plan (LTP) commitments, the NHS People Plan and operational planning priorities.

This report provides the NENC position in relation to the 2022/23 planning priorities and the themes set out in the 2022/23 NHS OF. Published data is available for October and November 2022 unless otherwise stated.

The Performance and Quality elements of this report have been discussed at the NENC ICB Executive Committee Meeting on 10 January 2023. The report was not discussed at the Finance and Performance Committee in January due to the focus on the publication of the NHS Operational planning guidance for 2023/24 at this meeting. NHS England » NHS operational planning and contracting guidance.

The finance summary within the report is at month 8 (November 2022).

Item: 7.2

Key changes from previous report - Quality

CQC – South Tees	The CQC undertook a further inspection to South Tees Hospital NHS Foundation Trust in November 2022 and a well led inspection is planned for January 2023. The Trust will remain in the inspection window until after this time with the final inspection report expected by March 2023.
Maternity – South Tyneside and Sunderland	South Tyneside & Sunderland FT: reopened their Midwifery Led Birthing Unit (MLBU) from 1 November 2022, after it was temporarily closed earlier in the year. The enhanced surveillance of maternity services was stood down in October 2022 owing to the level of assurance gained.
Contract performance notice	A contract performance notice has been issued to an independent provider in relation to their unauthorised use of Patient Group Directives, including Mifepristone, for cervical preparation. Recommendation on the next steps were considered and accepted by the ICB Executive Board. The ICB has requested that the provider delivers written assurance on a number of immediate and remedial actions, with set deadlines.

Key changes from the previous report - Performance

Handover delays	A rapid process improvement workshop (RPIW) took place in November 2022 led by the NENC Urgent and Emergency Care Network. It was agreed that a different approach was needed to address the issue of handover delays and the impact on patients waiting in the community. A draft report has been prepared which includes two approaches. The ICB Chief Executive has requested to meet with all Trusts regarding the plan and a 'go live' date is to be confirmed.
NHSE escalation for cancer and elective	County Durham and Darlington NHS FT is under enhanced national surveillance due to the 78+ week waiters reduction being behind plan. The Trust anticipate 78+ week waiters to peak at the end of December before reducing in Q4. NHS E has confirmed that the trust will be moved into Tier 2 escalation to support recovery with the first meeting in January. North Tees & Hartlepool NHS FT had moved into Tier 2 escalation for cancer and the first support meeting was held on 16 December and positive improvement was demonstrated to the extent that the trust has now been moved out of Tier 2. North Cumbria Integrated Care NHS FT - Notable progress continues in the cancer 62 day backlog and following review the trust has been moved from Tier 1 into Tier 2 escalation.
12 hour delays in A&E from decision to admit	Patients waiting in A&E more than 12 hours following decision to treat continues to increase, from 1106 in October to 1393 in November across NENC. Challenges across the health and social care system continue to impact, with increased levels of urgent and emergency care activity, increased ambulance arrivals and patients with high acuity placing significant demands on ED departments. Ongoing challenges in social care and high bed occupancy continue to impact on patient flow. Evidence-based process improvement work in this area remains a priority across NENC.

Cancer 62 day performance (85% standard)	Currently 59.8% patients are waiting longer than 62 days compared to the 85% standard in NENC, this is a deteriorating position and is slightly below the national at 60.3% for October.

Key themes of the report and areas of focus - Quality

NEAS Independent Enquiry Update
The planned timescale for completion is the end of the year. Support continues to be offered to NEAS from the ICB and system.

Mortality
All Trusts are showing within the 'expected range' for the Summary Hospital-level Mortality Indicator (SHMI). STSFT was previously an outlier, but their position has improved and remains on a reducing trend, which is expected to reduce further once hospice data is excluded from their SHMI data.

Serious Incident (SI) Reporting

- 15 never events have been reported across the region YTD (30 November 2022) and these will continue to be monitored via SI processes. STHFT have reported 6 never events YTD.
- One Trust (STSFT) remains in quality escalation in relation to never events and has undertaken a thematic review of incidents to identify wider organisational learning. This will be presented at the next quality review group (QRG) meeting.

Healthcare Acquired Infections

- MRSA - one case (hospital onset) was reported in October 2022, which brings the year to date (YTD) total across the region to 5 cases (4 hospital onset (STHFT, NHCFT, NUTH, STSFT and 1 community onset at STHFT).
- Clostridium Difficile - four Trusts are exceeding their YTD national thresholds for the number of infections reported.
- E. Coli - five Trusts are exceeding their YTD national thresholds for the number of cases reported.
- Klebsiella pneumoniae - six Trusts are exceeding their YTD national thresholds for the number of cases.
- Pseudomonas. Aeruginosa - two Trusts are exceeding their YTD national thresholds for the number of cases.
- All providers are signed up to a set of principles for the management of COVID-19 Infection, Prevention and Control (IPC) and there is a system wide approach to antimicrobial resistance (AMR)

Patient Safety Alerts
One Trust (STHFT) is showing with an alert open past its completion deadline. This will be raised with the Trust to seek confirmation this has been actioned and closed.

Sickness absence Rates
Ten Trusts across NENC were above the England average (6.05%) in July 2022. Workforce pressures continue due to sickness absence and vacancies, although some improvement has been seen. Measures are in place to ensure operational challenges are managed, safe staffing levels are in place and support is offered to staff to maintain their health and wellbeing.

Friends and Family Test
Five Trusts had recommendation scores below the England average.

Item: 7.2

Key themes of the report and areas of focus - Performance

Primary care

- GP appointment levels at pre-pandemic levels continue to increase, with a total of 1.7m during October 22 which is within planned trajectory for October and a marked increase on September (1.5m).
- DNAs as a proportion of all appointments remain high at 5.5% in October, an increase on September (5%) but below the national rate (5.9%).
- Practices routinely offering face to face appointments where clinically necessary and they continue to increase, up to 75.3% of total appointments delivered in October. This exceeds the level nationally at 70.1%

Urgent and emergency care (UEC):

- Pressures due to high level of attendances, high bed occupancy and delays with social care discharges continue resulting in sustained pressure on UEC pathways. High levels of medically optimised patients is an ongoing feature across the system. NENC system is working hard to increase capacity and operational resilience with a continued focus on ambulance performance and response and discharge.
- Ambulance response times continue to be a pressure although NEAS is meeting C1 mean and 90th Centile for November. Cat 2 mean and 90th percentile standards continue to not be met although November performance has improved from 57:34 in October to 49m:18 in November. This is higher than the national however, which has also significantly improved in November to 41:21.
- Handover delays continue, resulting in 98.9 average hours lost per day across NENC as at December 2022 compared to a target of 60.9. 80.1% of handovers took place under 30 minutes compared to a 95% standard, and 88.8% of handovers were under 60 minutes in December 2022 (expected standard of zero >60 mins). It should be noted that only 65.3% of ambulance arrivals with a handover time were recorded in NENC which will skew the data.
- Although not meeting the 95% standard, NENC performance is performing favourably compared to the national for November (all types) at 72.9%, compared to 61.4% nationally.
- Patients waiting in A&E more than 12 hours following decision to treat has increased significantly from to 1106 in October to 1393 in November. The % of patients waiting longer than 12 hours from arrival to discharge is above the 2% standard for September at 3% in NENC.
- Patients who no longer meet the criteria to reside and whose discharge is delayed is at 7.6% compared to the target level of 9.2% in NENC in October. Pressures with social care discharges continue to create considerable pressure in hospital bed occupancy and flow.
- Type 1 General and Acute bed occupancy remains high and has increased significantly to 91.5% in November. This is above the 85% national expectation, and above the operational plan level in NENC.

Tier 1 and Tier 2 Meetings – NHSE escalation for cancer/elective

The allocation of providers to tiers in relation to their elective and cancer backlog positions is a relatively new process initiated by NHS England. Trusts who are placed in Tier 1 will have regular (usually fortnightly) escalation meetings initiated by the NHS NEY Regional Team. For trusts placed in Tier 2 similar meetings will be initiated by the ICB. The ICB will work with colleagues from the Regional Team to ensure these meetings are arranged to include all the relevant parties and focused on identifying and deploying high-quality support to aid rapid performance improvement. In NENC the following Trusts are in Tiers 1 and Tier 2:

Tier 2:
North Cumbria – Cancer

- Notable progress continues in the cancer 62-day backlog and following review the trust has been moved from Tier 1 into Tier 2 escalation.
- The trust has a range of actions in place linked to validation, pathways and diagnostics
- NHS England has allocated funds to the Northern Cancer Alliance to support NCIC in implementing rapid improvement plans for diagnostics and histopathology.

Newcastle – Cancer & Elective

- Tier 2 cancer and elective escalation; meeting chaired by ICB Executive Director of Place with NHS E, ICB and trust representation.
- The trust has implemented and sustained a range of improvements linked to validation, pathways and diagnostics.
- The trust has a number of initiatives to increase capacity including the opening of the day treatment centre in September and maximising use of the independent sector.
- Some progress has been made in reducing the cancer 62-day backlog.
- There has been a sustained and significant reduction in the number of people waiting beyond 104 weeks for elective procedures, complex spinal procedures being the remaining area of pressure. This has slightly increased however over recent weeks due to a national blood products issue impacting planned procedures which has now been resolved although planned industrial action may impact further.
- There is a growing pressure of over 78 week waits demonstrated by more current weekly unvalidated data. Dermatology, Orthopaedics and Spinal are key areas of risk.

County Durham & Darlington FT

- County Durham and Darlington NHS FT is under enhanced national surveillance due to the 78+ week waiters reduction being behind plan.
- The Trust anticipated that 78+ week waiters would peak at the end of December before reducing in Q4.
- NHS E has confirmed that the trust will be moved into Tier 2 escalation to support recovery with the first meeting in January.

Non-tiered:
North Tees & Hartlepool – Cancer

- North Tees & Hartlepool NHS FT had moved into Tier 2 escalation for cancer and the first support meeting was held on 16 December and positive improvement was demonstrated to the extent that the trust has now been moved out of Tier 2.
- An initial meeting was positive, noting continued improvement at the Trust and a shared commitment to understand the challenges with demand and supportive initiatives to manage this.

- **South Tees** has also been stepped down from Tier 2 for Cancer due to notable improvements
- Both North and South Tees Trusts are committed to a collaborative approach, with pressures across Urology and Lung.

Elective care:

- The total number of patients on the waiting list continues to grow, exceeding the operational plan trajectory for October 22 and is at an all-time high for NENC at 327,379. More recent weekly unvalidated data shows a further increase in waiting list size across NENC from 344,489 (w/e 30 Oct) to 353,345 w/e 4 December).
- There were 23 104+ week waiters as at end of October 2022, the key pressure are being spinal patients at Newcastle upon Tyne Hospitals NHS FT. This is within the planned level for NENC (48 plan). The Trust continues to manage patients and seek additional capacity including through the independent sector (IS) providers. It is anticipated that this level will be at 22 by the end of March 2023. It should be noted however that more

recent unvalidated data has shown this to have increased to 27 w/e 4th December, with 1 at NCIC, in addition to those spinal patients at NUTH. This has been impacted by a national shortage of blood products.

- 78+ waiters are increasing in NENC after a continual reduction over recent months and are now above planned levels in October (896 compared to 419 plan). The majority of 78+ waiters are at NUTH, with a proportion at South Tees, and CDDFT in addition. More recent unvalidated weekly data shows a continued increase across NENC to data 1005 (w/e 4 Dec).
- 52+ week waiters continue to increase and are above planned levels, this is the seventh consecutive monthly increase observed. Of the 8467 in total as at the end of October, the majority were at NUTH, followed by South Tees, and CDDFT. Pressures exist across high volume specialties at NUTH including T&O, Dermatology, Ophthalmology and Plastic Surgery. The plan is expected to be maintained at this level through to March 2023 with a significant focus at NUTH on 78+ waiters. More recent unvalidated weekly data shows a further increase in NENC through October to 9451 (w/e 4 Dec).
- Diagnostics > 6 week performance for the 15 key diagnostic tests is relatively stable across NENC and continues below the requirement for 1% of patients to wait longer than 6 weeks, with 17.2% patients waiting over 6 weeks for a diagnostic test in October 2022, compared to 27.5% nationally. Key pressure areas include Echo-cardiography, Endoscopy and Audiology.

Cancer

- NENC are not currently achieving the faster diagnosis standard for October 22 which stands at 75.6% v the 75% target, a slight improvement since September. This compares favourably to the national performance (68.5%). Variation between Trusts exists with highest performance at CDD FT, (88.7%) and Gateshead at 81.2% and lowest at NCIC (64.8%).
- 31 day treatment standard and the 62 days referral to treatment standards are not currently being met across NENC. Currently 59.8% patients waiting longer than 62 days compared to the 85% standard in NENC, this is a deteriorating position and is slightly below the national at 60.3% for October. Variation between Trust 62-day performance ranges from 73.5% at Northumbria HC to 45.3% at NUTH.
- South Tees, North Tees, NUTH, and North Cumbria have recently submitted revised trajectories for monitoring against the proportion of patients on cancer PTLs waiting longer than 62 days. There is current focus for Trusts on cancer performance through tier 1 & 2 cancer meetings at NUTH and NCIC FTs.

Mental Health:

Please note Mental Health data has not been updated this month due to changes with the NHSE Publication.

- IAPT % waits greater than 90 days is above the 10% standard in NENC and continues to increase to 37.89%
- Patients accessing IAPT services is below plan
- Dementia Diagnosis rate is at 65.3% as at August, below the trajectory of 66.1%
- Proportion of people on SMI register receiving a full Health check continues to increase towards the end of year standard and is currently on plan.

Learning Disabilities and Autism

- Reducing Reliance on inpatient (IP) care trajectories are on track overall for September, with a total of 146 patients in IP care, working towards no more than 71 adults in NENC by 2023/24.
- Learning Disability Health checks is a cumulative target and as at August YTD NENC has completed 24% of the register which is a 20% increase on this time last year.

Item: 7.2

Key themes of the report and areas of focus – Finance month 8

- For the financial year 2022/23 the ICS, including the Q1 position of the NENC CCGs is on track to deliver the planned breakeven position reporting a small surplus of £0.04m at month 8.
- The ICB is reporting a year to date variance of £3.15m and an outturn variance of £5.55m, prior to expected retrospective funding adjustments of £11.22m – Deficit/(Surplus)
- The ICB is reporting an outturn variance of £5.68m, after expected retrospective funding adjustments of £11.22m, an improved position of £3.05m against the planned surplus of £2.63m – Deficit/(Surplus)
- The ICB is reporting a year to date and forecast outturn underspend of £1.37m and £1.96m respectively compared with the submitted financial plan
- The ICS is reporting a forecast outturn against the capital allocation in line with plan for primary care and £13.88m over on provider capital. At month 8 there is a year to date underspend against the capital allocation of £50.19m.
- The ICS is reporting year to date QIPP savings of £141.2m and forecast savings of £246.21m with the ICB delivering £48.72m which is slightly over the submitted QIPP/Efficiency plan. Providers are currently forecasting an under-delivery against target of £2.91m.
- The ICB is on track to achieve the MHIS target for 2022/23 (growth in spend of 6.68%), the target now includes the impact of the pay award and additional uplift.

Risks and issues

- Growing Health Inequalities
- Systemwide workforce pressures
- Spinal 104+ waiters and increasing 78+ week waiters
- Urgent care and discharges remain pressured across the NENC ICS
- Ambulance response times and handover delays
- Cancer 62-day backlogs

Assurances

- Oversight framework being implemented across NENC.
- Actions being undertaken as highlighted in body of report
- Further detailed actions available through local assurance processes

Recommendation/action required

This report is for information and assurance only. Actions are being undertaken at a local level.

Acronyms and abbreviations explained

- AMR - Antimicrobial resistance
- CAS – Central Alerting System
- C. Difficile – Clostridium Difficile
- CDDFT – County Durham and Darlington NHS Foundation Trust
- CNST – Clinical Negligence Scheme for Trusts
- CNTWFT – Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
- CQC – Care Quality Commission – independent regulator of health and social care in England
- CYPS – Children and Young People Service
- E.Coli – Escherichia coli
- FFT - Friends and Family Test
- FT - Foundation Trust

- GHFT - Gateshead Health NHS Foundation Trust
- GNBSI – Gram-Negative bloodstream Infections
- GP - General Practitioner
- HCAI – Healthcare Associated Infections
- IAPT – Improving Access to psychological Therapies – NHS service designed to offer short term psychological therapies to people suffering from anxiety, depression and stress.
- IPC - Infection Prevention and Control
- MRSA – Methicillin-resistant Staphylococcus aureus
- MSSA – Methicillin-sensitive Staphylococcus aureus
- NCICFT – North Cumbria Integrated Care Foundation Trust
- NEAS – North East Ambulance Service Foundation Trust
- NENC - North East and North Cumbria
- NHCFT – Northumbria Healthcare NHS Foundation Trust
- NHS LTP – Long Term Plan – the plan sets out a number of priorities for healthcare over the next 10 years, published in 2019.
- NHS OF – NHS Oversight Framework which outlines NHSE`s approach to NHS Oversight and is aligned with the ambitions set in the NHS Long Term Plan
- NTHFT – North Tees and Hartlepool NHS Foundation Trust
- NuTHFT – Newcastle upon Tyne Hospitals NHS FT
- SPC – Statistical Process Control – An analytical technique which plots data over time, it helps us understand variation and in doing so guides us to take the most appropriate action.
- STSFT South Tyneside and Sunderland NHS FT
- STHFT – South Tees Hospitals NHS FT
- TEWVFT – Tees, Esk and Wear Valleys NHS FT
- QIPP – Quality, Innovation, Productivity and prevention – Large scale programme introduced across the NHS to ensure the NHS delivers more for the same funding
- QRG – Quality Review Groups
- RCA – Root Cause Analysis
- SI – Serious Incident
- SIRMS – Safeguard Incident Risk Management System
- UEC – Urgent and Emergency Care
- YTD – Year to date

Sponsor/approving director	Jacqueline Myers, Executive Chief of Strategy and Operations Lucy Topping, Director of Performance and Improvement
Report author	Claire Dovell, Planning and Performance Manager

Link to ICB corporate aims (please tick all that apply)	
CA1: Improve outcomes in population health and healthcare	✓
CA2: tackle inequalities in outcomes, experience and access	✓
CA3: Enhance productivity and value for money	✓
CA4: Help the NHS support broader social and economic development	✓

Relevant legal/statutory issues
Note any relevant Acts, regulations, national guidelines etc

Item: 7.2

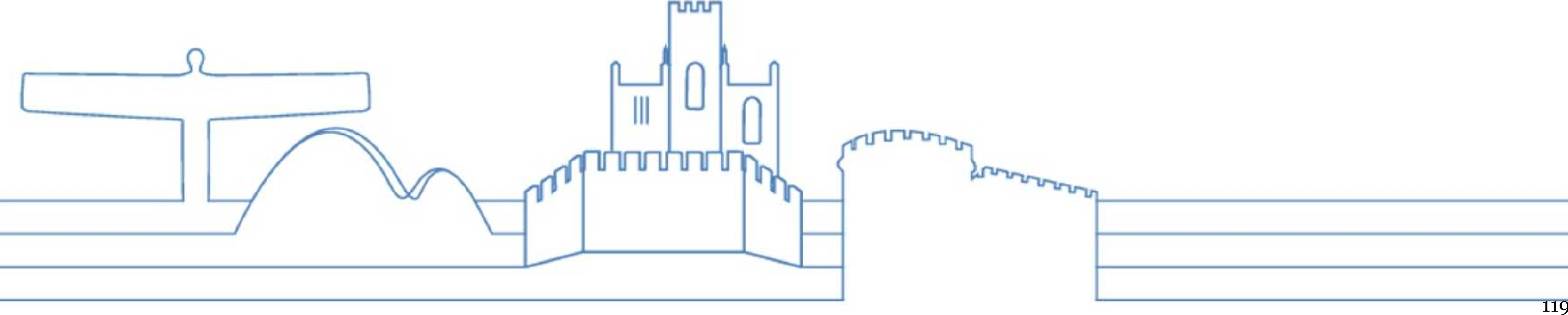
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**		**N/A**	✓
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓

Key implications	
Are additional resources required?	N/A
Has there been/does there need to be appropriate clinical involvement?	N/A
Has there been/does there need to be any patient and public involvement?	N/A
Has there been/does there need to be partner and/or other stakeholder engagement?	N/A

North East & North Cumbria ICB:

Board Meeting
31st January 2023

Integrated Delivery Report



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Executive Summary

Executive Summary	This report sets out the NENC position in relation to the NHS constitution, the principles and values of the NHS and its commitments to patients and staff. This report reviews Quality and Safety alongside Performance to ensure a parallel view, as recommended by the Francis Review (2013) and considered good practice. Published data is at October and November 2022 where possible, unless otherwise specified. NHS Oversight Framework (NHS OF) • The NHS OF delivers oversight to ensure delivery of the planning priorities and monitoring of the Long Term plan (LTP) commitments and encompasses quality, access and outcomes. This report provides the North East and North Cumbria (NENC) position in relation to the NHS planning priorities and is aligned to the NHS OF. Outcomes and Health Inequalities • A key focus in NENC is to address the health inequalities gap and improve outcomes for our populations through prevention, engagement with our communities and population health management. This section draws out some key points in relation to current system outcome measures, and work is currently underway to develop strategic outcomes and priorities of the NENC ICB. Quality •This section presents the quality dashboard for NHS Trusts set out by Area with Quality Exceptions narrative for the NENC ICB. Workforce and patient experience is included within this section. Performance • This report highlights key performance priority areas linked to the delivery of the Long Term Plan and any associated risks, achievements and mitigations. Finance •This report provides a summary for Month 8, November 2022, of the NENC ICB position in relation to Key Statutory Financial Duties and other financial Performance Metrics.
Key Changes from Previous Report	Quality • The CQC undertook a further inspection to South Tees Hospital NHS Foundation Trust in November 2022 and a well led inspection is planned for January 2023. The Trust will remain in the inspection window until after this time with the final inspection report expected by March 2023. • South Tyneside & Sunderland FT: reopened their Midwifery Led Birthing Unit (MLBU) from 1 November 2022, after it was temporarily closed earlier in the year. The enhanced surveillance of maternity services was stood down in October 2022 owing to the level of assurance gained. • A contract performance notice has been issued to an independent provider in relation to their unauthorised use of Patient Group Directives, including Mifepristone, for cervical preparation. Recommendation on the next steps were considered and accepted by the ICB Executive Board. The ICB has requested that the provider provides written assurance on a number of immediate and remedial actions, with set deadlines. Performance Handover delays: A rapid process improvement workshop (RPIW) took place in November 2022 regarding handover delays, which was led by the NENC Urgent and Emergency Care Network. It was agreed that a different approach was needed to address the issue of handover delays and the impact on patients waiting in the community. A draft report has been prepared which includes two approaches. The ICB Chief Executive has requested to meet with all Trusts regarding the plan and a 'go live' date is to be confirmed. Tier 1 and Tier 2 escalation meetings – NHSE escalation for cancer and elective: County Durham and Darlington NHS FT is under enhanced national surveillance due to the 78+ week waiters reduction being behind plan. The Trust anticipate 78+ week waiters to peak at the end of December before reducing in Q4. NHS E has confirmed that the trust will be moved into Tier 2 escalation to support recovery with the first meeting in January. North Tees & Hartlepool NHS FT had moved into Tier 2 escalation for cancer and the first support meeting was held on 16 December and positive improvement was demonstrated to the extent that the trust has now been moved out of Tier 2. North Cumbria Integrated Care NHS FT - Notable progress continues in the cancer 62 day backlog and following review the trust has been moved from Tier 1 into Tier 2 escalation. Key Performance measures: The following standards have shown a significant deterioration this month: 12 hour A&E breaches: Patients waiting in A&E more than 12 hours following decision to treat continues to increase, from 1106 in October to 1393 in November across NENC. Challenges across the health and social care system continue to impact, with increased levels of urgent and emergency care activity, increased ambulance arrivals and patients with high acuity patients placing significant demands on ED departments. Ongoing challenges in social care and high bed occupancy continue to impact on patient flow. Evidence-based process improvement work in this area remains a priority across NENC. Cancer 62 day performance (85% standard): Currently 59.8% patients waiting longer than 62 days compared to the 85% standard in NENC, this is a deteriorating position and is slightly below the national at 60.3% for October.

NENC Oversight report: Executive Summary November 2022

STRATEGIC UPDATE PLANNING PRIORITIES

Workforce
Covid
RTT
Cancer
Maternity
UEC
Community
Primary care
Mental health
Learning disability / autism
Health inequalities
Digital

PROGRESS UPDATE:

ICP Areas have reviewed their Q2 position against the 2022/23 planning commitments and produced a self-assessed review/rating based on plan development which will be available for operational use to assess progress and risks in detail and by exception. ICP Areas have worked together to facilitate consistency in assessment as far as possible.

ICP Areas and places have local arrangements in place to monitor detailed risks and mitigating actions for all planning commitments within each of the over-arching categories.

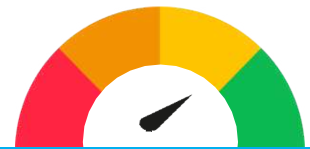
The narrative and detail within the integrated delivery report provides detail on current performance against the key commitments. Key points worthy of note include:

The narrative and detail within the integrated delivery report provides detail on current performance against the key commitments. Key points worthy of note include:

- Urgent and Emergency Care (UEC) continues to be a significant pressure and NENC is working hard to increase capacity and operational resilience ahead of winter
- Continued focus on ambulance performance and the roll out of virtual wards to support patients at home
- Ongoing work with social care partners to improve Length of Stay (LoS) and discharges
- Plans continue for the restoration of cancer services – increasing pressures, mitigations required, working closely with NCA.
- Digital - Managed convergence is happening across the NENC ICS, at strategic programme level, with system-wide collaboration in the delivery of regional interoperability programmes and innovations eg: Great North Care Record (GNCR) - Comprising of a regional Health Information Exchange (HIE) and Patient Engagement Platform (PEP – 'MyGNCR').

PREVENTION, HEALTH INEQUALITIES AND OUTCOMES

	ICB/Or highest & lowest place	NATIO-NAL
Inequality in life expectancy male	8.5 Cumbria 14.3 Stockton	9.4 (years)
Inequality in life expectancy female	6.9 S Tyneside 13.3 Stockton	7.6 (years)
Childhood obesity	40.3 Hartlepool 33% Northumberland	35.2%
Smoking at time of delivery	15%	10.4%
People with LD in suitable accommodation and supported into paid employment	4.1%	5.1%
<75 mortality rate for cancers (persons)	152.5	129.2
<75 mortality rate for respiratory disease	44	34.2
Children living in poverty	15.6 Cumbria 42.4 Middlesbrough	18.5%



SYSTEM OVERSIGHT AND SEGMENTATION

In 2021/22 NENC ICS has been allocated segment 2, as have the providers within NENC ICB, with the exception of Newcastle upon Tyne Hospitals NHS FT, Cumbria, Northumberland, Tyne and Wear NHS FT (CNTW FT) and Northumbria Healthcare NHS FT who have been allocated segment 1 and South Tees NHS FT, North Cumbria Integrated Care NHS FT (NCIC FT) and Tees, Esk and Wear Valleys NHS FT (TEWV) segment 3.

PEOPLE LEADERSHIP AND WORKFORCE

Effective staff engagement is the measure of success of an organisation and demonstrates strong leadership .
Work is ongoing on the development of the care workforce plan incorporating domiciliary care and care home objectives. This is to be developed to be reported towards the end of the year.

People Promise
A suite of metrics within the "People Promise" domain have been illustrated for regular peer comparison and review. Key highlights include:

Staff engagement score: Northumbria HC staff engagement theme score was 9.69% higher than the NENC median value and 7.83% higher than the national median. Conversely North Cumbria IC NHS FT staff engagement theme score was 6.83% lower than the national median.

We are always learning People Promise score: was 9.75% higher at Northumbria HC NHS FT in comparison to North Cumbria ICNHS FT which was 9.24% lower than the national median and CDDFT which was 6.34% lower than the national average for this theme.

FINANCE

Month 6 Position	Plan (Surplus) / Deficit £m	Actual/FOT (Surplus) / Deficit £m
NENC Commissioner		
YTD	(0.01)	3.15
FOT	(2.63)	(5.68)*
NENC Provider		
YTD	4.82	20.9
FOT	2.63	5.64

**this is the Forecast position following receipt of additional allocations to cover the Additional Roles in Primary Care*

PATIENT EXPERIENCE

GP Patient experience Survey 2022

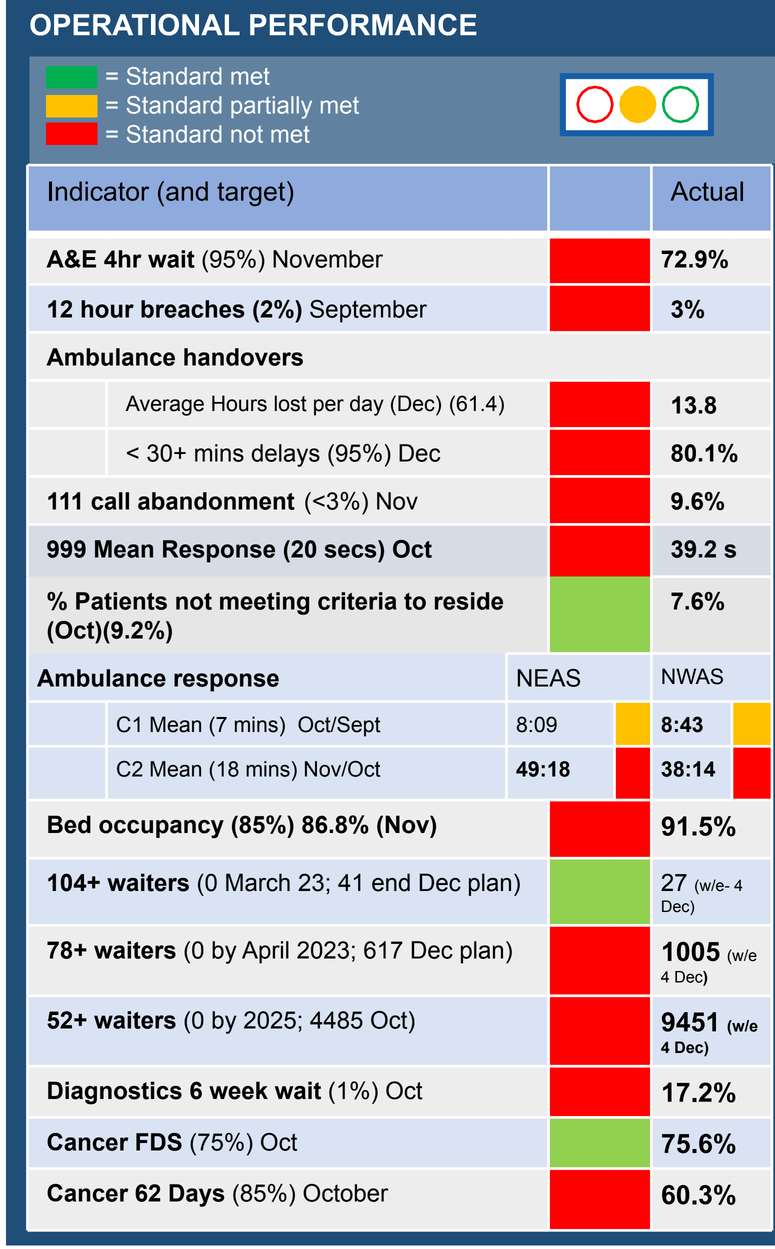
At their last appointment....

94% said they had confidence and trust in the healthcare professional (96% in 2021 and 96% in 2020) This score was better than the national average (72.4%)

92% said their needs were met (95% in 2021, 85% in 2020) This score was better than the national average (91%)

86% Said the healthcare professional was good at treating them with care and concern (90% in 2021, 88% in 2020) This score was better than the national average (83%)

NENC Quality, Access & Outcomes



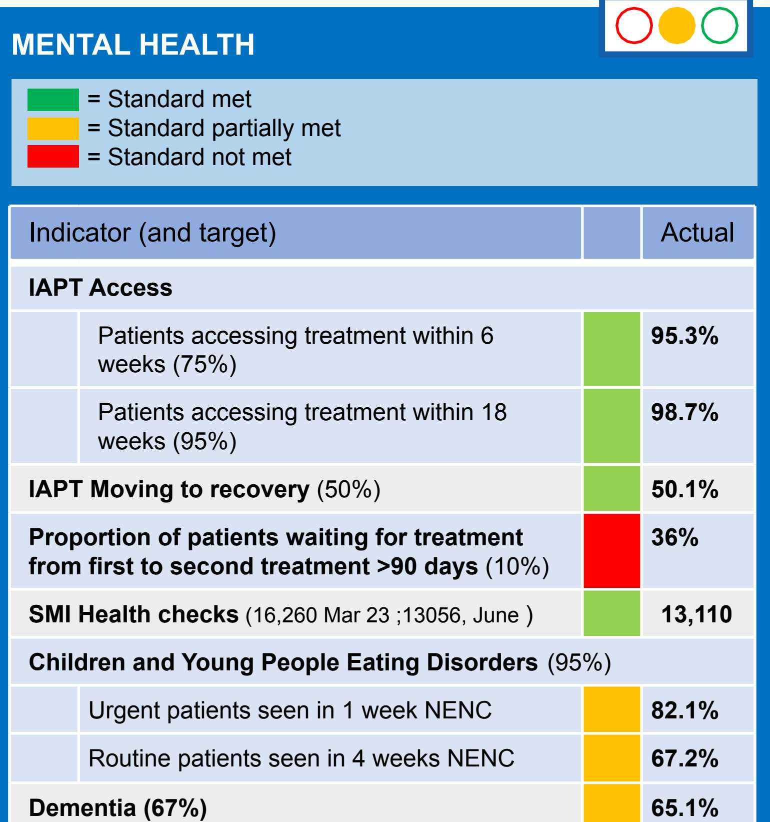
OPERATIONAL PERFORMANCE

- Green = Standard met
- Amber = Standard partially met
- Red = Standard not met

Indicator (and target)			Actual	
A&E 4hr wait (95%) November		Red	**72.9%**	
12 hour breaches (2%) September		Red	**3%**	
Ambulance handovers				
Average Hours lost per day (Dec) (61.4)		Red	**13.8**	
< 30+ mins delays (95%) Dec		Red	**80.1%**	
111 call abandonment (<3%) Nov		Red	**9.6%**	
999 Mean Response (20 secs) Oct		Red	**39.2 s**	
% Patients not meeting criteria to reside (Oct)(9.2%)		Green	**7.6%**	
Ambulance response	NEAS		NWAS	
C1 Mean (7 mins) Oct/Sept	8:09	Amber	**8:43**	Amber
C2 Mean (18 mins) Nov/Oct	**49:18**	Red	**38:14**	Red
Bed occupancy (85%) 86.8% (Nov)		Red	**91.5%**	
104+ waiters (0 March 23; 41 end Dec plan)		Green	27 (w/e- 4 Dec)	
78+ waiters (0 by April 2023; 617 Dec plan)		Red	**1005** (w/e 4 Dec)	
52+ waiters (0 by 2025; 4485 Oct)		Red	**9451** (w/e 4 Dec)	
Diagnostics 6 week wait (1%) Oct		Red	**17.2%**	
Cancer FDS (75%) Oct		Green	**75.6%**	
Cancer 62 Days (85%) October		Red	**60.3%**	

PRIMARY CARE ACTIVITY

- GP appointment levels at pre-pandemic levels continue to increase, with a total of 1.7m during October 22 which is within planned trajectory for October and a marked increase on September (1.5m).
- DNAs as a proportion of all appointments remain high at 5.5% in October, an increase on September (5%) but below the national rate (5.9%).
- Practices routinely offering face to face appointments where clinically necessary and they continue to increase, up to 75.3% of total appointments delivered in October. This exceeds the level nationally at 70.1%



MENTAL HEALTH

- Green = Standard met
- Amber = Standard partially met
- Red = Standard not met

Indicator (and target)		Actual
IAPT Access		
Patients accessing treatment within 6 weeks (75%)	Green	**95.3%**
Patients accessing treatment within 18 weeks (95%)	Green	**98.7%**
IAPT Moving to recovery (50%)	Green	**50.1%**
Proportion of patients waiting for treatment from first to second treatment >90 days (10%)	Red	**36%**
SMI Health checks (16,260 Mar 23 ;13056, June)	Green	**13,110**
Children and Young People Eating Disorders (95%)		
Urgent patients seen in 1 week NENC	Amber	**82.1%**
Routine patients seen in 4 weeks NENC	Amber	**67.2%**
Dementia (67%)	Amber	**65.1%**

LEARNING DISABILITY & AUTISM

- Green = Standard met
- Amber = Standard partially met
- Red = Standard not met

Indicator (and target)		Actual
Learning Disability health checks (73% 22/23)	Amber	**24%** YTD
Reduction in ICS IP beds (69 beds)	Amber	**73** (Aug)
Reduction in Secure Services IP beds (76 beds)	Green	**73** (Sept)

QUALITY

Indicator (and target)		Actual
Never events (zero tolerance) 30 Nov	Red	**15** to date
MRSA (zero tolerance)	Amber	**5**
Serious incidents 2 day reporting (95% target)		4 trusts outside the target in month
C Difficile Infection		4 Trusts over trajectory

NENC System Oversight

The integrated delivery report is structured around the 2022/23 planning priorities and linked to the NHS Oversight framework (NHS OF) which applies to all Integrated Care Systems (ICSs), NHS Trusts and Foundation Trusts to provide oversight of our delivery of the NHS Long Term Plan (LTP) commitments, the NHS People Plan and operational planning priorities.

Following publication of the NHS OF for 2022/23 in July 2022, the published framework of metrics which measures our progress against the LTP through assessment against quality, access and outcomes, people, health inequalities and prevention has now been published.

NENC ICB has reported 22 metrics within the highest performing quartile nationally, 22 in the interquartile range and 8 in the lowest performing quartile.

Indicators reported within the lowest performing quartile are addressed throughout the narrative of this report and include IAPT access, diagnostic activity, cancer treatments, and MRSA rates.

Indicators which fall within the highest performing quartile nationally but are not meeting the national standards include anti-biotic prescribing, clostridium difficile rates, cancer faster diagnosis rate, MMR and Cervical screening coverage.

Segmentation

To provide an overview of the level and nature of support required across systems, inform oversight arrangements and target support capacity as effectively as possible, ICSs and trusts have been allocated to one of four 'segments' in 2021/22. A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4).

In 2021/22 NENC ICS has been allocated segment 2, as have the providers within NENC ICB, with the exception of Newcastle upon Tyne Hospitals NHS FT, Cumbria, Northumberland, Tyne and Wear NHS FT (CNTW FT) and Northumbria Healthcare NHS FT who have been allocated segment 1 and South Tees NHS FT, North Cumbria Integrated Care NHS FT (NCIC FT) and Tees, Esk and Wear Valleys NHS FT (TEWV) segment 3.

System overview – CQC and Oversight framework

Provider	CQC Rating	Oversight framework segment	Oversight arrangements
Tees, Esk and Wear Valleys NHSFT	Requires Improvement (2021)	3	Quality Board
Cumbria, Northumberland, Tyne and Wear NHSFT	Outstanding (2022)	1	ICB led Oversight Meeting
South Tees NHSFT	Requires Improvement (2019)	3	Quality Board
North Tees and Hartlepool NHSFT	Good, inspected 2018	2	ICB led Oversight Meeting
Sunderland and South Tyneside NHSFT	Good, inspected 2021 Inspection June 2022 report published in due course	2	ICB led Oversight Meeting
North East Ambulance Service	Good, inspected 2019 Visit in July and inspection in September 2022	2	Quality Board to be established
County Durham and Darlington NHSFT	Good (2019)	2	ICB led Oversight Meeting
Gateshead Health NHSFT	Good (2019)	2	ICB led Oversight Meeting
Newcastle Upon Tyne Hospital NHSFT	Outstanding (2019)	1	ICB led Oversight Meeting
Northumbria Healthcare NHSFT	Outstanding (2019)	1	ICB led Oversight Meeting
North Cumbria Integrated Care NHSFT	Requires Improvement (2020)	3	NHSE Quality Board

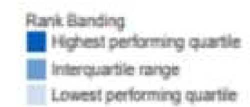
NHS Oversight Framework (NHS OF) - Preventing ill health and reducing inequalities

Sub Category	Indicator	Aggregation	Period	Value	Direction	National Value	Rank Banding	Standard	Standard Met
Prevention and long term conditions	S053a: % of atrial fibrillation patients with a record of a CHA2DS2-VASc score of 2 or more who are treated with anticoagulation drug therapy	SubICB	2021-22	89.80%	Increase	89%	Interquartile Range	90%	Not Met
	S053b: % of hypertension patients who are treated to target as per NICE guidance	SubICB	2021-22	65.90%	Increase	60.40%	Highest Performing Quartile	80%	Not Met
	S053c: % of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	SubICB	2022 03	58.80%	Increase	56.90%	Highest Performing Quartile	45%	Met
	S055a: Number GP referrals to NHS Digital weight management services per 100k population	SubICB	22-23 Q2	71.4 per 100,000	Increase	63.8 per 100,000	Interquartile Range		
	S115a: Proportion of diabetes patients that have received all eight diabetes care processes	ICB	21-22 Q4	46.50%	Increase	46.70%	Interquartile Range		
	S116a: Proportion of adult inpatient settings offering tobacco dependence services	ICB	2022 08	10%	Increase	8.16%	Interquartile Range	100%	Not Met
	S116b: Proportion of maternity settings offering tobacco dependence services	ICB	2022 08	25%	Increase	13.90%	Highest Performing Quartile	100%	Not Met
	S117a: Proportion of patients who have a first consultation in a post covid service within six weeks of referral	Provider	2022 09	31.90%	Increase	26.20%	Interquartile Range		
Screening, vaccination and immunisation	S046a: Population vaccination coverage: MMR for two doses (5 year olds)	SubICB	21-22 Q4	92.30%	Increase	85.90%	Highest Performing Quartile	95%	Not Met
	S047a: Proportion of people over 65 receiving a seasonal flu vaccinatio	SubICB	2022 02	85.50%	Increase	82.30%	Highest Performing Quartile	85%	Met
	S050a: Cervical screening coverage : % females aged 25 : 64 attending screening within the target period	SubICB	21-22 Q4	74.70%	Increase	70.80%	Highest Performing Quartile	75%	Not Met

NHS Oversight Framework (NHS OF) - People and Use of resources

Sub Category	Indicator	Aggregation	Period	Value	Direction	National Value	Rank Banding	Standard	Standard Met
Belonging in the NHS	S072a: Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	ICB	2021	60.70%	Increase		Highest Performing Quartile		
Growing for the future	S074a: FTE doctors in General Practice per 10,000 weighted patients	ICB	2022 09	5.55 per 10,000	Increase	5.88 per 10,000	Interquartile Range		
	S075a: Direct patient care staff in GP practices and PCNs per 10,000 weighted patients	ICB	22-23 Q1	5.68 per 10,000	Increase	4.98 per 10,000	Interquartile Range		
Looking after our people	S063a: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	ICB	2021	9.95%	Decrease		Interquartile Range		
	S063b: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	ICB	2021	16.60%	Decrease		Highest Performing Quartile		
	S063c: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	ICB	2021	26.10%	Decrease		Interquartile Range		
	S067a: Leaver rate	ICB	2022 08	9.02%	Decrease	9.21%	Interquartile Range		
	S068a: Sickness absence rate	ICB	2022 06	6.17%	Decrease	5.34%	Lowest Performing Quartile		
	S069a: Staff survey engagement theme score	ICB	2021	6.07/10	Increase		Highest Performing Quartile		

NHS Oversight Framework (NHS OF) - Quality, Access and Outcomes Mental Health



Sub Category	Indicator	Aggregation	Period	Value	Direction	National Value	Rank Banding	Standard	Standard Met
Cancer	S010a: Total patients treated for cancer compared with the same point in 2019/20	ICB	2022 09	99.60%	Increase		Lowest Performing Quartile	100%	Not Met
	S011a: Cancer - percentage of patients on the waiting list who have been waiting more than 62 days	Provider	w/e 30/10/2022	10.10%	Decrease	11.50%	Interquartile Range		
	S012a: Proportion of patients meeting the faster cancer diagnosis standard	ICB	2022 09	71.80%	Increase	66.70%	Highest Performing Quartile	75%	Not Met
Leadership	S060a: Aggregate score for NHS staff survey questions that measure perception of leadership culture	ICB	2021	6.87/10	Increase		Interquartile Range		
Maternity and children's health	S022a: Stillbirths per 1,000 total births	ICB	2020	3.13 per 1,000	Decrease	3.29 per 1,000	Interquartile Range		
	S104a: Neonatal deaths per 1,000 total live births	ICB	2020	1.41 per 1,000	Decrease	1.5 per 1,000	Interquartile Range		
Mental health services	S081a: Access rate for IAPT services	ICB	22-23 Q1	63.60%	Increase		Lowest Performing Quartile	100%	Not Met
	S084a: Number of children and young people accessing mental health services as a % of population	ICB	2022 06	94.90%	Increase		Interquartile Range	100%	Not Met
	S085a: Proportion of people with severe mental illness receiving a full annual physical health check and follow up interventions	ICB	2022 09	79.40%	Increase	74.50%	Interquartile Range	100%	Not Met
	S086a: Inappropriate adult acute mental health placement out of area placement bed days	ICB	Jun 2022 - Aug 2022	1,720	Decrease		Lowest Performing Quartile	0	Met
	S110a: Access rates to community mental health services for adult and older adults with severe mental illness	ICB	2022 06	96.90%	Increase		Interquartile Range	100%	Not Met
Safe, high quality care	S037a: Percentage of patients describing their overall experience of making a GP appointment as good	ICB	2022	58.70%	Increase	56.20%	Interquartile Range		
	S040a: Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Provider	2022 09	6	Decrease	260	Interquartile Range	0	Met
		SubICB	2022 09	27	Decrease	731	Lowest Performing Quartile	0	Met
	S041a: Clostridium difficile infection rate	Provider	2022 09	100.70%	Decrease	114.20%	Highest Performing Quartile	100%	Met
		SubICB	2022 09	98.40%	Decrease	109%	Highest Performing Quartile	100%	Not Met
	S042a: E. coli bloodstream infection rate	Provider	2022 09	104.30%	Decrease	108.60%	Interquartile Range	100%	Met
		SubICB	2022 09	103.30%	Decrease	106.50%	Interquartile Range	100%	Met
	S044a: Antimicrobial resistance: total prescribing of antibiotics in primary care	SubICB	Sep 2021 - Aug 2022	108.60%	Decrease	88.90%	Lowest Performing Quartile	87.10%	Met
	S044b: Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	SubICB	Sep 2021 - Aug 2022	7.61%	Decrease	8.38%	Highest Performing Quartile	10%	Not Met
	S121a: NHS Staff Survey compassionate culture people promise element sub-score	ICB	2021	7.2/10	Increase		Interquartile Range		
	S121b: NHS Staff Survey raising concerns people promise element sub-score	ICB	2021	6.7/10	Increase		Highest Performing Quartile		
	S123a: Adult general and acute type 1 bed occupancy (adjusted for void beds)	Provider	2022 10	92.20%	Decrease	95.90%	Highest Performing Quartile		
	S124a: Percentage of beds occupied by patients who no longer meet the criteria to reside	Provider	2022 10	10.60%	Decrease	15.30%	Highest Performing Quartile		

NHS Oversight Framework (NHS OF) - Quality, Access and Outcomes 2/2

Rank Banding
- Highest performing quartile
- Interquartile range
- Lowest performing quartile

Sub Category	Indicator	Aggregation	Period	Value	Direction	National Value	Rank Banding	Standard	Standard Met
Elective care	S007a: Total elective activity undertaken compared with 2019/20 baseline	ICB	2022 07	99.50%	Increase		Interquartile Range	104%	Not Met
	S007b: Elective Activity : Completed pathway elective activity growth	ICB	2022 09	109.20%	Increase		Highest Performing Quartile	110%	Not Met
	S009a: Total patients waiting more than 52 weeks to start consultant led treatment	Provider	2022 09	8,857	Decrease	381,413	Interquartile Range		
		SubICB	2022 09	8,579	Decrease	366,930	Interquartile Range		
	S009b: Total patients waiting more than 78 weeks to start consultant led treatment	Provider	2022 09	845	Decrease	48,231	Interquartile Range		
		SubICB	2022 09	790	Decrease	46,080	Interquartile Range		
	S009c: Total patients waiting more than 104 weeks to start consultant led treatment	Provider	2022 09	24	Decrease	1,975	Interquartile Range	0	Met
		SubICB	2022 09	19	Decrease	2,066	Interquartile Range	0	Met
	S013a: Diagnostic activity levels: Imaging	Provider	2022 09	103.20%	Increase	102.90%	Interquartile Range	120%	Not Met
		SubICB	2022 09	102.50%	Increase	100.90%	Interquartile Range	120%	Not Met
	S013b: Diagnostic activity levels: Physiological measurement	Provider	2022 09	108.30%	Increase	99.50%	Interquartile Range	120%	Not Met
		SubICB	2022 09	109.20%	Increase	98%	Interquartile Range	120%	Not Met
	S013c: Diagnostic activity levels: Endoscopy	Provider	2022 09	79.10%	Increase	90.30%	Lowest Performing Quartile	120%	Not Met
		SubICB	2022 09	76.50%	Increase	87.90%	Lowest Performing Quartile	120%	Not Met
	S013d: Diagnostic activity levels: Total	Provider	2022 09	101.70%	Increase	101.70%	Interquartile Range	120%	Not Met
		SubICB	2022 09	100.80%	Increase	99.70%	Interquartile Range	120%	Not Met
Outpatient transformation	S101a: Outpatient follow up activity levels compared with 2019/20 baseline	ICB	2022 10	95.80%	Decrease		Interquartile Range	75%	Met
Personalised care	S031a: Rate of personalised care interventions	ICB	22-23 Q2	110.18 per 1,000	Increase	75.33 per 1,000	Highest Performing Quartile		
	S032a: Personal health budgets	ICB	22-23 Q1	1.13 per 1,000	Increase	1.45 per 1,000	Interquartile Range		
Primary care and community services	S001a: Number of general practice appointments per 10,000 weighted patients	ICB	2022 08	4231.35 per 10,000	Increase	4305.54 per 10,000	Interquartile Range		
	S106a: Available virtual ward capacity per 100k head of population	ICB	2022 10	9.5 per 100,000	Increase	13.4 per 100,000	Interquartile Range	40 per 100,000	Not Met
	S107a: Percentage of 2-hour Urgent Community Response referrals where care was provided within two hours	ICB	2022 08	80.10%	Increase	82.60%	Interquartile Range	70%	Met
	S108a: Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from a general practice	ICB	2022 03	28.9 per 100,000	Increase		Interquartile Range		
	S108b: Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from NHS111 per 100,000 population	ICB	2022 03	94.2 per 100,000	Increase		Highest Performing Quartile		
	S109a: Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	ICB	2022 09	67.10%	Increase	70.20%	Interquartile Range	100%	Not Met
Screening, vaccination and immunisation	S046a: Population vaccination coverage: MMR for two doses (5 year olds)	SubICB	21-22 Q4	92.30%	Increase	85.90%	Highest Performing Quartile	95%	Not Met
	S047a: Proportion of people over 65 receiving a seasonal flu vaccinatio	SubICB	2022 02	85.50%	Increase	82.30%	Highest Performing Quartile	85%	Met
	S050a: Cervical screening coverage : % females aged 25 : 64 attending screening within the target period	SubICB	21-22 Q4	74.70%	Increase	70.80%	Highest Performing Quartile	75%	Not Met

System Outcome Measures

Domain	Indicator	Metric Period	Northumberland	Newcastle upon Tyne	Gateshead	North Tyneside	Cumbria	South Tyneside	Sunderland	County Durham	Darlington	Stockton-on-Tees	Hartlepool	Middlesbrough	Redcar and Cleveland	NE&C	England
A reduction in health inequalities and an increase in healthy life years	Inequality in life expectancy at birth (Female) (PHOF A02a)	3 Years - 2017-19	▲ 9.9	▼ 8.4	▲ 9.6	▼ 10.6	▲ 8	▼ 6.9	▲ 8.7	▲ 7.9	▲ 9.7	▼ 13.3	▬ 10.4	▼ 11	▲ 8.6	N/A	▲ 7.6
	Inequality in life expectancy at birth (Male) (PHOF A02a)	3 Years - 2017-19	▲ 11.2	▼ 12.6	▲ 10.7	▲ 11.7	▼ 8.5	▲ 10.3	▼ 11	▲ 9.8	▼ 11.9	▼ 14.3	▲ 13.1	▲ 12.9	▲ 13.6	N/A	▼ 9.4
Every child has the best start in life	6-8 week breast feeding rate (PHOF 2.02ii)	Annual - 2019/20	▲ 38.8%	▲ 50.9%	38.7%	42.2%	N/A	N/A	▼ 25.7%	▼ 27.8%	▼ 33.5%	N/A	N/A	▲ 32.6%	▲ 27.6%	▲ 34.6%	▲ 48%
	Inequality in attainment between children eligible and not eligible for free school meals	Annual - 2019	▼ 26%	▲ 19%	▲ 22%	▲ 24%	▲ 25%	▼ 21%	▲ 20%	▬ 22%	▼ 17%	N/A	▲ 29%	▲ 22%	▼ 19%	N/A	▼ 21%
	Inequality in attainment between children eligible and not eligible for free school meals (Achievement of KS2 (RWM) pupils eligible for free school meals (Expected Level))	Annual - 2019	▲ 45%	▼ 53%	▼ 51%	▼ 47%	▼ 44%	▲ 50%	▼ 52%	▼ 48%	▲ 53%	N/A	▼ 48%	▼ 49%	▲ 56%	N/A	▲ 47%
	Inequality in attainment between children eligible and not eligible for free school meals (Achievement of KS2 (RWM) pupils not eligible for free school meals (Expected Level))	Annual - 2019	▲ 71%	▼ 72%	▼ 73%	▬ 71%	▲ 69%	▼ 71%	▼ 72%	▼ 70%	▲ 70%	N/A	▲ 77%	▲ 71%	▬ 75%	N/A	▬ 68%
	Number of children living in poverty (PHOF B05)	Annual - 2021	▲ 25.6%	▲ 32.2%	▲ 28.9%	▲ 23.9%	▼ 15.6%	▲ 31.1%	▲ 30.8%	▲ 28.8%	▲ 28.5%	N/A	▲ 30.1%	▲ 42.4%	▲ 30.7%	N/A	▼ 18.5%
	School readiness % children with free school meals achieving a good level of development at the end of reception (PHOF B02a - free school meals)	Annual - 2019	▲ 61%	▬ 61%	▬ 53%	▼ 54%	▼ 50%	▼ 60%	▲ 63%	▼ 55%	▲ 61%	N/A	▲ 62%	▲ 55%	▼ 53%	N/A	▬ 57%
	Smoking at time of delivery (PHOF C06)	Annual - 2019/20	▲ 13.8%	▼ 12.8%	▼ 12.8%	▲ 11.7%	▲ 13.6%	▼ 13.9%	▲ 18.3%	▼ 16.8%	▲ 16.4%	▼ 16.5%	▼ 16.5%	▼ 16.5%	▼ 16.5%	▼ 15%	▼ 10.4%
Health and care offer built around people families and communities	Unemployment rate	Annual - 2022	▲ 5.2%	▲ 7.6%	▬ 5.9%	▲ 5.6%	▲ 3.1%	▼ 6.3%	▼ 5.9%	▲ 5.3%	▬ 5.3%	▬ 5.6%	▬ 6.8%	▼ 7.3%	▲ 5.9%	N/A	N/A
Increased focus across the system on prevention and early help	Deaths from drug misuse (PHOF C19d)	Annual - 2017-19	▲ 6.1	▲ 10.3	▼ 9.8	▼ 7.4	▲ 6.8	▲ 8.2	▲ 9.5	▼ 7.4	▲ 8.8	▲ 10.1	▲ 15.5	▲ 16.3	▲ 11	▲ 8.1	▲ 4.7
	Prevalence of children in year 6 of excess weight (PHOF C09a)	Annual - 2020	▲ 33%	▼ 40.2%	▲ 38.7%	▲ 35.7%	▲ 34.3%	▲ 40%	▼ 36.7%	▼ 37.6%	▼ 37.6%	N/A	▼ 40.3%	▲ 40.2%	▲ 39.3%	N/A	▲ 35.2%
People and families are supported to live in their communities and to be as independent as possible	People with a learning disability supported into paid employment (ASCOF 1E)	Annual - 2020/21	▼ 4%	▲ 4.5%	▲ 10%	▲ 5.1%	▼ 2.5%	▼ 4.7%	▼ 3.2%	▼ 0.4%	▼ 4.4%	▼ 3.8%	▼ 21.8%	▼ 1.5%	▼ 6.4%	▲ 4.1%	▼ 4.8%
	Percentage of adult social care users who have as much social contact as they would like (ASCOF 1I)	Annual - 2019/20	▲ 100%	▲ 100%	▲ 100%	▲ 100%	▲ 100%	▲ 100%	▲ 100%	▲ 100%	▲ 100%	▲ 100%	▲ 100%	▲ 100%	▲ 100%	▲ 100%	▲ 100%
	The proportion of adults with a learning disability who li ve in their own home or with their family (ASCOF 1G)	Annual - 2020/21	▼ 86.1%	▲ 88.6%	▲ 84.2%	▲ 94%	▼ 71.4%	▲ 86.4%	▲ 93.7%	▼ 81.3%	▼ 95.3%	▲ 75.7%	▲ 91.5%	▲ 83.5%	▲ 85.9%	▲ 84.5%	▲ 78.8%
People experience excellent co-ordinated care with dignity and respect	Self-reported user experience (ADSC users survey)	Annual - 2019/20	▲ 64.7	▼ 62.7	▲ 64.2	▲ 66.4	▲ 74.4	▲ 65.9	▲ 72.2	▲ 69.6	N/A	▲ 70.2	▲ 69.3	▼ 70.2	▼ 68	N/A	▼ 64.2
Reduce avoidable disease/death	Under 75 mortality rate for cancers (persons) (PHOF E05a)	3 Years - 2017-19	▼ 125	▼ 157.9	▼ 157.2	▼ 147.3	▼ 122.8	▼ 155.5	▲ 165.1	▼ 145.5	▲ 137.4	▼ 146.8	▼ 160.1	▼ 175.1	▼ 150.8	▼ 152.5	▼ 129.2
	Under 75 mortality rate for circulatory disease (persons) (PHOF E04a)	3 Years - 2017-19	▼ 69.9	▲ 87.9	▼ 86	▼ 77.7	▲ 75.5	▲ 90.3	▲ 89	▲ 78.9	▼ 74.3	▼ 73.1	▲ 99.1	▼ 100.8	▼ 88	▲ 85	▼ 70.4
	Under 75 mortality rate for respiratory disease (persons) (PHOF E07a)	3 Years - 2017-19	▲ 31.3	▼ 46.3	▲ 48.2	▲ 40	▼ 27.8	▼ 54.3	▲ 45.3	▲ 43	▲ 47.3	▼ 42	▲ 49.4	▲ 69.3	▲ 49	▲ 44	▼ 34.2

System outcome measures are being developed with health and Local Authority (LA) partners at place, requiring partners to work together to deliver the prevention agenda and address health inequalities.
Metrics within an agreed framework (Gateshead System Partnership) linked to the Health and Wellbeing priorities have been pulled into Power BI and illustrated at ICS level and place where available (North Cumbria is not available currently therefore Cumbria has been utilised as a proxy measure). This section will be developed in line with NENC strategic outcome measures once these are agreed.
Summary of key themes against the health and wellbeing domains:

Reduction in Health inequalities
- Inequality in life expectancy at birth (Female) is widest in Stockton on Tees at 13.3 years (although an improving picture) compared to County Durham (7.9 years) and the national (7.6 years).
- Inequality in life expectancy at birth (Males) is widest in Stockton (14.3 years) compared to 8.5 years in Cumbria and 9.5 national.

Every child has the best start in life
- The number of mothers still breast feeding at 6-8 weeks is highest in Newcastle (50.9%) and lowest in Sunderland at 25.7%. NB this data is not available for 4 of our LAs. The national value is 48% compared to NENC 34.6%.
- Inequality in attainment between children eligible and not eligible for school meals is highest in Northumberland (26%) compared to 17% in Darlington. The national value is 21%.
- The number of children living in poverty is lowest in Cumbria (15.6% improving) and highest in Newcastle upon Tyne (32.2% worsening) and South Tyneside (31.1% worsening). Nationally this is 18.5%.
- % children with free school meals achieving a good level of attainment at the end of reception is highest in Sunderland (63% improving) and lowest in Cumbria (50%), Gateshead (53%) and Redcar and Cleveland (53% worsening). Nationally this is 57%.
- % of mothers smoking at the time of delivery is lowest in Gateshead and Newcastle (12.8% and improving) and highest in Sunderland (18.3% - worsening). The national value is 10.4% compared to NENC 15%.

Families and communities
- Unemployment rate is highest in Newcastle (7.6 and worsening) and Hartlepool 6.8% and lowest in Cumbria 3.1%

Prevention and Early help
- Deaths from drug misuse is highest in Middlesborough (16.3 per 100,000 population) and Hartlepool (15.5 per 100,000 population) and lowest in Northumberland (6.1 per 100,000). Nationally this is 4.1 per 100,000.
- Prevalence of children in year 6 of excess weight is highest in Hartlepool 40.3% and Middlesbrough 40.2% and lowest in Northumberland (33%) . Nationally this is 35.2%.

Supporting people and families to be independent
- People with LD in suitable accommodation and supported into paid employment is lowest in Durham (0.7%) and highest in Hartlepool (22.3%)
- % of adult social care users who have as much social contact as they would like is highest in Sunderland (55%) and lowest in Newcastle (46.5%)
- Proportion of adults with a learning disability who live in their own home or with family is highest in Darlington (95.8%) and lowest in Stockton (72%)

Coordinated care
- Self reported survey scores for users of adult social care were highest in Sunderland 72.2 and lowest in Newcastle 62.7 . Nationally this was 64.2.

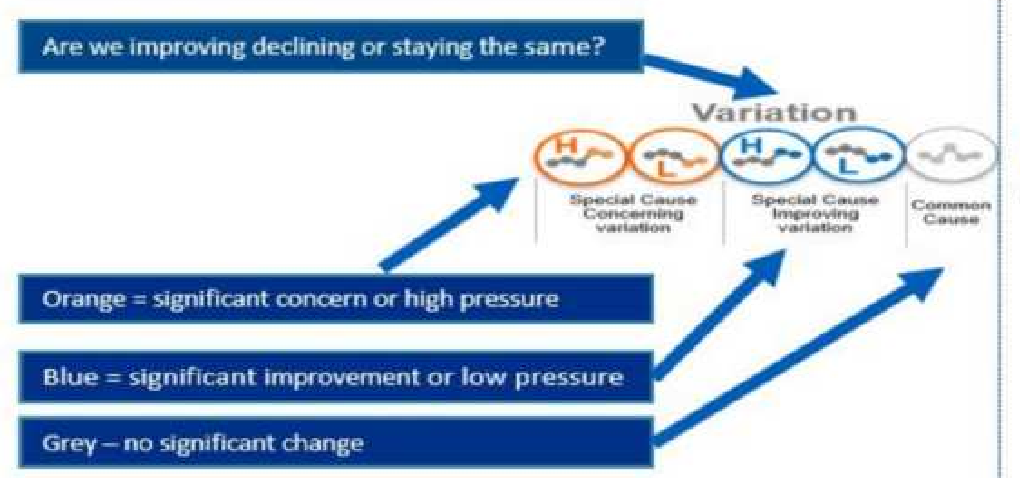
Reduce Avoidable disease/death
- Under 75 mortality rate for cancer highest in Middlesborough (175.1 per 100,000) and lowest in Cumbria (122.8) and Northumberland (125). Nationally this was 129.2 compared to NENC overall 152.5.
- Under 75 mortality for circulatory disease is highest in Middlesborough (100.8 per 100,000) and lowest in Northumberland (69.9 per 100,000) . The national value is 70.4 compared to NENC overall 85..
- Under 75 mortality rate for respiratory disease is highest in Middlesborough (69.3 per 100,000) and lowest in Cumbria (27.8 per 100,000). The national value was 34.2 compared to NENC overall 44.

Quality

Quality - Executive Summary

	Performance
Healthcare Acquired Infections	• MRSA - one case (hospital onset) was reported in October 2022, which brings the year to date (YTD) total across the region to 5 cases (4 hospital onset (STHFT, NHCFT, NUTH, STSFT and 1 community onset at STHFT). • Clostridium Difficile - four Trusts are exceeding their YTD national thresholds for the number of infections reported. • E. Coli - five Trusts are exceeding their YTD national thresholds for the number of cases reported. • Klebsiella pneumoniae - six Trusts are exceeding their YTD national thresholds for the number of cases. • Pseudomonas. Aeruginosa - two Trusts are exceeding their YTD national thresholds for the number of cases. • All providers are signed up to a set of principles for the management of COVID-19 Infection, Prevention and Control (IPC) and there is a system wide approach to antimicrobial resistance (AMR)
Serious Incident (SI) Reporting	• 15 never events have been reported across the region YTD (30 November 2022) and these will continue to be monitored via SI processes. • One Trust (STSFT) remains in quality escalation in relation to never events and has undertaken a thematic review of incidents to identify wider organisational learning. This will be presented at the next quality review group (QRG) meeting.
Sickness absence Rates	Ten Trusts across NENC were above the England average (6.05%) in July 2022. Workforce pressures continue due to sickness absence and vacancies, although some improvement has been seen. Measures are in place to ensure operational challenges are managed, safe staffing levels are in place and support is offered to staff to maintain their health and wellbeing.
Patient Safety Alerts	One Trust is showing with an alert open past its completion deadline. This will be raised with the Trust to seek confirmation this has been actioned and closed.
Mortality	All Trusts are showing within the 'expected range' for the Summary Hospital-level Mortality Indicator (SHMI). STSFT was previously an outlier, but their position has improved and remains on a reducing trend, which is expected to reduce further once hospice data is excluded from their SHMI data.
Friends and Family Test	Five Trusts had recommendation scores below the England average.
CQC Inspections	Two Trusts have had recent CQC inspections and outcome from this is awaited as follows: • STSFT: Unannounced inspection took place in June 2022 and a well-led assessment in August 2022. The CQC process remains ongoing and as yet there is no date on when inspection report will be published. • STHFT: CQC undertook a further inspection in November 2022 with a well led inspection planned for January 2023. The Trust will remain in the inspection window until after this time with the final inspection report expected by March 2023.
Handover Delays	A rapid process improvement workshop (RPIW) took place in November 2022 regarding handover delays, which was led by the NENC Urgent and Emergency Care Network. It was agreed that a different approach was needed to address the issue of handover delays and a draft report has been prepared which includes two approaches. ICB Chief Executive has requested to meet with all Trusts regarding the plan and a 'go live' date is to be confirmed.
NEAS Independent Enquiry Update	The planned timescale for completion is the end of the year. Support continues to be offered to NEAS from the ICB and system.
Maternity Safety	STSFT: reopened their Midwifery Led Birthing Unit (MLBU) from 1 November 2022, after it was temporarily closed earlier in the year. Bookings up until late January 2023 have all been transferred to Sunderland Royal Hospital owing to choice and clinical reasons, however the unit is open for new bookings. Staffing pressures remain due to sickness absence and further midwifery recruitment is underway. The enhanced surveillance of maternity services was stood down in October 2022 owing to the level of assurance gained.
TEWVFT Patient Safety Team	There are staffing pressures in the patient safety team and there are currently 40 unallocated serious incident reviews. The Trust has advertised posts on a number of occasions, but recruitment has been challenging. The Trust is trying to recruit from abroad and also develop a bank workforce that could be used in the patient safety team.
Independent Providers	A contract performance notice has been issued to an independent provider in relation to their unauthorised use of Patient Group Directives, including Mifepristone, for cervical preparation. The provider submitted an options appraisal to the commissioners which was considered by clinical, contracting, commissioning and quality leads from the ICB and NECS. Recommendation on the next steps were considered and accepted by the ICB Executive Board. The ICB has requested that the provider provides written assurance on a number of immediate and remedial actions, with set deadlines.

Variation and Assurance Icons



Variation	Assurance	Description
H	F	Special cause of a concerning nature where the measure is significantly HIGHER. This occurs where there is higher pressure in the process or deteriorating performance. This process is not capable. It will FAIL the target without process redesign.
H	P	Special cause of a concerning nature where the measure is significantly HIGHER. This occurs where there is higher pressure in the process or worse performance. However despite deterioration the process is capable and will consistently PASS the target.
H	?	Special cause of a concerning nature where the measure is significantly HIGHER. This occurs where there is higher pressure in the process or worse performance. This process will not consistently hit or miss the target. This occurs when target lies between process limits.
L	F	Special cause of a concerning nature where the measure is significantly LOWER. This process is not capable. It will FAIL the target without process redesign.
L	P	Special cause of a concerning nature where the measure is significantly LOWER. However the process is capable and will consistently PASS the target.
L	?	Special cause of a concerning nature where the measure is significantly LOWER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
	F	Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.
	P	Common cause variation, no significant change. This process is capable and will consistently PASS the target.
	?	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Variation	Assurance	Description
H	F	Special cause of an improving nature where the measure is significantly HIGHER. This process is still not capable. It will FAIL the target without process redesign.
H	P	Special cause of an improving nature where the measure is significantly HIGHER. This process is capable and will consistently PASS the target.
H	?	Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
L	F	Special cause of an improving nature where the measure is significantly LOWER. This process is still not capable. It will FAIL the target without process redesign.
L	P	Special cause of an improving nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.
L	?	Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
		Special cause variation where UP is neither improvement or concern
		Special cause variation where DOWN is neither improvement or concern

Quality exceptions and concerns including CQC visits

NHS

	Performance	Risks, Actions and Identified Learning
STSFT	Unannounced CQC Inspection: There was an unannounced inspection visit to the Trust in June 2022 and a well-led assessment in August 2022. The CQC process remains ongoing and as yet there is no date on when the inspection report will be released. Maternity: The Midwifery Led Birthing Unit (MLBU), which was temporarily closed earlier in the year, reopened from 1 November 2022. Bookings between then and late January 2023 have all been transferred to Sunderland Royal Hospital owing to choice and clinical reasons however the unit is an option for new bookings. Staffing pressures remain due to sickness absence and further midwifery recruitment is underway. Staff flu vaccinations: As of December 2022, there has been poor performance regarding staff flu vaccination uptake. This is in part related to issues with NHS Professionals who were initially being used to support the campaign.	CQC inspection: Report will be published in due course. Maternity: The work is on track with the proposal for a Director of Midwifery role and a Consultant Midwife post has been agreed. The enhanced surveillance of maternity services was able to be stood down in October 2022 owing to the level of assurance gained. Staff flu vaccinations: The Trust has an improvement plan underway to increase the roll out and uptake of staff flu vaccinations.
NTHFT	CQC inspection Report (published September 2022): An overall rating of 'requires improvement' was awarded. The Safe, Effective and Well-led domains were all rated 'requires improvement' and the caring and responsive domains were rated as 'good'.	CQC inspection (published September 2022): The Trust's improvement action plan was discussed at the CQRG in December 2022 and regular progress updates will continue to be provided.
STHFT	Unannounced CQC inspection: The CQC conducted a focused inspection on a small number of wards at James Cook University Hospital and Friarage Hospital in February 2022. The CQC issued a Section 29A warning notice identifying improvements required in relation to ward-based documentation, nutrition, and hydration, MCA/DOLS and discharge. The Trust were already acting on these areas as part of its clinically led recovery from the winter Omicron surge and feedback from a follow-up visit in September 2022 was positive. The CQC undertook a further inspection in November 2022 with a well led inspection planned for January 2023. The Trust will remain within the inspection window until after this time with the final inspection report expected by March 2023.	The Trust continue to work to embed the improvements identified at the initial visit in February 2022 and awaits feedback from the ongoing visit.
NEAS	National Independent Enquiry: The Secretary of State for Health and Social Care has confirmed that the NHS will hold a full independent review into the allegations made against NEAS. Handover delays: A rapid process improvement workshop (RPIW) took place in November 2022 regarding handover delays, which was well attended by stakeholders. This event was led by the NENC Urgent and Emergency Care Network and facilitated by NECS colleagues. It was agreed that a different approach was needed to address the issue of handover delays and the impact on patients waiting in the community.	Independent Review: The planned timescale for completion of the enquiry is the end of 2022. Support continues to be offered to the Trust via the QRG, ICB and wider system. Handover Delays: A draft report has been prepared which includes two approaches. Firstly, NEAS crews will leave patients in the care of ED staff at 59 minutes; it is suggested that Trusts have clinical responsibility for patients starting at 15 minutes from arrival (i.e., handover timescale target). Secondly, cohorting of patients in ED which will enable NEAS crews to be released sooner; the plan for this is under development and the system-risk posed by this approach is accepted. The ICB Chief Executive has requested to meet with all Trusts regarding the plan and a 'go live' date is to be confirmed.

Quality exceptions and concerns including CQC visits

NHS

	Performance	Risks, Actions and Identified Learning
CNTWFT	18 Week Waiters: there has been an increase in patient waiting longer than 18 weeks to be seen in the Older Persons Services and Children and Young People Services.	Localities have committed to meeting quality standards by the end of Q4 2022/23 which includes a focus on underperforming contract requirements. The Access and Waiting Times group has taken on more of a performance management role and an updated reporting proforma has been developed for localities to highlight issues and provide key action points for areas of improvement. Localities provide monthly updates on key deliverables and issues.
TEWVFT	Patient Safety team: there are staffing pressures within the patient safety team, there has been three full time reviewers leave in a short period of time. There are currently 40 unallocated Serious Incident Reviews. Quality Board and Governance: The Quality Improvement Board has been meeting regularly to support the Trust with the risks identified within the organisation, further discussions have taken place to understand if an operational group is required to discuss operational issues within the Trust. NECS, NHS England and TEWVFT are going to meet to discuss all the current meetings in place and the scope of each one to highlight if there are any gaps.	Patient Safety team: The Trust has advertised the posts on a number of occasions, but recruitment is challenging due to low applications, applicants not having the right skills and successful applicants then being offered alternative employment. The Trust are trying to recruit from abroad and also develop a bank workforce of band 7's that could be used within the patient safety team. Quality Board and Governance: NECS, NHS England and TEWVFT are going to meet to discuss all the current meetings in place and the scope of each one to highlight if there are any gaps.
North Cumbria Update	Adult Safeguarding - a thematic review has been undertaken on the 17 domestic homicide review cases currently open and in review. DOLS assessments – a detailed recovery plan is being developed for the backlog of cases identified which have waited beyond 24 months for review. Children Looked after Service: Is in 'business continuity' due to workforce challenges. Asylum Seekers: A third hotel has opened in Carlisle.	Adult Safeguarding: The review did not identify any specific overarching themes and anticipates a review over a larger scale may yield more learning. DOLS assessments: This is now being escalated and added to the risk register. A more detailed separate briefing paper is being prepared. Children Looked after Service: An action plan is being developed by the provider to give assurance on how they will ensure that the statutory functions are prioritised during this time. The key risk areas are the growing backlog of Review Health Assessments (RHA) and lack of assurance from NCICFT to support the medical advisor role for fostering and adoption. Asylum Seekers: Cumbria Health on Call and Primary Care are providing health screening and the maternity service has also been asked to give support.
Independent Providers	Butterwick Hospices: Updated CQC (August) report for Stockton site, all domains now rated as good apart from safe which requires improvement. Alice House: Two serious incidents have been reported, one fall which resulted in a fracture, and another was a perforated bowel post PEG insertion. Both are currently in the SI process and waiting to be presented at panel. There are ongoing medical staffing vacancies, which appears to reflect the national shortage of palliative care specialists across both medicine and nursing. BPAS Middlesborough CQC Inspection: The CQC undertook a comprehensive unannounced follow-up inspection of BPAS Middlesbrough in April 2022 and conditions imposed on the providers registration in respect of regulated activities remained. BPAS Patient Group Directives (PGD) for Cervical Preparation: A Contract Performance Notice (CPN) covering all services commissioned by the ICB has been issued to BPAS. This was in response to concerns around their unauthorised use of PGDs, including the use of Mifepristone for cervical preparation, which is not legally permitted.	Butterwick Hospices: The provider continues to meet with the ICB on a regular basis in contract and recovery meetings to discuss overarching service improvement plan. Alice House: Both are currently in the SI process and waiting to be presented at panel. BPAS Middlesborough: has undertaken an extensive improvement programme and have completed the required actions outlined within the CQC improvement plan. This has been communicated with the CQC and a formal request to review the conditions placed on the provider has now been submitted. Regular contract and quality meetings continue. BPAS: Tees Valley ICB representatives met with BPAS, and it was agreed that they would provide an options appraisal to the commissioners for consideration, which has now been received. This was considered by clinical, contracting, commissioning and quality leads from the ICB and NECS, and recommendations on the next steps were considered and accepted by the ICB Executive Board. The ICB has requested written assurance from BPAS on a number of immediate and remedial actions, with set deadlines. Once received this will be considered and if appropriate the CPN will be withdrawn/closed. BPAS has confirmed they are working at pace to implement the use of Patient Specific Directions (PSD) for the use of cervical preparation in their systems and teams, with a go live date of 20 December 2022.

Quality - North and North Cumbria

NHS

-	-	NCIC				Northumbria				NuTH				Gateshead FT			
-	Indicator	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.
Quality - Serious Incidents	Proportion of incidents submitted within 60 days - November 2022	50%				20%				52.2%				0%			
	Proportion of incidents reported within 2 days - November 2022	100%				85.7%				63%				100%			
	Number of Serious Incidents reported - November 2022	3				7				27				4			
	Number of Serious Incident Never Events reported - November 2022	0				0				0				0			
Quality - Mortality	Summary Hospital-level Mortality Indicator (SHMI) value - July 2022	1.1015				0.956				0.9149				0.9353			
Quality - HCAI	Incidence of P. aeruginosa - October 2022	2	1			1	1			5	3			0	1		
	Incidence of MSSA - October 2022	5				5				12				2			
	Incidence of MRSA - October 2022	0	0			0	0			0	0			0	0		
	Incidence of Klebsiella spp - October 2022	3	2			2	4			9	13			4	2		
	Incidence of E Coli - October 2022	7	8			5	11			17	17			4	6		
	Incidence of C Difficile - October 2022	7	4			9	4			20	14			1	3		

-	-	NCIC				Northumbria				NuTH				Gateshead FT			
-	Indicator	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.
Quality - Staff	Staff Absence Rate - July 2022	6.4%				6.8%				6.7%				6.2%			
	Staff Turnover Rate - August 2022	1.4%				1.4%				1.5%				1.6%			
Quality - Friends and Family	Proportion of service users that would recommend Community Health Services - October 2022	97.9%				93.2%				92.1%				100%			
	Proportion of service users that would recommend Emergency Department - October 2022	75.2%				82.6%				85.7%				70.4%			
	Proportion of service users that would recommend Inpatient Services - October 2022	98.7%				93.6%				97.4%				94.6%			
	Proportion of service users that would recommend Maternity Services - October 2022	50%				66.3%				89.3%				0%			
	Proportion of service users that would recommend Mental Health Services - October 2022					87.5%								100%			
	Proportion of service users that would recommend Outpatient Services - October 2022	98.8%				95.4%				97.2%				93.3%			

Quality - Central and South

		STSFT				CDDFT				NTHFT				STHFT			
	Indicator	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.
Quality - Serious Incidents	Proportion of incidents submitted within 60 days - November 2022	66.7%				0%				0%				14.3%			
	Proportion of incidents reported within 2 days - November 2022	100%				100%				66.7%				85.7%			
	Number of Serious Incidents reported - November 2022	1				4				3				14			
	Number of Serious Incident Never Events reported - November 2022	0				0				0				1			
Quality - Mortality	Summary Hospital-level Mortality Indicator (SHMI) value - July 2022	1.1085				1.1141				0.9919				1.0715			
Quality - HCAI	Incidence of P. aeruginosa - October 2022	4	2			0	1			3	1			1	1		
	Incidence of MSSA - October 2022	10				6				1				2			
	Incidence of MRSA - October 2022	0	0			0	0			0	0			1	0		
	Incidence of Klebsiella spp - October 2022	4	4			5	3			2	2			4	4		
	Incidence of E Coli - October 2022	16	10			3	9			5	6			12	12		
	Incidence of C Difficile - October 2022	14	5			4	5			7	4			18	9		

		STSFT				CDDFT				NTHFT				STHFT			
	Indicator	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.
Quality - Staff	Staff Absence Rate - July 2022	5.9%				6.9%				6.9%				6.8%			
	Staff Turnover Rate - August 2022	1.2%				1.5%				1.1%				1.3%			
Quality - Friends and Family	Proportion of service users that would recommend Community Health Services - October 2022	100%				100%				95.1%				99.1%			
	Proportion of service users that would recommend Emergency Department - October 2022	75%				82.5%				71.6%				77.9%			
	Proportion of service users that would recommend Inpatient Services - October 2022	95.3%				95.5%				89.4%				97.4%			
	Proportion of service users that would recommend Maternity Services - October 2022	87%				99%				85.7%				91.4%			
	Proportion of service users that would recommend Mental Health Services - October 2022	95.6%															
	Proportion of service users that would recommend Outpatient Services - October 2022	95.2%				98.1%				95%				95.6%			

Quality - Mental Health and Ambulance

-	Indicator	NEAS Value	NEAS Traj.	NEAS Var	NEAS Ass.	TEWV Value	TEWV Traj.	TEWV Var	TEWV Ass.	CNTW Value	CNTW Traj.	CNTW Var	CNTW Ass.
Quality - Serious Incidents	Proportion of incidents submitted within 60 days - November 2022					0%				60%			
	Proportion of incidents reported within 2 days - November 2022	100%				100%				100%			
	Number of Serious Incidents reported - November 2022	5				5				2			
	Number of Serious Incident Never Events reported - November 2022	0				0				0			

-	Indicator	NEAS Value	NEAS Traj.	NEAS Var	NEAS Ass.	TEWV Value	TEWV Traj.	TEWV Var	TEWV Ass.	CNTW Value	CNTW Traj.	CNTW Var	CNTW Ass.
Quality - Staff	Staff Absence Rate - July 2022	9.1%				6.5%				7.3%			
	Staff Turnover Rate - August 2022	1%				1.1%				1.1%			
Quality - Friends and Family	Proportion of service users that would recommend Mental Health Services - October 2022					92.7%				85.4%			

Quality - Exceptions - Safe

	Performance	Risks, Actions and Identified Learning
Healthcare Associated Infections (HCAI) (published data – October 2022)	MRSA: STHFT reported 1 MRSA (hospital onset) case. This brings the year to date (YTD) total across the region to n=5 including 4 hospital onset (NHCFT, NuTHFT, STSFT and STHFT) and 1 community-onset (STHFT). C Difficile Infection: YTD 412 cases have been reported across the region, with four Trusts (NHCFT, CDDFT, STSFT, STHFT) exceeding their YTD national thresholds. E. Coli: YTD 576 cases have been reported across the region, with five Trusts (NuTHFT, NCICFT, STSFT, CDDFT NTHFT) exceeding their YTD national thresholds. MSSA: YTD 250 cases have been reported across the region. NuTHFT is the highest reporter (64 cases). Klebsiella spp: YTD 265 cases have been reported across the region. Six Trusts (GHFT, NHCFT, NCICFT, STSFT, STHFT, NTHFT) are exceeding their YTD national thresholds. P. Aeruginosa: YTD 77 cases reported across the region. Two Trusts (NuTHFT, NTHFT) are exceeding their YTD national thresholds.	All providers are signed up to a set of principles for the management of Covid Infection, Prevention and Control (IPC), and there is a systemwide approach to antimicrobial resistance (AMR). STHFT - Regular Trust panels are held to discuss cases in more detail and identify learning, of which the place-based commissioners are involved. Following prolonged discussion and planning the Trust is undertaking fogging across all wards. Monitoring and surveillance of primary care prescribing continues. NuTHFT - the Gram-Negative Bacteraemia Blood Stream Infections (GNBSI) Steering Group continues to monitor and review a wide range of ongoing Quality Improvement (QI) projects. The Trust's IPC team were recently awarded the Infection Prevention Society national gold award for their initiative to reduce glove use and support hand hygiene, which has maintained a significant reduction in glove use. CDDFT - as part of their overall HCAI reduction plans for C-Difficile and Carbapenamase-Producing Enterobacteriaceae a full mattress and pillow audit was to be completed in September/October 2022 due to concerns of potential contamination. The audit at University Hospital of North Durham (UHND) is now complete, with 50 mattresses being changed. The audit at Darlington Memorial Hospital and Bishop Auckland Hospital has not yet been completed. STSFT - Combined South Tyneside/Sunderland place based HCAI/AMR action plan is in place and the Trust is operating a business-as-usual process for the management of E. Coli, C. Difficile and MRSA. NENC AMR/HCAI Board are aware of increasing activity of C. Difficile and consideration is being given to support an approach. The place-based Directors of Nursing have escalated to the Chief Nurse, the need for a NENC system wide approach to address increasing GNBSI and C. Difficile activity. In the meantime, central areas IPC teams are promoting and offering educational work in the community around C. Difficile and E. Coli and are also raising awareness about other seasonal infections.
Never Events	NENC ICS year to date (YTD) total n=15 as at 30.11.2022 STHFT reported a further never event in November 2022 involving wrong site surgery (8th and 9th rib sutured in error as opposed to 9th and 10th rib). YTD the Trust has reported 6 never events.	Never events continue to be monitored via the serious incident management processes. STHFT remains in quality escalation in relation to never events and has undertaken a thematic review of incidents to identify wider organisational learning. Progress against the findings and recommendations from the thematic review is to be presented at the next QRG.
Serious Incident (SI) reporting (September 2022)	2-day reporting: Four Trusts (NuTHFT, NTHFT, NHCFT and STHFT) were outside the 95% threshold for reporting serious incidents within two days of identification. 60-day reporting: The 60-day timeframe is no longer a requirement under SI framework/Patient Safety Incident Response Framework (PSIRF). The timeframe was suspended at the start of the pandemic and has since been permanently removed. However, timescale remains in place as a measure for monitoring submission of reports.	Regular discussion on SI performance takes place at all Trust QRG meetings and commissioner SI panels to gain assurance there are processes in place to manage the backlog of any cases. STHFT LTFU Theme: A programme of improvement work has commenced to address themes including staffing pressures, diagnostic reporting processes, incident identification and reporting. This has been included in the Trust Recovery Program and a report has been prepared which is currently going through the Trust internal governance processes. The report is expected in January 2023. CDDFT Electronic Patient Record (EPR) System: Since EPR go live there has been a recognised generic issue where patient discharge letters/ED discharge letters have not been sent to GPs. Over recent weeks continued work, support and training has been undertaken by the Trust to remove this error and ensure the correct discharge workflow has been followed. Examples of this include inpatient/outpatients, and the recording of deaths. Multiple efforts have been made to work through outstanding discharges to ensure GPs have updated patient information and documentation following a patient discharge. The Trust reported this as a SI in December 2022. NTHFT Deteriorating patient The Trust continues with the Deteriorating Patient Steering Group and improvement work. The Trust has a number of SI's which have involved patients with Autism, as part of their action plan they are reviewing the potential of becoming a pilot site for the 'Worries and Concerns' initiative. They have employed two Deteriorating Patient Specialist nurses to implement the improvement work.

Quality Exceptions - Safe and Caring

	Performance	Risks, Actions and Identified Learning
NHS Sickness Absence Rates	Ten Trusts were above the England average for July 2022 (6.05%). Workforce pressures continue due to sickness absence and vacancies, although some improvement has been seen.	A range of measures are in place to ensure operational challenges are managed, safe staffing levels are in place and support is being offered to staff to maintain their health and wellbeing. Safe staffing updates are provided at QRG meetings.
Outstanding Patient Safety Alerts Open on Central Alerting System (CAS) -- December 2022	One Trust (STHFT) is showing with an outstanding patient safety alert open on the national CAS system. This relates to 'NatPSA/2022/009/MHRA Prenoxad 1mg/ml Solution for Injection in a pre-filled syringe, McCarthy's Laboratories, (Aurum Pharmaceuticals Ltd), caution due to potential needles in sealed kits', which was issued on 10.11.22 with a completion date of 17.11.22.	This will be raised with the Trust to seek assurance that the alert has been actioned and closed.
Mortality – Summary Hospital-level Mortality Indicator (SHMI)	All Trusts are showing within the 'expected range' of deaths for SHMI. As previously reported STSFT was showing as an outlier for this measure, however this position has improved. STSFT SHMI data for the 12-month period August 2021 to July 2022 is now within the expected range with a value of 110.85 and remains on a reducing trend. This is anticipated to reduce further once the hospice data is excluded from their SHMI data.	
Family and Friends Test	GHFT: A drop in FFT recommendation score for A&E has been noted this month. NTHFT: A drop in FFT recommendation score for inpatients and A&E has been noted this month. NHCFT and NuTHFT: A drop in FFT recommendation score for community services has been noted this month. CNTWFT: A drop in FFT recommendation score for mental health services has been noted this month.	Trusts continue to monitor positive and negative comments received via FFT on a regular basis to ensure that issues or concerns are acted upon to reduce the recurrence of similar issues in the future.

Performance

Performance - Executive Summary

Performance

Primary Care

- GP appointment levels at pre-pandemic levels continue to increase, with a total of 1.7m during October 22 which is within planned trajectory for October and a marked increase on September (1.5m).
- DNAs as a proportion of all appointments remain high at 5.5% in October, an increase on September (5%) but below the national rate (5.9%).
- Practices routinely offering face to face appointments where clinically necessary and they continue to increase, up to 75.3% of total appointments delivered in October. This exceeds the level nationally at 70.1%

Urgent and Emergency Care (UEC)

- Pressures due to high level of attendances, high bed occupancy and delays with social care discharges continue resulting in sustained pressure on UEC pathways. High levels of medically optimised patients is an ongoing feature across the system. NENC system is working hard to increase capacity and operational resilience ahead of winter with a continued focus on ambulance performance and response and discharge.
- Ambulance Response times continue to be a pressure although NEAS is meeting C1 mean and 90th Centile for November. Cat 2 mean and 90th percentile standards continue to not be met although November performance has improved from 57:34 in October to 49m:18 in November. This is higher than the national however, which has also significantly improved in November to 41:21.
- Handover delays continue, resulting in 98.9 average hours lost per day across NENC as at December 2022 compared to a target of 60.9. 80.1% of handovers took place under 30 minutes compared to a 95% standard, and 88.8% of handovers were under 60 minutes in December 2022 (expected standard of zero >60 mins). It should be noted that only 65.3% of ambulance arrivals with a handover time were recorded in NENC which will skew the data.
- Although not meeting the 95% standard, NENC performance is performing favourably compared to the national for November (all types) at 72.9%, compared to 61.4% nationally.
- Patients waiting in A&E more than 12 hours following decision to treat has increased significantly from to 1106 in October to 1393 in November. The % of patients waiting longer than 12 hours from arrival to discharge is above the 2% standard for September at 3% in NENC.
- Patients who no longer meet the criteria to reside and whose discharge is delayed is at 7.6% compared to the target level of 9.2% in NENC in October. Pressures with social care discharges continue to creating considerable pressure.
- Type 1 General and Acute bed occupancy remains high and has increased significantly to 91.5% in November. This is above the 85% national expectation, and above the operational plan level in NENC.

Elective Care

- The total number of patients on the waiting list continues to grow, exceeding the operational plan trajectory for October 22 and is at an all-time high for NENC at 327,379. More recent weekly unvalidated data shows a further increase in waiting list size across NENC from 344,489 (w/e 30 Oct) to 353,345 w/e 4 December).

There were 23 104+ week waiters as at end of October 2022, the key pressure are being spinal patients at Newcastle upon Tyne Hospitals NHS FT . This is within the planned level for NENC (48 plan). The Trust continues to manage patients and seek additional capacity including through the independent sector (IS) providers. It is anticipated that this level will be at 22 by the end of March 2022. It should be noted that more recent unvalidated data has shown this to have increased to 27 w/e 4th December, with 1 at NCIC, in addition to those spinal patients at NUTH. This has been impacted by a national shortage of blood products.

- 78+ waiters are increasing in NENC after a continual reduction over recent months and are now above planned levels in October (896 compared to 419 plan). The majority of 78+ waiters are at NUTH, with a proportion at South Tees, and CDDFT in addition. More recent unvalidated weekly data shows a continued increase across NENC to data 1005 (w/e 4 Dec).

- 52+ week waiters continue to increase and are above planned levels, this is the sixth consecutive monthly increase observed. Of the 8467 in total as at the end of October, the majority were at NUTH, followed by South Tees, and CDDFT. Pressures exist across high volume specialties at NUTH including T&O, Dermatology, Ophthalmology and Plastic Surgery. The plan is expected to maintain this level through to March 2022 with a significant focus at NUTH on 78+ waiters. More recent unvalidated weekly data shows a further increase in NENC to 9451 (w/e 4 Dec).

- Diagnostics >6 week performance for the 15 key diagnostic tests is relatively stable across NENC and continues below the requirement for 1% of patients to wait longer than 6 weeks, with 17.2% patients waiting over 6 weeks for a diagnostic test in October 2022 compared to 27.5% nationally. Key pressure areas include Echo-cardiography, Endoscopy and Audiology.

Performance - Executive Summary

Performance

Cancer

• NENC are currently achieving the faster diagnosis standard for October 22 which stands at 75.6% v the 75% target, a slight improvement since September. This compares favourably to the national performance (68.5%). Variation between Trusts exists with highest performance at CDD FT (88.7%) and Gateshead at 81.2% and lowest at NCIC (64.8%).

• 31 day treatment standard and the 62 days referral to treatment standards are not currently being met. Currently 59.8% patients waiting longer than 62 days compared to the 85% standard in NENC, this is a deteriorating position and is slightly below the national at 60.3% for October. Variation between Trust 62 day performance ranges from 73.5% at Northumbria HC to 45.3% at NUTH.

• South Tees, North Tees, NUTH, and North Cumbria have recently submitted revised trajectories for monitoring against the proportion of patients on cancer PTLs waiting longer than 62 days. There is current focus for Trusts on cancer performance through tier 1 & 2 cancer meetings at NUTH, North Tees and Hartlepool and NCIC FTs.

Mental Health

Please note Mental Health data has not been updated this month due to changes with the NHSE Publication.

• IAPT % waits greater than 90 days is above the 10% standard in NENC and continues to increase to 37.89%

• Patients accessing IAPT services is below plan

• Dementia Diagnosis rate is at 65.3% as at August, below the trajectory of 66.1%

• Proportion of people on SMI register receiving a full Health check continues to increase towards the end of year standard and is currently on plan.

Learning Disabilities and Autism:

• Reducing Reliance on IP care trajectories are on track overall for September, with a total of 146 patients in IP care, working towards no more than 71 adults in NENC by 2023/24.

• Learning Disability Health checks is a cumulative target and as at August YTD NENC has completed 24% of the register which is a 20% increase on this time last year.

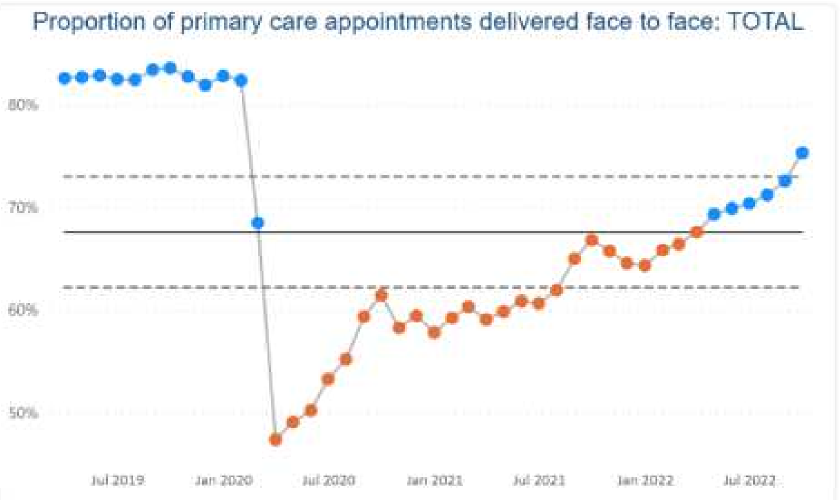
Tier 1 and Tier 2 Meetings

	Performance
Overview	The allocation of providers to tiers in relation to their elective and cancer backlog positions is a relatively new process initiated by NHS England. Trusts who are placed in Tier 1 will have regular (usually fortnightly) escalation meetings initiated by the NHS NEY Regional Team. For trusts placed in Tier 2 similar meetings will be initiated by the ICB. The ICB will work with colleagues from the Regional Team to ensure these meetings are arranged to include all the relevant parties and focussed on identifying and deploying high-quality support to aid rapid performance improvement. In NENC the following Trusts are in Tiers 1 and Tier 2:
Tier 2	North Cumbria – Cancer • North Cumbria Integrated Care NHS FT - Notable progress continues in the cancer 62 day backlog and following review the trust has been moved from Tier 1 into Tier 2 escalation. • the trust has a range of actions in place linked to validation, pathways and diagnostics • NHS England has allocated funds to the Northern Cancer Alliance to support NCIC in implementing rapid improvement plans for diagnostics and histopathology
Tier 2	Newcastle – Cancer & Elective • Tier 2 cancer and elective escalation; meeting chaired by ICB Executive Director of Place with NHS E, ICB and trust representation • the trust has implemented and sustained a range of improvements linked to validation, pathways and diagnostics • the trust has a number of initiatives to increase capacity including the opening of the day treatment centre in September and maximising use of the independent sector in particular for dermatology • some progress has been made in reducing the cancer 62 day backlog • there has been a sustained and significant reduction in the number of people waiting beyond 104 weeks for elective procedures, complex spinal procedures being the remaining area of pressure. This has slightly increased however over recent weeks due to a national blood products issue impacting planned procedures which has now been resolved. • there is a growing pressure of over 78 week waits demonstrated by more currently weekly unvalidated data. Dermatology, Orthopaedics and Spinal are key areas of risk. County Durham and Darlington - Elective County Durham and Darlington NHS FT is under enhanced national surveillance due to the 78+ week waiters reduction being behind plan. The Trust anticipate 78+ week waiters to peak at the end of December before reducing in Q4. NHS E has confirmed that the trust will be moved into Tier 2 escalation to support recovery with the first meeting in January.
Non-Tiered	North Tees & Hartlepool NHS FT had moved into Tier 2 escalation for cancer and the first support meeting was held on 16 December and positive improvement was demonstrated to the extent that the trust has now been moved out of Tier 2. South Tees has been stepped down from Tier 2 for Cancer

Primary care

Metric	Latest date	Value	National	Target	Variation	Assurance
Primary Care Attends	Oct-22	1650317				
Primary Care Appointments	Oct-22	1747249		1863570		
Primary Care Appointments % DNA	Oct-22	5.5%	5.9%			
Proportion of primary care appointments delivered face to face	Oct-22	75.3%	70.1%			
Percentage of 111 calls abandoned	Dec-22	37.1%		3%		

Target



Performance

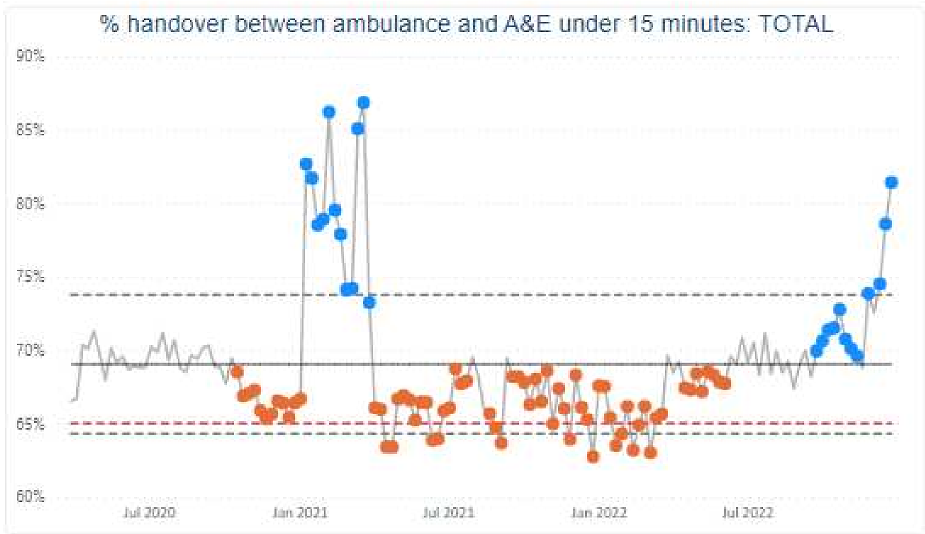
Increased and continued patient demand for all primary care services.

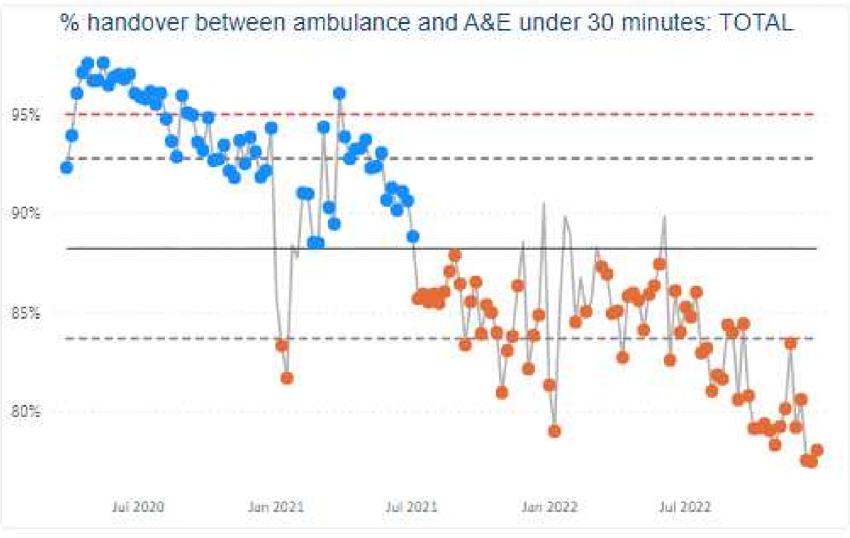
- GP appointment levels at pre-pandemic levels continue to increase, with a total of 1.7m during October 22 which is within planned trajectory for October and a marked increase on September (1.5m).
- DNAs as a proportion of all appointments remain high at 5.5% in October, an increase on September (5%) but below the national rate (5.9%).
- Practices routinely offering face to face appointments where clinically necessary and they continue to increase, up to 75.3% of total appointments delivered in October. This exceeds the level nationally at 70.1%
- Practices and PCNs supported to review their Health Inequalities
- The percentage of 111 calls abandoned (NEAS only) is at 9.6% in November, compared to the national threshold of 3%. Work is underway to establish a position for NWAS covering North Cumbria.

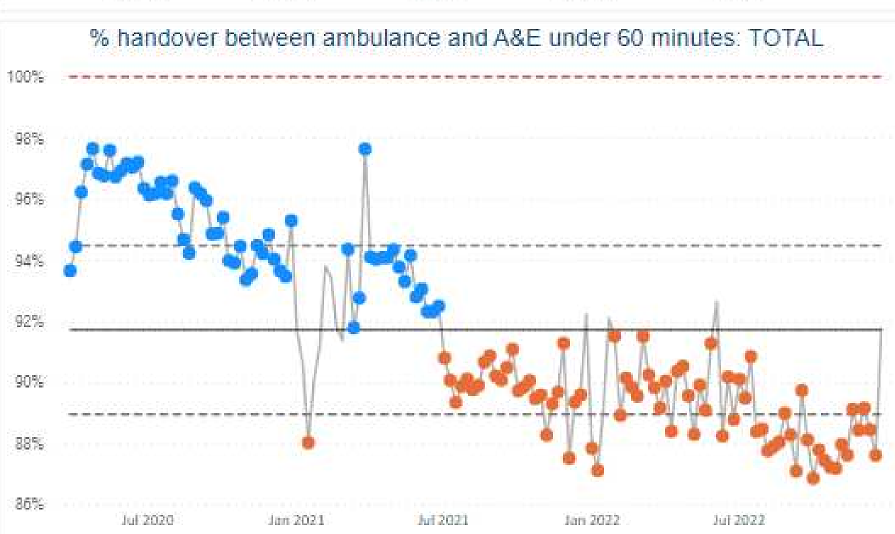
Ambulance Handover

Metric	Latest date	Value	National	Target	Variation	Assurance
Average hours lost to handover delays per day vs local trajectory	Dec-22	98.9		60.9		
% handover between ambulance and A&E under 30 minutes	Dec-22	78%		95%		
% handover between ambulance and A&E under 15 minutes	Dec-22	81.4%		65%		
% handover between ambulance and A&E under 60 minutes	Dec-22	91.8%		100%		

Target







Performance

- NENC are working towards the following standards for ambulance handovers at our FTs: eliminating handover delays of over 60 minutes; ensuring 95% of handovers take place within 30 minutes; ensuring 65% of handovers take place within 15 minutes.

- Handover delays continue, resulting in 98.9 average hours lost per day across NENC as at December 2022 compared to a target of 60.9. 78% of handovers took place under 30 minutes compared to a 95% standard, and 91.8% of handovers were under 60 minutes in December 2022 (expected standard of zero >60 mins). It should be noted that only 65.3% of ambulance arrivals with a handover time were recorded in NENC.

- STHFT are a regional outlier for the number of Ambulance handover Delays. These delays are felt by both Ambulance Providers who utilise the JCUH site, North East Ambulance Service and Yorkshire Ambulance Service. This results in an unacceptable number of hours lost to the Ambulance Services.

Risks and Mitigations

- A rapid process improvement workshop (RPIW) took place in November 2022 regarding handover delays, which was led by the NENC Urgent and Emergency Care Network. It was agreed that a different approach was needed to address the issue of handover delays and the impact on patients waiting in the community. A draft report has been prepared which includes two approaches. The ICB Chief Executive has requested to meet with all Trusts regarding the plan and a 'go live' date is to be confirmed.

NWAS:

- Performance remains extremely variable and there are still issues at times of surge and when access to beds in the wider hospital is an issue. NCIC continues to work collaboratively with NWAS to implement fit to sit, conveyance direct to SDEC and cohorting to reduce ambulance delays to get crews back on the road quickly.

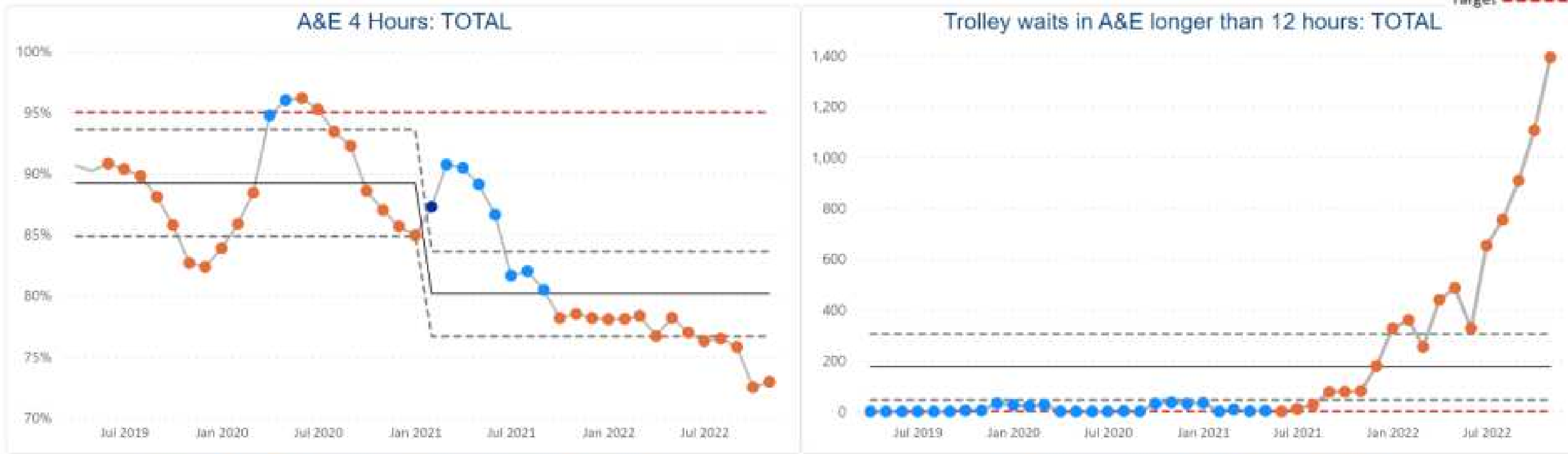
NEAS:

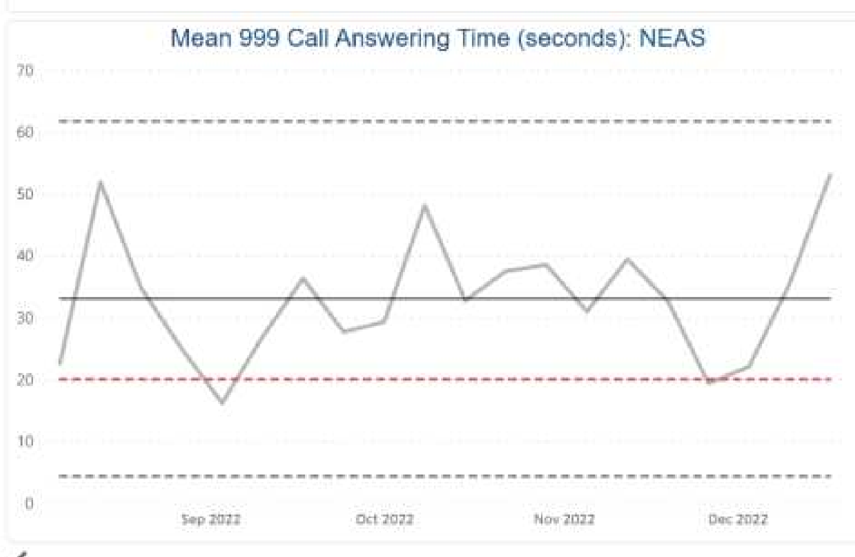
- Regional Acute trust visits have taken place. The visits have informed a set of recommendations to be implemented. Local improvement plans will now be developed reflective of the recommendations and other local issues. Delivery of these plans will be governed by the Urgent Emergency Care Network Board. Recommendations include developing Consistent data flows to UEC RAIDR app. An engagement exercise has commenced to seek patient public views on the implementation of an integrated Urgent Care model at the James Cook site, a QI lead into the Trusts 2 days per week and an IMPACT nurse to clinically manage up to 3 patients in the handover area. STFT are a regional outlier and delays impact both NWAS and YAS providers. Discussions are ongoing at STHFT to determine if the PIN input should be carried out by NEAS or Trust staff.

Note: % of ambulance arrivals with a handover time recorded across NENC is 65.3%

Accident and Emergency

Metric	Latest date	Value	National	Target	Variation	Assurance
Mean 999 Call Answering Time (seconds)	Dec-22	53.1		20		
% Patients spending 4 Hours or less in A&E	Nov-22	72.9%	61.4%	95%		
A&E 4 Hours (T1 only)	Nov-22	56.7%	47.6%	95%		
Trolley waits (from DTA) in A&E longer than 12 hours	Nov-22	1393		0		
% A&E waits from arrival to discharge, admission or transfer longer than 12 hours	Sep-22	3%		2%		





Performance

•November 22 A&E 4 hour wait performance continues to be a pressure due to volatile activity levels in the urgent care system with Type 1 performance still under significant pressure (56.7% NENC compared to 47.6% nationally)

•Although not meeting the 95% standard, NENC performance is performing favourably compared to the national for November (all types) at 72.9%, compared to 61.4% nationally.

• Patients waiting in A&E more than 12 hours following decision to treat has increased significantly from to 1106 in October to 1393 in November. The % of patients waiting longer than 12 hours from arrival to discharge is above the 2% standard for September at 3% in NENC.

Risks and Mitigations

Central:
• Performance continues to deteriorate and local A&E Delivery Boards continue to focus on actions to improve flow. Winter planning sessions have taken place, but workforce challenges continue to be a concern as does the acuity of patients and the impact of mental health presentations which is impacting 12-hour trolley waits. A 7 point plan has been agreed across Sunderland and South Tyneside, work has commenced to co-locate GP OOHs within the UTC and digital streaming is being mobilised. In Durham the focus is on enhanced patient flow and extension of arrangements with discharge.

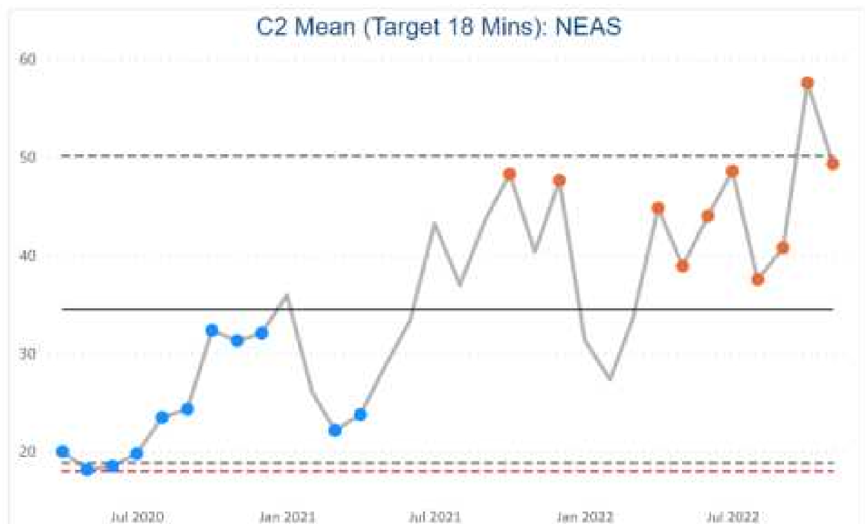
Tees Valley:
The impact of challenges across the health and social care system continues to be observed at STHFT. Actions include the ECIST improvement project, and estate expansion and reconfiguration. NTHFT continue to receive a high number of ambulance diverts and is reviewing the operational model.

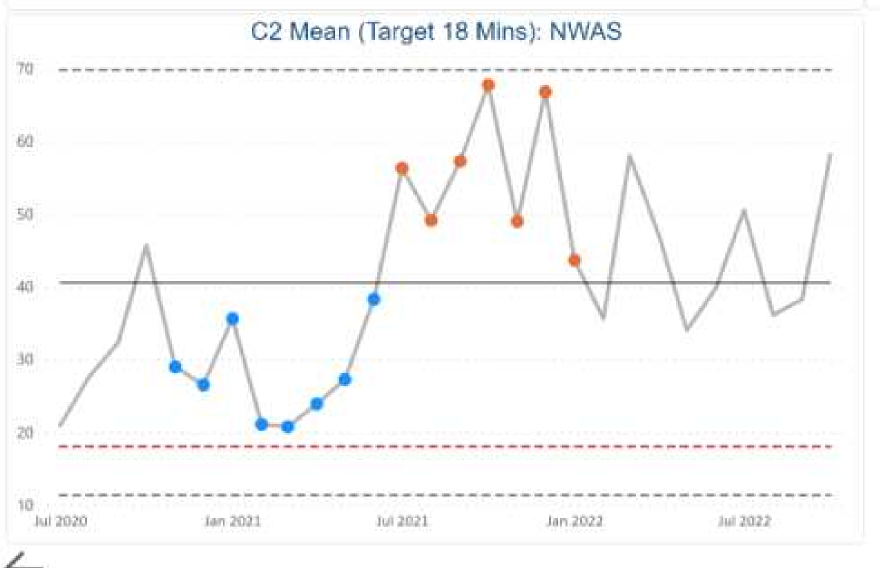
North Cumbria:
• Levels of medically optimised patients remain high and the system is working with social care colleagues to mitigate this. NCIC is implementing the recommendations from the national Emergency Care Improvement Support Team (ECIST) on Ward Round improvements, Rapid Access and Treatment, additional clinical support from Cardiology and Respiratory has been introduced into the Assessment Medical Unit. Same day Emergency care (SDEC) went operational seven days a week across both sites in November.

North:
• Trust wide urgent and Emergency Care (UEC) action plans are in place corresponding to the national UEC 10 point plan. Key focuses include increasing staffing in both the short term and long term. Through the North ICP Strategic A&E Board and NEAS transformation board we will continue to work with each Trust to refine and develop their SDEC model to provide consultant assessment and diagnosis, rapid treatment and early facilitated discharge. Pressures continue to be particularly acute at GH who have reported the highest level of bed occupancy in NENC area with significant 12 hour breaches and delays in the department. High bed occupancy, lower social care discharges and no escalation area due to the work associated with the new operating model. has caused additional challenges in the managing and placing of patients.

Ambulance Response Times

Metric		Latest date	Value	National	Target	Variation	Assurance
C2 Mean (Target 18 Mins):	NWAS	Oct-22	00:58:03		00:18:00		
C2 Mean (Target 18 Mins):	NEAS	Nov-22	00:49:18	00:41:21	00:18:00		





Target

Metric	Target	NEAS Value	NEAS Variation	NEAS Assur.	NWAS Value	NWAS Variation	NWAS Assur.
C1 Mean (Target 7 Mins)	00:07:00	00:07:48	H	?	00:09:19		F
C1 90th Centile	00:15:00	00:13:51	H	P	00:15:54		?
C2 Mean (Target 18 Mins)	00:18:00	00:49:18	H	F	00:58:03		?
C2 90th centile	00:40:00	01:43:39	H	?	02:05:56		?
C3 90th centile	02:00:00	06:07:42	H	?	10:42:42		?
C4 90th centile	03:00:00	05:37:56	H	?	12:29:37		?

Performance

- Urgent and Emergency Care (UEC) continues to be a significant pressure and NENC is working hard to increase capacity and operational resilience ahead of winter with a continued focus on ambulance performance and response.

NWAS:

- Response times for North Cumbria CCG remain challenged in October and below standard. C1 mean has been flagged a high concern and consistently failing the target. However, NWAS performance in North Cumbria continues to be notably better than other areas of the North West. C2 performance is at 58:14 for October compared to the 18 minute standard.

NEAS:

- Response times continue to be a pressure although NEAS is meeting C1 90th Centile for November. Cat 2 mean and 90th percentile standards continue to not be met with November performance improving from 57:34 in October to 49:18 in November. This no longer compares favourably to the national at 41:21 however.

Risks and Mitigations

- National work to review Category 2 calls with a focus on improving safety for patients waiting for an ambulance to ensure all patients receive the right response for their clinical presentation.
- A three-year programme to increase capacity has been identified to enable patients to be responded to in a timely manner and minimise risk to life and outcomes.
- Recruitment of additional paramedics, Clinical Care Assistants, and health advisors
- Implementation of sickness absence plan focused on mental health and wellbeing
- RPIW focussing on increasing Clinical Assessment Service across the system and increasing alternative dispositions via 2UCR.
- NWAS has recently escalated to REAP 4 for short periods with ambulance teams required to complete handovers within 15 minutes otherwise require A&E staff to complete the handover so that they can attend awaiting Cat 1 and 2 calls.

Patient Flow & Discharge

Metric	Latest date	Value	National	Target	Variation	Assurance
Admissions with Length of Stay of 21 days plus	Nov-22	1167		878		
Admissions with Length of Stay of 7 days plus	Nov-22	3035.6				
Adult general and acute type 1 bed occupancy (adjusted for void beds)	Nov-22	91.5%		87.2%		
Proportion of patients not meeting criteria to reside (acute hospitals) vs local trajectory	Oct-22	7.6%		9.2%		

Admissions with Length of Stay of 7 days plus: TOTAL

Admissions with Length of Stay of 21 days plus: TOTAL

Adult general and acute type 1 bed occupancy (adjusted for void beds)

Proportion of patients not meeting criteria to reside (acute hospitals) vs local trajectory

Performance

- Pressures due to high level of attendances, high bed occupancy and delays with social care discharges continue.
- Length of stay for patients residing in hospital over 7 and 21 days has continued to increase and is above trajectory.
- Patients who no longer meet the criteria to reside and whose discharge is delayed is at 7.6% compared to the target level of 9.2% in NENC in October. Although this has remained relatively stable since April, the pressures with social care discharges is creating considerable pressure.
- Type 1 General and Acute bed occupancy remains high and has increased significantly to 91.5% in November. This is above the 85% national expectation, and above the operational plan level in NENC.
- Trusts have recently been asked to submit updated trajectories which will be monitored locally. For the purposes of this report we will continue to monitor against the operational planning trajectories.

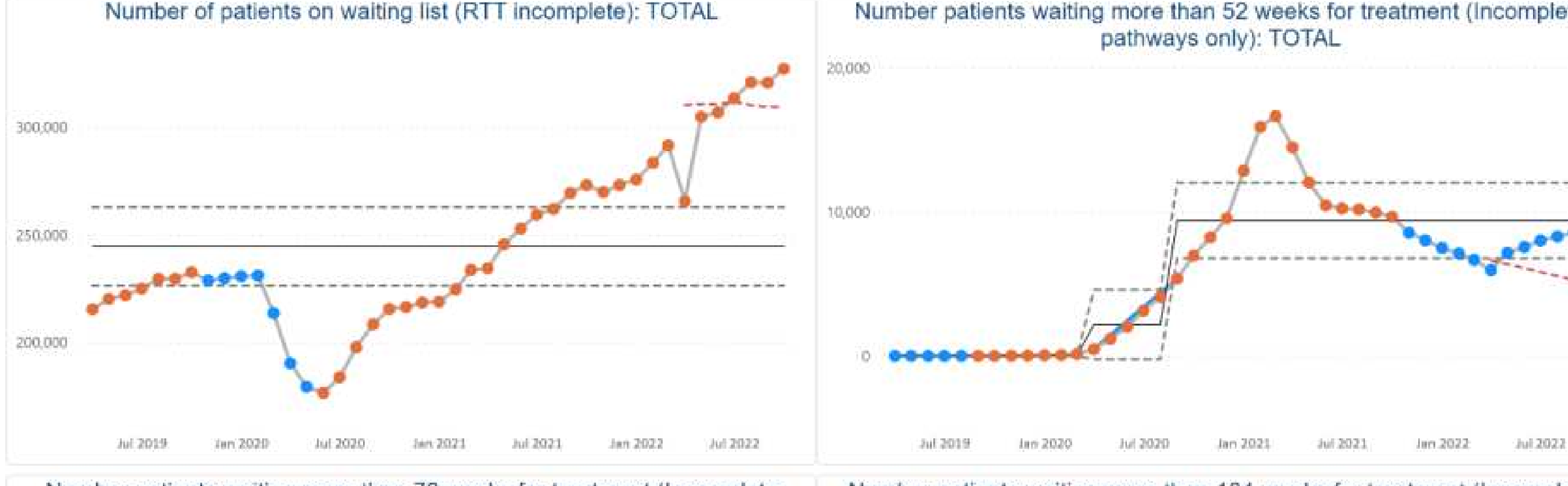
Risks and Mitigations

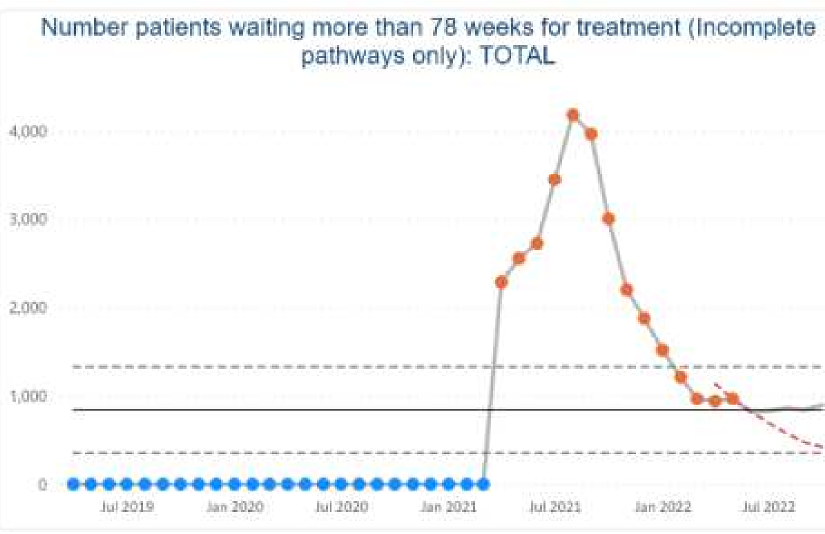
- Plans are underway to transform and build community services capacity to deliver more care at home and improve hospital discharge across NENC ICS.
- The ICS is committed to implementing new and enhancement of current virtual wards to support plans for elective recovery and improvement of UEC pathways.
- Local systems with their partners are making sure that their Urgent Crisis Response (UCR) models are part of the wider local health and care integration redesign. UCR data is being standardised across the ICS and will be included in future reports to ensure delivery of the 2 hour standard across the ICS.
- Both Virtual wards and Urgent crisis response wok plan has been established together with ICS wide working groups to explore and share pathway models to standardise across the ICS.

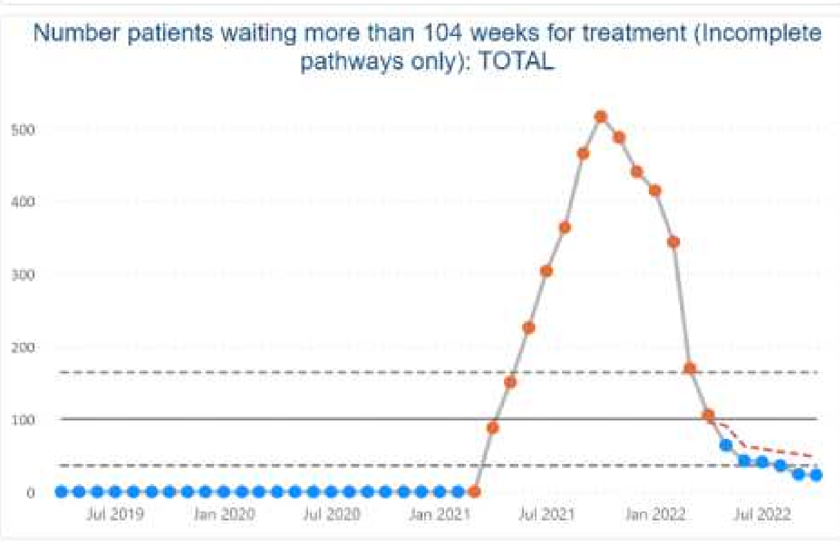
Referral to Treatment and Long Waiters

Metric	Latest date	Value	National	Target	Variation	Assurance
Number patients waiting more than 52 weeks for treatment (Incomplete pathways only)	Oct-22	8467		4996		
Number patients waiting more than 78 weeks for treatment (Incomplete pathways only)	Oct-22	896		419		
Number patients waiting more than 104 weeks for treatment (Incomplete pathways only)	Oct-22	23		48		
Number of patients on waiting list (RTT incomplete)	Oct-22	327379		309472		

Target







Performance

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Risks and Mitigations

North:

- Additional sessions through the "November Sprint" at NUTH, implementation of digital pathways in Dermatology, continued use of the Newcastle Westgate Cataract Centre and subcontracting with the IS has helped reduce long waiters. The Newcastle elective treatment centre was opened at the end of September and is expected to create additional capacity, as well as utilisation of the IS and local providers for additional capacity. Capacity alerts to distribute demand have been implemented in key specialties. NUTH is currently participating in regular tier 2 meetings which are focussed on identifying and deploying high-quality support to aid rapid performance improvement.

Tees Valley:

The focus remains on the longest waiters at STHFT– maintaining a zero position with 104 week waits, eliminating 78 week waits and reducing 52 week waits. Actions to manage 52ww remain in place; tracking, validation and appropriate prioritisation which are now impacting positively on position. NTHFT maintains its trajectory position in line with NHSE phase 1 and 2 elective recovery and reports no patients waiting more than 78 and 104 weeks. The Trust continues to see an increase in referrals, with a quarterly increase of 6% compared to 2019/20 levels and whilst the overall waiting list size continues to grow this has plateaued over recent months .

Central:

RTT performance continues to be strong in the Central patch despite increased seasonal pressures resulting in cancelled electives. CDDFT 78+ waiters are behind plan but hopeful for gradual improvements and to achieve end of year plan for 78+ of zero, and to deliver 0 52+ by March 24. Additional elective recovery schemes approved and being operationalised. Key pressure areas General Surgery and Gynaecology in relation to 78+ waits. Access to the I.S. across the Central patch continues with providers sub-contracting to secure additional capacity within pressure specialties such as orthopaedics and general surgery. Across Durham and Sunderland, advice and guidance for dermatology has been strengthened and pathways reaffirmed to ensure that patients are accessing the most appropriate community services to help alleviate pressures in secondary care.

North Cumbria:

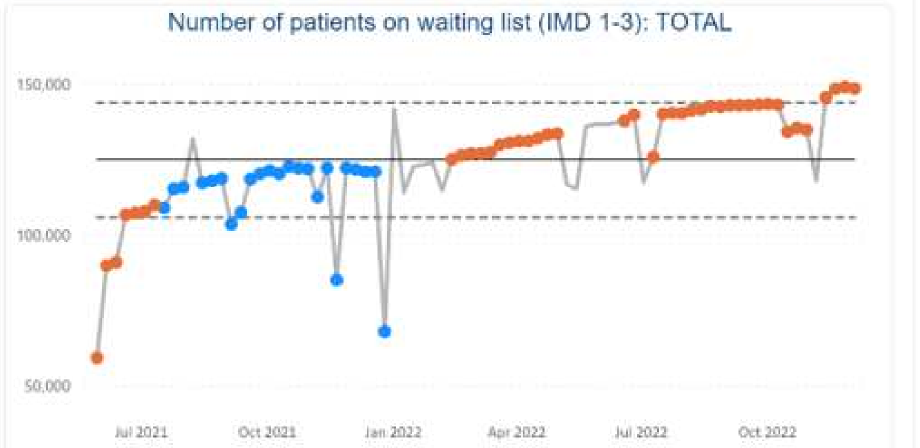
- NCIC successfully eliminated 104 week waits in 2021/22 although work is ongoing with validation process checks to eliminate instances where validation errors may occur and result in currently 1 pathway identified as a breach. Focus continues with the elimination of 78 week waits by the end of the current financial year and Trust within plan. Although waiting list continues to grow, NCIC has stretch ambitions to eliminate 52 week waits by the end of the financial year but acknowledge that the reduction is likely to happen at a slower pace than during 2021/22 and data to the end of November shows the Trust off plan for this.

Elective Waiting List - Health Inequalities

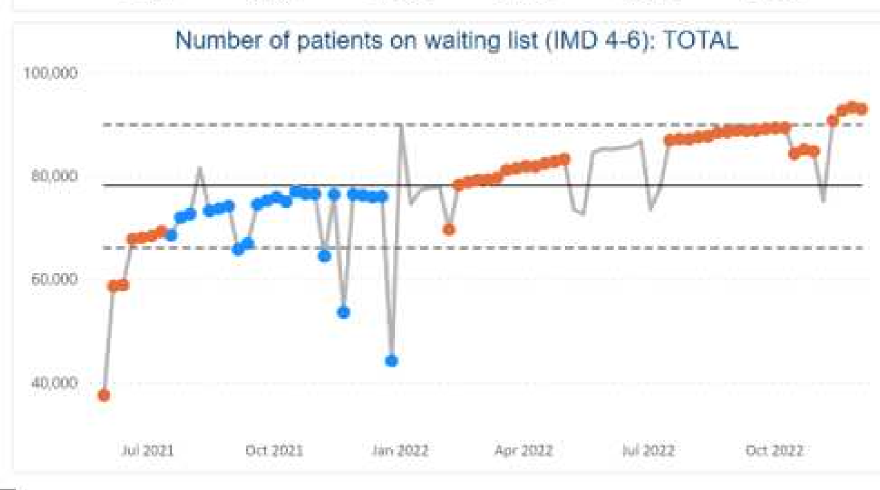
Provider	TOTAL Val.	TOTAL Var.	CDDFT Val.	CDDFT Var.	Gateshead FT Val.	Gateshead FT Var.	NCIC Val.	NCIC Var.	Northumbria Val.	Northumbria Var.	NTHFT Val.	NTHFT Var.	NuTH Val.	NuTH Var.	STHFT Val.	STHFT Var.	STSFT Val.	STSFT Var.
Number of patients on waiting list (Ethnicity White)	273452		35382		9523		28048		27733		15029		72896		37713		47128	
Number of patients on waiting list (Ethnicity BAME)	13399		704		320		435		367		1352		6186		2205		1830	
Number of patients on waiting list (Ethnicity Unknown)	65884		5164		2805		8991		5583		3700		22284		9469		7888	
Number of patients on waiting list (IMD 1-3)	148598		18222		6202		10690		10478		10447		41952		19641		30966	
Number of patients on waiting list (IMD 4-6)	92891		11916		3251		13875		10094		3437		25574		11076		13668	
Number of patients on waiting list (IMD 7-10)	105776		10635		3019		12149		12568		6034		32023		17853		11495	

Number of patients on waiting list with an ethnicity of Unknown: TOTAL

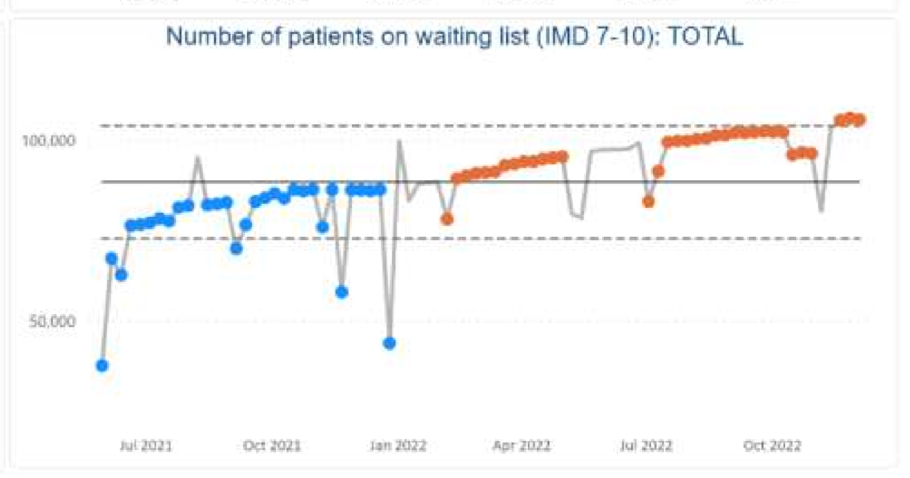
Number of patients on waiting list (IMD 1-3): TOTAL



Number of patients on waiting list (IMD 4-6): TOTAL



Number of patients on waiting list (IMD 7-10): TOTAL



Performance

Work continues across NENC to analyse the waiting list in accordance with ethnicity and deprivation.

As the waiting list continues to grow, the numbers of patients within the Trusts who have an unknown ethnicity status has increased. Currently 104,815 patient pathways have an unknown ethnicity status which is 25.14% of the total IP waiting list. Work is ongoing to improve coding within the FTs as any further analysis is currently limited.

Index of multiple deprivation (IMD) classifies the relative deprivation levels of small areas, with 1 being the most deprived through to 10 being the most affluent. Work is underway to review the waiting list by IMD level. Initial findings as demonstrated in the charts show that the there is little difference between the areas with highest deprivation levels when compared to the areas with least deprivation in terms of waiting list growth.

Diagnostic Waiting List

Metric	Latest date	Value	National	Target	Variation	Assurance
Number of patients waiting more than 6 weeks from referral for a diagnostic test	Oct-22	13066				
% Patients waiting more than 6 weeks from referral for a diagnostic test	Oct-22	17.2%	27.5%	1%		

Target -----

% Patients Waiting more than 6 weeks for a diagnostic test - by Modality

Metric	% Patients waiting more than 6 weeks from referral for a diagnostic test			Number of patients waiting more than 6 weeks from referral for a diagnostic test		
	Value	Variation	Assur.	Value	Variation	Assur.
AUDIOLOGY_ASSESSMENTS	37.7%	H	F	1606	H	
BARIUM_ENEMA	6%		?	9		
COLONOSCOPY	28.4%	L	F	948		
CT	6.8%		F	680		
CYSTOSCOPY	21.3%		F	250	H	
DEXA_SCAN	8.5%	L	F	248	L	
ECHOCARDIOGRAPHY	34.3%		F	2773		
ELECTROPHYSIOLOGY	0%		?	0		
FLEXI_SIGMOIDOSCOPY	28.2%		F	342	L	
GASTROSCOPY	31.7%		F	1223		
MRI	12.6%		F	1571		
NON_OBSTETRIC_ULTRASOUND	10.7%		?	2683		
PERIPHERAL_NEUROPHYS	41.3%		F	532	H	
SLEEP_STUDIES	24.1%	L	F	244	H	
URODYNAMICS	46.4%		F	166		

% Patients Waiting more than 6 weeks for a diagnostic test - by provider

Metric	% Patients waiting more than 6 weeks from referral for a diagnostic test			Number of patients waiting more than 6 weeks from referral for a diagnostic test		
	Value	Variation	Assur.	Value	Variation	Assur.
TOTAL	17.2%	L	F	13066	L	
CDDFT	10.8%		?	1063	H	
Gateshead FT	18.8%	L	F	1003	L	
NCIC	15.9%	L	F	1228	L	
Northumbria	3.2%	L	?	335	L	
NTHFT	25.9%		F	2430	H	
NuTH	17.8%	L	F	2310	L	
STHFT	26.4%		F	2737	H	
STSFT	20.1%	L	F	1660	L	

% Patients waiting more than 6 weeks from referral for a diagnostic test: TOTAL

Performance

- Diagnostics >6 week performance for the 15 key diagnostic tests is relatively stable across NENC and continues below the requirement for 1% of patients to wait longer than 6 weeks, with 17.2% patients waiting over 6 weeks for a diagnostic test in October 2022 compared to 27.5% nationally. Key pressure areas include Echo-cardiography, Endoscopy and Audiology.

- ICSs have been asked to develop a local diagnostic performance improvement plan that delivers 95% achievement of the 6ww diagnostic target by March 25. The NENC Diagnostics workstream has recently set trajectories with FTs with a focus on a subset of 8 of the key diagnostic tests.

Risks and Mitigations

- ICSs have been asked to review the national improvement plan and explore collaborative solutions to address current backlog progress which is to be reported through the diagnostic programme board.

Specific actions include:

Central:
- The diagnostic position continues to improve overall with the number of long waiters decreasing. Significant progress has been made in echocardiography due to the increased capacity secured in 2022/23. Pressures now remain in some areas of imaging and in sleep studies where additional resources have been agreed to improve performance.

North:
- Significant echo backlogs have been cleared at NUTH through additional capacity. Gateshead continue with insourcing to clear echo backlog with a trajectory to do so in 2023. Cystoscopies continue to be a pressure at Northumbria with review of the Urology pathway across the North and Audiology workforce pressures are significant. A paper is being reviewed to understand how pathway changes in audiology could positively impact the position at NUTH.

North Cumbria:
- An additional cardio-echo machine at West Cumberland Hospital, provides a further 30% capacity in Cumbria.

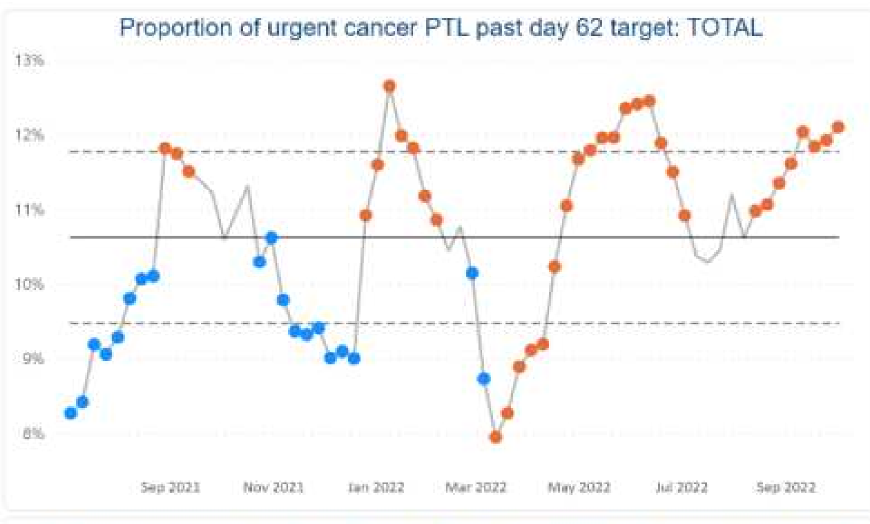
Community diagnostics funded schemes are increasing capacity in Radiology and endoscopy across NENC as well as additional capacity sought through the Independent sector. Audiology workforce pressures remain a risk across NENC. Endoscopy activity has improved through a mobile unit, although a backlog of complex patients with limited capacity continues to put pressure on this modality.

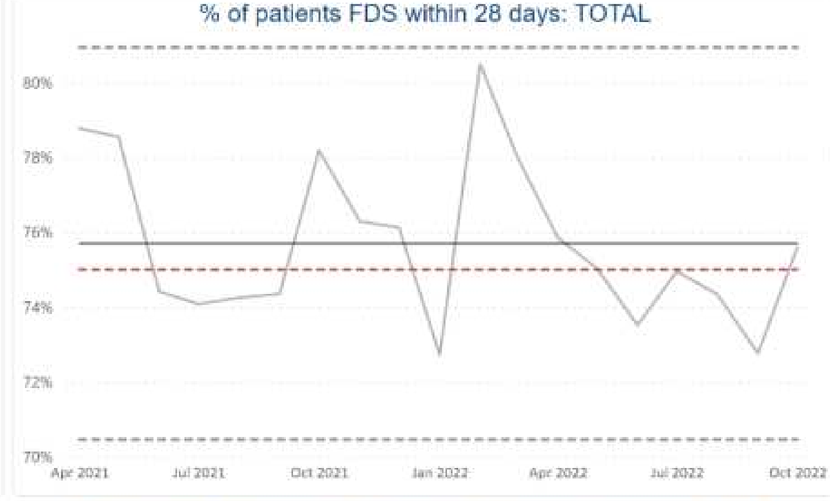
Tees Valley:
Action plans are in place per modality and activity and compliance trajectories are discussed with regional diagnostic programme. Additional capacity in endoscopy at both JCUH and FHN has been implemented. This will in turn have a positive impact on Cancer metrics. NTHFT pressures remain primarily related to staffing. The largest impact continues to be seen in non-obstetric Ultrasound. A locum sonographer has been recruited (in August) to support recovery and some additional insourcing has also been arranged. Endoscopy capacity has reduced in September due to staffing issues in Nursing, which has led to an increase in 6-week breaches. Improvement is expected as there is increased capacity from October. Radiology reporting issues continue, outsourcing is still in place, but external providers are now experiencing resource pressures.

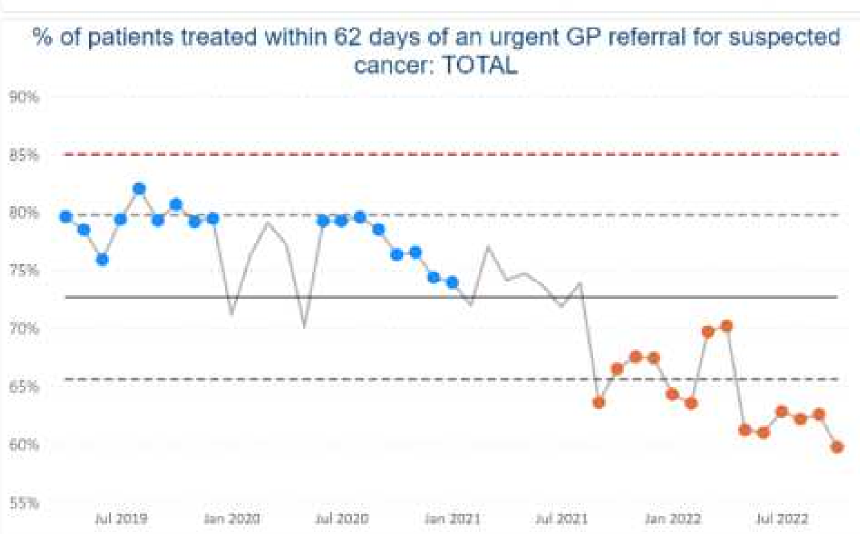
Cancer

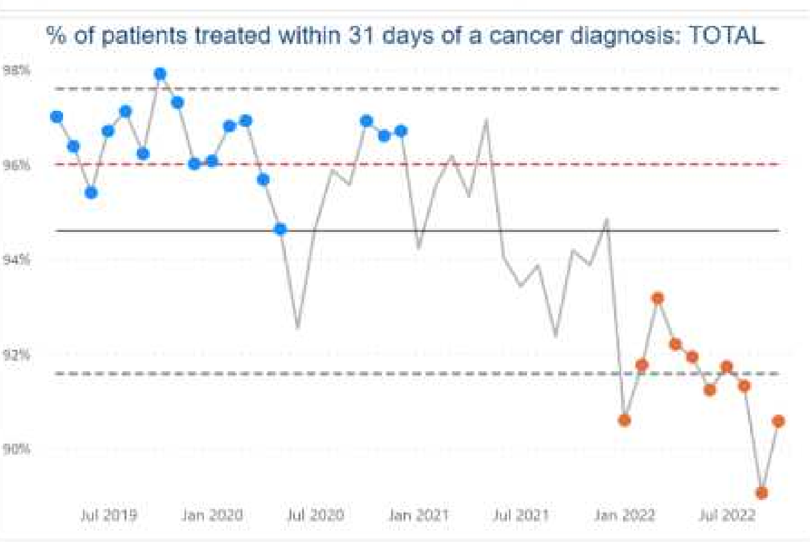
Metric	Latest date	Value	National	Target	Variation	Assurance
Proportion of urgent cancer PTL past day 62 target	Oct-22	12.1%				
% of patients FDS within 28 days	Oct-22	75.6%	68.5%	75%		
% of patients treated within 62 days of an urgent GP referral for suspected cancer	Oct-22	59.8%	60.3%	85%		
% of patients treated within 31 days of a cancer diagnosis	Oct-22	90.6%	92%	96%		

Target









Performance

- NENC are currently achieving the faster diagnosis standard for October 22 which stands at 75.6% v the 75% target, a slight improvement since September. This compares favourably to the national performance (68.5%). Variation between Trusts exists with highest performance at CDD FT,(88.7%) and Gateshead at 81.2% and lowest at NCIC (64.8%).

- 31 day treatment standard and the 62 days referral to treatment standards are not currently being met. Currently 59.8% patients waiting longer than 62 days compared to the 85% standard in NENC, this is a deteriorating position and is slightly below the national at 60.3% for October. Variation between Trust 62 day performance ranges from 73.5% at Northumbria HC to 45.3% at NUTH.

- South Tees, North Tees, NUTH, and North Cumbria have recently submitted revised trajectories for monitoring against the proportion of patients on cancer PTLs waiting longer than 62 days. There is current focus for Trusts on cancer performance through tier 1 & 2 cancer meetings at NUTH, North Tees and Hartlepool and NCIC.

Risks and Mitigations

- Key pressure areas are Urology, Lung and Colorectal. NCA continue to roll out optimal pathways but pressures remain in skin, lung, colorectal and breast, impacted by workforce and capacity pressures. Cancer care coordinators and navigators support rapid diagnostics initiatives as well as enhanced cancer tracking capacity.

- Urology is a particular pressure across North Area footprint and a working group is being established to review optimal pathways with an action plan developed including proposed roll out of prostate straight to MRI.

- Skin - Successful roll out of tele-dermatology pathway at NUTH has eased pressures in skin although seasonal referrals are creating additional pressure.

Central: An improvement plan is being developed by ATB which is impacting positively on chest Xray performance. To support the personalised care agenda, additional roles have been recruited by PCNs across the ICP.

N. Cumbria - NCIC continues to receive additional support from NHS England through Tier 1 meetings, but improved performance which has seen NCIC move out of the bottom 40 worst performing Trusts. Key actions include a robust clinical harm process for 104-day breaches, cancer education days held in October, completion of pathway analysis for Prostate, Skin and Lower GI and the successful recruitment of ACPs and Band 7s. Secondary twice-weekly PTL with Cancer Trackers is now started from Day 35.

Tees Valley - Although STHFT has moved out of tier 2 support for cancer, North Tees has moved into tier 2 for additional support. The Trusts remain committed to a collaborative approach through the Cancer cell initiative, ensuring equitable access to treatment for all patients. Initiatives include, insourcing supporting additional week and weekend lists, cancer delivery groups led by lead clinicians and specialist nurses and cancer navigator posts in all tumour groups.

North - NUTH remains in tier 2 for cancer support, key pressures in Skin, Urology, Upper and Lower GI. Mitigations continuing including additional 2ww sessions, additional CT capacity for colorectal, and 4th endoscopy room for backlog, Urology T&F across the North looking to review MDT and MRI straight to test pathway.

NHS North East & North Cumbria

Improving Access to Psychological Therapies (IAPT)

NHS North East & North Cumbria

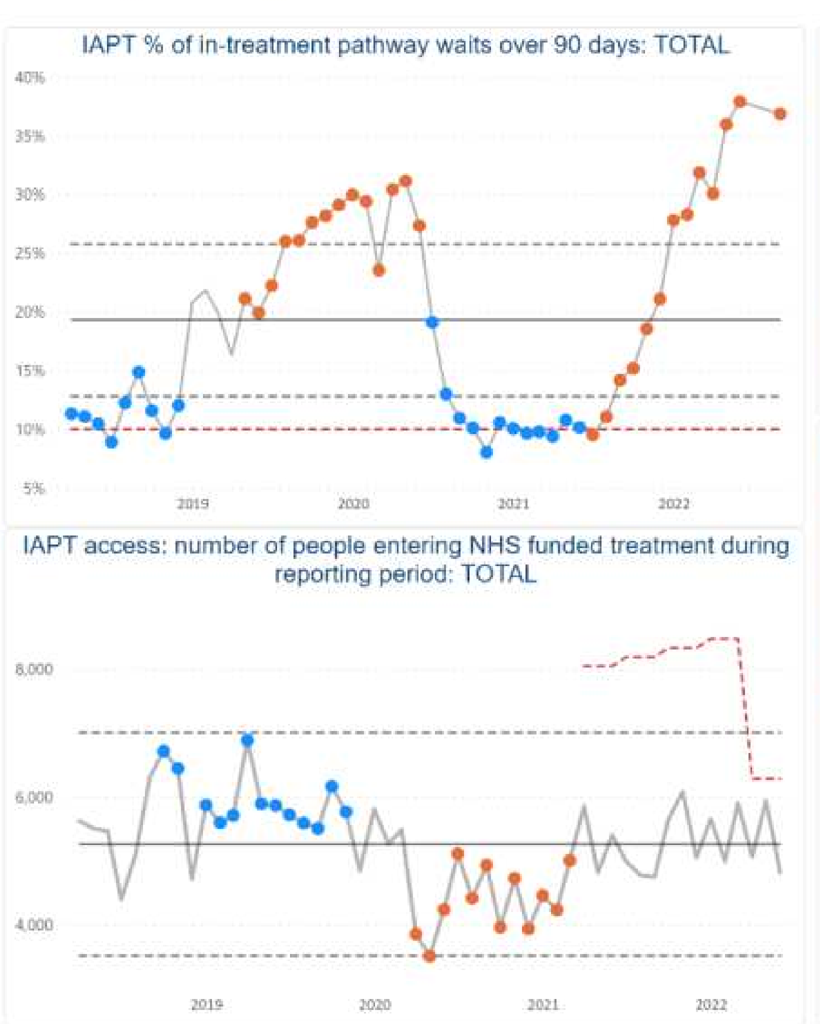
Metric	Latest date	Value	National	Target	Variation	Assurance
IAPT access: number of people entering NHS funded treatment during reporting period	Jun-22	4815		6286		
IAPT recovery rate for Black, Asian or Minority Ethnic groups	Sep-22	45%	47.3%	50%		
IAPT % of in-treatment pathway waits over 90 days	Sep-22	36.9%	23.4%	10%		
IAPT recovery rate: % of people that attended at least 2 treatment contacts and are m...	Sep-22	52.9%	49.8%	50%		
IAPT % of people receiving first treatment appointment within 6 weeks of referral	Jun-22	97.8%		75%		
IAPT % of people receiving first treatment appointment within 18 weeks of referral	Jun-22	99.1%		95%		

Please note, IAPT data has not been updated due to changes within the NHSE Publication

Target

IAPT Recovery by Sub ICB location

Metric	IAPT recovery rate for Black, Asian or Minority Ethnic groups			IAPT recovery rate: % of people that attended at least 2 treatment contacts and are moving to recovery		
	Value	Variation	Assur.	Value	Variation	Assur.
TOTAL	45%		?	52.9%		?
Co Durham	48%		?	52.9%	H	?
N Cumbria	50%		?	60.3%	H	?
N Tyneside	66.7%		?	59.5%	H	?
Ncl-Gateshead	43.9%		?	50%		?
Northumberland	20%		?	50%	L	?
S Tyneside	33.3%		?	54.2%		?
Sunderland	50%		?	52.6%		?
Tees Valley	44%		?	49.1%		?



Performance

Access rates continue to be sporadic and have been below plan and target. Over more recent months the IAPT access numbers have started to increase and more in line with pre-pandemic numbers. Contributing factors impacting IAPT delivery include workforce, and demand.

Moving to recovery rates are above the 50% expectation in NENC for all patients, however the recovery rate for black, Asian or minority groups is slightly lower.

Risks and Mitigations

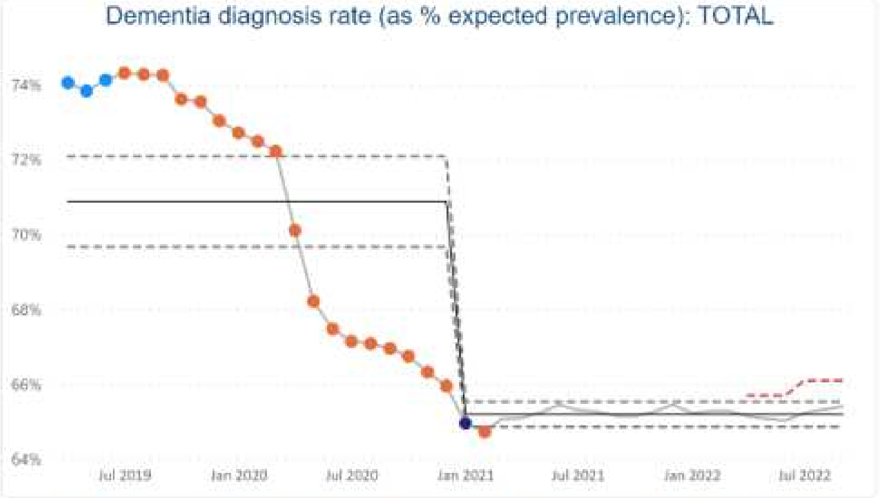
IAPT providers in the NENC are working to recovery plans to achieve national standard access rates and improve waiting times from first to second treatment which have remained static and are significantly above the national expectation of 10% at 37.89% for June. North Cumbria are currently within this standard at 5% Actions across the ICS include: mobilisation of the NENC ICS IAPT Delivery & Oversight Group, as well as publicity, targeting pathways such as older persons, DNA initiatives as well as recruitment drives, and subcontracting.

Mental Health (Adult)

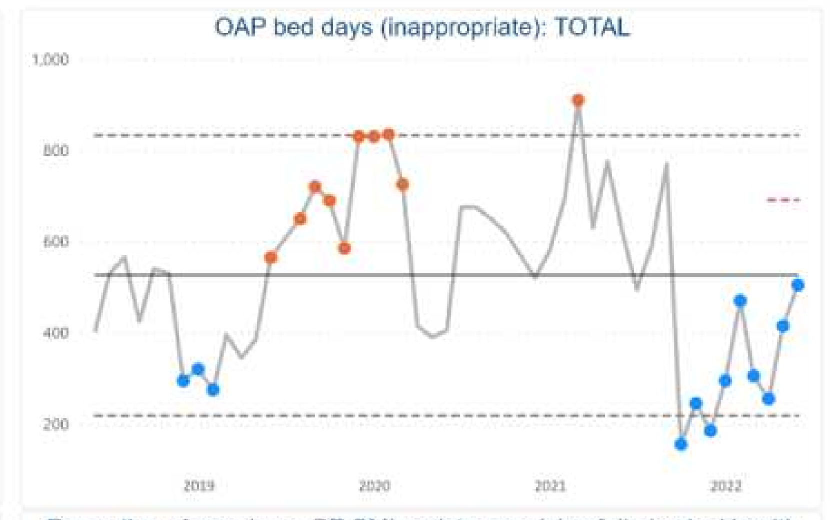
Metric	Latest date	Value	National	Target	Variation	Assurance
Total number of inappropriate Out of Area bed days	Jun-22	505		691		
EIP % of people who started treatment within 2 weeks of referral - All ages	Jun-22	64.8%		60.1%		
Number of people on GP SMI register receiving full physical health check in primary care setting	Sep-22	13856		14191		
Dementia diagnosis rate (as % expected prevalence)	Sep-22	65.4%		66.1%		

Please note, MHSDS data has not been updated due to changes within the NHSE Publication

Dementia diagnosis rate (as % expected prevalence): TOTAL



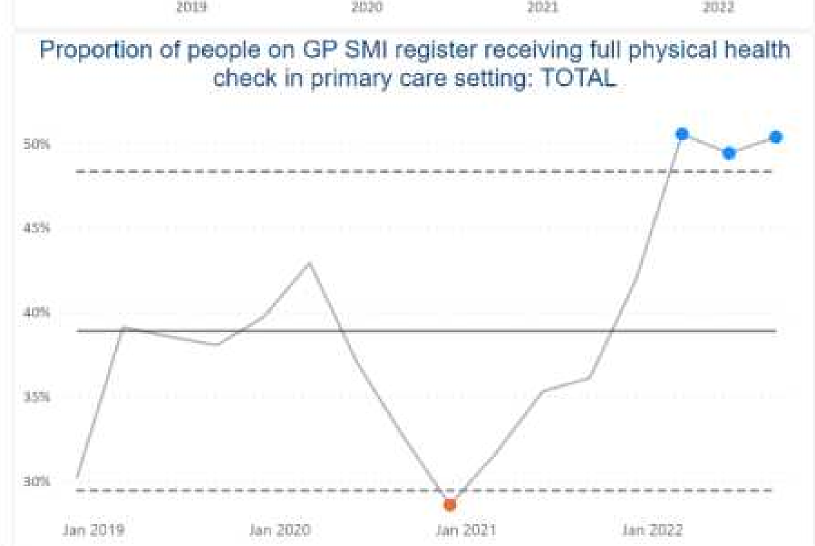
OAP bed days (inappropriate): TOTAL



% of people who started treatment within 2 weeks of EIP referral: TOTAL

90%
85%
80%
75%
70%
65%
60%
Jul 2019 Jan 2020 Jul 2020 Jan 2021 Jul 2021 Jan 2022

Proportion of people on GP SMI register receiving full physical health check in primary care setting: TOTAL



Performance

64.81% people in NENC started treatment within 2 weeks for Early intervention in Psychosis compared to the 60% standard.

Dementia diagnosis is at just below the 67% standard for NENC at 66.4% for Q4 and continues to increase for Q1. There was a dip in performance throughout the pandemic and teams are working to recover.

The number of Out of Area Placement bed days for NENC decreased throughout the pandemic and has been decreasing throughout 21/22 to Dec 21 where we have seen an increase. April and May 22 to date has seen inappropriate bed days decreasing and within local plan although the numbers remain above the target of 0.

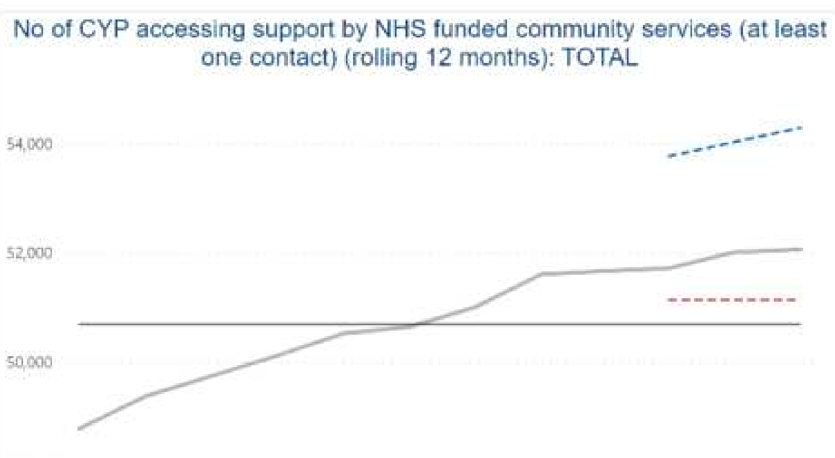
Risks and Mitigations

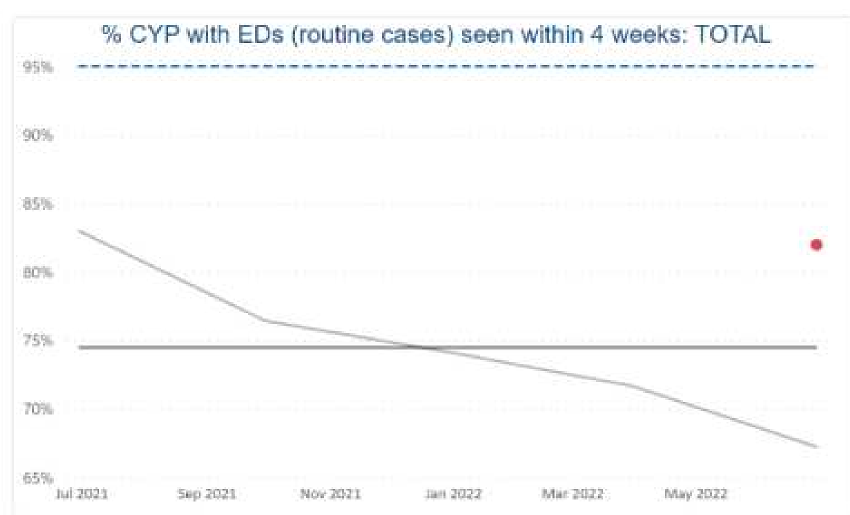
The Number of SMI Health checks completed has started to increase throughout 21/22 and into 22/23 and although below the 22/23 standard it is progressing above plan in NENC. Actions include: deployment of portable testing equipment, continued mobilisation of community mental health transformation models at place and local support to PCNs and clinical teams to ensure continued focus.

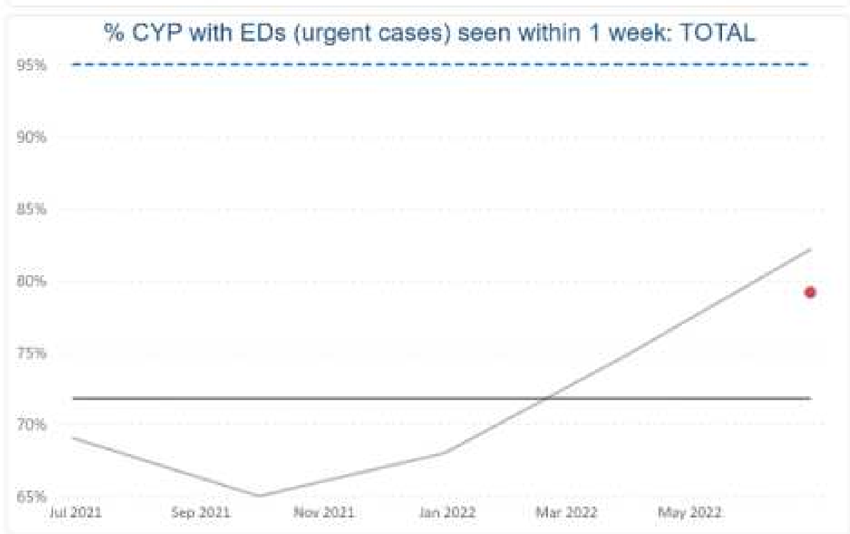
Children and Young People Mental Health

Metric	Latest date	Value	National	Target	Variation	Assurance
No of CYP accessing support by NHS funded community services (at least one contact) (rolling 12 months)	Jun-22	52060		51136		
% of CYP with eating disorders (routine cases) seen within 4 weeks of referral for NICE approved treatment	Jun-22	67.2%	81.3%	82%		
% of CYP with eating disorders (urgent cases) seen within 1 week of referral for NICE approved treatment	Jun-22	82.1%	87.5%	79.2%		

Please note, MHSDS data has not been updated due to changes within the NHSE Publication







Target ----- National Target -----

Performance

CYP Access

The number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact is showing some improvement in NENC throughout 21/22, although this is not the same rate of growth as the target. May 22 shows the CYP access above plan but below target.

Children and Young People Eating Disorders

The % of urgent patients with Eating disorders across NENC ICS starting treatment within 1 week of referral has deteriorated throughout 20/21 and into 21/22. However from September 21 onwards there has been continual improvements. Current performance is at 82% against the 95% target which is above the operational planned levels.

The % routine patients with eating disorders across NENC ICS starting treatment within 4 weeks of referrals has deteriorated throughout 20/21 and continues to do so. Current performance is at 67% against the 95% target which is also below planned levels.

Risks and Mitigations

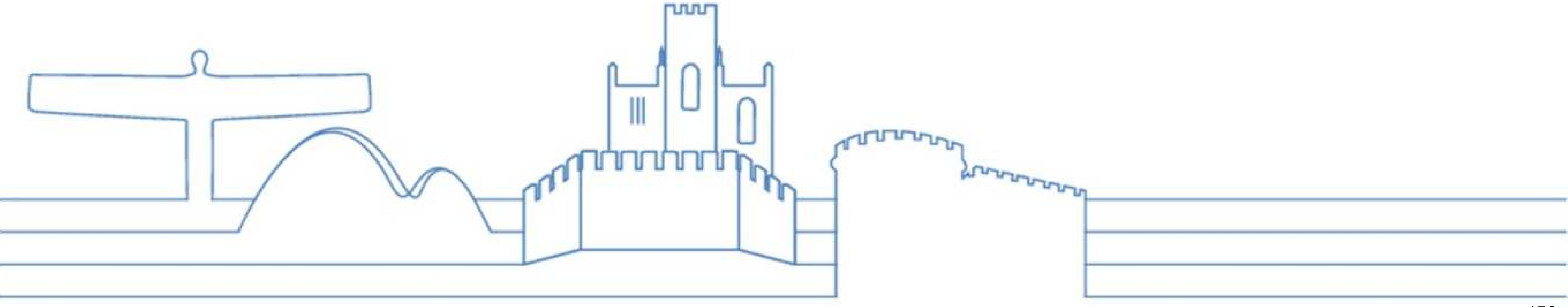
Place based actions to review pressure points and determine need include waiting list recover plans, alternative model implementation and pathway design. Workforce initiatives including recruitment and retention projects are also underway as well as system level digital action plans in place to support interoperability.

Sunderland - As a result of increased demand into CYP MH services, work has commenced on the mobilisation of a single point of access for CYP MH services. This is expected to be live April'23 and will ensure needs are met and CYP access the most appropriate services. The iTHRIVE model was also launched in November'22 which will change the way services are delivered in Sunderland for the long term. Additional support to schools via MH Support Teams is also in the process of being implemented.

Learning Disability and Autism LTP Deliverables RAG Rating

Long Term Plan commitment or mandate	Current position	RAG
Reducing reliance on inpatient care: • By 2023/24 there will be a reduction in reliance on inpatient care for people with a learning disability, autism or both to no more than 30 inpatients per million adult population; i.e. no more than 71 adults in NENC (Secure and ICS commissioned services) • By 2023/24 no more than 12 to 15 children or young people with a learning disability, autism or both per million, will be cared for in an inpatient facility; i.e. no more than 8 children or young people in NENC	Total adult inpatients in NENC as at 30th September 2022 = 146 ICS commissioned: 73 (4 above trajectory) Secure Services: 73 (3 under trajectory) Children and young people: 5	Green
Care (Education) and Treatment Reviews (CETRs); compliance with national policy	2 areas non-compliant as at 31st August 2022 Under 18's: Pre or Post admission CETRs = 50% (2 of 4 completed) Adults: Pre or Post admission CTR = 73% (11 of 15 completed)	Amber
Learning from Life and Death Reviews (LeDeR); compliance with national policy	As at 4th August 2022 87% of reviews after June 2020 are complete of which 13% are focussed reviews (target 35% focussed reviews). No issues reported against achievement of 6 month KPI ICS LeDeR annual report to be published via https://necldnetwork.co.uk/ Governance board established and chaired by the ICS Executive Chief Nurse Learning and sharing event 8th November 2022	Green
Annual health checks • By 2023/24 - 75% of people on the learning disability register will have had an annual health check.	2022-23 Long Term Plan Target 73% (achieved 77% in 20-21) Reported data via NECS from April 22 to August 2022: 4741 reviews completed – which is 24% of the register for 22/23 (a 20% increase on this time last year) Annual health checks to be offered to all people who did not receive one in 21/22 by Sept 2022. 2023-24 Target 75%	Green

Finance



Executive Summary

	M08 - November 2022		YTD	Forecast
Key Statutory Financial Duties	**Overall ICS 2022/23 In Year Financial Position - (Surplus) / Deficit**			
	For the financial year 2022/23 the ICS, including the Q1 position of the NENC CCGs, is on track to deliver the planned breakeven position reporting a small surplus of £0.04m at Month 8	Plan	£3.95 m	£0.00 m
		Actual	£24.01 m	(£0.04) m
	Overall ICB 2022/23 In Year Financial Position - (Surplus) / Deficit			
	Overall ICB 2022/23 In Year Financial Position prior to retrospective funding - (Surplus) / Deficit	Plan	(£0.87) m	(£2.63) m
	The ICB is reporting a year to date variance of £3.15m and an outturn variance of £5.55m, prior to expected retrospective funding adjustments of £11.22m - Deficit / (Surplus)	Actual	£3.15 m	£5.55 m
	Expected ICB 2022/23 In Year Financial Position after retrospective funding - (Surplus) / Deficit	Plan	(£0.87) m	(£2.63) m
	The ICB is reporting an outturn variance of £5.68m, after expected retrospective funding adjustments of £11.22m, an improved position of £3.05m against the planned surplus of £2.63m - Deficit / (Surplus)	Actual	£3.15 m	(£5.68) m
	ICB Running Costs Position - July 2022 to March 2023			
	The ICB is reporting a year to date and forecast outturn underspend of £1.37m and £1.96m respectively, compared with the submitted financial plan	Plan	£23.92 m	£44.76 m
		Actual	£22.55 m	£42.80 m
		Variance	(£1.37) m	(£1.96) m
	Overall ICS 2022/23 Capital Funding			
	The ICS is reporting a forecast outturn against the capital allocation in line with plan for primary care and £13.88m over on provider capital. At Month 8 there is a year to date underspend against the capital allocation of £50.19m.	Allocation	£128.32 m	£200.71 m
		Actual	£78.14 m	£214.59 m
		Variance	(£50.19) m	£13.88 m
Other Financial Performance Metrics				
	Overall ICS 2022/23 QIPP/Efficiency	Plan	£157.80 m	£248.83 m
	The ICS is reporting year to date QIPP savings of £141.20m and forecast savings of £246.21m with the ICB delivering £48.72m which is slightly over the submitted QIPP/Efficiency plan. Providers are currently forecasting an under-delivery against target of £2.91m.	Actual	£141.20 m	£246.21 m
		Variance	(£16.60) m	(£2.62) m
	Overall 2022/23 Mental Health Investment Standard (MHIS)		6.68%	6.68%
	The ICB is on track to achieve the MHIS target for 2022/23 (growth in spend of 6.68%), the target now includes the impact of the pay award and additional uplift.			

ICB Financial Position - Overview

Month 8 - November 2022	YTD Plan	YTD Actual	YTD Variance	2022/23 Annual Plan	2022/23 Forecast Outturn	2022/23 Forecast Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Revenue Resource Limit	(2,806,592)			(5,066,945)		
Programme						
Acute Services	1,427,328	1,440,051	12,723	2,524,679	2,545,604	20,926
Mental Health Services	338,141	341,358	3,217	604,514	612,049	7,535
Community Health Services	274,717	273,455	(1,262)	485,847	482,448	(3,399)
Continuing Care	165,736	166,523	787	300,822	304,014	3,192
Prescribing	239,228	236,962	(2,266)	427,842	428,484	642
Primary Care	48,416	44,313	(4,103)	84,461	77,998	(6,463)
Primary Care Co-Commissioning	230,629	232,916	2,287	418,169	427,325	9,156
Other Programme Services	26,970	28,508	1,538	45,620	47,922	2,302
Other Commissioned Services	10,595	10,618	23	19,143	19,021	(122)
Programme Reserves	5,682	822	(4,861)	86,231	67,322	(18,909)
Contingency	2,695	0	(2,695)	4,725	0	(4,725)
Total ICB Programme Costs	**2,770,139**	**2,775,527**	**5,389**	**5,002,052**	**5,012,187**	**10,135**
Admin						
Running Costs	23,919	22,551	(1,368)	44,761	42,803	(1,958)
Total ICB Admin Costs	**23,919**	**22,551**	**(1,368)**	**44,761**	**42,803**	**(1,958)**
In Year (Surplus) / Deficit	867	0	(867)	2,632	0	(2,632)
Total In Year ICB Financial Position	**2,794,925**	**2,798,079**	**3,153**	**5,049,445**	**5,054,990**	**5,545**
Central Funding expected for ARRS costs	0	0	0	11,224	0	(11,224)
Total In Year ICB Financial Position after expected retrospective funding	**2,794,925**	**2,798,079**	**3,153**	**5,060,669**	**5,054,990**	**(5,679)**

The ICB is currently reporting a forecast outturn surplus of £5.7m after expected retrospective central funding of £11.22m relating to the Primary Care Additional Roles Reimbursement Scheme (ARRS). This contributes to a balanced forecast position across the ICS.

The main factors driving this performance are:

- Acute overspend mainly relating to Independent Sector provider activity where Elective Recovery Fund income has not been assumed
- Mental Health overspend in particular pressures on s117 packages and specialist packages of care
- Continuing Healthcare pressures, in particular backdated high cost packages of care for children
- Prescribing overspend based on 6 months Prescription Pricing Data
- Management of reserves to balance overall ICB position and release of non-recurring benefits across a number of budget areas.

The financial plan of the ICB required an overall efficiency target of £48.4m and the ICB is slightly above target.

Whilst the ICS is reporting a balanced forecast position, a number of potential financial risks have been identified with total unmitigated financial risk of £35m across the ICS. Work is continuing with ICS partners to manage risks and identify appropriate mitigations.

ICB Financial Position – ‘Place/Area’ level

Month 8 - November 2022	YTD Plan	YTD Actual	YTD Variance	2022/23 Annual Plan	2022/23 Forecast Outturn	2022/23 Forecast Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Financial Position at 'Place/Area' level						
North Cumbria	280,378	291,612	11,234	509,441	521,217	11,776
North Cumbria Area	**280,378**	**291,612**	**11,234**	**509,441**	**521,217**	**11,776**
Newcastle	302,656	300,462	(2,194)	542,136	538,184	(3,952)
Gateshead	245,930	244,928	(1,002)	439,828	438,578	(1,250)
North Tyneside	172,916	171,266	(1,650)	310,963	308,992	(1,971)
Northumberland	262,012	264,447	2,435	473,153	476,305	3,152
North Area	**983,514**	**981,104**	**(2,410)**	**1,766,080**	**1,762,058**	**(4,022)**
County Durham	468,388	466,972	(1,415)	855,766	852,503	(3,263)
South Tyneside	139,449	136,357	(3,093)	251,842	247,639	(4,202)
Sunderland	252,069	250,560	(1,509)	452,321	450,016	(2,305)
Central Area	**859,906**	**853,889**	**(6,017)**	**1,559,929**	**1,550,158**	**(9,771)**
Tees Valley	575,005	576,344	1,339	1,041,339	1,044,150	2,811
Tees Valley (South) Area	**575,005**	**576,344**	**1,339**	**1,041,339**	**1,044,150**	**2,811**
System	**96,122**	**95,129**	**(993)**	**183,880**	**177,407**	**(6,473)**
Total ICB Financial Position excl. Allocations	**2,794,925**	**2,798,079**	**3,153**	**5,060,669**	**5,054,990**	**(5,679)**

ICS Overall Financial Position

Month 8 - November 2022	YTD Plan (Surplus) / Deficit	YTD Actual (Surplus) / Deficit	YTD Variance (Surplus) / Deficit	Annual Plan (Surplus) / Deficit	Forecast (Surplus) / Deficit	Forecast Variance (Surplus) / Deficit
	£000s	£000s	£000s	£000s	£000s	£000s
NENC Commissioner (ICB)						
Q1 CCG	22,903	0	(22,903)	22,903	0	(22,903)
Q2-Q4 ICB	(23,770)	3,153	26,924	(25,536)	5,545	31,081
Total In Year ICB Position	**(867)**	**3,153**	**4,021**	**(2,633)**	**5,545**	**8,178**
Central Funding expected for ARRS costs	0	0	0		(11,224)	(11,224)
Total In Year ICB Position after central funding	**(867)**	**3,153**	**4,021**	**(2,633)**	**(5,679)**	**(3,046)**
NENC Providers	4,815	20,861	16,046	2,633	5,642	3,009
Total Provider Position	**4,815**	**20,861**	**16,046**	**2,633**	**5,642**	**3,009**
Total ICS Financial Position 2022/23	**3,948**	**24,014**	**20,067**	**0**	**(37)**	**(37)**

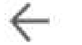
Appendices

Mental Health Core Data Monitoring Summary

Please note, MHSDS data has not been updated due to changes within the NHSE Publication. As a result, MH Core Data Pack measures have not been updated.

Locality	CYP Access (1+ Contact)	A&E Waits of 12+ Hours (CYP)	CYP Eating Disorder Waiting Time - Urgent	CYP Eating Disorder Waiting Time - Routine	IAPT Access - All (Monthly)	IAPT Access - All (Rolling Quarter)	IAPT Recovery Rate	IAPT 6 Week Wait	IAPT 18 Week Wait	IAPT 1st to 2nd Treatment > 90 Days	IAPT Access: Older Persons	IAPT Recovery: White British	IAPT Recovery: BAME	Dementia Diagnosis Rate
County Durham	10,365	0	77.8%	35.5%	870	2,995	52.0%	100.0%	100.0%	38.0%	160	53.0%	47.0%	66.3%
Newcastle Gateshead	6,615	0	100.0%	58.1%	800	2,555	52.0%	97.0%	99.0%	17.0%	125	51.0%	39.0%	73.4%
North Cumbria	3,615	0	100.0%	53.2%	400	1,280	53.0%	100.0%	100.0%	15.0%	105	54.0%	41.0%	55.7%
North Tyneside	3,060	0	100.0%	89.6%	235	890	55.0%	96.0%	99.0%	73.0%	55	57.0%	54.0%	66.1%
Northumberland	4,690	0	87.5%	81.3%	600	1,455	54.0%	53.0%	100.0%	55.0%	150	53.0%	42.0%	58.6%
South Tyneside	3,895	0	100.0%	88.9%	275	1,035	52.0%	92.0%	100.0%	31.0%	105	52.0%	60.0%	68.1%
Sunderland	5,045	0	75.0%	88.1%	670	1,745	57.0%	99.0%	100.0%	58.0%	170	55.0%	39.0%	60.1%
Tees Valley	14,775	0	66.7%	77.3%	965	4,005	55.0%	63.0%	79.0%	48.0%	205	52.0%	45.0%	69.9%
NENC ICS	51,785	5	82.1%	67.2%	4,815	15,960	53.0%	88.0%	96.0%	38.0%	1,065	53.0%	44.0%	65.2%
North East & Yorkshire	119,620	20	71.0%	76.0%	15,612	47,852	52.0%	89.0%	98.0%	28.0%	2,910	53.0%	44.0%	64.0%
England	691,935	295	68.1%	68.9%	98,827	311,673	49.5%	88.9%	98.4%	23.7%	20,018	51.0%	47.8%	62.0%

Locality	Discharges Followed Up within 72 Hours	EIP Waiting Times - MHSDS	SMI Physical Health Checks	OAP Bed Days (Inappropriate)	OAP % External (Inappropriate)	Community MH Access (2+ Contacts)	Admissions with No Prior Contacts (All Patients)	Admissions with No Prior Contacts (White British)	Admissions with No Prior Contacts (BAME)	Adult Acute LOS (60+ Days)	Older Adult Acute LOS (90+ Days)	Individual Placement and Support	A&E waits 12+ Hours (Adults)	Perinatal Access (No. of Women)	Perinatal Access YTD
County Durham	93.0%	58.1%	2,391	245	100.0%	7,160	8.0%	7.0%	0.0%	5.7%	11.8%	130	60	445	230
Newcastle Gateshead	94.0%	67.5%	2,456	230	100.0%	4,765	19.0%	12.0%	40.0%	7.1%	8.4%	130	20	360	175
North Cumbria	91.0%	42.9%	1,242	220	100.0%	5,120	10.0%	10.0%	0.0%	9.8%	10.6%	65	10	210	80
North Tyneside	75.0%	69.2%	778	5	100.0%	1,450	16.0%	0.0%	0.0%	7.3%	0.0%	30	0	140	70
Northumberland	88.0%	53.3%	1,196	90	100.0%	3,440	14.0%	15.0%	0.0%	7.1%	6.3%	45	0	220	105
South Tyneside	95.0%	100.0%	1,022	45	100.0%	2,505	0.0%	0.0%	0.0%	6.7%	16.3%	45	0	90	50
Sunderland	90.0%	94.1%	1,332	195	100.0%	4,665	21.0%	21.0%	0.0%	3.6%	23.7%	40	15	155	80
Tees Valley	86.0%	67.5%	2,693	135	100.0%	5,800	15.0%	13.0%	23.0%	5.5%	13.0%	125	50	465	225
NENC ICS	90.0%	66.2%	13,110	1,160	100.0%	34,800	13.0%	12.0%	24.0%	6.1%	11.7%	610	160	2,060	1,010
North East & Yorkshire	82.0%	71.0%	36,213	7,511	100.0%	86,110	16.0%	15.0%	22.0%	6.9%	10.6%	1,275	540	5,725	2,455
England	75.0%	67.8%	227,076	51,390	99.3%	505,580	14.0%	12.0%	16.0%	8.7%	10.9%	9,770	4,725	45,411	20,514



Constitutional Standards - Provider

NHS
North East & North Cumbria

Cancer Indicators

Indicators	Target	Period	CDDFT	Gateshead FT	NCIC	Northumbria	NTHFT	NuTH	STHFT	STSFT	England
% of patients seen within 2 weeks of an urgent GP referral for suspected cancer	93%	Oct 2022	83.2%	85.3%	80.8%	95%	88.3%	68%	71.8%	91.8%	77.8%
		YTD	76.7%	86.2%	80.9%	94.5%	84.3%	73.1%	60.9%	91.7%	77.8%
% of patients treated within 31 days of a cancer diagnosis	96%	Oct 2022	91%	99.2%	93.5%	98.9%	94.2%	81.5%	93.1%	96.3%	92%
		YTD	94%	98.7%	89.5%	97.5%	95.4%	82%	93.4%	98.1%	92%
% of patients treated within 62 days of an urgent GP referral for suspected cancer	85%	Oct 2022	73.3%	59.5%	53.9%	73.5%	54%	45.3%	63.2%	65.8%	60.3%
		YTD	74.6%	59.1%	49.1%	74.9%	60.9%	51.1%	62%	72.1%	60.3%
% of patients treated within 62 days of an urgent referral from an NHS Cancer Screening Service	90%	Oct 2022	90%	88.7%	76.9%	100%	86.4%	45.6%	50%	60%	67.1%
		YTD	70.3%	90.6%	52%	72.2%	85.9%	50.1%	58.3%	81.5%	67.1%
% of patients treated for cancer within 62 days of consultant decision to upgrade status	N/A	Oct 2022	72.2%	66.7%	52.2%	81.3%	100%	47.2%	84.6%	76%	73.9%
		YTD	72.3%	80%	72%	75%	91.3%	52.8%	78.9%	85.9%	73.9%

RTT

Indicators	Target	Period	CDDFT	Gateshead FT	NCIC	Northumbria	NTHFT	NuTH	STHFT	STSFT
% patients waiting for initial treatment on incomplete pathways within 18 weeks	92%	Oct 2022	65.4%	73.4%	60.4%	82.9%	77.8%	69.8%	66.7%	76.3%
		YTD	69.4%	75%	61.7%	84%	79.9%	70.1%	65.9%	79.9%
Number patients waiting more than 52 weeks for treatment (Incomplete pathways only)	0	Oct 2022	1959	89	758	24	42	4442	1352	113
Number of unjustified mixed sex accommodation breaches	0	Oct 2022	1	0	20	0	0	78	16	0
		YTD	21	0	102	0	0	233	146	0

Diagnostics

Indicators	Target	Period	CDDFT	Gateshead FT	NCIC	Northumbria	NTHFT	NuTH	STHFT	STSFT	England
% patients waiting < 6 weeks for any the 15 Diagnostic Tests	99%	Jul 2022	91.3%	76.6%	78.9%	94.3%	78.8%	85.9%	68.6%	80.5%	72.1%
		YTD	93.2%	76.4%	74.7%	90.1%	84.8%	84.6%	69.6%	76.5%	71.7%

Dementia

Unavailable at Provider Level

A&E (Excl. North Tees)

Indicators	Target	Period	CDDFT	Gateshead FT	NCIC	Northumbria	NuTH	STHFT	STSFT
% Patients spending 4 Hours or less in A&E	95%	Nov 2022	68.5%	71.7%	66.5%	90.7%	75.6%	62.3%	70.2%
		YTD	69.5%	74.5%	69.1%	91.3%	79.4%	67.5%	73.7%

Constitutional Standards - Sub-ICB

Cancer Indicators

Indicators	Target	Period	Co Durham	N Cumbria	N Tyneside	Newcastle Gateshead	Northumberland	S Tyneside	Sunderland	Tees Valley	England
% of patients seen within 2 weeks of an urgent GP referral for suspected cancer	93%	YTD	79.4%	81%	86.6%	78.2%	86.8%	85%	87.8%	70.9%	77.8%
% of patients treated within 31 days of a cancer diagnosis	96%	YTD	93.6%	88.7%	86.3%	87.4%	86.8%	95.2%	96.9%	94.2%	92%
% of patients receiving subsequent treatment for cancer within 31 days - drugs	98%	YTD	98.5%	96%	98.2%	97.7%	97.7%	100%	99.8%	97.7%	98.8%
% of patients receiving subsequent treatment for cancer within 31 days - surgery	94%	YTD	83.1%	69.3%	67.9%	66.4%	70.8%	76.3%	82.4%	83.2%	80.9%
% of patients receiving subsequent treatment for cancer within 31 days - radiotherapy	94%	YTD	91%	98.4%	100%	96.8%	97.2%	98.1%	97.7%	86.4%	90.8%
% of patients treated within 62 days of an urgent GP referral for suspected cancer	85%	YTD	64.2%	46.8%	68.3%	54.1%	66.8%	70.2%	71.3%	64.2%	60.3%
% of patients treated within 62 days of an urgent referral from an NHS Cancer Screening Service	90%	YTD	83.1%	54.1%	56.1%	69.1%	47.1%	93.8%	85.7%	79.9%	67.1%
% of patients treated for cancer within 62 days of consultant decision to upgrade status	N/A	YTD	77.6%	64%	59.4%	57%	67.2%	82.6%	83.2%	78.8%	73.9%

RTT

Indicators	Target	Period	Co Durham	N Cumbria	N Tyneside	Newcastle Gateshead	Northumberland	S Tyneside	Sunderland	Tees Valley
Number patients waiting more than 52 weeks for treatment (Incomplete pathways only)	0	Oct 2022	1705	907	753	2361	868		306	1360
Number of unjustified mixed sex accommodation breaches	0	Oct 2022	13	22	9	37	14	2	5	10
		YTD	67	124	16	103	38	12	20	105

Diagnostics

Indicators	Target	Period	Co Durham	N Cumbria	N Tyneside	Newcastle Gateshead	Northumberland	S Tyneside	Sunderland	Tees Valley	England
% patients waiting < 6 weeks for any the 15 Diagnostic Tests	99%	Jul 2022	85.7%	79.1%	90.9%	82.3%	90.3%	88.8%	75.5%	75.6%	72.1%
		YTD	88.3%	75.1%	86.8%	82.3%	86.9%	83.8%	73.9%	77.5%	71.7%

Dementia

Indicators	Target	Period	Co Durham	N Cumbria	N Tyneside	Newcastle Gateshead	Northumberland	S Tyneside	Sunderland	Tees Valley
Dementia diagnosis rate (as % expected prevalence)	70%	Sep 2022	66.2%	55.8%	66.9%	73.2%	58.6%	68%	62%	69.8%
		YTD	66%	55.8%	65.7%	73.3%	58.7%	67.7%	60.4%	70%

A&E

Unavailable at Sub-ICB Level

Item: 7.3

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

NORTH EAST & NORTH CUMBRIA ICB BOARD MEETING

31 January 2023

Report Title:	**ICB Finance Report**

Purpose of report

To provide the Board with an update on the financial performance of the North East and North Cumbria Integrated Care Board (NENC ICB) and NENC Integrated Care System (ICS) in the financial year 2022/23 for the period to 30 November 2022 ('month 8').

Key points

The full financial report for the period was reviewed in detail by the Finance, Performance and Investment Committee at its meeting on 5th January 2023. The report presented here provides a high level summary of the position.

ICB Revenue Position:

As at 30th November 2022 the ICB is reporting a forecast deficit of £5.6m, prior to expected receipt of additional funding from NHS England (NHSE) of £11.2m to cover costs associated with the Primary Care Additional Roles Reimbursement Scheme (ARRS).

Once this funding is received, the ICB will report a forecast surplus of £5.7m against a planned surplus of £2.6m. The additional £3m surplus will offset a forecast deficit across relevant NHS providers, allowing a balanced financial position to be maintained across the ICS.

Significant financial pressures are being seen in independent sector (IS) acute activity linked to elective recovery with a forecast overspend of almost £19m on IS contracts. A significant increase in forecasts has been seen in month. The expectation at planning stage was that overspending on IS would be "reclaimable" from NHSE as long as the NENC ICS was over target on performance or that the risk would be managed collectively across the ICS (via under-performance within relevant NHS Providers). At present the ICB has held back on implementing this so as to assist delivery of the NHS Provider Foundation Trust (FT) level financial targets. Significant pressures are also evident in prescribing linked to the impact of price concessions (£5.7m impact year to date and forecast impact of £12.3m).

Pressures are also being reported on continuing healthcare and section 117 packages of care. These pressures are currently being offset through underspends on other budgets, non-recurring benefits and use of programme reserves.

The significant forecast overspend on primary care delegated budgets largely relates to the additional costs associated with the ARRS. As part of national funding arrangements in this area only a portion of this funding is included within ICB baseline budgets, with the remainder to be drawn down from NHSE only once baseline budgets are exceeded. Total additional funding of £11.2m is expected based on current forecast ARRS costs.

At this stage of the year there is always limited data available for the majority of commissioned services with a time lag of two months in respect of prescribing data.

ICS Revenue Position:

From an ICS perspective the forecast out-turn is a surplus against plan of £37k, as shown in Table 2. As reported previously, one of the FTs reported a deterioration in forecast out-turn of £5.6m (from surplus to break-even) earlier in the year. This forecast deficit has been offset by a combination of additional surplus in the ICB as reported above of £3m and another FT provider improving its forecast out-turn by £2.6m.

ICB Running Costs:

A forecast underspend is expected on ICB running costs, largely due to the impact of vacancies in the current year. This remains a potential risk area on a recurring basis if vacancies are filled.

ICS Capital Position:

There is a potential forecast pressure of almost £14m on capital spending plans across the ICS in comparison to the confirmed ICS capital departmental expenditure limit (CDEL) allocation. This is a significant reduction on the forecast pressure of £26m reported previously. Work continues to review relevant capital plans with individual provider trusts and discussions continue with NHSE in respect of additional capital funding allocation for the year.

2023/24 Planning:
Work is underway across the ICS to understand underlying expenditure run rates across both the ICB and Provider FTs. The 2022/23 financial position across the ICS includes significant non-recurring benefits, both in respect of balance sheet movements and non-recurring delivery of efficiency programmes for example. The non recurrent nature of these savings will present a significant financial challenge to develop a balanced plan for 2023/24. Initial planning guidance published by NHS England and draft financial allocations are currently being reviewed to understand implications for the ICS, however initial estimates indicate a significant recurring financial deficit across the ICS in both the ICB and the FT Provider side.

Risks and issues

Whilst the ICB has reported a forecast in line with plan, a number of potential financial risks have been identified, totaling £16m for the ICB.

Key risks identified at this stage include:

- Risk that prescribing price concessions continue at current exceptionally high levels until the end of the financial year,
- Risk that growth in continuing healthcare (CHC) expenditure is above planned levels, and

- Risk that the growth in independent sector activity and therefore cost is unfunded through the national Elective Servcies Recovery Fund due to missed system targets.

Mitigations have been identified to manage the majority of potential ICB risks, leaving an unmitigated potential risk of £5m linked to elective recovery fund activity and prescribing costs. The unmitigated risk amounts to less than 0.1% of total ICB funding and will continue to be reviewed and managed as far as possible.

In addition to ICB specific financial risks there are a number of potential risks to the wider ICS financial position within Foundation Trusts. Unmitigated financial risk is assessed at £30m at Month 8, a reduction from the previous month. This includes potential financial pressures associated with the pay award of £20m alongside risks relating to general cost pressures and delivery of cost savings in a number of FTs totaling £10m. Work is continuing across the system to conduct a deeper dive exercise to review potential pressures, risks and identify appropriate mitigations where possible as well as seeking additional funding for the ICS.

Please see Table 4 for more information.

Assurances

ICB finance teams will monitor and report monthly on the risks noted above. This will include actions being taken to mitigate these risks.

The ICB Executive Director of Finance meets monthly with the ICS Directors of Finance to coordinate the review and management of the ICS finance position.

The financial position of both the ICB and the wider ICS will continue to be reviewed in detail on a monthly basis by the Finance, Investment and Performance Committee.

Recommendation/action required

The Board is asked to:

- note the latest year to date and forecast financial position for 2022/23 and take assurance that overall performance is in line with plan,
- note there are a number of potential financial risks across the ICS still to be mitigated.

Acronyms and abbreviations explained

ARRS – Primary Care Networks Additional Roles Reimbursement Scheme
BPPC – Better Payment Practice Code
CHC – Continuing Healthcare
ERF – Elective Recovery Fund
FT – NHS Provider Foundation Trust
ISFE – Integrated Single Financial Environment (financial ledger system)
MHIS – Mental Health Investment Standard
QIPP – Quality, Innovation, Productivity and Prevention

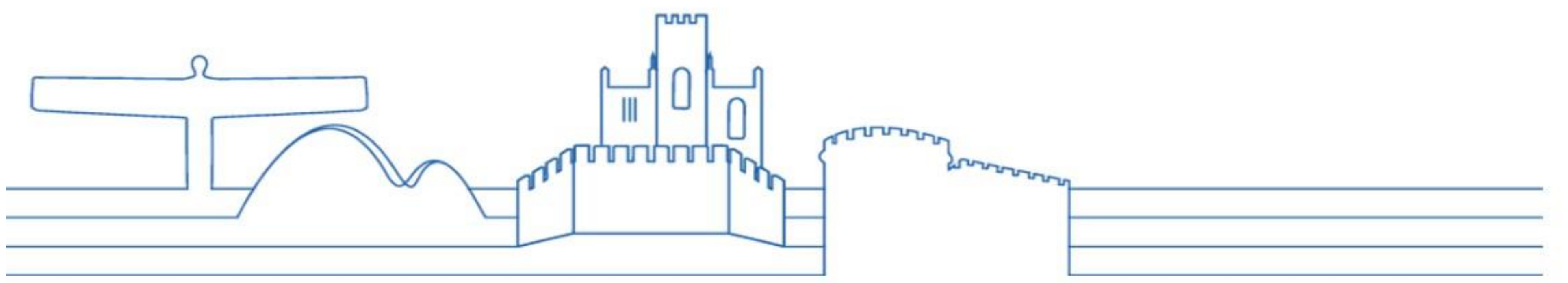
Sponsor/approving director	D Chandler, Interim Executive Director of Finance
Report author	R Henderson, Director of Finance (Corporate) A Thompson, Senior Finance Manager

Item: 7.3

Link to ICB corporate aims (please tick all that apply)						
CA1: Improve outcomes in population health and healthcare						
CA2: tackle inequalities in outcomes, experience and access						
CA3: Enhance productivity and value for money						✓
CA4: Help the NHS support broader social and economic development						
Relevant legal/statutory issues						
Health and Care Act 2022						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
If yes, please specify						
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**	✓
Key implications						
Are additional resources required?	N/A					
Has there been/does there need to be appropriate clinical involvement?	N/A					
Has there been/does there need to be any patient and public involvement?	N/A					
Has there been/does there need to be partner and/or other stakeholder engagement?	Yes, engagement within the ICB and the wider ICS on financial position.					

NENC ICB

Finance Report for the period ending 30th November 2022



Executive Summary

	M08 - November 2022		YTD	Forecast
Key Statutory Financial Duties	**Overall ICS 2022/23 In Year Financial Position - (Surplus) / Deficit**			
	For the financial year 2022/23 the ICS, including the Q1 position of the NENC CCGs, is on track to deliver the planned breakeven position reporting a small surplus of £0.04m at Month 8	Plan	£3.95 m	£0.00 m
		Actual	£24.01 m	(£0.04) m
	Overall ICB 2022/23 In Year Financial Position - (Surplus) / Deficit			
	Overall ICB 2022/23 In Year Financial Position prior to retrospective funding - (Surplus) / Deficit	Plan	(£0.87) m	(£2.63) m
	The ICB is reporting a year to date variance of £3.15m and an outturn variance of £5.55m, prior to expected retrospective funding adjustments of £11.22m - Deficit / (Surplus)	Actual	£3.15 m	£5.55 m
	Expected ICB 2022/23 In Year Financial Position after retrospective funding - (Surplus) / Deficit	Plan	(£0.87) m	(£2.63) m
	The ICB is reporting an outturn variance of £5.68m, after expected retrospective funding adjustments of £11.22m, an improved position of £3.05m against the planned surplus of £2.63m - Deficit / (Surplus)	Actual	£3.15 m	(£5.68) m
	ICB Running Costs Position - July 2022 to March 2023			
	The ICB is reporting a year to date and forecast outturn underspend of £1.37m and £1.96m respectively, compared with the submitted financial plan	Plan	£23.92 m	£44.76 m
		Actual	£22.55 m	£42.80 m
		Variance	(£1.37) m	(£1.96) m
	Overall ICS 2022/23 Capital Funding			
	The ICS is reporting a forecast outturn against the capital allocation in line with plan for primary care and £13.88m over on provider capital. At Month 8 there is a year to date underspend against the capital allocation of £50.19m.	Allocation	£128.32 m	£200.71 m
		Actual	£78.14 m	£214.59 m
		Variance	(£50.19) m	£13.88 m
Other Financial Performance Metrics				
	Overall ICS 2022/23 QIPP/Efficiency	Plan	£157.80 m	£248.83 m
	The ICS is reporting year to date QIPP savings of £141.20m and forecast savings of £246.21m with the ICB delivering £48.72m which is slightly over the submitted QIPP/Efficiency plan. Providers are currently forecasting an under-delivery against target of £2.91m.	Actual	£141.20 m	£246.21 m
		Variance	(£16.60) m	(£2.62) m
	Overall 2022/23 Mental Health Investment Standard (MHIS) The ICB is on track to achieve the MHIS target for 2022/23 (growth in spend of 6.68%), the target now includes the impact of the pay award and additional uplift.		6.68%	6.68%
	Cash The ICB cash balance for October is 0.37% and within the target set by NHS England of <1.25% of the monthly cash drawdown.		0.34%	<1.25%
	BPPC		by volume	by value
	The BBPC target is for 95% of NHS and Non NHS invoices to be paid within 30 days	NHS	99.69%	100.00%
		Non NHS	99.12%	99.23%

Overview of the Financial Position

This report provides an update on the financial performance of the ICB and wider ICS in the financial year 2022/23 for the period to 30th November 2022.

The ICB is currently reporting a forecast outturn deficit of £5.6m, prior to expected retrospective central funding of £11.22m relating to the Primary Care Additional Roles Reimbursement Scheme (ARRS). Once this funding is received, the ICB will report a forecast surplus of £5.7m against a planned surplus of £2.6m. The additional £3.0m surplus will offset a forecast deficit across relevant NHS providers, resulting in a balanced financial position across the ICS.

The main factors driving this performance are:

- Acute overspend mainly relating to Independent Sector provider activity where Elective Recovery Fund income has not been assumed (£20.9m forecast overspend)
- Mental Health overspend in particular pressures on s117 packages and specialist packages of care (£7.5m forecast overspend)
- Continuing Healthcare pressures, in particular backdated high cost packages of care for children (£3.2m forecast overspend)
- Prescribing overspend based on 6 months Prescription Pricing Data (£0.6m forecast overspend)
- Management of reserves to balance overall ICB position and release of non-recurring benefits across a number of budget areas

NHS England have confirmed a total historical surplus from the former Clinical Commissioing Groups (CCGs) of £17.5m for the ICB which is shown as part of the cumulative surplus position at the bottom of Table 1. Access to this historical surplus is subject to approval by NHS England.

The financial plan of the ICB required an overall efficiency target of £48.4m and the ICB is slightly above target.

The ICB is on track to deliver the Mental Health Investment Standard, the target investment has increased from 5.26% to 6.68% and now includes the impact of the pay award and additional inflationery uplift.

NHS Providers remain on block contracts for 2022/23, this arrangement gives the ICB certainty over the expenditure associated with these contracts for the year. NHS expenditure accounts for approximately 65% of total ICB expenditure.

The main areas of risk and uncertainty for the ICB arises from non nhs activity, including in particular independent sector acute spend, prescribing and continuing healthcare costs.

At this stage of the year there is still relatively limited data available for the majority of commissioned services, with a time lag of two months in respect of prescribing data and other activity based contract information. This adds a level of risk and uncertainty to the reported forecast outturn position.

Whilst the ICB has reported a forecast in line with plan, a number of potential financial risks have been identified, totalling £16m. This includes in particular potential risks around prescribing and the continued increase in price concessions, continuing healthcare and independent sector acute activity, linked to the elective recovery programme.

Mitigations have been identified to manage the majority of potential risks, leaving an unmitigated potential risk of £5m linked to elective recovery fund (ERF) activity and prescribing. Additional elective recovery funding to cover these costs is subject to overall system performance which presents a significant risk. In addition, a number of potential risks to the wider ICS financial position have been identified for NHS provider trusts, with unmitigated financial risk assessed at £30m. Work is continuing across the system to review potential pressures and identify appropriate mitigations where possible.

Table 1: ICB Financial Position

Month 8 - November 2022	YTD Plan	YTD Actual	YTD Variance	2022/23 Annual Plan	2022/23 Forecast Outturn	2022/23 Forecast Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Revenue Resource Limit	(2,806,592)			(5,066,945)		
Programme						
Acute Services	1,427,328	1,440,051	12,723	2,524,679	2,545,604	20,926
Mental Health Services	338,141	341,358	3,217	604,514	612,049	7,535
Community Health Services	274,717	273,455	(1,262)	485,847	482,448	(3,399)
Continuing Care	165,736	166,523	787	300,822	304,014	3,192
Prescribing	239,228	236,962	(2,266)	427,842	428,484	642
Primary Care	48,416	44,313	(4,103)	84,461	77,998	(6,463)
Primary Care Co-Commissioning	230,629	232,916	2,287	418,169	427,325	9,156
Other Programme Services	26,970	28,508	1,538	45,620	47,922	2,302
Other Commissioned Services	10,595	10,618	23	19,143	19,021	(122)
Programme Reserves	5,682	822	(4,861)	86,231	67,322	(18,909)
Contingency	2,695	0	(2,695)	4,725	0	(4,725)
Total ICB Programme Costs	**2,770,139**	**2,775,527**	**5,389**	**5,002,052**	**5,012,187**	**10,135**
Admin						
Running Costs	23,919	22,551	(1,368)	44,761	42,803	(1,958)
Total ICB Admin Costs	**23,919**	**22,551**	**(1,368)**	**44,761**	**42,803**	**(1,958)**
In Year (Surplus) / Deficit	867	0	(867)	2,632	0	(2,632)
Total In Year ICB Financial Position	**2,794,925**	**2,798,079**	**3,153**	**5,049,445**	**5,054,990**	**5,545**
Central Funding expected for ARRS costs	0	0	0	11,224	0	(11,224)
Total In Year ICB Financial Position after expected retrospective funding	**2,794,925**	**2,798,079**	**3,153**	**5,060,669**	**5,054,990**	**(5,679)**
Cumulative Surplus Position for information:						
Historic (Surplus) / Deficit	11,667	0	(11,667)	17,500	0	(17,500)
Total Cumulative ICB Financial Position	**2,806,592**	**2,798,079**	**(8,514)**	**5,078,169**	**5,054,990**	**(23,179)**

Table 1.1: ICB In Year Financial Position

Month 8 - November 2022	YTD Plan	YTD Actual	YTD Variance	2022/23 Annual Plan	2022/23 Forecast Outturn	2022/23 Forecast Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Financial Position at 'Place/Area' level						
North Cumbria	280,378	291,612	11,234	509,441	521,217	11,776
North Cumbria Area	**280,378**	**291,612**	**11,234**	**509,441**	**521,217**	**11,776**
Newcastle	302,656	300,462	(2,194)	542,136	538,184	(3,952)
Gateshead	245,930	244,928	(1,002)	439,828	438,578	(1,250)
North Tyneside	172,916	171,266	(1,650)	310,963	308,992	(1,971)
Northumberland	262,012	264,447	2,435	473,153	476,305	3,152
North Area	**983,514**	**981,104**	**(2,410)**	**1,766,080**	**1,762,058**	**(4,022)**
County Durham	468,388	466,972	(1,415)	855,766	852,503	(3,263)
South Tyneside	139,449	136,357	(3,093)	251,842	247,639	(4,202)
Sunderland	252,069	250,560	(1,509)	452,321	450,016	(2,305)
Central Area	**859,906**	**853,889**	**(6,017)**	**1,559,929**	**1,550,158**	**(9,771)**
Tees Valley	575,005	576,344	1,339	1,041,339	1,044,150	2,811
Tees Valley (South) Area	**575,005**	**576,344**	**1,339**	**1,041,339**	**1,044,150**	**2,811**
System	**96,122**	**95,129**	**(993)**	**183,880**	**177,407**	**(6,473)**
Total ICB Financial Position excl. Allocations	**2,794,925**	**2,798,079**	**3,153**	**5,060,669**	**5,054,990**	**(5,679)**

Table 2: Overall ICS (Surplus) / Deficit

Month 8 - November 2022	YTD Plan (Surplus) / Deficit	YTD Actual (Surplus) / Deficit	YTD Variance (Surplus) / Deficit	Annual Plan (Surplus) / Deficit	Forecast (Surplus) / Deficit	Forecast Variance (Surplus) / Deficit
	£000s	£000s	£000s	£000s	£000s	£000s
NENC Commissioner (ICB)						
Q1 CCG	22,903	0	(22,903)	22,903	0	(22,903)
Q2-Q4 ICB	(23,770)	3,153	26,924	(25,536)	5,545	31,081
Total In Year ICB Position	**(867)**	**3,153**	**4,021**	**(2,633)**	**5,545**	**8,178**
Central Funding expected for ARRS costs	0	0	0		(11,224)	(11,224)
Total In Year ICB Position after central funding	**(867)**	**3,153**	**4,021**	**(2,633)**	**(5,679)**	**(3,046)**
NENC Providers	4,815	20,861	16,046	2,633	5,642	3,009
Total Provider Position	**4,815**	**20,861**	**16,046**	**2,633**	**5,642**	**3,009**
Total ICS Financial Position 2022/23	**3,948**	**24,014**	**20,067**	**0**	**(37)**	**(37)**

Table 3: ICS Efficiencies

Month 8 - November 2022	YTD Plan	YTD Actual	YTD Variance	2022/23 Annual Plan	2022/23 Forecast Outturn	2022/23 Forecast Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Acute	1,470	1,470	0	2,650	2,650	0
Community Healthcare	5,428	5,428	0	8,144	8,144	0
Primary Care (inc. Primary Co-Commissioning)	11,066	11,066	0	16,592	16,592	0
Continuing Healthcare	13,481	14,036	555	20,229	20,513	284
Other Programme Services	542	542	0	818	818	0
Total ICB Efficiencies	**31,987**	**32,542**	**555**	**48,433**	**48,717**	**284**
Of Which:						
Recurrent	11,529	12,620	1,091	17,280	18,371	1,091
Non Recurrent	20,458	19,922	(536)	31,153	30,346	(807)
Total ICB Efficiencies	**31,987**	**32,542**	**555**	**48,433**	**48,717**	**284**
Providers within system	125,817	108,658	(17,159)	200,396	197,491	(2,905)
Total Provider Efficiencies (within system)	**125,817**	**108,658**	**(17,159)**	**200,396**	**197,491**	**(2,905)**
Of Which:						
Recurrent	75,094	34,764	(40,330)	124,103	66,354	(57,749)
Non Recurrent	50,723	73,894	23,171	76,293	131,137	54,844
Total Provider Efficiencies (within system)	**125,817**	**108,658**	**(17,159)**	**200,396**	**197,491**	**(2,905)**
Total ICS Efficiencies	**157,804**	**141,200**	**(16,604)**	**248,829**	**246,208**	**(2,621)**
Of Which:						
Recurrent	86,623	47,384	(39,239)	141,383	84,725	(56,658)
Non Recurrent	71,181	93,816	22,635	107,446	161,483	54,037
Total ICS Efficiencies	**157,804**	**141,200**	**(16,604)**	**248,829**	**246,208**	**(2,621)**

ICS Efficiencies key points

The tables above shows the efficiency targets set out in the ICS plan. For the ICB this is by ISFE category and at Month 8 the ICB is forecasting a slight over-delivery against CHC schemes with the remaining schemes on target to deliver the planned efficiencies.

For providers within the system there is a YTD under-delivery against target of £17.2m and forecast under-delivery of £2.91m. The forecast outturn for recurrent efficiencies is an underachievement of £57.7m and is partly mitigated by a forecast over delivery of non-recurrent schemes totalling £54.8m. Of the eleven providers within the ICS, there is now only one forecasting achievement of recurrent efficiencies. For the other providers the main reasons for under delivery include costs associated with COVID continuing longer than planned, continued use of agency staffing and delays in progressing development schemes.

Table 4: ICS Risks and Mitigations

Risks	Potential impact before mitigations	Mitigating actions	Potential impact after mitigations
	£000s		£000s
ICB Risks			
Continuing Healthcare - risk around activity increases and fee rates	(4,323)	NR measures / stretch efficiency	0
Prescribing	(5,595)	NR measures / stretch efficiency	(1,000)
Potential additional IS activity pressures (Elective Recovery Fund gap)	(4,500)	Anticipated ERF income	(3,956)
Winter pressures including Covid Medicines Delivery Unit (CMDU) Surge and PC Extended Access	(1,025)	NR measures / stretch efficiency	0
Other (including backdated FNC, dom care rates & s117s)	(1,038)	NR measures / stretch efficiency	0
System Risks			
Pay award risk	(20,000)	System actively working collaboratively to develop plans to mitigate this risk	(20,000)
ERF and other pay/non-pay provider risks	(46,000)	System actively working collaboratively to develop plans to mitigate this risk	(9,838)
Total ICS Risks	**(82,481)**		**(34,794)**

Item: 7.4

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

NORTH EAST & NORTH CUMBRIA ICB BOARD MEETING

31 January 2023

Report Title:	**Integrated Care Strategy**

Purpose of report

The attached Integrated Care Strategy was approved by the Integrated Care Partnership Board on 15 December 2022. It is presented to the ICB Board in order that it can be formally received.

Key points

- All ICBs were required to develop an integrated care strategy in collaboration with their Integrated Care Partnership Board, and to approve it by the end of December 2022.
- ICBs were encouraged to publish their agreed strategies by the end of 2022 and this was done in NENC.
- The Board is asked to receive the strategy and note that the date of the Board will be marked by a public launch of the strategy.

Risks and issues

- The ICB is now required to produce a 5 year Forward Plan that sets out how the strategy will be delivered. This Plan must garner the support of both the foundation trusts and the local authority partners in the ICB. A draft is required by the end of March with a final approved version by the end of June 2023.

Assurances

N/A

Recommendation/action required

The ICB Board is asked to formally receive the Integrated Care Strategy approved by the Integrated Care Partnership Board on 15 December 2022.

Item: 7.4

Acronyms and abbreviations explained						
Set out in full at first use.						
Sponsor/approving director	Jacqueline Myers, Executive Chief of Strategy and Operations					
Report author	Peter Rooney, Director of Strategy and Planning					
Link to ICB corporate aims (please tick all that apply)						
CA1: Improve outcomes in population health and healthcare						√
CA2: tackle inequalities in outcomes, experience and access						√
CA3: Enhance productivity and value for money						√
CA4: Help the NHS support broader social and economic development						√
Relevant legal/statutory issues						
NHSE guidance in relation to the production of an Integrated Care Strategy (various)						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**		**N/A**	√
If yes, please specify						
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**	√
Key implications						
Are additional resources required?	This will be assessed as part of the development of the 5 Year Forward View					
Has there been/does there need to be appropriate clinical involvement?	Yes, wide involvement of clinical and public health colleagues					
Has there been/does there need to be any patient and public involvement?	Yes – draft strategy published and over 300 responses received					
Has there been/does there need to be partner and/or other stakeholder engagement?	Yes - wide stakeholder involvement throughout the strategy production process					

Better health and wellbeing for all

a strategy for the
North East and North Cumbria

16 December 2022

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Foreword by Professor Sir Liam Donaldson

Over the past year I've seen first-hand the passion and commitment of people across our health and care organisations who are all focused on doing the very best for our communities.

We have much to be proud of thanks to the strong partnerships and collaborative working which have been built on over many years.

In recent years, we have made some improvements to health with the number of people dying from cancer or heart disease decreasing and fewer people smoking.

The quality of our health and care services are rated amongst some of the best in England. But despite all of this we still have some of the poorest health outcomes in the country. Something which our communities have endured for far too long.

Facts and figures about the health of people in the region, and their lived experience, make for uncomfortable reading.

For instance, we know men living in our region spend almost a quarter of their lives in ill health.

We have the second highest rates of heart disease and liver disease in the country and our rates of respiratory disease are 42% higher than the national average.

In nine of our 13 local authority areas there is a healthy life expectancy of less than 60 years. In the south of England there are only four areas out of 67 that are this low.

I am always conscious of the fact that behind these statistics are individuals and communities. People who could be enjoying a longer and healthier life. A child who could be thriving - not just surviving, and getting the very best start in life, which we know is so important for our future generations.

So, if you were to ask me what this document is about - it is about building a new momentum which sets out our shared ambition and desire to change this and make a real difference for the people in our region.

This Integrated Care Strategy is a joint plan between our local authorities, the NHS and our partners including the community, voluntary and social enterprise sector. It starts to set out our goals to address the many challenges we have been grappling with for some time.

It describes out how we will reduce the gap between how long people live in the North East and North Cumbria compared to the rest of England, so that our communities live longer, healthier and happier lives.

Our plans describe how we will ensure fairer health outcomes for people as we know not everyone has the same opportunities to be healthy because of the environments where they are born, grow up, live, work, and their age too.

Alongside this, we want to ensure our health and care services are not only high-quality but the same quality - no-matter where you live and who you are. That they are also joined-up and that people have the same access to the right care.

We know that our ambitions cannot be achieved without supporting our committed workforce who are crucial to our success – this includes looking after their physical and mental wellbeing and building a health and care workforce for the future.

This strategy document has been developed in partnership with many people and organisations. I would like to thank everyone who has contributed to and shared their views which have helped us to shape and develop this document.

We have more to do to discuss, involve and engage with our communities about their lived experiences and how we improve their health and experience of health and care services. But the discussions we have had, and the comments we have received, have all been invaluable and we have reflected this within this document.

We recognise we are publishing this plan at a challenging time for everyone including the NHS and social care. We know that we are yet to understand the full impact of the pandemic, services are still in recovery, and rising energy costs and the cost-of-living crisis is of grave concern for all and impacting significantly on the quality of life for our citizens.

As a result, it is fair to say there have been some debates as to whether we are we being too ambitious, given these challenges.

I would argue this is exactly why we need to be ambitious and clear about what it is we want to change, together. Because we can't keep doing the same thing if we want different results.

So, this really is just the start – we will continue to engage and involve our communities in the months and years ahead. I have no doubt that this plan will continue to evolve.

We have set a vision and ambitions which we hope will mean that, in time, all our communities can live healthier and happier lives.

Bringing this plan to life, making it happen - is what we all want to see. I have no doubt we can do that, together.

Professor Sir Liam Donaldson

Chair of the North East and North Cumbria Integrated Care Board

1 Introduction

1.1 Our Integrated Care Partnership

The North East and North Cumbria Integrated Care Partnership (ICP) is a statutory committee of the thirteen local authorities (fourteen from April 2023 as two new unitary authorities begin in Cumbria) and the NHS Integrated Care Board (ICB).

The ICP is responsible for setting and developing our strategy for health and care in the region. It is an equal partnership between local government and the NHS, with a key purpose to align the ambition and strategies of partners across the area to improve the health of our communities.

The ICP is made up of our four partnerships based around our main centres of population.

These are:

• North Cumbria
• Central (County Durham, Darlington, Sunderland and South Tyneside)
• North (Gateshead, Newcastle, North Tyneside, Northumberland)
• Tees Valley (Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-on-Tees)

We have committed to working together through a single overarching ICP alongside four local ICP arrangements. These local ICPs will develop a strategic picture of health and care needs from their constituent local authority places working with partners including existing health and wellbeing boards.

We will continue to focus on the importance of working at local authority place to:

- Build on our existing arrangements
- Ensure co-production between partners at local authority place
- Ensure a principle of subsidiarity, and that form to follows function, respecting the responsibilities of individual partner organisations
- Remain focussed on making improvements for the population.

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

1.2 Our partnership working

The ICP is part of what we call our **Integrated Care System (ICS) -** a new way of working across the North East and North Cumbria which aims to bring organisations together to combine their collective resources and expertise to plan, deliver and join-up health and care so our communities can live happier and healthier lives.

The Integrated Care Board for the North East and North Cumbria (ICB) is also part of this system. It is a new statutory NHS organisation which formed on 1 July 2022 and took over the responsibilities of the eight clinical commissioning groups (CCGs) in our region. The ICB will receive further responsibilities, over the coming years ahead, for the specialised commissioning of dentistry, optometry and pharmacy.

The ICB is responsible for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services. As well as its strategic functions, the ICB works locally with health and wellbeing boards in each of our 13 local authority areas. The ICB's place-based teams also work alongside our 64 primary care networks (PCNs) which are groups of local GP practices, social care teams and other community-based care providers.

1.3 Our Integrated Care Strategy

The purpose of the Integrated Care Strategy is to provide a strategic direction and agreed key commitments to improve the health and care of people in the North East and North Cumbria. This is based on the understanding of health and care needs across the region and at the 13 local authority places.

The strategy is focussed much more on what we want to achieve, rather than how we will meet our ambitions. Over time we will develop more detailed delivery plans to achieve the ambitions outlined in the Integrated Care Strategy. In this way it sets out an overarching framework which leaves room for local flexibility and delivery.

The strategy is written to support the broader work of partnership arrangements, especially at local level. Local authorities and the NHS are required to give full attention to the strategy in how they plan, commission and deliver services.

1.4 Developing our strategy

In late July 2022, the Department for Health and Social Care published guidance for the development of integrated care strategies. We have worked to develop the strategy in line with that guidance. During the summer of 2022 we established a steering group to oversee the development the strategy, jointly chaired by a local

authority and ICB representative. The steering group was supported by task and finish groups, including a data and intelligence group.

In late July, the steering group issued a 'call for evidence' requesting key documents including joint strategic needs assessments (JSNAs) from a wide range of partners.

In total more than 300 documents were received. The call for evidence has strongly informed the content of the draft strategy, alongside the population health data, which can be viewed through the link: Picture of Health - ICS edition 2022.

In October 2022, we began to draft the strategy. On 26 October we published the first draft of the strategy and a survey to enable members of the public and stakeholders to give feedback. Nearly 400 survey responses were received and analysed, as well as further detailed responses from individuals, partnerships including health and wellbeing boards, and organisations. We also took the opportunity, wherever practically possible, to speak with key stakeholders for example through health and wellbeing board meetings.

The feedback to the first draft has been invaluable in developing the final version of the strategy.

Information in the draft strategy has been calculated taking data published at local authority geographies and applying a population weighted method to generate estimates as actual data is not available for the ICP geographic area. The estimates have been provided by Office for Health Improvement and Disparities (OHID).

Source data at local authority level is taken from Office for Health Improvement and Disparities (OHID) Fingertips platform and Life Expectancy Segment tool.

2 Our case for change

2.1 The current position

It is important to be realistic about the current position. Across the North East and North Cumbria many people are struggling in their daily lives and are having to make difficult choices about how they spend their money. This can have a very real detrimental impact on health and wellbeing, especially in communities that already have higher levels of deprivation and poorer health outcomes.

Across the North East and North Cumbria many people have sadly experienced a bereavement, or a long-lasting worsening of their own physical or mental health, either directly or indirectly due to the Covid-19 pandemic.

During the heights of the pandemic people and communities showed incredible resilience, support and solidarity. But we know that the pandemic led to higher levels of anxiety and social isolation, and caused a major disruption to education, employment and home life. For example, there is clear evidence that domestic violence and broader adult and children safeguarding issues increased during the pandemic.

Health and care organisations have struggled to sustain vital services. Demand is at a very high level, with some services still working to recover and to address increased levels of unmet demand. The impact on the whole social care sector, for adults and children, has been enormous, and the NHS is now working to reduce its highest ever backlog of care, as measured by waiting lists and waiting times.

The health and care workforce has worked incredibly hard, with great ingenuity and flexibility during the heights of the pandemic. Many staff members are tired and are living with the emotional impact of the pandemic, having been through an extremely challenging time.

This sets a very difficult context for the Integrated Care Strategy. Most measures of health and wellbeing, population health, health inequalities and performance measures for health and care services, have worsened over the last three years.

We would not choose to start from here.

Despite this being a challenging starting point we have a once in a generation opportunity through our partnership to convene the widest, deepest and strongest coalition of public and community bodies ever seen in the region. With a shared ambition to deliver a programme of health and care improvement for the people of the North East and North Cumbria that reverses these negative trends and delivers the healthier and fairer lives they deserve.

2.2 Health and wellbeing outcomes

2.2.1 Measuring health and wellbeing

The World Health Organisation (WHO) defines health as '*a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'.* This definition moves beyond bio-medical models of health, but the definition can feel unrealistic as very few of us will ever feel truly healthy against this definition. There are a wide number of definitions of wellbeing. Some are subjective, for example feeling well, being able to function successfully and having positive thoughts and relationships. Others are objective measures such as having access to good housing, education, food and safety.

It is difficult to give a single definition of health and wellbeing, and even more difficult to properly measure health and wellbeing. We have selected two key measures for population level health outcomes as a source of focus for this strategy. We recognise the short comings in this, and over time will seek to build more inclusive and satisfactory measures.

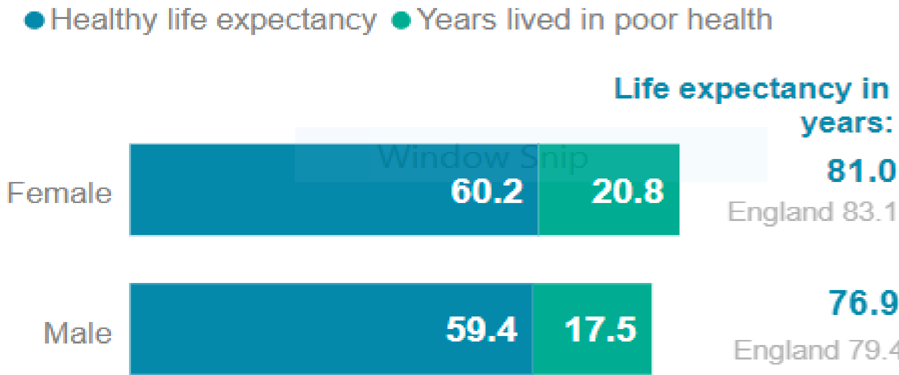
Our key measures are:

- Life expectancy at birth: this is the average number of years that would be lived by babies born in a given time period if mortality levels at each age remain constant.
- Healthy life expectancy at birth: this is an estimate of the average number of years babies born this year would live in a state of 'good' general health if mortality levels at each age, and the level of good health at each age, remain constant in the future. The healthy life expectancy measure adds a 'quality of life' dimension to estimates of life expectancy by dividing it into time spent in different states of health.

We recognise that these are not the only measures of health outcomes, and that they have the potential to focus on physical health, or to miss the very real issues for people living with a long-term condition or disability (across physical and mental health). They have been chosen as good overall indicators, which are widely and routinely measured, meaning we can track progress and make comparisons.

2.2.2 Life expectancy and healthy life expectancy at birth

Life expectancy at birth in our ICP has been persistently lower than the England average for a long time. The most recent measurement is for 2018-20 as shown below.



Source: Population weighted estimates (experimental) for NENC via Picture of Health - ICS edition 2022 based on data available from OHID Public Health Profiles 2022.

Population weighted estimates for healthy life expectancy at birth are also lower than the England average for 2018-20:

- For women this was 60.2 years in our ICP compared to 63.5 for England
- For men this was 59.4 years in our ICP compared to 63.1 for England.

Using these measures, our ICP has some of the worse health outcomes in England.

On average, people in the North East and North Cumbria are expected to die at a younger age than people in most other parts of England and have a longer period of ill health before they die. This needs to change.

2.3 Health inequalities

2.3.1 Inequality in health outcomes

Health inequalities are socially produced, unjust and avoidable systematic differences in health between groups of people. Health inequalities arise because of variations in the conditions in which we are born, grow, live, work and age. We do not all have the same opportunities to be healthy. Inequalities are driven by structural factors beyond individual control.

One key measure of health inequalities are inequalities in life expectancy, the difference in how long groups of people in they live average. The graphic below shows the difference in life expectancy at birth between the most deprived 20% and least deprived 20% areas within our ICP in 2020/21.

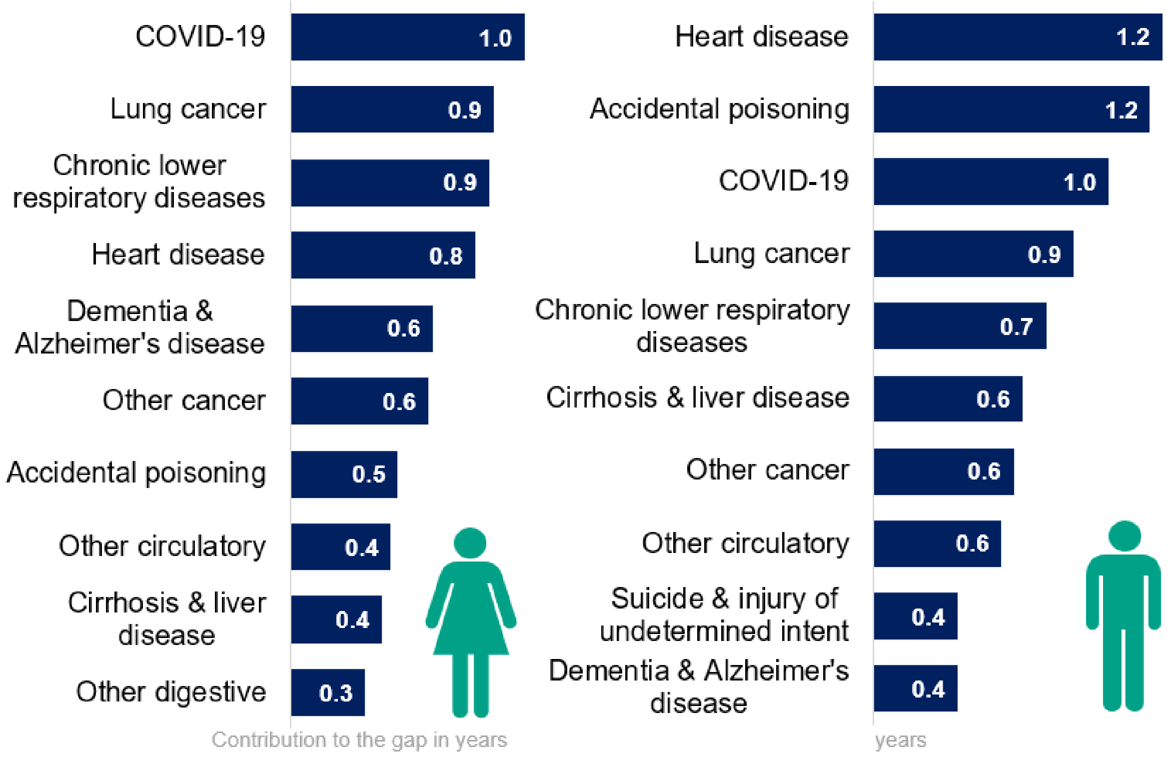
The difference was approximately 8.1 years for women and 10.4 years for men. This difference is much larger than the comparable inequality gap for England.

Source: Population weighted experimental estimates based on OHID Segment tool

Mortality rates from Covid-19 have been considerably higher in the more deprived areas, deepening health inequalities. By April 2022, the cumulative death rates since the start of the pandemic in people aged under 75 were 3.5 times higher in the most deprived areas compared to the least deprived across the North East and North Cumbria.

2.3.2 Main causes of in inequality by disease groups

The graphic below shows the main causes of inequality in health outcomes between our ICP and England by disease groups for 2020 – 21.



Source: Population weighted experimental estimates based on OHID Segment tool

Most of the gap in outcomes is attributable to avoidable mortality. For our region, inequalities in life expectancy are heavily associated with:

- Covid-19: As there is much higher Covid-19 mortality in more deprived communities
- Smoking: This causes respiratory disease and lung cancer
- Alcohol: This can cause cirrhosis and liver disease
- Smoking, alcohol, and healthy weight: Which causes heart disease, circulatory disease and cancers
- Substance misuse: Accidental poisonings are most frequently drug related deaths. The North East (not including North Cumbria) had the highest rate of drug related deaths in England in each of the past nine years.
- Emotional and mental wellbeing: which is a significant factor in all causes of mortality, including suicide.

Accidental poisoning, suicide and injury of undetermined intent, and cirrhosis and liver disease contribute considerably to the gap in life expectancy between our ICP and England, as highlighted below:

For women these causes contribute **20%** (310 excess deaths) to the gap in life expectancy.

For men, these causes contribute **39%** (700 excess deaths) to the gap in life expectancy.

Source: Population weighted experimental estimates based on OHID Segment tool

2.4 Social determinants of health and wellbeing

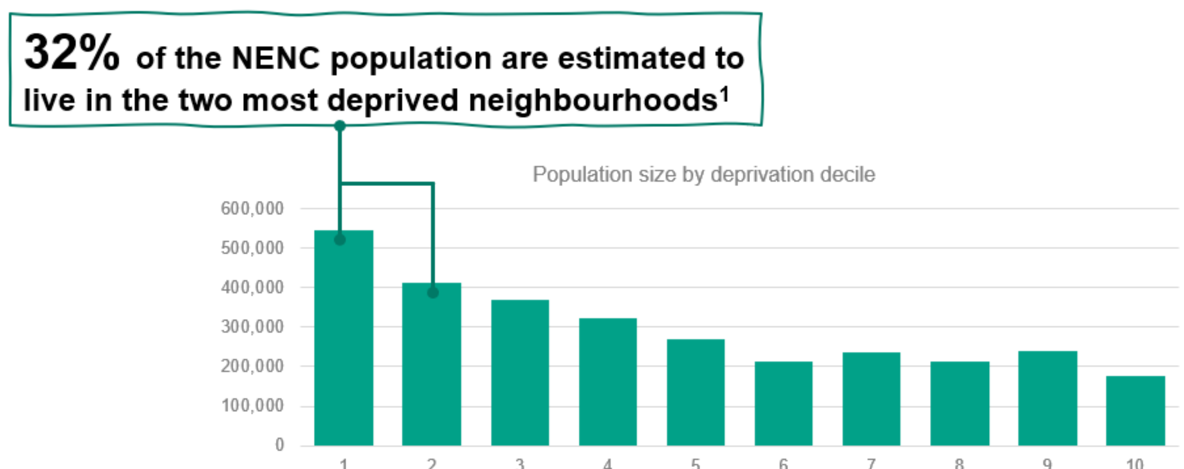
2.4.1 Socio-economic deprivation

Poor social and economic circumstances affect health throughout life. People living in poverty and multiple dis-advantage have greater risks of serious illness and premature death. They face increasing health inequalities and spend a greater proportion of their shorter lives living with long term conditions and disabilities.

People living with this disadvantage also begin to use health services at an earlier age, increasing the demand for health and social care for a longer period. Although the root causes of health inequalities are driven by factors outside of the NHS and social care, these services deal with the often-preventable consequences and should therefore play an active role in supporting local communities.

In the North East and North Cumbria this is a major challenge. Our population overall has much lower levels of wealth, and a much higher percentage of our population

live in the twenty percent (two deciles) most deprived neighbourhoods for England as shown below.



Source: ONS mid 2020 population estimates and index of multiple deprivation

In total 32% of people in the North East and North Cumbria live in neighbourhoods which are in the 20% most deprived in England. This is even starker for children and young people, where the figure rises to 40% of infants aged 0 – 4, much higher than the England average of 25%.

This is set to worsen in the context of the current cost of living crisis. Average pay growth is well below the current rate of inflation and in 2022/23 and 2023/24 we are anticipating the largest fall in real incomes since records began. This will have a disproportionate impact on people living in more deprived neighbourhoods.

2.5 Health and care services

Across a range of metrics the quality of health and care services in the North East and North Cumbria is consistently rated amongst some of the best in England. However, people do not always experience services as excellent. There are real challenges in:

- The unwarranted variation in the quality of services, and inequalities in access, experience and outcomes
- The experience of using services, including access, navigating different systems, waiting times, geographical distance and culturally appropriate services
- The safety of services, including for some people experiencing harm from their contact with services
- The outcomes delivered.

There are now more services across all sectors with a 'Requires Improvement' or 'Inadequate' Care Quality Commission (CQC) rating and worsened indicators of performance than pre-pandemic. In the short term at least, without very concerted action, this is only likely to continue to worsen. We also know that the way health and care services are delivered and experienced can be very inequitable. This also needs to change.

3 Strengths to build on

In the North East and North Cumbria we have much to be proud of. We have outstanding strengths that provide a credible source of hope and collectively we can make real improvements with confidence and realistic optimism.

We have strong communities, with hundreds of thousands of people providing unpaid care to support their loved ones, or freely giving their time and skills through volunteering. Our voluntary, community and social enterprise (VCSE) sector makes a huge contribution to the health and wellbeing of our region and our communities.

We are home to areas of outstanding natural beauty and habitats of international importance. Millions of people visit our area every year to enjoy our environment and cultural assets. We have vibrant industries in all sectors, providing employment and infrastructure of national value.

We also have some of the best research and development programmes of any health system, developing the next generation of treatments, and procedures and cures (including world leading genetic research programmes) alongside dedicated research capacity through our Academic Health Science Network (ASHN) and Applied Research Collaborative (ARC).

Our medical training is rated as among the best in the UK. We are home to one of the UK's top ten medical schools at Newcastle, and an innovative new medical school in Sunderland, dedicated to widening access to ensure the profession reflects the communities it serves. By taking the lead in apprenticeships and training we have offered a way into highly skilled and rewarding professions for thousands of young people and our future generations.

We have a very strong foundation of partnership and collaborative working, across the ICP and at local authority place level. These and our many other strengths and assets provide a fantastic foundation for us to make a real and lasting difference to the health and wellbeing of or population.

4 Our vision, goals and ambition

4.1 Introduction and overview

From our case for change, and feedback on our initial draft strategy, we have developed a basic framework to show our vision, goals and enabling actions.

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 and North Cumbria.

The pandemic has further reduced the life expectancy at birth of our population and there is need for focused work to ensure we recover from this position

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

This framework provides the structure for the remaining sections of the strategy.

4.2 Longer and heathier lives for all

Our first goal is to achieve to longer, healthier lives for everyone. Our key measurable commitment is to:

Goal 1: Reduce the gap between our ICP and the England average in life expectancy and healthy life expectancy at birth, by at least 10% by 2030.

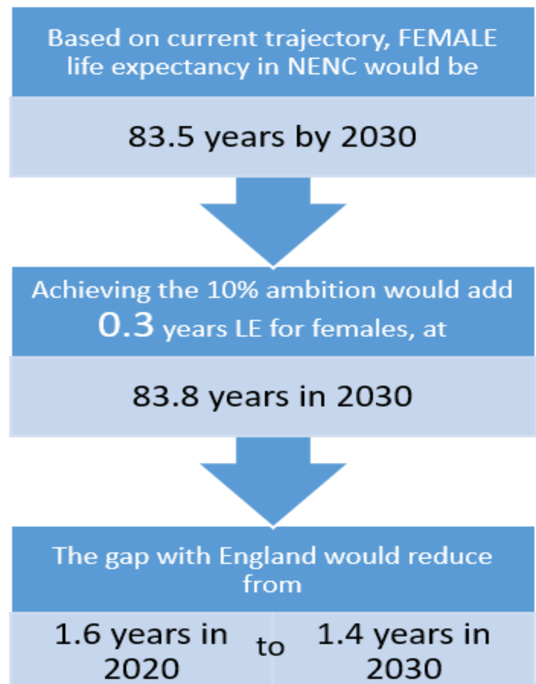
As set out in our case for change, we have lower life expectancy and healthy life expectancy at birth than the England average. In the longer term our ambition is to eliminate this inequality. The people of the North East and North Cumbria deserve at least the same level of health outcomes as people in the rest of the country. But this will take time, this inequality is longstanding and worsened during the Covid-19 pandemic.

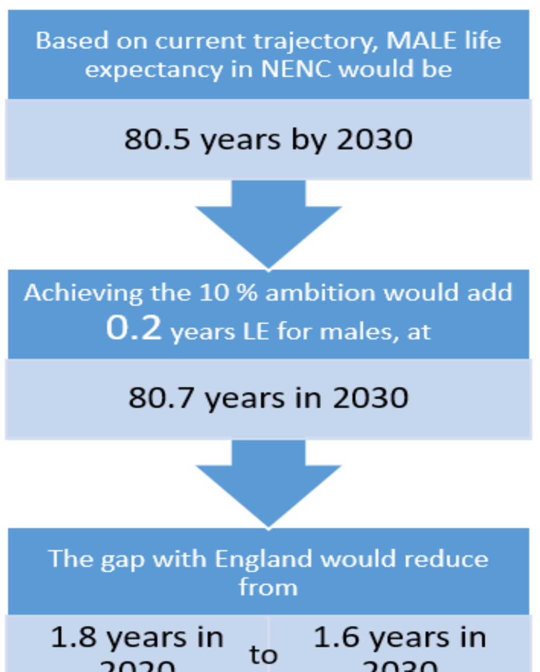
Our first collective task is to reverse the current trajectory, to recover our pre-pandemic position, and to begin to set a real momentum towards a longer-term transformation in health outcomes.

The wording of this goal can be confusing. We cannot know in advance what the England average for life expectancy and healthy life expectancy at birth will be in 2030. We can model the current position, and the current trajectory – meaning the 'if we did nothing different' scenario.

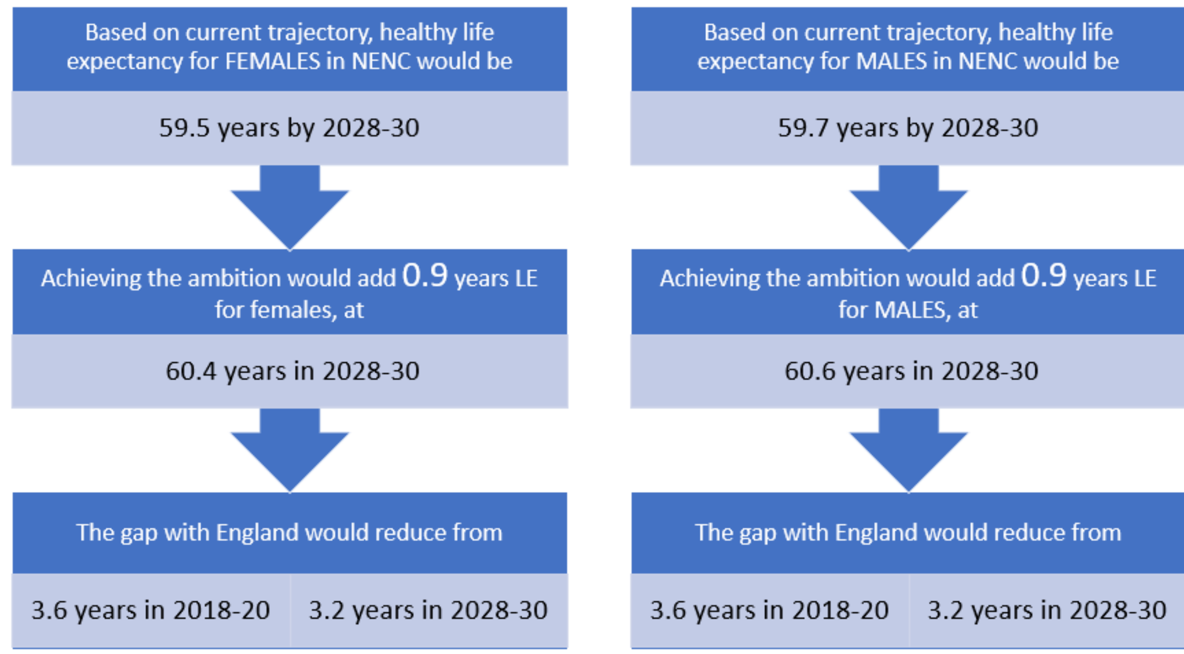
The charts below show the modelling.

Life expectancy at birth





Healthy life expectancy at birth



4.3 Fairer health outcomes for all

Our second goal relates to delivering fairer outcomes. Our key measurable commitment is to:

Goal 2: Reduce the inequality in life expectancy and healthy life expectancy at birth between people living in the most deprived 20% of neighbourhoods and the least deprived 20% - by at least 10% by 2030.

This is a measure of reducing health inequalities in the quality of life at population level. This means preventing ill health, delaying the onset of long-term conditions and reducing the gap in health outcomes all along the social gradient. We are committed to improving health outcomes for everyone, but to make the biggest difference for the people and communities who currently experience the poorest health outcomes.

As described in our case for change, the current level of inequalities in health outcomes is large and deeply entrenched. Over time we will work to deliver a much bigger change, but in recognition of the current position we are seeking to set a challenging yet realistic ambition.

4.4 Best start in life for our children and young people

Our third goal is a specific focus on children and young people. Our experiences during infancy, childhood and as young people deeply shape our long term, and often lifelong ability to reach full potential as well as enjoy good health and wellbeing. Children and young people in our region often experience significant inequalities. We want to enable children and young people to have the best possible start in life, as a worthwhile commitment in its own right, but also because this will have a lasting positive effect on health outcomes and fairer outcomes.

Early in 2023, we will work with children and young people, and across partner organisations, to agree the most appropriate overall measurable commitment in relation to this goal. Provisionally, we have set a goal to:

Goal 3: Increase the percentage of children with good school readiness at reception, especially for children from disadvantaged groups.

This recognises the multiple issues that impact on to a young child's life as they enter school, including family support, good nutrition, healthy lifestyle – activity, play, sleep, socialisation, language development, physical development and growing in a truly healthy environment.

4.5 Improving health and care services

Our fourth goal relates to improving health and care services. Our key measurable commitment is:

Goal 4: To ensure that our Integrated Care System is rated as good or outstanding by the Care Quality Commission (CQC).

We accept that there are limitations to how we can measure the quality of our health and care services. This measure has been selected as the CQC will in the future, and for the first time, undertake inspections of whole system from a broader partnership perspective.

4.6 Supporting goals

Alongside our measurable goal, we have also set some supporting goals which are critical in our ambition to achieve the overall goals described in the above section. These are important in their own right and in combination also contribute to the achievement of our measurable goals. The combination of goals will form our performance framework for assessing how well we are meeting our strategy commitments.

By 2030, we aim to:

1. Reduce smoking prevalence from 13% of people aged over 18 in 2020 to 5% or below.

2. Reduce alcohol related admissions to hospital by 20%.

3. Halve the difference in the suicide rate between our ICP and England in 2019/2021 (three year rolling average) by 2029/31.

4. Reduce drug related deaths by at least 15% by 2030.

5. Increase the percentage of people diagnosed at the early stages of cancer (stage 1 and 2) to the national target of 75% by 2028.

6. Increase the percentage of regulated services, across each of social care, primary care, and secondary care, that are rated as good or outstanding by the Care Quality Commission.

During 2023 we will additionally seek to set stretching yet realistic supporting commitments in relation to:

7. Increase the number of people children, young people and adults with a healthy weight.

8. Reduce social isolation, especially for older and vulnerable people.

9. Reduce the gap in life expectancy for people in the most excluded groups (see section 6.3, inclusion health).

5 Longer and healthier life expectancy

5.1 Supporting economic and social development

We recognise that health and care services only play a small but important part in determining overall health and wellbeing outcomes. Health and care services cannot resolve the broader social and economic structures that give rise to poorer health outcomes and health inequalities. However, there are active steps that we can take to make improvement.

We will ensure there is clarity in our leadership, collaborative and advocacy actions to address the underlying causes of poor population health outcomes and inequalities.

We will be an active partner in advocating for economic and social development in the North East and North Cumbria and support and develop strong links with leading organisations and partnerships - for example Local Economic Partnerships.

5.2 Health and wellbeing related services

A broad range of services can have a positive impact on health and wellbeing. We will work with partners across a broad range of sectors to integrate approaches to health and wellbeing.

Housing plays a very important role. Living in a house with poor energy insulation, damp or living in overcrowded housing can all have a major detrimental impact on wellbeing. We will work in partnership with local authorities, and through them partner with registered social landlords and the independent/private sector to find support approaches to improve housing.

Services which support people to access benefits, legal advice and other advice services are also deeply important. For example, there is clear evidence that people supported by the Citizens Advice Bureau and community led advice and support services feel a health and wellbeing gain.

Leisure services have an obvious health and wellbeing positive impact, as do other approaches to encouraging or enabling physically active lives.

Education and employment services have a major impact on health and wellbeing. Educational attainment is the strongest correlative factor in health outcomes, and employment, particularly in better paid roles, is a protective factor for health and wellbeing.

Particularly working at local authority place level, we will seek to work in partnership with a broad coalition of services that have a positive impact on health, not just

health and care services. Such services need to be included in our approach to integrated neighbourhood teams to support broader wellbeing.

5.3 Community centred and asset-based approaches

Asset-based approaches emphasise the need to redress the balance between meeting needs and nurturing the strengths and resources of people and communities. We will use asset-based approaches to address health inequalities in access, experience and outcomes building on the knowledge, skills, experience, resilience, and expertise that lie within the communities we serve. We will build on the learning from the Covid-19 pandemic in which community centred approaches across the region played a key role in a number of the key strands for the pandemic response.

5.4 Community wealth and anchor institutions

Local authorities, working with place partners, have a leading role in building community wealth.

Large partner organisations, rooted in their local communities, can make a big difference to social determinants by acting as 'anchor institutions'. The term anchor institutions refers to large organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchors get their name because they are unlikely to relocate, given their connection to the local population, and can help improve the health and wellbeing of communities by:

- Purchasing more locally for social benefit
- Using buildings and spaces to support communities
- Widening access to quality employment
- Working with local partners, spreading good ideas for civic responsibility
- Reducing environmental impact

5.5 Prevention and health promotion

5.5.1 Healthier and Fairer Committee of our ICP

We will continue to implement evidence-based programmes of preventive interventions, recognising the key leadership role of local authorities in public health, but including all partner organisations.

Health and wellbeing boards and local authority place-based partnerships are already actively delivering a wide range of prevention and health promotion approaches.

To support their work we have established a Healthier and Fairer Committee of our ICP, jointly led by the ICB medical director and the chair of the North East Directors of Public Health network. The healthier and fairer committee will provide leadership across the ICP, and give support to local authority places, focussed on:

Prevention, including:

- Reducing the harms from alcohol, substance misuse and smoking
- Promoting healthy weight and active lives
- Supporting people to prepare well when waiting for planned operations.

Core20Plus5 (this is explained in sections 6.2 and 7.4)

- For both children and young people and adults
- Deep End Network (a network of general practices based in deprived communities)

Broader economic and social benefits, including:

- Acting as anchor institutions
- Digital inclusion
- Promoting health literacy
- Responding to the cost of living
- Poverty proofing services – working with people on low incomes to identify and overcome the barriers that might prevent access to services.

5.5.2 Improving nutrition and supporting active lives

Health weight is a key factor in health outcomes. We do not want to stigmatise anyone, but we do want to find improved ways to support children, young people and adults to have good nutrition and to live active lives. This is a complex issue and national support will be needed to make healthier food more accessible to everyone in addition to health promoting interventions. We will work to include programmes promoting healthy weight, good nutrition and active lifestyles in our partnerships at neighbourhood, local authority place and regional level. This will include social prescribing programmes.

5.5.2 Smoking and alcohol programmes

Fresh and Balance are the ICP tobacco and alcohol programmes. Their purpose is to work with partners and the public to help drive a societal shift around two of our biggest preventable causes of ill health in our region.

The programme works at population level and is a valuable resource to assist both NHS and local authority partners as they support people to stop smoking or reduce drinking. Equally important is a focus on shifting the norms around both tobacco and alcohol use, coupled with enforcement of legislation and a call for action to prioritise both issues at national level.

The Fresh Balance programme supports local action to highlight the impact of alcohol and tobacco on families, communities, public services and the wider economy. It encourages healthier behaviours through award winning media campaigns and advocates on behalf of the region for evidence-based policy through collaboration with the Smokefree Action Coalition and Alcohol Health Alliance.

The Fresh and Balance approach recognises the role of all partners across the system partners including the Association of Directors of Public Health North East, the Office of Health Improvement and the ICP Healthier and Fairer Committee

The North East and North Cumbria has made significant progress in reducing overall adult smoking rates through a multi-strand approach led by Fresh. Tobacco remains a key driver of health inequalities and smoking rates are significantly higher in some groups. There is a commitment to achieve less than 5% smoking rates across all groups. This will be achieved through action from national to local level.

The region has made some progress around alcohol with the ground-breaking campaigns led by Balance resulting in significantly more people knowing the fact that alcohol causes cancer compared to the national average. Evaluation has shown that almost half of the people who saw the most recent campaign took steps to cut down their alcohol consumption as a result. However, nearly one million adults are still drinking above the Chief Medical Officer's low risk guidelines and putting their health at risk. The 20 year high in alcohol related deaths in England signifies that there is an urgent need for national action to support work within the region.

5.5.3 Social isolation

High-quality social connections are essential to our mental and physical health and our well-being. Social isolation and loneliness are important, yet neglected, social determinants of the health of older people. A large body of research shows that social isolation and loneliness have a serious impact on older people's physical and mental health, quality of life, and their longevity. The effect of social isolation and loneliness on mortality are comparable to that of other well-established risk factors such as smoking, obesity, and physical inactivity.

Health and care organisations need to work in support of local organisations, particularly voluntary, community social enterprise and faith-based organisations at neighbourhood level to reduce social isolation.

5.5.4 Health literacy

Health literacy is about people's ability to understand and act upon information relating to their health. The World Health Organisation (WHO) recognises that improving health literacy provides a foundation for people to be active in their own care and improve their health. It also highlights that improving health literacy has the potential to reduce health inequalities. We will support the skills of people to be active in their own health, and of how services communicate with people.

6 Fairer health outcomes

6.1 Health inequalities

We are committed to delivering fairer health outcomes by reducing health inequalities across our entire population. Health and wellbeing inequalities are the unfair, unjust, systemic and avoidable differences in the health and well-being of our communities. The conditions in which people are born, grow, develop and age are the underlying causes of health inequalities – the key drivers are social, economic and environmental conditions.

Inequalities:

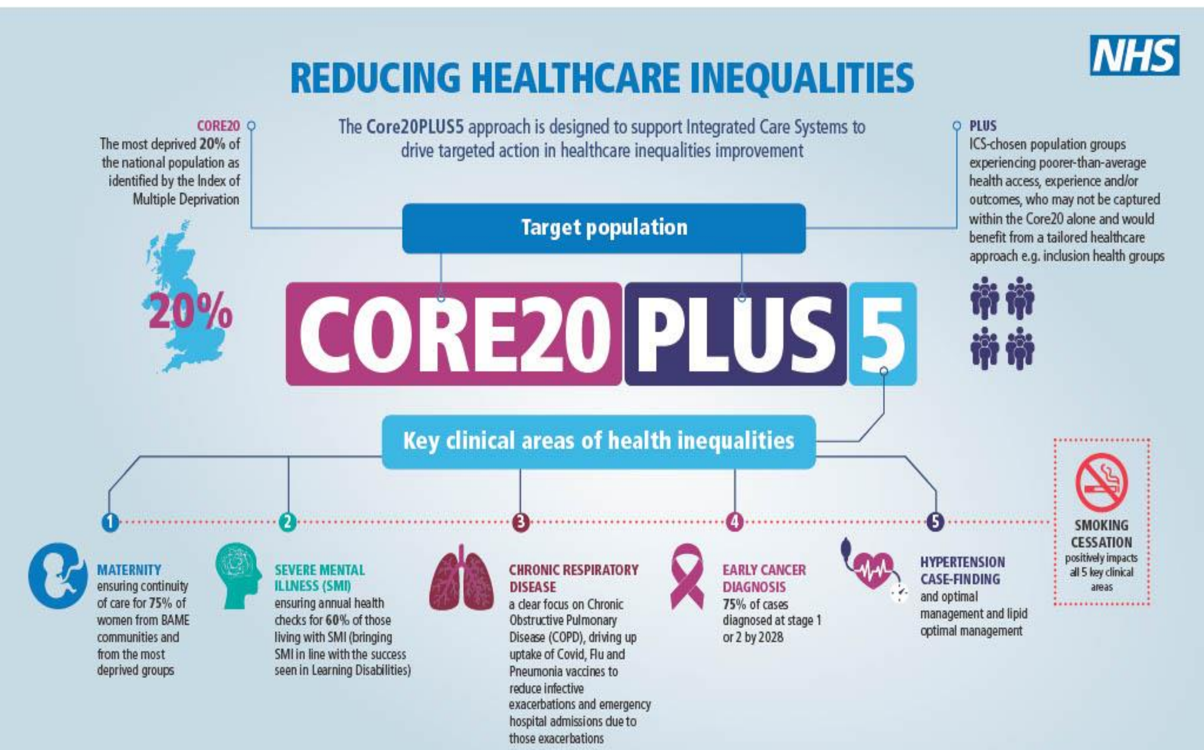
- Are a result of complex interaction between factors to produce differences across population groups
- Occur by socio-economic status, geography, protected characteristics or social exclusion, vulnerability and deprivation
- Are not inevitable and addressing them requires cross sector action by organisations, communities, business and government
- Require understanding, approaches to tackle health inequalities need to reflect the complexity of how inequalities are created, made worse and perpetuated.

These are complex issues and reducing health and wellbeing inequalities will be challenging. In this section, we outline some of the key approaches that will begin to turn around the current position and move us towards fairer outcomes.

6.2 Core20Plus5 for adults

Core 20 PLUS 5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. The equivalent children and young people's framework is described in section 7.

The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement, as summarised in the graphic below.



The most deprived 20 per cent of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

Across the North East and North Cumbria, a third of our population lives in the 20% most deprived areas of the country. This is not uniformly distributed with some of our local authority areas having much higher proportions of their populations living in the most deprived 20% of neighbourhoods nationally.

The PLUS population groups within the Core20Plus5 include a number of groups where the outcomes are poorer compared to the rest of the population. These include people from Black Asian and Minority Ethnic groups, people living with a learning disability and/or autism, coastal communities with pockets of deprivation; people with multi-morbidities; and protected characteristic groups; people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in the justice system, victims of modern slavery and other socially excluded groups.

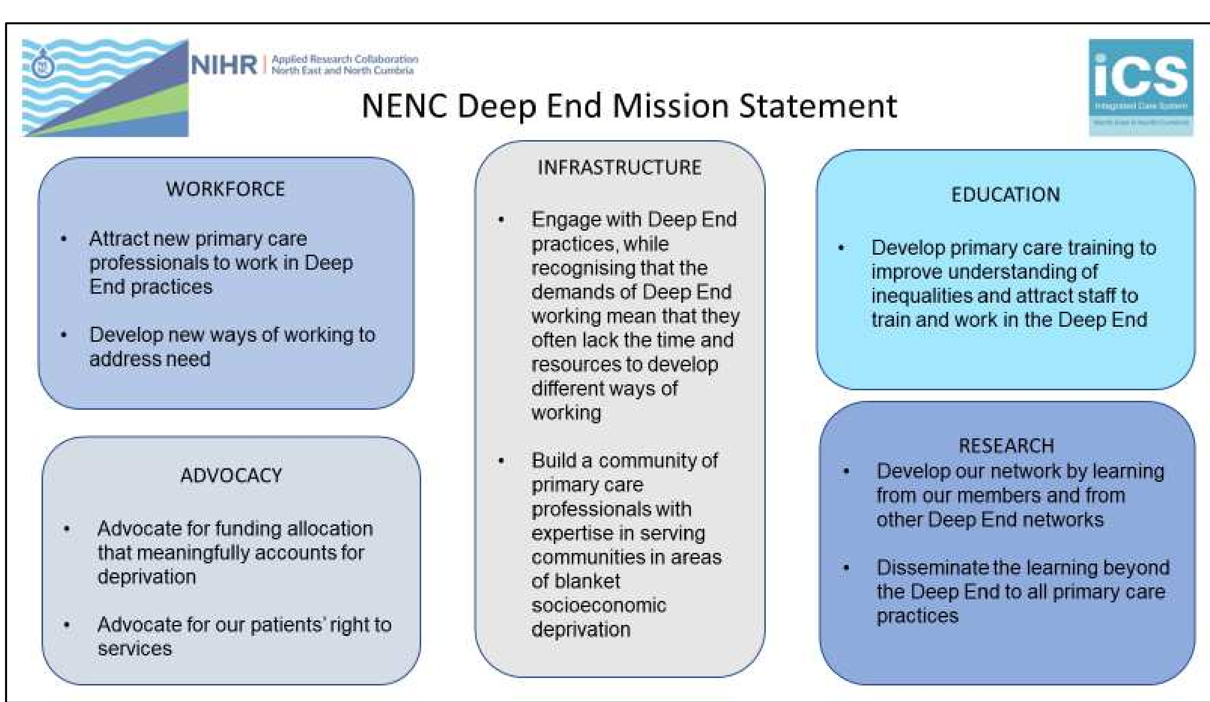
The final part of Core20plus5 sets out five clinical areas of focus:

1. Maternity: ensuring continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the most deprived groups.
2. Severe mental illness (SMI): ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).
3. Chronic respiratory disease: a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of Covid-19, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.

4. Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028.
5. Hypertension case-finding and optimal management and lipid optimal management: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

The partners within the ICP will work together to deliver these priorities across the North East and North Cumbria, although noting the impact of Covid-19 and the current position, we are working towards 2030 for the early cancer diagnosis aim.

A key intervention we will continue to develop is a work programme supporting general practice and partners at neighbourhood level through our Deep End Network, summarised below. Deep End General Practices are those working in our most disadvantaged communities.



More generally, the ICP will develop a process to ensure all significant decision and investments consider the impact on the fairness of health and wellbeing outcomes.

6.3 Inclusion health

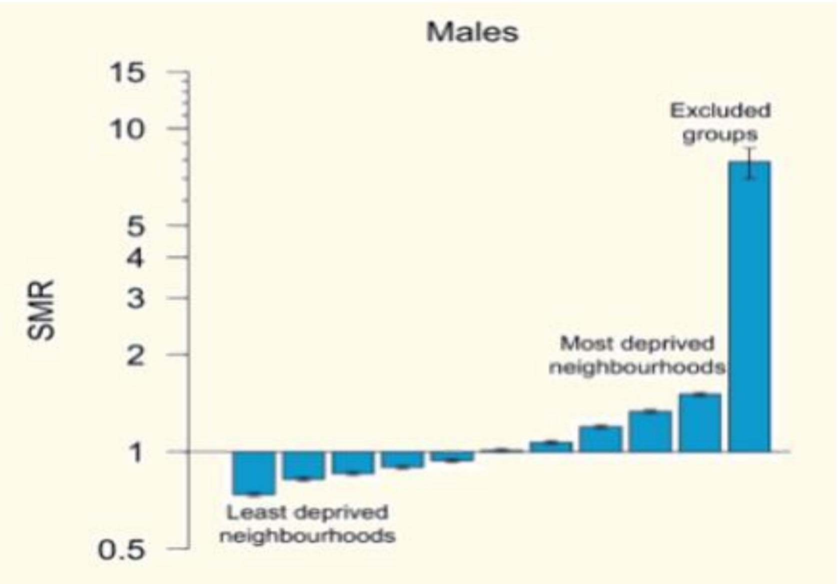
We know that some groups of people are especially disadvantaged and vulnerable. People who are socially excluded, experience multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma), stigma and discrimination and are not consistently accounted for in databases. This includes for example:

- People experiencing homelessness

- Vulnerable migrants, including asylum seekers
- Gypsy, Roma, traveller communities
- Sex workers
- People involved in the criminal justice system

People from these and other socially excluded groups often have higher use of crisis and acute services, and for example emergency admissions, longer inpatient stays, delayed transfers of care and more frequent re-admittance. This is in part because they also experience significant barriers in access to health and social care.

They also have significantly worse health outcomes. The chart below shows the Standardised Mortality Rate (SMR) for men in excluded groups compared to men across the least and most deprived neighbourhoods.



Our approach to inclusion health will seek to properly recognised and respond to the needs of the most excluded groups of people. This will include:

- Using evidence and taking opportunities for research where there are gaps in evidence of health and care need, or needs might be effectively met
- involving people, including seldom heard voices
- developing approaches to health and care which are responsive to multiple dis-advantage.

6.4 Inequalities in health and care

The way health and care services are delivered can contribute to health inequalities. Some groups of the population have lower participation in routine screening programmes or present at a later stage of disease progression, due to the barriers people need to overcome in order to engage with services. These barriers include the cost of travel to health services, convenience, health literacy, unconscious bias,

diagnostic overshadowing and lack of agency and advocacy support. A key part of our work is to ensure that we eradicate, and at least minimise, those inequalities.

We will work with a focus on inequalities in access, experience and outcomes from how people interact (or have a lack of interaction) with health and care services. Some of the key issues we will seek to address are:

- Inequitable access can result in patient groups receiving less care or sub-optimal care than others leading to poor experience and poor outcomes
- The relationship, or intersection, between medical and social vulnerability
- The inverse care law is an example of healthcare inequalities – those with the greatest need having the least access
- Reduce unwarranted variation in access, experience and outcomes
- Access to services that prevent ill-health as well as primary, secondary and community services for people with ongoing health conditions.

6.5 Challenges for rural and coastal areas

Rural poverty and economic challenges

Rural areas in the North East and North Cumbria tend to be less deprived compared to the system's urban areas, and some of the most affluent areas in the region are found in rural areas. However, even in affluent areas there are pockets of deprivation, especially amongst older people. Furthermore, the low population density in rural areas creates some specific challenges for health and wellbeing in rural areas. There are dispersed market towns, coastal, ex-coal mining, commuter villages that experience some poorer health outcomes. Those areas of rural deprivation face many of the poorer health outcomes to deprived urban areas. Some of the highest levels of deprivation are in our former coal mining villages. In fact, an overlay of the collieries in the second part of the twentieth century corresponds to rural indices of deprivation.

People with less income in rural areas are prone to fuel poverty because homes in rural areas are typically less energy efficient and can be more reliant on potentially more expensive heating fuels.

Many young people leave to pursue higher education as most universities are situated in cities. The drain of skilled workers inhibits the opportunities for economic growth in rural areas.

Geographical isolation

Transport to healthcare is more difficult in rural areas owing to less public transport and less efficient roads. This is particularly a problem for people on low income who can't afford to run and maintain a car. These longer distances mean that rural residents can experience 'distance decay' where there is decreasing rate of service

use with increasing distance from the source of health care. Research by Age UK found that cuts to bus services had made it more difficult for older people to access their doctor's surgery and to get to hospital appointments.

7 Best start in life for our children and young people

7.1 Introduction

A strong theme in the feedback to our initial draft strategy was the need to focus on children and young people. All of the sections in this strategy apply implicitly to children and young people, but we have now included as a key goal the need to ensure we give our children and young people the best start in life.

Our ambition is for all children and young people to be given the opportunity to flourish and reach their potential, and to improve outcomes for children who face the most disadvantage. Partners within the ICP will work together and through co-production with children, young people and their families and carers, to provide a better start in life and enable all children to reach their potential.

Children and young people represent nearly 25% of our population, but more importantly hold 100% of the future outcomes. Evidence shows that adversity in childhood can lead to long term, and even life long, adverse health outcomes.

Children and young people in our region have multiple challenges to overcome:

- The voice of the child is not being heard strongly and consistently in an adult focused system
- The significant but unheard impact of Covid-19 pandemic on our young people followed by the unprecedented cost of living crisis in already high levels of poverty which impacts future health outcomes
- The complexity of the child system - diverse professional, organisational and child perspective as well as the family
- Children and young people are more likely to be living in neighbourhoods with higher levels of socio-economic deprivation than any other age group in the population. We have some of the highest levels of childhood poverty in England
- Half of all mental health problems are established by the age of 14 and 75% by the age of 24.

7.2 Maternity services

Our aim is for maternity and neonatal services across the North East and North Cumbria to become safer, more personalised, kinder, professional and more family friendly.

Our ambition is to be the safest place to be pregnant, give birth and transition into parenthood – with all women who use or maternity and neonatal services receiving

the best care possible. Our commitment to reducing health inequalities and unwarranted variation will be crucial to this.

Planning and preparing for good health in pregnancy significantly influences a baby's development in the womb which, influences long-term health and educational outcomes. By giving every baby the best start in life, we will help them fulfil their potential.

Our maternity and neonatal services need to respond to each person's unique health and social situation, with increasing support as health inequalities increase, so that care is safe and personal for all.

This includes ensuring every woman has access to information to enable her to make decisions about her care and that every woman and her baby can access support that is centred around their individual needs and circumstances.

In the North East and North Cumbria, we know that most mothers and babies have a healthy pregnancy and birth. However, national and local research tells us that mothers and babies from a Black, Asian or mixed ethnicity background and those living in our more deprived communities are more likely to be unwell and although rare, to experience serious complications during pregnancy and birth.

Such serious health implications are made more likely by a range of factors linked to genetics, where and how they live, these are often referred to as risk factors.

People who live in more deprived areas also experience higher levels of other 'risk factors' like smoking, being overweight, not using folic acid, having limited access to services, being younger or older when pregnant.

Our areas of focus will include:

- Setting clear priorities to continue to deliver our maternity and neonatal safety ambitions and provide more personalised care
- Bringing together actions from the recently published national maternity reports into one delivery plan for maternity and neonatal services. For example the final Ockenden report, the report into maternity services in East Kent, the NHS Long-Term Plan and our maternity Transformation Programme deliverables.
- Reducing health inequalities and address any unwarranted variation across maternity and neonatal services
- Co-produce our work with service users, frontline colleagues, system leaders and wide range of stakeholders from across the integrated care system.

7.3 Health and care services for children

We will work in partnership to strengthen health and care services for children and young people - recognising the need to work together but also reflecting the key roles of organisations. For example, the NHS plays a leading role in universal

services for pre-school children, and local authorities have a key leadership role in relation to education and support to families.

Since 2020 there has been a sustained increase in demand for a wide range of children's services including:

- Emotional wellbeing and mental health services
- Referrals for autism, attention deficit and hyperactivity disorder (ADHD) and other developmental disorder assessments
- Services to effectively support children and young people (and their families and carers) with Special Educational Needs and Disabilities (SEND)
- Complex packages of care across education, social care and health care
- Safeguarding

Working in partnership, we will seek to:

- Improve access to social care, physical and mental health services

- Improve pathways for children with long term conditions and life limiting illness, including access to effective psychological support

- Ensure measures to tackle the wider determinants of health include a focus on children and young people, and in particular those from our poorest communities

- Support mental wellbeing through 'Mental Health First Aid' and increase early intervention and prevention for mental and emotional wellbeing

- Ensure a focussed improvement in all tiers of child and adolescent mental health services (CAMHS), delivering and learning from the CAMHS whole pathway commissioning 'pilot'. This is one of only four successful pilot sites across the country.

- A focussed improvement in transitions from children and young people's services to adult services

- Work across sectors to more effectively commission jointly funded packages of care for children and young people with complex support needs across education, social care and health care

- Address the challenges and opportunities highlighted in Special Educational Needs and Disabilities (SEND) inspections across local authorities and the NHS. We recognise that SEND goes up to the age of 25 and therefore transitions into adult services

- Ensure specific support when children and young people experience adverse life events such as a bereavement, abuse, neglect, or experiencing a parent being involved in the criminal justice system. Childhood trauma can have a life-long impact, including in physiological as well as psychological changes.

7.4 Core20Plus5 for children and young people

In Autumn 2022, NHS England published the Core20Plus5 framework for children and young people. This is summarised in the graphic below.

In the North East and North Cumbria we will adapt and adopt the Core20Plus5 programmes as one of our key areas of work with children and young people.

Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level.

This approach defines a target population cohort and identifies '5' focus clinical areas requiring accelerated improvement.

Core20 is the most deprived 20% of the national population as identified by the national Index of multiple deprivation (IMD).

Target populations

PLUS population groups include ethnic minority communities; inclusion health groups; people with a learning disability and autistic people; coastal communities with pockets of deprivation hidden amongst relative affluence; people with multi-morbidities; and protected characteristic groups; amongst others.

Specific consideration should be taken for the inclusion of young carers, looked after children/care leavers and those in contact with the justice system.

Inclusion health groups include: people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

Clinical areas of focus

The final part sets out five clinical areas of focus:

- Asthma: Addressing over reliance on reliever medications and decreasing the number of asthma attacks.
- Diabetes: Increasing access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds; as well as increasing the proportion of those with Type 2 diabetes receiving recommended NICE care processes.
- Epilepsy: Increasing access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism.
- Oral health: Tooth extractions due to decay for children admitted as inpatients in hospital, aged 10 years and under.
- Mental health: Improving access rates to children and young people's mental health services for 0-17 year olds, for certain ethnic groups, age, gender and deprivation

7.5 The voice of children and young people

We will work to ensure the voice of children and young people is strongly represented so that high quality engagement is in place in the development and delivery of strategies and work plans and ensure supporting systems are in place to in achieve high quality engagement through the sharing of good practice.

The vital involvement of children, young people and families must take place in earnest to give validity to this strategy. This will include the development of media that is accessible and engaging to young people.

8 Improving health and care services

8.1 Core principles and cross cutting services

8.1.1 Improving quality and safety

Improving the quality of health and care services including experience, access, safety and outcomes is a key area of focus of our plans. The ICP and its partners will deliver the improvements needed as highlighted by people using services, people working in our services, and regulators.

We will do this by

- Improving safety culture within our provider organisations so that incidences are reduced
- Identifying the causes of adverse events and learn from them, ensuring improved practice is implemented and sustained
- Reducing the unwarranted variability of the service offer and increase the consistency of the care.

We will deliver fairer access to our services by adapting and personalising services, so they reach vulnerable people, of all ages. We will target those groups of people that our data show do not currently access services at a level we would expect for their needs. For example, people from our poorest neighbourhoods, those from Black and Minoritised Ethnic communities and people with a learning disability.

The ICP recognises the critical role of the Care Quality Commission (CQC) and other regulators, such as the Office of Standards for Education, Children's Services and Skills (OFSTED), play in assuring quality and safety and in supporting improvement where needed. We will work closely with our regulatory bodies to maximise the impact of our collective efforts to oversee the quality of care provided.

We acknowledge that there have been some serious failings in relation to safety. As an ICP we begin from a clear position that all serious harm is avoidable. We will work to ensure that all serious incidents or other safety failures are properly recorded, reported and most importantly shared with a focus on learning and improvement.

We will develop an open, transparent and supportive learning environment. An environment where staff members feel confident to report adverse incidents and risks to safety and are actively supported to address them by making changes to the way in which services are delivered. We will promote the effective use of qualitative and quantitative data to identify themes for improvement and act upon them.

8.1.2 Sustainable services

Health and care organisations are facing major challenges in sustainability. Many are long standing and have been compounded by the impact of the Covid-19 pandemic. In some parts of our system, there are intractable difficulties in providing stable and

high-quality services. The ICP partners will work together to improve sustainability in the most fragile services including:

- Intensive support and improvement, including drawing in learning
- Supporting local teams to implement new models of care
- Implementing networked and collaborative models of care from the wider North East and North Cumbia system where local solutions cannot deliver sustainability on their own
- Joint planning and aligned commissioning, particularly to support the management of the Social Care market and providers of services funded through Continuing Health Care and joint section 117 arrangements.

To deliver sustainable service provision form should follow function. As care models evolve, some organisational change may need to follow, for example in GP practices or groups of hospitals. There will also need be active management of the social care market, with all partners in the ICP working together to ensure sustainable social care. We will be mindful of avoiding adverse unintended consequences in our future service design work and will consider sustainability alongside reducing inequalities.

Partly our work to improve sustainability will be delivered through organisations working together in closer partnership, including:

- Work to establish stronger partnerships between Social Care providers
- Networks of Primary Care Networks and General Practice Federations working together at scale, supported by the Primary Care Collaborative
- The Mental Health Collaborative responsible for some specialist services under delegation from NHS England. We will seek to further develop the potential for a wider focus to mental Health collaboratives
- The NHS Foundation Trust (FT) Provider Collaborative.

Over time, our provider collaboratives will play an increasingly important role within the ICP, taking on leadership of clinical networks and strategic programmes and brokerage of key deliverables with their members. Each provider collaborative will be supported with programme resource from both the ICB and their members.

Some parts of the North East and North Cumbria geography have sustainability challenges across multiple parts of their health and care system. Partners will give an appropriate level of focus and resource to these geographies and ensure an holistic response for them to achieve all of the goals set out in this strategy.

8.1.3 Equal value of mental and physical health services

We will deliver services with a key principle of parity of esteem – giving as great a focus to emotional and mental wellbeing, mental health, and learning disability and/or autism as we do for physical health. Mental wellbeing and mental illness needs to be focussed on in its own right, but there is a major interplay between mental health and physical health, as summarised by the Centre for Mental Health:

- Mental illness reduces life expectancy - it has a similar effect on life-expectancy as smoking, and a greater effect than obesity
- Mental ill health is also associated with increased chances of physical illness, increasing the risks of the person having conditions such as coronary heart disease, type 2 diabetes or respiratory disease.
- Poor physical health increases the risk of mental illness - the risk of depression is doubled for people with diabetes, hypertension, coronary artery disease and heart failure, and tripled in those with stroke, end-stage renal failure and chronic obstructive pulmonary disease
- Children experiencing a serious or chronic illness are also twice as likely to develop emotional disorders. Prevention, early detection and early intervention can all have a positive impact.

We will be purposeful in ensuring parity of esteem. In particular we will pay attention to access to mental health servies, applying the NHS consitutional waiting times and achieving parity with physical health waiting tiimes.

8.1.4 Personalising health and care

Personalised Care is the practice of enabling people to have choice and control over the way their care is planned and delivered, based on what matters to them and their individual strengths, needs and preferences. We will deliver a Personalised Care Programme across the ICP, which invests in meeting health and wellbeing needs, using the Universal Personalised Care model. Our key guiding principle will be 'what matters to me', enabling service users to have greater control.

We will embed personalised care approaches including shared decision making, personalised care and support planning, supported self-management, personal health budgets, choice and community-based support in all programmes.

8.1.5 Supporting unpaid carers

Unpaid carers are a very diverse group. It includes Young Carers - children and young people who support family members, usually one or both of their parents or their siblings, who have additional caring needs. This might result from a long-term disability, long term condition or an acute illness. It also often relates to social circumstance, for example children of drug or alcohol dependent parents. Young carers often experience multiple dis-advantage, through reduced time available to focus on their education, or to build peer social groups, and often also experience other features of socio-economic deprivation.

Adult Carers include parents providing support to their children and adult children, including those with physical care needs, learning disabilities or severe and enduring mental illness. It also includes carers providing support for older adults, particularly elderly family members who need support for the normal functions of daily living, for example due to a significant cognitive impairment or dementia. Carers themselves often experience poorer health outcomes, and consistently report that the experience of care for their loved one, and indeed for themselves, could be improved.

We will become better at identifying carers and provide more support to them in terms of their own health and wellbeing, and to the people for whom they care.

8.1.6 Better integration and co-ordination of care

Too often, service users and their families and carers experience care which is disjointed; they have interactions with multiple health and care teams which are not co-ordinated, and certainly not around working together to meet the service user needs holistically. To do this we will ensure a key work programme to deliver integration between:

- Health and Social Care
- Primary Care and Secondary Care
- Mental and Physical Health, including the delivery of the Mental Health Community Transformation programme

We will be highly focussed on delivering the recommendations of the Next Steps for Integrating Primary Care: Fuller Report Stocktake May 2022. We already have strong programmes of integration at neighbourhood and locality level, which provide a foundation to build on. In taking this work forward we will be recognise the work that already been done and build on the existing strengths rather than imposing a new model.

A key element of the report is to join up servies through integrated neighbourhood teams, building on the development of primary care networks (PCNs) and local partnerships.

8.1.7 Ageing well

All areas in our ICP have an increase in the 65 and older population. This is more marked in rural areas, for example Northumberland and North Cumbria have hyper-ageing populations. The hyper ageing population has more complex health needs. As the number of people over 65 continue to increase and particularly those aged over 85, the need to understand how to live well with not only the main long-term condition but also the impact of other related conditions greatens, for example:

- More older people are affected by depression in later life than any other age group, with higher rates of disability or illness, loneliness and isolation.
- The prevalence of social isolation increases with age, often due to the loss of friends or family, decreased mobility or reduced income. Loneliness impacts adversely on quality of life and on health. Those who frequently suffer from loneliness are much more likely to report a lower level of satisfaction with their lives overall. Research has shown that social interaction can be key to enjoying later life.
- Increased long term conditions, including diabetes, dementia, depression, heart disease and chronic obstructive pulmonary disease.
- Dementia is characterised by progressive deterioration of mental faculties ending in severe incapacity. As people grow older, their health needs become more complex with physical and mental health needs impacting on each other.

- Unintentional injuries, particularly falls, are the most frequent type of injury suffered among older people in the UK.
- Acute Frailty Syndrome, some older people live with acute frailty and multiple long-term conditions.

We will work with partners across the system to develop specific plans to support people to age well, promote independence, and to take asset-based approaches.

8.1.8 Better end of life care

We will all die. Death is a natural part of the life cycle which will affect everyone. We will enable a dedicated overarching plan to improve palliative and end of life across the health and social care system that goes beyond the need for advanced care planning. This will include working closely with the providers of hospice services, the NHS, social care and the voluntary, community and social enterprise Sector. It will also include the approach for children and young people with life limiting illness.

There is currently significant unmet need for palliative and end of life care. High quality and end of life care in community settings can also help to reduce wider system pressures, including the reliance on residential and nursing home care and hospital admissions. The latest figures on emergency admissions at the end of life show that across England 7% of deaths are preceded by at least three emergency admissions in the last three months of life. We will enable people to live well in their own homes, with the right support, for as long as possible, recognising that most people wish to stay at home, and ultimately to die well at home.

8.2 Protecting health and wellbeing

8.2.1 Safeguarding

Safeguarding is an integral part of providing high-quality health and care. Safeguarding children, young people and adults is a collective responsibility. It's crucial that as an Integrated Care Partnership we ensure the safe and effective delivery of our statutory safeguarding functions as they align to all the integrated care strategic goals. We will continue to build on the foundations of the integrated working that support our local safeguarding arrangements.

We will ensure effective safeguarding arrangements are in place including safeguarding oversight, support, supervision and training, delivered in partnership to prevent harm and safeguard our people, their families and communities. We will use our collective resources in the most effective way possible to support local partnerships and organisations.

We will give due regard to the need to eliminate discrimination, harassment and victimisation and to advance equality of opportunity and to the need to reduce inequalities between people in their access to and the experience of and outcomes from healthcare services and to all Articles of the Human Rights Act.

We will ensure a well-supported, sustainable and skilled safeguarding leadership across all health and care services to enable staff at all levels to be confident and competent in delivering person centred safeguarding practice.

We will use data, intelligence and consistent narrative to drive practice improvements that will connect national, regional and local intelligence to routinely describe the safeguarding "landscape". This will enable more responsive planning and inform service developments at local authority place and across the ICP.

We will promote a strong culture of learning that directly supports lessons learnt and drives safeguarding practice improvements, reduces risk and promotes prevention and early intervention.

8.2.2 Health protection

The UK Health Security Agency (UKHSA) Health Protection Team are responsible for providing specialist public health advice to support the NHS, local authorities, and other agencies in preventing and reducing the impact of infectious diseases and environmental hazards. The experience of the COVID-19 Pandemic brought to the fore the vital importance of effective Health Protection Programmes. We will work with partners, including the UK Health Security Agency (UKHSA) to ensure:

- High uptake of all relevant vaccinations across our population, including occupational vaccination across the health and social care workforce.
- The health of the population is protected from new emerging and re-emerging infectious diseases
- Harms are mitigated when incidents involving chemicals, poisons or radiation threaten the health of the population.
- That people are kept safe from unintended harm when engaging with health and care services
- That services, protocols, and pathways are in place to respond to cases or incidents of infectious disease.

8.2.3 Emergency preparedness, resilience and response (EPRR)

The COVID-19 pandemic emphasised the importance of effective emergency preparedness, resilience and response in delivering a co-ordinated whole system response. We will deliver our statutory duties and work with partners to deliver their statutory duties under the Civil Contingencies Act 2004 including:

- Fully engaging with Local Resilience Forums (LFR) and the Local Health Resilience Partnership (LHRP)
- Ensuring robust response plans are in place across organisations
- Co-ordinating joint system training and exercising opportunities
- Facilitating the sharing of lessons and notable practice
- Embedding cross system learning from COVID-19.

8.3 Long term conditions and cancer

8.3.1 Cancer

Evidence shows that up 4 out of 10 cancers are preventable. The biggest long-term difference we can make is through effective prevention programmes, as referenced in section 5.

Public Health analysis highlights the inequalities in the cancer mortality by area of deprivation. It is estimated for every 1, 000 people aged 65+ with cancer, 142 within the most deprived areas will die compared with 88 in the least deprived. We will use population data to deliver targeted case finding and surveillance to enable people to access diagnostics, assessment and treatment earlier.

The National Cancer Plan sets the ambition that by 2028, 75% of cancers diagnosed will be stage 1 or 2 cancers. Early-stage cancers that are more amenable to curative treatment, leading to improvement in the 5-year survival rates for cancers.

Further improvements in cancer diagnosis and treatment will increase the population living with and beyond cancer. We will increase the personalisation and accessibility of support for people following their diagnosis and treatment, so people know the signs and symptoms of recurrence and have access to support services and personalised follow up care.

To deliver our ambitious programme for cancer care, we will deliver a transformation plan for the specialist cancer workforce. This will include extending the roles of the members of multidisciplinary teams such as therapy radiographers and pharmacists and developing new innovative and emerging roles for future medical and clinical staff. Specific improvements we will work to deliver include:

- Delivering the early diagnosis and faster diagnosis national targets
- Exceeding the national standards for screening uptake for all population segments
- To reduce avoidable new cases of cancer
- Improve the experience, care and quality of life for people living with and beyond cancer as measured by the National Cancer Patient Survey

8.3.2 Long term conditions

Nearly all of us will live with one or more long term condition during our life, and particularly in later life we are likely to live with multiple long-term conditions. Common long-term conditions, including diabetes, heart failure, hypertension asthma and chronic obstructive pulmonary disease are major causes of poorer health outcomes and inequalities in our ICP. Some long terms conditions begin in childhood, while others become more common the longer we live. Some are deeply associated with age, for example dementia.

We need to improve how we respond to long term conditions across all services and throughout the life course, including:

- Pathways, from prevention to end of life care
- Prevention, reducing the occurrence of preventable long-term conditions
- Case finding, improving our detection of long-term conditions
- Support for self-management, we need to equip people with the knowledge, skills and strategies to successfully manage their own condition, for example through structured education programmes
- Providing effective interventions that reduce the progression of long-term conditions and reduce exacerbations
- Physical health psychology, people living with a long-term condition often require bespoke psychological support
- Social care and voluntary, community and social enterprise sector services play a huge role in supporting people to live more successfully and independently without unnecessary health interventions.

8.4 Mental health, learning disability and/or autism and substance misuse

8.4.1 Mental health

The COVID-19 pandemic significantly impacted the mental wellbeing of the whole population, including for example direct effects such as experiencing bereavement and illness, social isolation, anxiety about personal finances and employment, and an increase in domestic violence. This has exacerbated already high levels of poor mental wellbeing and mental illness. The demand for both children's and adult mental health services has risen significantly, and many services are currently operating with long waiting lists and operational pressures.

Mental illnesses have a major impact on overall health outcomes and health inequalities. People with a severe and enduring mental illness have much poorer physical health outcomes and are likely to die as much as twenty years younger than the general population. In our ICP area we have some of the highest rates of suicide in England. Suicide is the leading cause of death for men aged 15-49 and women aged 20-34.

The ICP will develop a comprehensive plan for improving the mental health of its population, building up from the services provided at neighbourhood and local authority place, with close working with the VCSE sector as a full partner, including:

- Strengthening core community, in-patient and crisis services, including peri-natal mental health services and psychiatric liaison services
- Delivering the Mental Health Community Transformation programmes, which focus on enabling patients in long term hospital care to move into a community setting with a package of support

- Moving towards trauma informed, and psychologically informed services across all of health and car services, recognising the often life-long impact of trauma (for example Adverse Childhood Experiences)
- A concerted and universal suicide prevention programme
- Improving the physical health of people with severe and enduring mental illness, including targeted prevention and health programmes and participation in screening programmes
- An improved service offer for people with substance misuse issue and poor mental wellbeing or mental ill health.

8.4.2 Learning disability and/or autism

Compared to the whole population, people with a learning disability, and autistic people, on average die at a much younger age. We will focus on tackling long waits for people to have assessments for autism spectrum conditions and for people assessed as having a learning disability, making sure that their health and social care needs are properly assessed and met in both health and social care.

We will work to ensure that health and care services make reasonable adjustments, provide holistic care, and do not miss other health and care needs by over focussing on a person's learning disability.

In July, the Health and Care Act 2022 introduced a requirement that regulated service providers ensure their staff receive training on learning disability and autism which is appropriate to the person's role. The Oliver McGowan Mandatory Training on Learning Disability and Autism is the standardised training that was developed for this purpose and is the government's preferred and recommended training for health and social care staff to undertake. It is named after Oliver McGowan, whose death shone a light on the need for health and social care staff to have better training. It is the only training with permission to include Paula McGowan OBE, telling Oliver's story and explaining why the training is taking place. Training across health and social care services will include the Oliver McGowan Mandatory Training.

We will implement the new learning from death reviews (LeDeR) policy to review the deaths of people with a learning disability and identify learning, opportunities to improve, and good practice. We will redesign pathways to reduce waiting times for autism assessment. We will reduce the number of people in specialist in-patient services and reducing the number of emergency admissions to hospital.

A key focus will be to develop stronger joint commissioning frameworks across health and social care to improve community provision.

8.4.3 Substance misuse

As described in our case for change, illnesses associated with alcohol, and alcohol and drug related deaths, are a major cause of health inequalities in the North East and North Cumbria. For the last nine years we have had the highest rate of drug related deaths in England, and we have high rates of alcohol related hospital

admissions. This is population health challenge, requiring multi-agency working, to address the complex nature of drug and alcohol related harms. This will include:

- Increasing the delivery of brief interventions in all settings
- Increasing the participation in treatment services for dependent drinkers and drug users, including both harm reduction and abstinence-based programmes
- Improved support for children of alcohol or drug dependent parents, and for carers of people with drug or alcohol dependence
- Population focussed interventions as outlined in section 5.

8.5 Adult social care

8.5.1 Demand for services

Adult social care experienced extremely difficult challenges through the peaks of the COVID-19 pandemic, which exposed the longstanding and underlying fragility in many services. Additionally, adult social care is experiencing significant pressure from:

- Increased referrals because of mental health issues, domestic abuse, safeguarding concerns and the breakdown of unpaid carer arrangements
- Supporting an increasing number of people to access the right care in the right place, at the right time.
- Increased complexity of need – people who need social care support are needing a much higher level of care, for a longer period of time.
- Challenges in sustaining the independent sector care market in both the residential and nursing home sector and for home care provision
- Supporting people being discharged from hospital to access the support they need in a timely manner
- The implementation of social care reforms
- Workforce challenges, partly as some staff pay rates have fallen below competing sectors such as retail and hospitality.

The majority of adult social care is provided to older adults, as the number of older people increases it will drive demand for services, which is compounded by a much lower growth in the number of working age adults to provide these services.

8.5.2 Economic contribution

Adult social care is often viewed as a burden on public finances. It is important to note the enormous contribution to the local economy and social infrastructure from adult social care.

Across our ICP, social care is well over £1 billion annually, with over £200 million of self-funded care, and a much higher value-added contribution (at least in excess of £2.5 billion and probably over £3 billion per year) to local economies.

Across the ICP, local authorities support more than 55,000 people with long term care and support needs, with a further 4,000 people in receipt of NHS-funded continuing health care (CHC).

Local authorities fund 9.3 million hours of home care provision each year. The level of demand rises when the numbers of people funding their own care are taken into account.

There are an estimated 5,800 care home residents in the North East who pay for their own care home accommodation, whilst self-funders also buy an additional 4 million home care hours pa. Local Authorities also support 13,000 people through direct payments and personal budgets meaning an estimated 3,900 individual employers in the region. It is also estimated that there are 286,000 unpaid carers in the region, of whom around 120,000 people were providing 20 or more hours of unpaid care each week.

Across our ICP partners are committed to working together to support adult social care, and to develop new ways of supporting people to live well within their communities. This has never been more important as the escalating cost of living in the UK is causing ever more people to struggle to afford the basic needs to sustain their health and wellbeing.

8.5.3 Sustainability

The ICP recognises that in order make this possibility a reality, a significant and sustained investment in required into social care. A particular challenge is the pay rates for staff in home care and care home roles. In recent years this has changed from being slightly higher than alternative jobs within the retail and hospitality sector than slightly lower. The ICP will develop and deliver a plan to expand and sustain the care workforce across our region. We will work with partners to deliver a comprehensive workforce strategy, where social care is valued, rewarded, and allows people to learn use skills within a carer progression structure.

8.5.4 Prevention and promoting independence

We will work in partnership with the VCSE sector and NHS partners to deliver a much stronger prevention offer to the population. This will support people to live independently and ensure that vital capacity in the regulated care sector is reserved for the people who most need it.

8.5.5 Areas of focus

Some of the key programmes we will deliver include:

- Strengthening the provision on Home Care and Extra Care Housing, and reduce the reliance on residential and nursing homes
- Working with the care market to increase capacity and sustainability
- Reducing the time people spend in hospital whose needs could be better met by access to social care

- Expanding the adult social care workforce
- Developing shared solutions alongside housing, and maximise the opportunities of digital and technology
- Working to identify and support more people who are providing unpaid care within the region.

8.6 NHS services

8.6.1 Primary care and community services

The majority of NHS patient interactions are delivered in primary care, through general practice, dentistry, optometry and community pharmacy. Some parts of our geography are struggling to maintain their primary care services due to severe workforce shortages, particularly of general practitioners (GPs) and dentists.

Primary care does not work in isolation. Community services, including mental health services, play a vital role in meeting patient needs in the community, often working in partnership with social care and the VCSE sector.

The Fuller Report, published by NHS England earlier this year, makes a range of recommendations for the improvement of primary care. The ICP will make implementing the Fuller Report recommendations a priority, working closely with the primary care networks (PCNs) that have been set up to support primary care development. The ICB will further develop primary care collaboration, in partnership with the PCNs to develop models of care to support sustainability and resilience in the places where staffing levels are lowest in relation to population served.

8.6.2 Urgent and emergency care

Urgent and emergency care (UEC) services across our ICP face significant pressure. We will work together to deliver an ambitious redesign of the provision of urgent and emergency care to:

- Increase the proportion of urgent care which is delivered in community settings including in the home
- Increase the proportion of 111 and 999 calls that are clinically assessed and maximise hear and treat and see and treat pathways
- Eradicate 12 hour waits in emergency departments, and ambulance handover delays in excess of 30 minutes, and improve ambulance response times
- Expand the range and uptake of 2 hour community response services, to enable people to receive timely care in the right place
- Enable people to return to their permanent place of residence with the right support once they no longer need medical treatment in hospital.

8.6.3 Elective care

The COVID-19 pandemic has created pressure within elective services across the North East and North Cumbria geography. Reducing elective waiting times will be a significant challenge for the NHS given the array of pressures in the system. It will demand a mix of increasing capacity to diagnose and treat patients and a redesign of patient pathways and service delivery models to ensure clinical capacity is optimally utilised.

The ICB Elective Recovery Programme, which is led by the Foundation Trust Provider Collaborative, will incorporate the following elements:

- Additional elective diagnostic and treatment capacity
- System-wide joint working to ensure the longest waiters are treated in line with national targets
- Outpatient Transformation Programme
- Implementation of the best practice pathways identified by Getting It Right First Time Programme (a clinically led national evidenced based improvement programme)
- Implementation of a Waiting Well Service to support patients experiencing long waiting times patients to be a fit as possible for their treatment, especially those in our most deprived communities
- Eliminating waiting times over 1 year by April 2025.

8.6.4 NHS England delegation

From April 2023, the ICB will take on the commissioning of pharmacy, optometry and dentistry. The ICP recognises there are significant challenges with timely access to dentistry in parts of the region and that this is a matter of significant public concern.

The ICB will work with the dentistry sector to improve access, through a combination of new models of care and a concerted effort on recruitment. The ICP will also work with NHS England to press for improvement to the national dentistry contract.

The Specialised Commissioning and Health and Justice Team are responsible for commissioning services across a diverse portfolio of care that is provided at specialist tertiary centres, within prison settings as well as in specialised inpatient mental health units across the region. These services are planned at a regional level due to low volume, complexity of the services, and the potential financial risk associated with provision. The responsibility for commissioning some of these services will transfer to the ICB in April 2024, with joint working during 2023/24 as a transition year.

Working in partnership with the ICB, the NHSE specialised commissioning will explore ways to deliver new service models for advanced place-based arrangements to integrate specialised services into care pathways, focussing on population health for the ICB. We will do this through joint collaborative commissioning approaches as set out in the roadmap for integrating specialised services within Integrated Care

Boards, published in May 2022. We will explore opportunities for more advanced integrated arrangements where these will support the delivery of outcomes for our population.

To optimise equity of access we will build on our current clinical engagement to expand new models of service delivery through network approaches.

9 Enabling strategies

9.1 A skilled, compassionate and sufficient workforce

People are at the heart of our health and care services and are our biggest strength. We are fortunate to have a highly skilled, dedicated and committed. People working in health and care services showed exceptional resilience throughout the COVID-19 pandemic, but our workforce is stretched:

- Nationally as of September 2021 the NHS was advertising nearly 100, 000 vacant posts, and Social Care a further 105, 000
- Nationally an estimated extra 475,000 jobs are needed in health and 490,000 in social care by the early part of the next decade
- Workforce wellbeing remains a key priority, for example in August 2021 the NHS lost 560,000 days to sickness and absence due to anxiety, stress and depression.

Our ICP area is not exempt from those challenges. Some organisations are experiencing severe challenge in the recruitment and retention of staff, but we want the North East and North Cumbria will be the best place to work in health and care, becoming the employer of choice.

We will aim to reduce the vacancy rate across health and social care services by 50% by 2030.

To achieve this we will ensure safe staffing levels across all of our services and sectors, in every local authority place, and we will enable our workforce to enjoy satisfying careers, feeling valued and able to make their best contribution. Our collective leadership to deliver these commitments will be organised through the North East and North Cumbria People Board. It will act as the system convenor, supported by a Stakeholder Engagement Forum, and will be structured around 6 priority areas:

- Workforce supply, including enabling local people to be able to access employment and career structures in our local services
- Workforce health and wellbeing
- System Leadership and Talent
- Equity, Inclusion and Belonging
- The development of the learning and improvement community
- Build on existing workforce plans, for example the North East ADASS Workforce Strategy.

A key focus will be on developing improved career structures across and between health and social care. This will include better ways to enable people living in in our communities to enter the health and social care workforce, with good training and

support, recognising that many talented and committed people currently face barriers to joining our workforce.

We will also work to maximise the terms and conditions of staff across sectors and services, wherever possible ensuring that people are appropriately rewarded for their work.

To achieve our aim of 'being the best at getting better' we have created the Learning and Improvement Collaborative to mobilise people from across the region. This work is very much at an early stage. We will work with people and partner organisations across the ICP to build the learning and improvement collaborative.

9.1.1 Becoming a learning system

There is an excellent record of research, innovation and quality and service improvement in the North East and North Cumbria. The ICB has signalled its intent to build on this with the launch of the Learning System, with a stated aim of supporting staff and partner members, teams, organisations and the system to become 'The best at getting better'. This work is very much at an early stage. We will work with people and partner organisations across the ICP to build the Learning System as a culture, a community and a collection of assets that support learning at every opportunity.

The ICB will build a learning approach into its operating model, for example into its governance arrangements and its oversight framework.

The ICP will also ensure it develops and maintains an open learning culture, that whilst being 'tough on problems' is kind and supportive to people. Achievement of this aim will be measured through the NHS staff survey and other bespoke staff engagement measurement tools across our partners.

9.2 Working together to strengthen our neighbourhoods and places

Our collective services, including the work of unpaid carers and the VCSE sector, rely on strong joint working at local neighbourhood and local authority place level. We have strong partnership-based foundations particularly through the leadership of our Health and Wellbeing Boards, and over time across the four local ICPs.

The government's Integration White Paper 'Joining-Up Care for People, Places and Populations' set out further expectations for place-based working by 2023. This includes strengthening governance arrangements between Integrated Care Boards and local authorities, with joint accountability for delivering of local shared plans.

To further support local partnership working we will agree formal of local governance arrangements at local authority place level by March 2023, and encourage local networks and collaboratives across sectors in each local authority area. A key focus

will be to implement integrated neighbourhood teams, in line with the Fuller report, bringing together all partners, including the primary care, voluntary sector, social care and Ambulance services. This will build on existing partnership working, strengthening how teams already work together at locality level.

9.3 Innovating with improved technology, data, equipment and research

9.3.1 Research and innovation

The ICP is home to many research and innovation organisations, institutes and infrastructure, that collectively result in a vibrant ecosystem that is unique across England. Some of our opportunities for improvement include:

- Develop inclusive approaches for involving service users and staff in identifying unmet needs.
- Making the use of data, research evidence and insights more accessible.
- Continuing to support both frontline NHS and industry innovators.
- Support for potentially impactful solutions to gain traction across the system, and through strong evaluation drive adoption of new solutions.
- Increasing investment in innovation across health and care services.
- Expanding socially focussed research on challenges experienced across our communities, clinical practice and the wider determinants of health.
- The creation of a 'Health and Life Sciences Pledge' involving all organisations across the research and innovation ecosystem, that results in recognition for the region, on both a national and international stage.
- Building on the work of the AHSN in further establishing and embedding the NENC Innovation Pathway as a recognised regional brand.

9.3.2 Digital technology and data

Digital technology has changed our lives beyond recognition in the last twenty years. We have yet to fully exploit the benefits digital technology can bring to the health and care system, and to enable people to manage their own health and wellbeing. We have been laying down solid foundations for improvement, for example to help meet the technical challenge of linking complex systems together, putting in the right infrastructure, standards and security measures. With the emergence of new digital systems and services we will support and equip our workforce to be ready to embrace these digital opportunities.

We will continue to deliver the commitments within our existing digital strategy, and where necessary, will review and revise the strategy to align and support the delivery of the ICP Integrated Care Strategy.

The health and care system collects a significant amount of data from patients, carers and service users. The majority of data is not used beyond care delivery,

performance management and contract management. Through the advances in computing powers, abilities to link datasets and use this data to develop insights and deep understanding of the communities we serve. We will develop and implement a complimentary, data, intelligence and insights strategy placing information at the centre of our collective decision making.

We will accelerate the use of technology to support people to live as independently as possible, for example older people living with frailty and/or a cognitive impairment. We will also invest in technology that supports people to make healthy choices and prevent ill health or slow the progression of their long-term conditions.

9.3.3 Estates

Our health and care services are delivered across a huge number and range of buildings, with over 490 primary care sites alone. We will develop a collective estates plan, focussed on providing contemporary, sustainable, fit for purpose estate that is accessible and capable of reacting to changes in population size and demand. Where beneficial, this will include:

- Consolidating services onto fewer sites to maximise the use of existing infrastructure and to promote joint working
- Adopt 'one public estate' principles at local authority place level, including the potential to use shared estates to deliver jointed up clinical and care services
- Prioritising capital investment to effectively meet need
- Support to health and social care provider organisations to ensure well planned and prioritised capital investments.

9.4 Making the best use of our resources

Nationally and across our ICP, local authorities are facing financial pressures in adult and children's social services, public health and the broader services that impact health and wellbeing outcomes. All NHS organisations are experiencing severe financial pressure. Key to our financial planning will be:

- Using the strength of our collective voice to advocate for more resources to be provided to the North East and North Cumbria across all sectors – bringing our health outcomes into line with the rest of England requires funding
- Over time we will target resources to where they are most needed to improve health outcomes and to reduce health inequalities. Our commitment to fairer outcomes must be supported by investment
- Removing the barriers to using resources flexibly between organisations, so that we can achieve best value from a whole system perspective
- Living within our means, with good financial stewardship across and within organisations
- Work with partners to tackle areas of inefficiency and inequity, recognising touch points between services and collective ambition and challenges

- Improve the productivity of our services, utilising the Model Hospital Data and learning from others
- Redesign service delivery models where there is evidence that better or comparable outcomes can be achieved in less resource intensive ways
- Commit to improving funding arrangements for VCSE, creating innovative solutions that enable the sector to deliver shared outcomes
- Harness the strength of integrated working at local authority place to drive transformation and efficiency across health and care.

9.5 Protecting the Environment

The North East and North Cumbria Health and Care system is committed to playing its part in tackling climate change. To this end it launched its Green Plan in July 2022. This set out targets and actions for the NHS members of the partnership to meet the sustainability challenge through an agreed programme of activity and by exploiting synergies between the member organisations. Many of our local authorities and NHS foundation trusts have already declared a climate emergency recognising the scale and urgency of the challenge.

Many local authorities already have clear plans to achieve a carbon net zero ambition. The Health and Care Act 2022 placed new duties on NHS to contribute to statutory emissions and environmental targets. We will meet the following for carbon emissions:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032.
- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045.

As an ICP we will publicly declare a climate emergency and commit to fast-track the decarbonisation of our regional health and care services, as part of a broader strategy to become the greenest region in England by 2030.

9.6 Involving people

In the development of the strategy we relied on engaging with partnerships and organisations. We fell short of our intention to really focus on good co-production with citizens and experts by experience, due to the infancy of our new organisation and the timeframes set nationally for development of the strategy. We are deeply committed to ensuring an active and real commitment to involving people and will ensure future strategy and plan developments are properly co-produced.

Community participation in decision making at all levels will be given greater significance. We acknowledge that too often there remains a tendency for decisions to be made ‘within’ institutions whereas community engagement and involvement can provide invaluable knowledge from ‘without’.

We will work to ensure that people are actively involved in how we take forward the delivery of the strategy. This will include tapping into the extensive community assets people are already involved in, and sometimes represented by. For example, the voluntary, community and social enterprise sector, pre-existing and potential networks, and trusted institutions such as community centres. We will also recognise and respect the role of elected members in local authorities as community leaders, and we will work closely with the Health Watch organisations and network.

The approach to involving people will be inclusive all ages, specifically including children and young people.

The ICP is committed to involving people in the design and delivery of care, which is essential if health and care services are to become more responsive, personalised, valued and efficient.

10 Delivering the strategy

10.1 Partnership working at all levels

Neighbourhoods

Delivering this strategy will require focussed work at community and neighbourhood level. A key foundation will be strengthening the approach to integrated neighbourhood teams everywhere, and really engaging with local people to understand their assets and needs. Each local authority place based local system, with support, will find ways to enable and support neighbourhood approaches, including devolving decision making to as near to people as possible.

Place and local authority areas

Our Integrated Care Strategy aims to be complementary to existing plans in each local authority area and is not about 'imposing' requirements.

Partnerships in each local authority area will be supported to consider the strategy and seek to align local work to the key areas of the strategy. Delivering the strategy will require:

- The leadership of our health and wellbeing boards
- The leadership of local authority place-based structures, including broad 'collaboratives' across sectors for each local authority place.

Local ICPs

The four local ICPs will provide:

- A forum to support groups of local authority places to work together where beneficial across a broader geography
- A bridge between the work in local authority areas and the whole North East and North Cumbria ICP.

ICP level

The ICP will provide an overarching strategic leadership role across the whole region. This formal governance will be enhanced by partnership arrangements across the whole ICP, including for example:

- Association of Directors of Adult Social Services (ADASS) network
- Directors of children’s services network
- Directors of public health network
- The directors of finance and ADASS group
- Emerging shared fora for housing
- Provider collaboratives covering the whole of the ICP area
- Emerging networks for general practice, including a strong collaboration between primary care networks

- Using the networks across Health Watch and voluntary, community and social enterprise sector to ensure strong partnerships with communities, experts by experience and third sector organisations
- Clinical networks, for example the Northern Cancer Alliance
- Networks focussed on population groups, for example the Child Health and Wellbeing Network.

Each of these whole ICP arrangements will be responsible for supporting local authority places, and for whole ICP working.

10.2 Delivering the strategy

Delivery plans and measuring progress

To support the delivery of this strategy we will develop delivery plans for:

- Local areas covered by each Integrated Neighbourhood Team
- Local authority places
- Each of our key work programmes (for example each enabler in section 9) across the ICP, including frameworks to support delivery at local authority place level. We will review our strategic programmes to align them to the key deliverables within the strategy.

We will also develop a clear dashboard to measure and report progress in our delivery of our strategy on a quarterly and annual basis. This will be publicly available to ensure transparency and promote accountability. This will be based on our goals and supporting commitments outlined in section 4.

Communicating the strategy

Once agreed for publication, the ICB will on behalf of the ICP develop a range of materials to support the communication of the strategy and make these available to all partners and interest groups. This includes commissioning easy read versions of this document.

Reviewing the strategy

The ICP will undertake an annual review of the strategy and as part of this will agree whether to recommit to it for a further year, refresh elements of it or fully review it.

Item: 7.5

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

BOARD

31 January 2023

Report Title:	The use and development of information systems for the work of the Integrated Care Board (ICB).

Purpose of report

The purpose of this paper is to contribute to a board level exploration of the capability of existing sources information to underpin the delivery of these responsibilities and to generate a common understanding across the Integrated Care System (ICS) of where progress is being made, where improved performance is needed, and whether required goals and standards are being met.

Key points

- The paper presents a series of questions that will be used to determine the current data provision capabilities
- The paper compliments a supporting presentation that sets out the ICB's data, analytics and insights ambitions, resulting in an assessment of the questions and the ability to respond with current and/or future data service provisions.

Risks and issues

- There is an increasing dependency on data and analytics services to support the ICB's strategic and operational needs, as well as broader insight to inform and transform population health and associated care services.
- The ICB's data, analytics and insight strategic approach, requires all parts of the integrated care system to provide, high quality timely and accurate data.
- Subject matter/domain experts will need to work in partnership with data and analytics experts to contextualize data and develop appropriate actionable insights.

Item: 7.5

Assurances
• The ICB's data and analytics service development has the full commitment and support of the ICB board and Executive team and is recognised as a critical service.
Recommendation/action required
To fulfil the strategic ambitions outlined in this paper, it is essential that source data and the information systems that it fuels are: a) relevant, meaningful, accurate and up-to-date; b) capable of enabling valid judgements based on comparisons of service performance over time and between similar services delivered in different localities; c) accepted and valued by clinicians and other staff; d) used and relied on by system and organisational leaders and managers; e) trusted by patients, service users and the public.

Acronyms and abbreviations explained						
All acronyms/abbreviations used have been explained within the body of the report.						
Sponsor/approving director						
Report author	Professor Sir Liam Donaldson					
Link to ICB corporate aims (please tick all that apply)						
CA1: Improve outcomes in population health and healthcare						✓
CA2: tackle inequalities in outcomes, experience and access						✓
CA3: Enhance productivity and value for money						✓
CA4: Help the NHS support broader social and economic development						✓
Relevant legal/statutory issues						
N/A						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a	**Yes**		**No**		**N/A**	✓

quality impact assessment been undertaken? (please tick)						
Key implications						
Are additional resources required?	No					
Has there been/does there need to be appropriate clinical involvement?	N/A					
Has there been/does there need to be any patient and public involvement?	N/A					
Has there been/does there need to be partner and/or other stakeholder engagement?	No					

Item: 7.5

CHAIRMAN'S CHALLENGE: WHAT IS THE CAPABILITY OF CURRENT INFORMATION SYSTEMS TO ANSWER KEY PERFORMANCE QUESTIONS ABOUT THE INTEGRATED CARE SYSTEM?

Purpose

The members of the Integrated Care Board (ICB) for the North-East and North Cumbria and the ICB's executive team have key responsibilities, including: to meet the health needs of a wide range of diverse communities, to assure and improve the quality and safety of services, to raise levels of population health and well-being, to reduce the burden of preventable disease and premature death, whilst achieving greater equity in all these service domains.

The purpose of this paper is to contribute to a Board level exploration of the capability of existing sources information to underpin the delivery of these responsibilities and to generate a common understanding across the Integrated Care System (ICS) of where progress is being made, where improved performance is needed, and whether required goals and standards are being met.

Illustrative questions

The 10 challenge questions are intended to explore strength and weaknesses of existing data and information systems. At this point in its development, the ICB has less experience of local authority information systems and those used by wider partners, and this will be the subject of future discussion.

The questions are not intended to systematically and comprehensively cover the ICB's work. Nor is the list of data 'requests' intended to be exhaustive, simply to enable a free-ranging discussion amongst board members.

1. ***Are people with diabetes receiving a standard of care that gives the lowest possible level of avoidable complications of their disease?***

Rationale*: Diabetes is a common non-communicable disease that affects large numbers of people. If it is well-managed, known adverse outcomes can be eliminated or their onset delayed. These include premature death or disability (e.g. from heart disease or stroke), blindness, skin ulceration (sometimes leading to limb amputation), kidney disease, nerve damage, obesity (with its attendant risks).*

Availability of information*: What information is routinely available to describe where people with diabetes are living within the ICS area? How well is diabetes being controlled amongst residents in different ICS Places? What level of known complications is occurring amongst residents in different ICS Places?*

2. *How early is bowel cancer being detected and treated?*

***Rationale**: Colo-rectal cancer is the fourth commonest cancer in the UK and the second biggest killer. Of those diagnosed in the earliest cancer stage, 90% survive for five years or more whilst for those cancers recognised at the latest stage, survival is 10%.*

***Availability of information**: What is the incidence of colo-rectal cancer amongst residents in each ICS place? What is its incidence in the under-50 age groups? What is the distribution of stages of cancer at diagnosis amongst residents in each ICS Place? What are the rates of five- and 10-year survival for different stages of cancer at diagnosis amongst residents of different ICS Places? What are the rates of five- and 10-year survival for different stages of cancer at diagnosis according to which hospital the patients were treated at?*

3. *What is the health and health care experience of the most deprived areas?*

***Rationale**: The population served by the ICS contains some of the highest levels of economic and social deprivation in the country. These conditions are powerful determinants of poor health and well-being and have proved to be intractable over time.*

***Availability of information**: Taking the smallest population areas as the unit of analysis, which are the 50 such areas in the ICS that score worst on deprivation indices? Using five markers (expectation of life at birth, expectation of life at 65 years, death from cardiovascular disease, infant mortality, suicide rate) compare the 50 small areas collectively with all other areas combined.*

4. *How good is population uptake and coverage for preventive health interventions?*

***Rationale**: A number of preventive health services organised NHS-wide reduce disease incidence and mortality, but their effectiveness depends on achieving high uptake.*

***Availability of information:** For the following four preventive services - bowel cancer screening, breast cancer screening, childhood immunisation, proportion of over-65s with high blood pressure being successfully controlled - what is the percentage coverage of the eligible population in each of the ICS areas? For the same four measures in small areas, across the whole ICS, what are the five best and five worst performers?*

5. *What is known about levels of incapacity and frailty of older people living at home?*

***Rationale**: Three-quarters of people aged 75 years and older have more than one long-term condition. People of this age and older living at home are at greatly increased risk of attending an accident and emergency department, being acutely admitted to hospital or needing to be in a residential care facility. These risks are dependent on the nature of their illness, but also the extent of their physical and mental capacity and the presence of frailty.*

***Availability of information:** What are the numbers of men and women aged over 65 years with moderate and severe levels of frailty living within the ICS area? What age*

groups are they in? How many live alone? What are the same data for each of the ICS Places?

6. ***What is the level and causal nature of avoidable harm generated by care providers and in care settings?***

***Rationale**: Studies of patient safety and review of data arising from incident reporting systems carried out nationally and internationally have shown that the level of avoidable harm associated with care is higher than it is generally perceived to be. Action to reduce it and sustain improvement have been of limited success.*

***Availability of information:** What numbers of serious patient safety incidents have occurred in the past five years (2018-2022) in each of the providers of care within the ICB's jurisdiction? What types of incidents were they? Acknowledging that there will be overlap between serious incident and Never Events, what numbers and types of Never Events have occurred in each of the providers of care within the last five years?*

7. ***What are the risks to patients of acquiring an infection during their care?***

***Rationale:** In hospitals providing acute care in high-income countries like the United Kingdom, the World Health Organisation has estimated that, out of every 100 patients, seven will acquire at least one health care-associated infection during their hospital stay. The COVID-19 pandemic has clearly shown how central infection prevention and control is to maintain vital services and ensuring patient and staff safety. Health care-associated infections and the spread of antimicrobial resistance in health care settings are a consequence of poorly organised and delivered infection prevention and control programmes. Key failures include low compliance with hand hygiene and aseptic practices, contaminated medical equipment and supplies, inadequate environmental cleaning, insufficient training in infection prevention and control policies and practices, very high bed occupancy, understaffing and suboptimal infrastructure for patient isolation, weak leadership and adverse cultures.*

***Availability of information:** For each provider of acute care show the number of healthcare-associated infection in the following categories:*
i) surgical site infections ii) catheter associated urinary tract infections iii) central line associated blood stream infections iv) Methicillin-resistant staphylococcus aureus (MRSA) bacteraemia v) Clostridium difficile for each year 2017-2022. For each provider of acute care show the number of cases of COVID-19 acquired in hospital by patients and staff for the years 2020-2022. For each provider of acute care show the rate of hand hygiene compliance in clinical areas in the most recent available time period.

8. ***What do patients think of the care that they receive and what information about services is available to them?***

***Rationale:** Looked at from first principles the kind of questions a user or potential user of a service might ask about their care could include: How quickly will I be first seen; how quickly will I get a diagnosis and how quickly will I receive definitive treatment? If my condition is potentially life-threatening, will the local service give me the best odds of survival, or could I do better elsewhere? Will the staff treating me be competent and up to date in their practice? Does the service have a low level of complications for treatment like mine compared to other services? Does the service have good quality assurance and quality improvement systems in place? What is the safety record of the service*

concerned? How good are the amenities and environment of the hospital or health centre where I will be treated? Is the medical equipment for diagnosing and treating patients like me, state of the art? Have patients treated by this service in the recent past rated it highly on dignity, respect, information-giving? How does the service compare to others around the country and elsewhere in the world? Many of these practical and common-sense questions that patients and families might have are not readily available to them.

Availability of information: *What information is produced by each provider of care within the ICS about patients' views and experience of care? What range of information about quality of services (particularly comparative and benchmarking data) is available for patients and families? How extensively are Patient Reported Outcome Measures (PROMS) used by providers of care and what are the main findings of analysis of these data?*

9. ***Children and young people's mental health***

Rationale: *In 2022, in England, 18% of children aged 7 to 16 years and 22% of young people aged 17 to 24 years had a probable mental disorder. In children aged 7 to 16 years, rates rose from 1 in 9 (12.1%) in 2017 to 1 in 6 (16.7%) in 2020. Rates of probable mental disorder then remained stable between 2020, 2021 and 2022. In young people aged 17 to 19 years, rates of a probable mental disorder rose from 1 in 10 (10.1%) in 2017 to 1 in 6 (17.7%) in 2020. Rates were stable between 2020 and 2021, but then increased from 1 in 6 (17.4%) in 2021 to 1 in 4 (25.7%) in 2022. The numbers of suicides amongst the 15–19-year-olds in England rose by 35% between 2020 and 2021 and is the highest for 30 years.*

Availability of information: *How many referrals to children and adolescent mental health services were made from each of the ICS's Places each year from 2018 to 2022? Which are the small areas with the highest number of such referrals? How many suicides were there amongst young people aged 15 to 19 years for each of the years 2018 to 2022 and where did they live?*

10. ***What progress is being made in controlling tobacco-related disease?***

Rationale: *Smoking remains the leading cause of preventable death in the ICS region. Although smoking rates are still higher than the national average, the region has achieved the largest reduction in smoking prevalence in the country (15.3% in 2019 vs 29% in 2005). Tobacco is a major causal contributor to health inequalities.*

Availability of information: *What is the prevalence of smoking in each of the ICS Places? Which are the small areas that collectively contain 80% of the ICS's current smokers? Which are the ten small areas with the highest smoking prevalence? How many people attending smoking cessation services in each of the ICS Places in the years 2018-2022? What were the quit rates achieved by each of these services in the same time periods?*

Item: 7.5

Conclusions

Information on the performance of services is needed for at least four main purposes: accountability, quality improvement, choice and management.

To fulfil these purposes it is essential that source data and the information systems that it fuels are: a) relevant, meaningful, accurate and up-to-date; b) capable of enabling valid judgements based on comparisons of service performance over time and between similar services delivered in different localities; c) accepted and valued by clinicians and other staff; d) used and relied on by system and organisational leaders and managers; e) trusted by patients, service users and the public.

Professor Sir Liam Donaldson
ICB Chair
January 2023

Item: 7.6

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

NORTH EAST AND NORTH CUMBRIA ICB BOARD MEETING

31 January 2023

Report Title:	Discharge Process

Purpose of report

A presentation will be delivered on the day which will:

- Highlight the current National drivers to enable effective discharge and the North East and North Cumbria position against these working jointly with Local Authorities.
- Highlight the potential harm to patients when discharge is delayed, and
- Shares examples of good practice in relation to hospital discharge.

Key points

The presentation will identify current performance on discharge best practice across our systems. A strategic view on what are our priorities across the system. Identifies use of additional funding to support social care and impact of the investment. Shares patient experience of discharge.

Risks and issues

Effective discharge allows for improved flow in hospitals. Poor discharge practice risks harm to patients who should no longer remain in hospitals. Delayed discharges contributes to capacity pressures leading to overcrowding in Emergency Departments and delayed ambulance handover. The boarding of medical patients in elective beds also negatively impacts on elective recovery.

Assurances

Daily discharge meetings are held chaired by the ICB Chief Nurse with the Place Directors to review pathways of care, identify early issues and to share best practice.

Recommendation/action required

For information

Item: 7.6

Acronyms and abbreviations explained						
Sponsor/approving director	David Purdue, Executive Chief Nurse					
Report author	David Purdue, Executive Chief Nurse					
Link to ICB corporate aims (please tick all that apply)						
CA1: Improve outcomes in population health and healthcare						x
CA2: tackle inequalities in outcomes, experience and access						x
CA3: Enhance productivity and value for money						x
CA4: Help the NHS support broader social and economic development						x
Relevant legal/statutory issues						
Health and Care Act, CQC regulatory framework						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	**x**	**N/A**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	**x**
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**	**x**
Key implications						
Are additional resources required?	Yes but as part of a National Fund					
Has there been/does there need to be appropriate clinical involvement?	Yes					
Has there been/does there need to be any patient and public involvement?	Yes					
Has there been/does there need to be partner and/or other stakeholder engagement?	Yes					

Item: 8.1

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

NHS North East & North Cumbria BOARD **31 January 2023**	
Report Title:	Governance Handbook (Issue 4)
Purpose of report	
To approve proposed amendments to documents held and published in the ICB's Governance Handbook, including the Scheme of Reservation and Delegation, Standing Financial Instructions (SFIs), Financial Delegations and Financial Limits, and committee terms of reference.	
Key points	

The documents which make up the ICB's Governance Handbook were approved by the Board on 1st July 2022 (issue 1), with further amendments to one or more documents approved by Board on 27 September 2022 (issue 2) and 29 November 2022 (issue 3).

As part of a process of ongoing review of the documents within the Governance Handbook, several proposed amendments have been identified to ensure the documents remain fit for purpose. The Audit Committee has reviewed the proposed amendments to the Scheme of Reservation and Delegation and financial documents at its meeting on 12 January 2023 and recommends the proposed amendments to Board for approval. Board is also being asked to approve updated committee terms of reference, as below and attached.

The amended documents are attached with changes highlighted or tracked and summarised below:

Material Changes to the Scheme of Reservation and Delegation (Appendix 1)

- Audit Committee to recommend changes to the Scheme of Reservation and Delegation to Board for approval instead of the Chief Executive;
- Audit Committee to recommend changes to the SFIs, Financial Delegations and Financial Limits to the Board for approval, instead of the Finance, Performance & Investment Committee.
- Clarification of approval limits as approved by Board on 29 November 2022;

- Deleted the determination of governance arrangements at Place, as all committees or sub committees must be approved by Board;
- Control of the staff establishment (tier 1- tier 3) added;
- Approve the appointment of internal auditors, changed from Board to Audit Committee;
- Approval of standard operating procedures (SOPs) changed from Executive Committee to the relevant director for than function;
- Footnote 1 replaced by table 1 which provides updated guidance;
- Individual Funding Request Panels (sub committee) as approved by Board in September 22) and Healthier and Fairer Advisory Group (sub committee) as approved by Board in November 2022) added to list of sub committees at Appendix 1; and
- Job title of the Executive Director of Place Based Delivery, changed to Executive Area Director.

Standing Financial Instructions (Appendix 2)

The SFIs have been updated based on the latest version published by NHS England. There are a few minor grammatical / wording changes highlighted in the document, but the two main changes are:

- Paragraph 4.1.4, bullet point removed as this is effectively covered in the following two bullet points
- Paragraph 10.1.4 (losses and special payments) updated to reflect latest guidance.

Both changes above are directly from latest NHSE template.

Financial Delegations (Appendix 3)

Key changes are as follows:

- Paragraph 1.1 and 1.2 have been updated to allow an ICB Director of Finance to approve capital schemes of up to £250,000, consistent with delegated revenue expenditure limits.
- Paragraph 2.1 has been added to clarify the limits above which competitive quotations are required and relevant procurement thresholds. This is in line with the current agreed position, the addition is simply to make the position clearer in the document
- Paragraph 2.6 – previously the signing of contracts was reserved to Executive Directors which was impractical and out of sync with delegated financial limits. The proposed amendment will allow other individuals to sign contracts in line with delegated limits, and allow other ICB Directors to sign contracts up to £1m that have been appropriately approved.
- Paragraph 6.1 – previously the engagement of solicitors was reserved to Executive Directors. The proposed amendment confirms this will now be approved in accordance with the legal services Standing Operating Procedure to be maintained by the Executive Director of Corporate Governance, Communications and Involvement, and in line with delegated financial limits.
- Paragraph 13 has been added to confirm arrangements for approval of any non-audit services from the external auditors, including compliance with relevant National Audit Office guidance
- Job title of the Executive Director of Place Based Delivery, changed to Executive Area Director where referenced.

Financial Limits (Appendix 4)

- One amendment has been proposed on the delegated limits for admin budgets such that expenditure up to £4,999,999 would be approved by Executive Committee rather than Finance, Performance and Investment Committee.
- Job title of the Executive Director of Place Based Delivery, changed to Executive Area Director where referenced.

The delegated financial limits will be reviewed again once formal place-based governance arrangements, including any relevant committees for example, are approved and established.

Executive Committee Terms of Reference (Appendix 5)

Job titles of some members changed to reflect their new titles.

Approving standard operating procedures has been removed from the terms of reference as it is now delegated to the relevant executive director.

Develop and implementation of Primary Care Strategy has been added to the committee's responsibilities.

Quality & Safety Committee Terms of Reference (Appendix 6)

Job title of Executive Director of Strategy and System Oversight changed to Chief of Strategy and Operations. (Membership remains unchanged).

Vice chair deleted from this statement: The Committee will be chaired by an Independent Non-Executive Member of the Board. The Chair cannot also be the Audit Committee Chair ~~or Vice Chair~~.

Finance, Performance & Investment Committee Terms of Reference (Appendix 7)

The Board agreed the establishment of the FPI Committee at its meeting on 1 July 2022, along with an agreed set of terms of reference. The FPI Committee held its first meeting on 1 September 2022 and have reviewed the terms of reference on an ongoing basis to ensure they were fit for purpose and would enable the Committee to deliver its delegated responsibilities effectively.

The review highlighted a number of areas that required amendment to ensure the effective functioning of the committee, these include:

- Combine Part 1 and 2 of the meeting agenda and the Chair will manage any conflicts of interest in the normal way
- Appropriate amendments to the membership
- Removal of "To recommend SFIs and financial delegations and limits to the Board for approval" as this is the remit of the Audit Committee
- Removal of "To develop a finance staff development strategy to ensure excellence by attracting and retaining the best finance talent" as this responsibility is not one for an individual committee but for the organisation

- Following approval of ICBP006 Commercial sponsorship and joint working with the pharmaceutical industry Policy, inclusion of 'Ratification of pooled budget arrangements relating to commercial sponsorship and joint working with the pharmaceutical industry'

The proposed changes have been reflected in the updated terms of reference at Appendix 7, with amendments marked in yellow.

Audit Committee Terms of Reference (Appendix 8)

The following responsibilities have been added to the remit of the Audit Committee:

- To recommend SFIs, financial delegations* and limits to the Board for approval. *The financial delegations include approval of Non-Audit Services (previously this was the responsibility of the Finance, Performance and Investment Committee)
- To recommend the Scheme of Reservation & Delegation to the Board for approval (previously this was the responsibility of the Chief Executive).
- Approving the appointment of Internal Auditors, retrospectively from 1 July 2022.

Amended reference to the NHS Standards for Commissioners, Fraud, Bribery and Corruption to Government Functional Standard 013 Counter Fraud: NHSCFA requirements.

Governance Structure (Appendix 9)

Addition of the following 3 approved sub committees:

- Healthier and Fairer Advisory (sub committee)
- Individual Funding Requests Panel North (sub committee)
- Individual Funding Requests Panel South (sub committee)

Risks and issues

There is a risk the ICB does not have a robust and clear control environment in relation to the effective stewardship and management of public funds and levels of delegation may not support local decision-making.

Assurances

The SORD, financial governance documents and committee terms of reference have been reviewed to ensure they remain fit for purpose and are in line with other required statutory guidance.

The SFIs have been prepared using the NHS England standard template and comply with all statutory and mandated guidance. The financial limits and proposed delegation levels have also been developed in consultation with relevant finance and governance experts to ensure they are robust and fit for purpose. Audit Committee has reviewed these and recommends them to Board.

Recommendation/action required

Board is asked to note the proposed changes to the governance documents described above and to approve the updated versions for insertion into the Governance Handbook (issue 4), as follows:

- Scheme of Reservation and Delegation **(Appendix 1)** – version 2-0
- Standing Financial Instructions **(Appendix 2)** – version 2-0
- Financial Delegations **(Appendix 3)** version 2-0
- Financial Limits **(Appendix 4)** version 2-0
- Executive Committee Terms of Reference **(Appendix 5)** version 2-0
- Quality & Safety Committee Terms of Reference **(Appendix 6)** version 2-0
- Finance, Performance & Investment Committee Terms of Reference **(Appendix 7)** version 2-0
- Audit Committee Terms of Reference **(Appendix 8)** version 2-0
- Governance Structure **(Appendix 9)** version 2-0

Acronyms and abbreviations explained	
SoRD - Scheme of Reservation and Delegation SFIs – Standing Financial Instructions SOP - Standard Operating Procedures IFR – Individual Funding Request	
Sponsor/approving director	Claire Riley, Executive Director of Corporate Governance, Communications, and Involvement David Chandler, Interim Executive Director of Finance
Report author	Richard Henderson, Director of Finance (Corporate) and Irene Walker, Head of Governance

Link to ICB corporate aims (please tick all that apply)	
CA1: Improve outcomes in population health and healthcare	
CA2: tackle inequalities in outcomes, experience and access	
CA3: Enhance productivity and value for money	✓
CA4: Help the NHS support broader social and economic development	

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**	

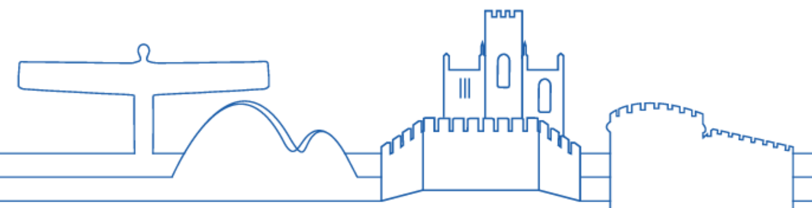
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**	✓	**N/A**	
Key implications						
Are additional resources required?	n/a					
Has there been/does there need to be appropriate clinical involvement?	n/a					
Has there been/does there need to be any patient and public involvement?	n/a					
Has there been/does there need to be partner and/or other stakeholder engagement?	n/a					

Item: 8.1
Enclosure: Appendix 1

NHS North East and North Cumbria Integrated Care Board

Scheme of Reservation and Delegation

Version 2-0, approved 31 January 2023 TBC



Schedule of Matter Reserved to the North East and North Cumbria Integrated Care Board and Scheme of Delegation

1. Introduction

The arrangements made by the North East and North Cumbria Integrated Care Board (NENC ICB) for the reservation and delegation of decisions are set out in this scheme of reservation and delegation.

The NENC ICB remains accountable for all its functions, including those that it has delegated.

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Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Regulation and Control						
Constitution 1.6	Consideration and approval of applications to NHS England on any matter concerning changes to the ICB's constitution, including arrangements for taking urgent decisions, and standing orders	✓ Approval of proposed changes		✓ Chair and/or Chief Executive may periodically propose amendments to the constitution		
Constitution 1.6.2	Approve Constitution (including Standing Orders)	✓ Approves (subject to NHSE approval)			✓ NHSE	
Constitution 4.4.2	Approve the ICB scheme of reservation and delegation (SoRD) and amendments to the SoRD	✓ Approves	✓ Audit Committee (Recommends)	✓ Chief Executive (~~recommends~~ Prepares)		

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Constitution Appendix 2, Section 5	Suspension of Standing Orders			✓ Chair in discussion with at least two other members		
Constitution Appendix 2, 4.9.4	Urgent Decisions			✓ Chair and Chief Executive (or relevant lead director in the case of committees)		In the first instance, every attempt will be made for the Board to meet virtually. Where this is not possible, the delegation to the Chair and Chief Executive (or relevant lead director in the case of committees) applies. The exercise of such powers shall be reported to the next formal meeting of the board for formal ratification and the Audit Committee for oversight

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Establish governance arrangements to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations.	✓				
Constitution 4.6	Approve terms of reference and membership for ICB Committees & Sub Committees	✓				Definition: A Committee is established by and accountable to the ICB Board. A Sub-Committee is accountable to its parent Committee. Parent Committees Audit Committee; Finance, Performance & Investment Committee; Quality & Safety Committee; Remuneration Committee; and Executive Committee
	Approve the ICB operating framework	✓ (Approves)		✓ Chief Executive (Recommends)		

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Approve the ICB operating structure	✓ (Approves)		✓ Chief Executive (Recommends)		
Constitution 1.4 Health & Care Act 14Z32 to 14Z44 & 14Z49	Approve the arrangements for discharging the ICB's functions including but not limited to: a) Having regard to and acting in a way that promotes the NHS Constitution (14Z32) b) Exercising its functions effectively, efficiently, and economically (14Z33) c) Securing continuous improvement in the quality of services (14Z34) d) Reducing inequalities (14Z35) e) Promote involvement of each patient (14Z36) f) Patient choice (14Z37)	✓				

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	g) Obtaining appropriate advice (14Z38) h) Promote innovation (14Z39) j) Research (14Z40) k) Education & training (14Z41) l) Promote integration (14Z42) m) Duty to have regard to effect of decisions (14Z43) n) Duties as to climate change etc (14Z44) o) Duty to keep experience of members under review (14Z49)					
Constitution 3.3.1	Appointment of ICB Chair				✓ NHSE, with the approval of the Secretary of State	

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Constitution 3.4.1 & 3.4.2	Appointment of ICB Chief Executive			✓ Appointed by ICB Chair in accordance with any guidance issued by NHS England*		*Appointment subject to approval of NHSE in accordance with any procedure published by NHS England
	Exercise or delegation of those functions of the ICB which have not been retained as reserved by the ICB Board, delegated to a committee or sub-committee or specified individual			✓ ICB Chief Executive		
Constitution 3.5.4, 3.6.5, 3.7.4	Appointment of Partner Member/s: • Trusts • Primary Medical Services • Eligible Local Authorities			✓ Approval ICB Chair*		*Supported by an Appointment Panel

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Constitution 3.8.3, 3.9.3, 3.10.3, 3.12.3	Appointment of: • Executive Medical Director • Executive Chief Nurse • Executive Director of Finance • Other Executive Board Members			✓ Appointed by ICB Chief Executive* ✓ Approval ICB Chair		*Supported by an Appointment Panel
Constitution 3.11.2	Appointment of Independent Non-Executive Member/s			✓ Approved by ICB Chair*		*Supported by an Appointment Panel
	Approve the System Collaboration and Financial Management Agreement	✓ (Approves)	✓ Finance, Performance & Investment Committee (Recommends)			In consultation with partners
Constitution 1.7.3 (c)	Approve Standing Financial Instructions (SFIs), Financial Delegations and Financial Limits	✓ (Approves)	✓ ~~Finance, Performance & Investment~~ Audit Committee (Recommends)	✓ Executive Director of Finance (Prepares)		

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Approval of individual funding requests in accordance with the ICB policy		✓ IFR Panels[1]	✓ Chief Executive up to £2,999,999 Executive Medical Director up to £500,000 Medical Directors Up to £250,000	~~Individual members appointed as decision makers (as approved by the Executive Medical Director) to make decisions on behalf of the ICB via individual funding requests, in line with ICB Policy[2]~~	[1]The IFR Panels are sub-committees of the Executive Committee (as approved by Board). A panel may support and advise the authoriser in their deliberations; however, the panel has no authority to approve individual funding requests. ~~[2]Appointed decision makers may make decisions not reserved to the IFR Panels.~~
Standing Orders, Section 6	Set out who can execute a document by signature / use of the seal	✓ In approving Standing Orders		✓ Authorised to authenticate the use of the seal by their signature: - ICB Chair - Chief Executive - Executive Director of Finance		

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Constitution 4.7	Approve terms of reference for place based partnership arrangements	✓ Approval ICB Board and Partners		✓ Proposed by Executive Area Director		
	Appoint ICB: • Caldicott Guardian • Conflicts of Interest Guardian • Senior Information Risk Officer • Data Protection Officer • Chief Information Officer • EPRR Accountable Emergency Officer			✓ ICB Chief Executive		
	Approve Patient Group Directions			✓ ICB Medical Director, following review by the Quality & Safety Committee		

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Strategy and Planning						
	Agree the vision, values, and overall strategic direction of the ICB	✓				
	Approving the strategy for improving population health and reducing health inequalities	✓				Having regard to the Integrated Care Partnership, Integrated Care Strategy
	Approve the Commissioning Strategy	✓ (Approves)	✓ Executive Committee (Recommends)			
Health & Social Care Act 2022,14Z52	Agree a system plan [with partner trusts] to meet the health and healthcare needs of the population within the North East and North Cumbria	✓ (Approves)	✓ Executive Committee* (Recommends)			*The Executive Committee will consult the Finance, Performance & Investment Committee in the development of the plan
	Complementary to the System Plan, agree a plan to meet the health and healthcare needs of the population within each place	✓ (Approves)		✓ Executive Area Director (Recommends)		

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Approval of the ICB's non-programme budgets	✓ (Approves)	✓ Finance, Performance & Investment Committee (Recommends)			
	Approval of the ICB's programme budgets	✓ (Approves)	✓ Executive Committee (Recommends)			
	Develop an approach to distribute ICB resources through commissioning and direct allocation to drive agreed change based on the ICB strategy	✓ (Approves)	✓ Finance, Performance & Investment Committee (Recommends)	~~✓~~ ~~Executive Directors~~ ~~(Implement their agreed resource allocation)~~		

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Approve all ICB programme costs	✓ Approved by the Board or as delegated in accordance with financial delegations and financial limits	✓ Executive Committee*	✓ Refer to financial delegations*		*Contracts will be approved by either the ICB Board, Executive Committee, or relevant individual in accordance with the financial delegations and financial limits
	Approve all ICB non programme costs	✓ Approved by the Board or as delegated in accordance with financial delegations and financial limits	✓ Finance, Performance & Investment Committee*	✓ Refer to financial delegations*		* Non-programme contracts will be approved by either the ICB Board, Finance, Performance & Investment Committee, or relevant individual in accordance with the financial delegations and financial limits

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Approve the strategic financial framework of the ICB, and manage overall resources, manage financial risk, monitor system financial performance and report material exceptions to the Board	✓ (Approves the strategic financial framework)	✓ Finance, Performance & Investment Committee (Recommends)			
	Approve a Performance and Outcomes Framework for Providers	✓ (Approves)	✓ Executive Committee (Recommends)			
	Monitor provider performance against contract and report material exceptions to the Board		✓ Executive Committee			
	Agree arrangements regarding the System Oversight Framework		✓ Executive Committee			

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Approval of variations to annual planned budgets	✓ Approved by the Board or as delegated in accordance with financial delegations and financial limits	✓ Finance, Performance & Investment Committee*	✓ Refer to financial delegations*		*Variations to budgets will be approved by the Board, or Finance, Performance & Investment Committee, or an individual, in accordance with financial delegations and financial limits
	Approval of variations to non-programme contracts	✓ Approved by the Board or as delegated in accordance with financial delegations & limits	✓ Finance, Performance & Investment Committee*	✓ Executive Director*		*Variations to non-programme contracts will be approved by the Board, or Finance, Performance & Investment Committee, or an Executive Director, in accordance with financial delegations and financial limits

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Approval of variations to programme contracts	✓ Approved by the Board or as delegated in accordance with financial delegations & limits	✓ Executive Committee*	✓ Executive Director*		*Variations to programme contracts will be approved by the Board, or Executive Committee, or an Executive Director, in accordance with financial delegations and financial limits
	In accordance with ICB policy, lead significant service reconfiguration programmes to achieve agreed outcomes	✓ (Approves)	✓ Executive Committee (Assurance)	✓ Executive Director (Recommends)		In leading service reconfiguration, the ICB will work with providers at scale and place
	Planning and commissioning of services (to include Procurement & Evaluation Strategies and Recommended Bidder Reports).	✓ Approved by the Board or as delegated in accordance with financial delegations & limits	✓ Executive Committee*	✓ Executive Director*		* Approval by the Board, or Executive Committee, or an Executive Director. in accordance with financial delegations and financial limits

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Delegation agreement	Specialist Commissioning delegation from NHSE Approve decisions on the review, planning and procurement of specialist commissioned services (consistent with the terms of the delegation agreement with NHSE)		✓ Executive Committee			
Delegation agreement	Primary Medical Services delegation from NHSE Approve decisions on the review, planning and procurement of primary medical services (consistent with the terms of the delegation agreement with NHSE)		✓ Executive Committee (Except for those items delegated to the Executive Area Director as shown in Appendix 2)	✓ Executive Area Director (Except for those items delegated to the Executive Committee, or other ICB Committee, as shown in Appendix 2)		
	Workforce planning		✓ Executive Committee			

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Agree system implementation of people priorities including delivery of the People Plan and People Promise by aligning partners across the ICS to develop and support 'one workforce' including through closer collaboration across the health and care sector, with local government, the Voluntary and Community Sector (VCS) and volunteers	✓ (Approves strategy)	✓ Executive Committee (Monitors)	✓ Executive Chief People Officer (System leadership)		
	Agree system-wide strategy and action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services	✓ (Approves strategy)	✓ Executive Committee (Monitors)	✓ Executive Chief Digital and Information Officer (System leadership)		
	Agree joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability	✓ (Approves strategy)	✓ Finance Committee	✓ Executive Director (System leadership)		

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Annual Report and Accounts						
	Approval of the ICB's annual report and annual accounts	✓ (Approves)	✓ Audit Committee (Assurance)			
Human Resources						
	Code of Conduct for staff (titled: Standards of Business Conduct Policy/Conflicts of interest policy and procedures)	✓ Approves	✓ Executive Committee (Recommends)			
Constitution3 .14	Approve the arrangements for determining the terms and conditions, remuneration and travelling or other allowances for Board members, employees and others who provide services to the ICB, including pensions and gratuities	✓ In approving Terms of reference of Remuneration Committee			✓ NHSEI (Terms of appointment of the Chair will be determined by NHS England)	

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Constitution 3.14	Approve the terms and conditions, remuneration and travelling or other allowances for Board members, including pensions and gratuities (subject to Prime Minister limit)	✓ (The Panel of the Board determines Remuneration for Non-Executive Members)	✓ ICB Remuneration Committee (Approves all except those delegated to the Panel of the Board or NHSEI)		✓ NHSEI (Remuneration for the Chair will be set by NHS England)	The Panel of the Board comprises the Chair, Chief Executive and Executive Chief People Officer
	Approve the terms and conditions, remuneration and travelling or other allowances for employees of the ICB and to other persons providing services to the ICB		✓ ICB Remuneration Committee			
	Approve arrangements for staff appointments		✓ Executive Committee (Approves)	✓ Executive Chief People Officer (Prepares)		

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Changes to staffing establishment, Tier 1			✓ Director (Approves)		Tier 1 Definition Exact like-for-like replacement of a leaver or any changes to post, grade or WTE with positive financial implications (ie a reduction in cost). This can be approved by the relevant place-based or corporate Director (ie a Director who reports to an Executive Director)
	Changes to staffing establishment, Tier 2			✓ Executive Director (Approves)		Tier 2 Definition Backfill for maternity, secondments or sickness absence; temporary acting up where funding is already available; and hosted/seconded-in posts where funding is already available. These can be approved by the relevant Executive Director

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Changes to staffing establishment, Tier 3		✓ Executive Committee (Approves)			Tier 3 Definition Any changes to post, grade or WTE with negative financial implications (ie an increase in cost); permanent re-gradings; agency workers; and any other changes not covered in Tiers 1 or 2. Changes of this type can only be approved by the ICB Executive Committee.
Quality and Safety						
	Approve arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes		✓ Quality and Safety Committee			
	Provide the ICB with assurance that it 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		✓ Quality and Safety Committee (assures the Board)			Local Quality Groups will review quality & safety issues and escalate any concerns or issues to the Quality and Safety Committee

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Operational and Risk Management						
	Approve the appointment of Internal Auditors	~~✓~~ ~~(Approves)~~	✓ Audit Committee (Approves) ~~(Consulted on recommendation)~~	✓ Executive Director of Finance (Recommends)		
	Approve the appointment of External Auditors	✓ (Approves)	✓ Auditor Panel (Recommends)			Note: the Auditor Panel is made up wholly of Audit Committee members (see Audit Committee Terms of Reference)
	Approve the ICB's counter fraud and security management arrangements	✓ (Approves)	✓ Audit Committee (Recommends)			
	Approve the ICB's risk management arrangements	✓ (Approves)	✓ Executive Committee (Recommends)			

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Approve the ICB's arrangements for managing conflicts of interest	✓				In proposing ICB Constitution to NHSE
	Establish a comprehensive system of internal control across the ICB		✓ Executive Committee			
	Approve arrangements for action on litigation against or on behalf of the ICB		✓ Executive Committee			
	Approve arrangements for planning, responding to and leading recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England and NHS Improvement		✓ Executive Committee			
	Approve the ICB's arrangements for handling complaints		✓ Executive Committee			

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Approve arrangements for ensuring the ICB has an integrated approach to the management standards of health and safety and has appropriate strategy and policies in place		✓ Executive Committee			
	Approve arrangements for complying with the NHS Provider Selection Regime		✓ Executive Committee			
	Approve Communications and Engagement Strategy	✓ (Approves)	✓ Executive Committee (recommends)			
	Approve and implement the ICB's information governance policies, including handling Freedom of Information requests, ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data		✓ Executive Committee			

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Policies						
	Approval of policies not specified elsewhere in this scheme of reservation and delegation	✓				
	Approve human resources policies for employees and for other persons working on behalf of the ICB	✓ (Approves)	✓ Executive Committee (Recommends)	✓ Executive Chief People Officer (Prepares)		
	Approve clinical, quality and safety policies		✓ Quality and Safety Committee			
	Approve ICB Corporate Policies (unless specified elsewhere)		✓ Executive Committee			
	Approve ICB Standard Operating Procedures (SOPs)		~~✓~~ ~~Executive Committee~~	✓ Directors, as relevant to their function		

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Approve the ICB's risk management policy		✓ Executive Committee			
	Determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change)		✓ Remuneration Committee			
	Approve the ICB's complaint's policy		✓ Executive Committee			
	Approve health and safety policies		✓ Executive Committee			
	Approve information governance policies		✓ Executive Committee			
	Approve Value Based Commissioning Policy	✓ (Approves)				

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Partnership Working						
Integrated care boards Guide to developing a SoRD, page 9	Approve arrangements for coordinating supra* commissioning arrangements with other ICBs or with local authorities, where appropriate	✓ (Approves)	✓ Executive Committee (Recommends)			*Where one service provider spans more than one ICB
Constitution 4.3.2 – 4.3.3 and 4.7	Authorisation of arrangements made under section 65Z5 or section 75 of the 2006 Act	✓ Approved by the Board or as delegated in accordance with financial delegations and financial limits	✓ Executive Committee*	✓ Refer to financial delegations*		*Arrangements will be approved by either the ICB Board, Executive Committee, or relevant individual in accordance with the financial delegations and financial limits See Table 1
	Approve decisions that individual members or employees of the ICB participating in joint arrangements on behalf of the ICB can make	✓				Such delegated decisions must be disclosed in this scheme of reservation and delegation

~~**FOOT NOTES**~~

1. ~~Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund. Where arrangements are made under section 65Z5 or section 75 of the 2006 Act the board must authorise the arrangement, which must be described as appropriate in the SoRD.~~

Table 1: Key legislative mechanisms for collaborative working

Mechanism for collaboration	Organisations	Description of mechanism
Section 65Z5 delegation	NHS England, ICBs, NHS trusts and foundation trusts	This is a voluntary arrangement whereby NHS organisations listed under s65Z5 delegate responsibility for carrying out specific functions to other listed NHS organisations and/or to LAs and/or to CAs. There are some constraints on what functions can be delegated and how these delegations are made, which are set out in the 2022 Regulations and in Annex E of this statutory guidance. HS organisations cannot delegate their functions to non- statutory, non-public organisations (that is, independent or voluntary sector providers). LAs and CAs cannot delegate their functions to statutory NHS organisations using this mechanism – although they can receive delegated responsibility for the functions of NHS organisations under s65Z5 arrangements. For delegation of LA

Mechanism for collaboration	Organisations	Description of mechanism
		functions, see s75 arrangements below.
Sections 65Z5 and 65Z6 joint exercise arrangements	NHS England, ICBs, NHS trusts and foundation trusts	Two or more NHS organisations within the scope of s65Z5 can choose to come together (including via a joint committee) to make legally-binding decisions and pool funds across agreed functions. Any constraints on how these arrangements are made and which functions can be part of them are set out in the 2022 Regulations and in Annex E of this statutory guidance. LAs and CAs can be part of these arrangements – but they cannot include their own functions in any joint decision- making using this mechanism. Joint working between Las and NHS organisations, including for LA functions, can be achieved using s75 and s65Z5 arrangements.
Section 75 partnership arrangements	NHS England and/or ICBs with LAs and/or CAs NHS trusts and/or foundation trusts with LAs and/or CAs	Section 75 partnership arrangements are a longstanding collaboration mechanism under the 2006 Act. These enable collaborative working between at least one NHS organisation (NHS England/ICB **or** NHS trust/foundation trust) and at least one LA to exercise or delegate a range of the NHS organisation's functions and the LA's health-related functions. Any delegation/joint exercise of health-related LA functions to/with NHS organisations will continue to be achieved using the powers in s75 of the 2006 Act and the associated partnership arrangement regulations. The 2022 Act requires ICPs to consider the use of section 75 arrangements in preparing their strategy for their system.
Conferral of discretions	NHS England, ICBs, NHS trusts and foundation trusts	This provision has been included to make clear the lawful scope of contractual arrangements between commissioners and providers. It confirms that a commissioner can lawfully give providers a wide degree of latitude as to the services they provide under a contract, both in terms of which services are delivered and how

Mechanism for collaboration	Organisations	Description of mechanism
		they are delivered, so as to resolve any doubt on this issue. The commissioner will still set the broad scope of what the provider is expected to achieve (clinical outcomes, for example) under a contract. A contract that confers discretion on a provider in respect of some or all services under the contract may be a useful alternative or precursor to delegation to trusts or foundation trusts under s65Z6.

[Extract from publication reference PR1560 - Statutory guidance: Arrangements for delegation and joint exercise of statutory functions, Guidance for integrated care boards, NHS trusts and foundation trusts (September 2022)]

Appendix 1

Committee and Sub Committees of NHS North East and North Cumbria Integrated Care Board (ICB)

1. Committees

The ICB has determined to establish the following Committees

- Audit Committee
- Remuneration Committee
- Finance, Performance, and Investment Committee
- Quality and Safety Committee
- Executive Committee

2. Sub Committees

The ICB has determined to establish the following sub committees:

- Healthier and Fairer Advisory Group (sub committee)
- Individual Funding Requests Panel North (sub committee)
- Individual Funding Requests Panel South (sub committee)

Appendix 2

Primary Medical Services: Allocation of Roles & Responsibilities within the ICB

In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England hereby delegates the exercise of the Delegated Functions to the ICB to empower it to commission a range of services for the people of the Area, as described in the Delegation Agreement relating to Primary Medical Services.

The ICB Board has determined the following delegations within this Scheme of Reservation & Delegation.

Number	Responsibility and Decision Making Delegated to the Executive Management Committee (or other ICB Committee where stated)	Responsibility and Decision Making Delegated to the Executive Area Director	Recommendation by the Executive Area Director to the Executive Committee for Action/Decision
1	Decisions in relation to the commissioning and management of Primary Medical Services, unless delegated to the Executive Area Director		
2	Planning Primary Medical Services for the NE&NC, including carrying out needs assessments		Carrying out primary care needs assessments at place and making recommendations to the Executive Management Committee
3	Undertaking reviews of Primary Medical Services across the NE&NC		Undertaking reviews of Primary Medical Services at Place and escalating any material issues to the Executive Management Committee for consideration/action
4	Management of the Delegated Funds in relation to Primary Medical Services (See ICB Financial Limits for authorisation limits)		Management of delegated funds where these are delegated to the Executive Director of Place Based, within the limits shown in the ICB's Financial Limits.
5	Co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies in respect of the NE&NC, where appropriate		
6	Identifying and implementing changes to		The Executive Area Director , identifies and

Number	Responsibility and Decision Making Delegated to the Executive Management Committee (or other ICB Committee where stated)	Responsibility and Decision Making Delegated to the Executive Area Director	Recommendation by the Executive Area Director to the Executive Committee for Action/Decision
	meet any unmet needs across the NE&NC which may be met through the delivery of Primary Medical Services		recommends to the Executive Management Committee any changes to meet any unmet needs at place which may be met through the delivery of Primary Medical Services
7	To manage the Primary Medical Services Contracts and perform all of NHS England's obligations under each of the Primary Medical Services Contracts in accordance with the terms of the Primary Medical Services Contracts as if it were named in the contract in place of NHS England		
8	Actively manage the performance of the Primary Medical Services Providers across the NE&NC in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support	Actively manage the performance of the Primary Medical Services Provider at place Non-material performance lapses may be managed at place by the Executive Area Director	Actively manage the performance of the Primary Medical Services Provider at place Escalate to the Executive Management Committee any material performance issues for action
9	Ensure that the ICB obtains value for money on behalf of NHS England, and avoids making any double payments under any Primary Medical Services Contracts		
10	Notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Primary Medical Services Contracts		

Number	Responsibility and Decision Making Delegated to the Executive Management Committee (or other ICB Committee where stated)	Responsibility and Decision Making Delegated to the Executive Area Director	Recommendation by the Executive Area Director to the Executive Committee for Action/Decision
11	Undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints		
12	Keep a record of all of the Primary Medical Services Contracts that the ICB manages setting out the details shown in Schedule 2A of the para 2.4.6 of the delegation agreement		
13	Reviewing the performance of the relevant Primary Medical Services Contract, including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance	Reviewing the performance of the relevant Primary Medical Services Contract, at place including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance Non-material performance lapses may be managed at place by the Executive Area Director	Reviewing the performance of the relevant Primary Medical Services Contract, at place including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance Escalate to the Executive Management Committee any material performance issues for action
14	<u>Delegated to ICB Quality & Safety Committee</u> Assessing quality and outcomes (including clinical effectiveness, patient experience, patient safety and addressing inequalities)	Assessing quality and outcomes (including clinical effectiveness, patient experience, patient safety and addressing inequalities) Non-material performance issues relating to accessing quality and outcomes may be managed at place by the Executive Area Director	Assessing quality and outcomes (including clinical effectiveness, patient experience, patient safety and addressing inequalities) Escalate to the ICB Quality & Safety Committee any material performance issues for action
15	Managing variations to the relevant Primary Medical Services Contract or services in accordance with national policy, service user needs and clinical developments		

Number	Responsibility and Decision Making Delegated to the Executive Management Committee (or other ICB Committee where stated)	Responsibility and Decision Making Delegated to the Executive Area Director	Recommendation by the Executive Area Director to the Executive Committee for Action/Decision
16	Agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit)		
17	Delegated to the Finance, Performance & Investment Committee Agreeing local prices, managing agreements or proposals for local variations and local modifications		
18	Conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes		
19	Compliance with and implementing any relevant Mandated Guidance issued from time to time		
20	**Information, Planning and Reporting** Compliance with Delegation agreement Schedule 2A, Section 2.6 as it relates to Information, Planning and Reporting		
21	**Primary Medical Services Contract Management** Compliance with any future national Mandated Guidance on equitable funding as may apply from time to time		
22	**Enhanced Services**		

Number	Responsibility and Decision Making Delegated to the Executive Management Committee (or other ICB Committee where stated)	Responsibility and Decision Making Delegated to the Executive Area Director	Recommendation by the Executive Area Director to the Executive Committee for Action/Decision
	Compliance with actions in Delegation agreement Schedule 2A, Section 5 as it relates to Enhanced Services)		
23		**Local Enhanced Services** The Executive Area Director may consider any local enhanced services entered into with Primary Medical Services Providers at place using NHS Standard Contracts. Where these would continue to be beneficial to the place, the ICB (at place) may manage the ongoing design and commissioning (including re-commissioning) of these services via a Local Incentives Scheme. This is to be in conjunction and coordination with the other Executive Area Director to ensure a consistent approach is taken across the ICB	
24		**Local Enhanced Services design** The Executive Area Director may design and offer Local Incentive Schemes for Primary Medical Services Providers and comply with the Delegation agreement Schedule 2A, Section 6 as it relates to Local Incentive Schemes. This is to be done in conjunction and coordination with the other Executive Area Director to ensure a consistent approach is taken across the ICB	
25		**Discretionary Payments**	

Number	Responsibility and Decision Making Delegated to the Executive Management Committee (or other ICB Committee where stated)	Responsibility and Decision Making Delegated to the Executive Area Director	Recommendation by the Executive Area Director to the Executive Committee for Action/Decision
		The Executive Area Director may make decisions on Discretionary Payments or Support (subject to available budget) and comply with the Delegation agreement Schedule 2A, Section 7 as it relates to discretionary payments. This is to be done in conjunction and coordination with the other Executive Area Director to ensure a consistent approach is taken across the ICB	
26		**Making Decisions about Commissioning Urgent Care for Out of Area Registered Patients** Design and commissioning of urgent care services (including home visits as required) for its patients registered out of area (including re-commissioning these services annually where appropriate) and compliance with the Delegation agreement Schedule 2A, Section 8. This to be done in conjunction and coordination with the other Executive Area Director to ensure a consistent approach is taken across the ICB	
27	**Transparency and freedom of information** Compliance with the Delegation agreement Schedule 2A, Section 9 as it relates to transparency and freedom of information		
28	**Planning the Provider Landscape**	**Planning the Provider Landscape**	

Number	Responsibility and Decision Making Delegated to the Executive Management Committee (or other ICB Committee where stated)	Responsibility and Decision Making Delegated to the Executive Area Director	Recommendation by the Executive Area Director to the Executive Committee for Action/Decision
	The ICB must plan the primary medical services provider landscape in the Area, including considering and taking decisions in relation to: Establishing new Primary Medical Services Providers in the NE&NC; The procurement or award of new Primary Medical Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time); Compliance with the Delegation agreement Schedule 2A, Section 10.2	Manage Primary Medical Services Providers providing inadequate standards of patient care at place Take decisions relating to closure of practices and branch surgeries at place Take decisions relating to dispersing the patient lists of Primary Medical Services Providers at place Take decisions relating to agreeing variations to the boundaries of Primary Medical Services Providers at place.	
29	**Primary Care Networks** Compliance with the Delegation agreement, Schedule 2A, Section 11	Supporting Primary Care Networks at place, subject to any budget allocation, in conjunction and coordination with the other Executive Area Director to ensure a consistent approach is taken across the ICB	
30		**Approving Primary Medical Services Provider Mergers and Closures** Compliance with the Delegation agreement, Schedule 2A, Section 12	
31	**Making Decisions in relation to Management of Poorly Performing Primary Medical Services Providers** Compliance with Delegation Agreement Schedule 2A, Section 13		

Number	Responsibility and Decision Making Delegated to the Executive Management Committee (or other ICB Committee where stated)	Responsibility and Decision Making Delegated to the Executive Area Director	Recommendation by the Executive Area Director to the Executive Committee for Action/Decision
32	Delegated to Finance Performance & Investment Committee **Premises Costs Directions Functions** Compliance with Delegation Agreement, Schedule 2A, Section 14		
33	**Maintaining the Performers List** Compliance with Delegation Agreement, Schedule 2A, Section 15		
34	**Procurement and New Contracts** Compliance with Delegation Agreement, Schedule 2A, Section 16		
35	**Complaints** Handle complaints made in respect of Primary Medical Services in accordance with the Complaints Regulations (Delegation agreement, Schedule 2A, Section 17)		
36	**Commissioning ancillary support services** Compliance with Delegation Agreement, Schedule 2A, Section 18.		
37	**Finance** Further requirements in respect of finance will be specified in Mandated Guidance		
38	**Workforce**		

Number	Responsibility and Decision Making Delegated to the Executive Management Committee (or other ICB Committee where stated)	Responsibility and Decision Making Delegated to the Executive Area Director	Recommendation by the Executive Area Director to the Executive Committee for Action/Decision
	Compliance with Delegation Agreement, Schedule 2A, Section 20		

GLOSSARY

2006 Act	National Health Service Act 2006
2012 Act	Health and Social Care Act 2012 (this Act amends the 2006 Act)
Chief Executive	An individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act (as inserted by Schedule 2 of the 2012 Act), appointed by the NHS Commissioning Board, with responsibility for ensuring the ICB: • complies with its obligations under: o sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act), o sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act), o paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), and o any other provision of the 2006 Act (as amended by the 2012 Act) specified in a document published by the Board for that purpose. • exercises its functions in a way which provides good value for money.
Area	The geographical area that the ICB has responsibility for, as defined in Chapter 2 of the Constitution
Audit Committee	A committee of the Board
Board	The body appointed under section 14L of the NHS Act 2006 (as inserted by section 25 of the 2012 Act), with the main function of ensuring that an ICB has made appropriate arrangements for ensuring that it complies with: • its obligations under section 14Q under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), and • such generally accepted principles of good governance as are relevant to it.
Board Member	Any member appointed to the Board of the ICB
Budget	A resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any, or all of the functions of the ICB.
Budget Holder	The director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.
C***hair of the Board***	The individual appointed by the ICB to act as chair of the Board

Executive Director of Finance	The qualified accountant employed by the ICB with responsibility for financial strategy, financial management and financial governance
Commissioning	The process for determining the need for and for obtaining the supply of healthcare and related services by the ICB within available resources.
Committee	A committee created and approved by the ICB Board
Sub-Committee	A sub-committee created by ICB Board or a committee of the ICB Board, and approved by the Board
Committee Members	Persons formally appointed by the Board to sit on or specific committees.
Constitution	A Constitution is the set of principles and rules by which an organisation is governed and managed.
Board Secretary	A person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the ICB's compliance with the law, Standing Orders, and Department of Health guidance.
Contracting and Procurement	The systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
Director of Public Health	A health care professional who is a specialist in Public Health or a Consultant in Public Health medicine who may hold the post of Director of Public Health.
Financial Directions	Any and all Directions made by the Secretary of State from time to time which relate to financial entitlements and or requirements.
Financial Year	This usually runs from 1 April to 31 March, but under paragraph 17 of Schedule 1A of the 2006 Act (inserted by Schedule 2 of the 2012 Act), it can for the purposes of audit and accounts run from when an ICB is established until the following 31 March.
Health and Wellbeing Board	The role of the Health and Wellbeing Board is to bring together the Local Authority, Voluntary Sector, Local Healthwatch, NHS and Public health to work together to improve the health and wellbeing of local people.
Health and Wellbeing Strategy	A strategy developed with Local Authorities for the purpose of purpose of advancing the health and wellbeing of the people in its area and implemented by the Health and Wellbeing Board

Healthcare Professional	An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.
Integrated Care System (ICS)	The ICS is a geographical partnership that brings together providers and commissioners of NHS services across the North East and North Cumbria.
Non – Executive Members	Independent members of the Board.
NHS England	NHS England (operating as the National Health Service Commissioning Board Authority prior to its formal establishment as a non-departmental public body).
Officer	Employee of the ICB or any other person holding a paid appointment or office with the ICB.
Officer Member	A member of the ICB who is either an officer of the ICB or is to be treated as an officer (i.e., the Chair of the ICB, or any person nominated by such a committee for appointment as an ICB member).
Registers of Interests	Registers an ICB is required to maintain and make publicly available under section 14O of the 2006 Act (as inserted by section 25 of the 2012 Act), of the interests of: • the members of the ICB. • the members of its Board. • the members of its committees or sub-committees and committees or sub-committees of its Board; and • its employees.
Remuneration Committee	A Committee of the Board
Scheme of Reservation and Delegation	Delegates powers and authority to the various elements of the ICB.
Standing Orders	The standing orders of the ICB
Standing Financial Instructions	They are part of the ICB's control environment for managing the organisation's financial affairs as they are designed to ensure regularity and propriety of financial transactions. They define the purpose, responsibilities, legal framework, and operating environment of the ICB.
Vice-Chair	The non-officer member appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

Item: 8.1
Enclosure: Appendix 2

Integrated Care Board Model Standing Financial Instructions

January 2023

V2-0 (Governance Handbook Issue 4)

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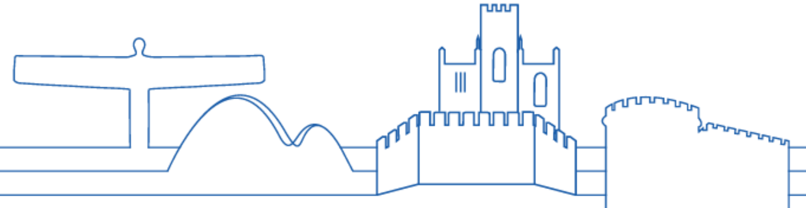

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1. Purpose and statutory framework

1.1.1 These Standing Financial Instructions (SFIs) shall have effect as if incorporated into the integrated Care Board's (ICB) constitution. In accordance with the National Health Service Act 2006, as amended by the Health and Care Act 2022, the ICB must publish its constitution.

1.1.2 In accordance with the Act as amended, NHS England is mandated to publish guidance for ICBs, to which each ICB must have regard, in order to discharge their duties.

1.1.3 The purpose of this governance document is to ensure that the ICB fulfils its statutory duty to carry out its functions effectively, efficiently and economically. The SFIs are part of the ICB's control environment for managing the organisation's financial affairs as they are designed to ensure regularity and propriety of financial transactions.

1.1.4 SFIs define the purpose, responsibilities, legal framework and operating environment of the ICB. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services.

1.1.5 The ICB is established under Chapter A3 of Part 2 of the National Health Service Act 2006, as inserted by the Health and Care Act 2022 and has the general function of arranging for the provision of services for the purposes of the health services in England in accordance with the Act.

1.1.6 Each ICB is to be established by order made by NHS England for an area within England, the order establishing an ICB makes provision for the constitution of the ICB.

1.1.7 All members of the ICB (its Board) and all other Officers should be aware of the existence of these documents and be familiar with their detailed provisions. The ICB SFIs will be made available to all Officers on the intranet and internet website for each statutory body.

1.1.8 Should any difficulties arise regarding the interpretation or application of any of these SFIs, the advice of the C~~c~~hief ~~e~~Executive or the Executive Director of Finance~~chief financial officer~~ must be sought before acting.

1.1.9 Failure to comply with the SFIs may result in disciplinary action in accordance with the ICBs applicable disciplinary policy and procedure in operation at that time.

2. Scope

2.1.1 All officers of the ICB, without exception, are within the scope of the SFIs without limitation. The term officer includes, permanent employees, secondees and contract workers.

2.1.2 Within this document, words imparting any gender include any other gender. Words in the singular include the plural and words in the plural include the singular.

2.1.3 Any reference to an enactment is a reference to that enactment as amended.

2.1.4 Unless a contrary intention is evident, or the context requires otherwise, words or expressions contained in this document, will have the same meaning as set out in the applicable Act.

3. Roles and Responsibilities

3.1 Staff

3.1.1 All ICB Officers are severally and collectively, responsible to their respective employer(s) for:

- abiding by all conditions of any delegated authority;
- the security of the statutory organisations property and avoiding all forms of loss;
- ensuring integrity, accuracy, probity and value for money in the use of resources; and
- conforming to the requirements of these SFIs.

3.2 Accountable Officer

3.2.1 The ICB constitution provides for the appointment of the Chief Executive by the ICB Chair. The Chief Executive is the Accountable Officer for the ICB and is personally accountable to NHS England for the stewardship of ICBs allocated resources.

3.2.2 The Executive Director of Finance reports directly to the ICB Chief Executive ~~officer~~ and is professionally accountable to the NHS England Regional Finance Director

3.2.3 The Chief Executive will delegate to the Executive Director of Finance the following responsibilities in relation to the ICB:

- preparation and audit of annual accounts;
- adherence to the directions from NHS England in relation to accounts preparation;
- ensuring that the allocated annual revenue and capital resource limits are not exceeded, jointly, with system partners;
- ensuring that there is an effective financial control framework in place to support accurate financial reporting, safeguard assets and minimise risk of financial loss;
- meeting statutory requirements relating to taxation;
- ensuring that there are suitable financial systems in place (see Section 6)
- meeting the financial targets set for it by NHS England;
- use of incidental powers such as management of ICB assets, entering commercial agreements;

- ensuring the Governance statement and annual accounts & reports are signed;
- ensuring planned budgets are approved by the ~~relevant~~ Board; developing the funding strategy for the ICB to support the Board in achieving ICB objectives, including consideration of place-based budgets;
- making use of benchmarking to make sure that funds are deployed as effectively as possible;
- ensuring executive members (partner members and non-executive members) and other officers are notified of and understand their responsibilities within the SFIs;
- specific responsibilities and delegation of authority to specific job titles are confirmed;
- financial leadership and financial performance of the ICB;
- identification of key financial risks and issues relating to robust financial performance and leadership and working with relevant providers and partners to enable solutions; and
- the Executive Director of Finance will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risk.

3.3 Audit Committee

3.3.1 The Board and Accountable Officer should be supported by an Audit Committee, which should provide proactive support to the Board in advising on:

- the management of key risks;
- the strategic processes for risk;
- the operation of internal controls;
- control and governance and the governance statement;
- the accounting policies, the accounts, and the annual report of the ICB;
- the process for reviewing of the accounts prior to submission for audit, management's letter of representation to the external auditors; and the planned activity and results of both internal and external audit.

4. Management accounting and business management

4.1.1 The Executive Director of Finance is responsible for maintaining policies and processes relating to the control, management and use of resources across the ICB.

4.1.2 The Executive Director of Finance will delegate the budgetary control responsibilities to budget holders through a formal documented process.

4.1.3 The Executive Director of Finance will ensure:

- the promotion of compliance to the SFIs through an assurance certification process;
- the promotion of long term financial heath for the NHS system (including ICS);
- budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for;
- the improvement of financial literacy of budget holders with the appropriate level of expertise and systems training;
- that the budget holders are supported in proportion to the operational risk; and
- the implementation of financial and resources plans that support the NHS Long term plan objectives.

4.1.4 In addition, the Executive Director of Finance should have financial leadership responsibility for the following statutory duties:

- ~~The duty of the ICB, in conjunction with its partner NHS trusts and NHS foundation trusts, to exercise its functions with a view to ensuring that, in respect of each financial year;~~
    - ~~local capital resource use does not exceed the limit specified in a direction by NHS England;~~
    - ~~local revenue resource use does not exceed the limit specified in a direction by NHS England;~~
- The duty of the ICB to perform its functions as to secure that its expenditure does not exceed the aggregate of its allotment from NHS England and its other income; and
- The duty of the ICB, in conjunction with its partner trusts, to seek to achieve any joint financial objectives set by NHS England for the ICB and its partner trusts.

4.1.5 The Executive Director of Finance and *any senior officer responsible* for finance within the ICB should also promote a culture where budget holders and decision makers consult their finance business partners in key strategic decisions that carry a financial impact.

5. Income, banking arrangements and debt recovery

5.1 Income

5.1.1 An ICB has power to do anything specified in section 7(2)~~(a), (b) and (e) to (h)~~ of the Health and Medicines Act 1988 for the purpose of making additional income available for improving the health service.

5.1.2 The Executive Director of Finance is responsible for:

- ensuring order to cash practices are designed and operated to support, efficient, accurate and timely invoicing and receipting of cash. The processes and procedures should be standardised and harmonised across the NHS System by working cooperatively with the Shared Services provider; and

- ensuring the debt management strategy reflects the debt management objectives of the ICB and the prevailing risks;

5.2 Banking

5.2.1 The Executive Director of Finance is responsible for ensuring the ICB complies with any directions issued by the Secretary of State with regards to the use of specified banking facilities for any specified purposes.

5.2.2 The Executive Director of Finance will ensure that:

- the ICB holds the minimum number of bank accounts required to run the organisation effectively. These should be raised through the government banking services contract; and

- the ICB has effective cash management policies and procedures in place.

5.3 Debt management

5.3.1 The Executive Director of Finance is responsible for the ICB debt management strategy.

5.3.2 This includes:

- a debt management strategy that covers end-to-end debt management from debt creation to collection or write-off in accordance with the losses and special payment procedures;

- ensuring the debt management strategy covers a minimum period of 3 years and must be reviewed and endorsed by the ICB Board every 12 months to ensure relevance and provide assurance;

- accountability to the ICB Board that debt is being managed effectively;

- accountabilities and responsibilities are defined with regards to debt management to budget holders; and
- responsibility to appoint a senior officer responsible for day to day management of debt.

6. Financial systems and processes

6.1 Provision of finance systems

6.1.1 The Executive Director of Finance is responsible for ensuring systems and processes are designed and maintained for the recording and verification of finance transactions such as payments and receivables for the ICB.

6.1.2 The systems and processes will ensure, inter alia, that payment for goods and services is made in accordance with the provisions of these SFIs, related procurement guidance and prompt payment practice.

6.1.3 As part of the contractual arrangements for ICBs officers will be granted access where appropriate to the Integrated Single Financial Environment ("ISFE"). This is the required accounting system for use by ICBs, Access is based on single access log on to enable users to perform core accounting functions such as to transacting and coding of expenditure/income in fulfilment of their roles.

6.1.4 The Executive Director of Finance will, in relation to financial systems:

- promote awareness and understanding of financial systems, value for money and commercial issues;
- ensure that transacting is carried out efficiently in line with current best practice – e.g. e-invoicing;
- ensure that the ICB meets the required financial and governance reporting requirements as a statutory body by the effective use of finance systems;
- enable the prevention and the detection of inaccuracies and fraud, and the reconstitution of any lost records;
- ensure that the financial transactions of the authority are recorded as soon as, and as accurately as, reasonably practicable;
- ensure publication and implementation of all ICB business rules and ensure that the internal finance team is appropriately resourced to deliver all statutory functions of the ICB;
- ensure that risk is appropriately managed;
- ensure identification of the duties of officers dealing with financial transactions and division of responsibilities of those officers;
- ensure the ICB has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of the ICB;
- ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data

during processing, transmission and storage. The contract should also ensure rights of access for audit purposes; and

- where another health organisation or any other agency provides a computer service for financial applications, the Executive Director of Finance shall periodically seek assurances that adequate controls are in operation.

7. Procurement and purchasing

7.1 Principles

7.1.1 The Executive Director of Finance will take a lead role on behalf of the ICB to ensure that there are appropriate and effective financial, contracting, monitoring and performance arrangements in place to ensure the delivery of effective health services.

7.1.2 The ICB must ensure that procurement activity is in accordance with the Public Contracts Regulations 2015 (PCR) and associated statutory requirements whilst securing value for money and sustainability.

7.1.3 The ICB must consider, as appropriate, any applicable NHS England guidance that does not conflict with the above.

7.1.4 The ICB must have a Procurement Policy which sets out all of the legislative requirements.

7.1.5 All revenue expenditure and investments must be appropriately approved~~,~~ in accordance with the ICB business case policy (where relevant) ~~[to be drafted]~~ and delegated financial limits, prior to an agreement being made with a third party that enters a commitment to future expenditure.

7.1.6 All officers must ensure that any conflicts of interest are identified, declared and appropriately mitigated or resolved in accordance with the ICB standards of business conduct policy.

7.1.7 Budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for. This includes obtaining the necessary internal and external approvals which vary based on the type of spend, prior to procuring the goods, services or works.

7.1.8 Undertake any contract variations or extensions in accordance with PCR 2015 and the ICB procurement policy.

7.1.9 Retrospective expenditure approval should not be permitted. Any such retrospective breaches require approval from any committee responsible for approvals before the liability is settled. Such breaches must be reported to the Audit Committee.

8. Staff costs and staff related non pay expenditure

8.1 Chief People Officer

8.1.1 The Executive Chief People Officer [ECPO] (or equivalent people role in the ICB) will lead the development and delivery of the long-term people strategy of the ICB ensuring this reflects and integrates the strategies of all relevant partner organisations within the ICS.

8.1.2 Operationally the ECPO will be responsible for;

- defining and delivering the organisation’s overall human resources strategy and objectives; and
- overseeing delivery of human resource services to ICB employees.

8.1.3 The ECPO will ensure that the payroll system has adequate internal controls and suitable arrangements for processing deductions and exceptional payments.

8.1.4 Where a third-party payroll provider is engaged, the ECPO shall closely manage this supplier through effective contract management.

8.1.5 The ECPO is responsible for management and governance frameworks that support the ICB employees’ life cycle.

9. Annual reporting and accounts

9.1.1 The Executive Director of Finance will ensure, on behalf of the Accountable Officer and ICB Board, that:

- the ICB is in a position to produce its required monthly reporting, annual report, and accounts, as part of the setup of the new organisation; and
- the ICB, in each financial year, prepares a report on how it has discharged its functions in the previous financial year;

9.1.2 An annual report must, in particular, explain how the ICB has:

- discharged its duties in relating to improving quality of services, reducing inequalities, the triple aim and public involvement;
- review the extent to which the Board has exercised its functions in accordance with its published 5 year forward plan and capital resource use plan; and
- review any steps that the Board has taken to implement any joint local health and wellbeing strategy.

9.1.3 NHS England may give directions to the ICB as to the form and content of an annual report.

9.1.4 The ICB must give a copy of its annual report to NHS England by the date specified by NHS England in a direction and publish the report.

9.2 Internal audit

9.2.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring there is appropriate internal audit provision in the ICB. For operational purposes, this responsibility is delegated to the Executive Director of Finance to ensure that:

- all internal audit services provided under arrangements proposed by the Executive Director of Finance are approved by the Audit Committee, on behalf of the ICB Board;
- the ICB must have an internal audit charter. The internal audit charter must be prepared in accordance with the Public Sector Internal Audit Standards (PSIAS);
- the ICB internal audit charter and annual audit plan, must be endorsed by the ICB Accountable Officer, Audit Committee and Board;
- the head of internal audit must provide an annual opinion on the overall adequacy and effectiveness of the ICB Board's framework of governance, risk management and internal control as they operated during the year, based on a systematic review and evaluation;

- the head of internal audit should attend Audit Committee meetings and have a right of access to all Audit Committee members, the Chair and Chief Executive of the ICB.

- the appropriate and effective financial control arrangements are in place for the ICB and that accepted internal and external audit recommendations are actioned in a timely manner.

9.3 External Audit

9.3.1 The Executive Director of Finance is responsible for:

- liaising with external audit colleagues to ensure timely delivery of financial statements for audit and publication in accordance with statutory, regulatory requirements;

- ensuring that the ICB appoints an auditor in accordance with the Local Audit and Accountability Act 2014; in particular, the ICB must appoint a local auditor to audit its accounts for a financial year not later than 31 December in the preceding financial year; the ICB must appoint a local auditor at least once every 5 years (ICBs will be informed of the transitional arrangements at a later date); and

- ensuring that the appropriate and effective financial control arrangements are in place for the ICB and that accepted external audit recommendations are actioned in a timely manner.

10. Losses and special payments

10.1.1 HM Treasury approval is required if a transaction exceeds the delegated authority, or if transactions will set a precedent, are novel, contentious or could cause repercussions elsewhere in the public sector.

10.1.2 The Executive Director of Finance will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risks from losses and special payments.

10.1.3 NHS England has the statutory power to require an Integrated Care Board to provide NHS England with information. The information, which is not limited to losses and special payments, must be provided in such form, and at such time or within such period, as NHS England may require.

10.1.4 ~~As part of the new compliance and control procedures, ICBs must submit an annual assurance statement confirming the following~~ICBs will work with NHS England teams to ensure there is assurance over all exit packages which may include special severance payments. ICBs have no delegated authority for special severance payments and will refer to the guidance on that to obtain the approval of such payments.~~:~~

- ~~details of all exit packages (including special severance payments) that have been agreed and/or made during the year;~~
- ~~that NHS England and HMT approvals have been obtained before any offers, whether verbally or in writing, are made; and~~
- ~~adherence to the special severance payments guidance as published by NHS England.~~

10.1.5 All losses and special payments (including special severance payments) must be reported to the ICB Audit Committee~~ and NHS England noting that ICBs do not have a delegated limit to approve losses or special payments~~.

10.1.6 For detailed operational guidance on losses and special payments, please refer to the ICB losses and special payment guide which includes delegated limits.

11. Fraud, bribery and corruption (Economic crime)

11.1.1 The ICB is committed to identifying, investigating and preventing economic crime.

11.1.2 The ICB Executive Director of Finance is responsible for ensuring appropriate arrangements are in place to provide adequate counter fraud provision which should include reporting requirements to the Board and Audit Committee, and defined roles and accountabilities for those involved as part of the process of providing assurance to the Board.

~~11.1.2~~11.1.3 These arrangements should comply with the NHS Requirements the Government Functional Standard 013 Counter Fraud as issued by NHS Counter Fraud Authority and any guidance issued by NHS England ~~and NHS Improvement~~.

12. Capital Investments & security of assets and Grants

12.1.1 The Executive Director of Finance is responsible for:

- ensuring that at the commencement of each financial year, the ICB and its partner NHS trusts and NHS foundation trusts prepare a plan setting out their planned capital resource use;

- ensuring that the ICB and its partner NHS trusts and NHS foundation trusts exercise their functions with a view to ensuring that, in respect of each financial year local capital resource use does not exceed the limit specified in a direction by NHS England;

- ensuring the ICB has a documented property transfer scheme for the transfer of property, rights or liabilities from ICB's predecessor clinical commissioning group(s);

- ensuring that there is an effective appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

- ensuring that there are processes in place for the management of all stages of capital schemes, that will ensure that schemes are delivered on time and to cost;

- ensuring that capital investment is not authorised without evidence of availability of resources to finance all revenue consequences; and

- for every capital expenditure proposal, the Executive Director of Finance is responsible for ensuring there are processes in place to ensure that a business case is produced.

12.1.2 Capital commitments typically cover land, buildings, equipment, capital grants to third parties and IT, including:

- authority to spend capital or make a capital grant;

- authority to enter into leasing arrangements.

12.1.3 Advice should be sought from the Executive Director of Finance or nominated officer if there is any doubt as to whether any proposal is a capital commitment requiring formal approval.

12.1.4 For operational purposes, the ICB shall have nominated senior officers accountable for ICB property assets and for managing property.

12.1.5 ICBs shall have a defined and established property governance and management framework, which should:

- ensure the ICB asset portfolio supports its business objectives; and

- comply with NHS England policies and directives and with this guidance.

12.1.6 Disposals of surplus assets should be made in accordance with published guidance and should be supported by a business case which should contain an appraisal of the options and benefits of the disposal in the context of the wider public sector and to secure value for money.

12.2 Grants

12.2.1 The Executive Director of Finance is responsible for providing robust management, governance and assurance to the ICB with regards to the use of specific powers under which it can make capital or revenue grants available to;

- any of its partner NHS trusts or NHS foundation trusts; and
- to a voluntary organisation, by way of a grant or loan.

12.2.2 All revenue grant applications should be regarded as competed as a default position, unless, there are justifiable reasons why the classification should be amended to non-competed.

13. Legal and insurance

13.1.1 This section applies to any legal cases threatened or instituted by or against the ICB. The ICB should have policies and procedures detailing:

- engagement of solicitors / legal advisors;
- approval and signing of documents which will be necessary in legal proceedings; and
- Officers who can commit or spend ICB revenue resources in relation to settling legal matters.

13.1.2 ICBs are advised not to buy commercial insurance to protect against risk unless it is part of a risk management strategy that is approved by the Accountable Officer.

Item: 8.1
Enclosure: Appendix 3

ICB Financial Delegation

All financial delegations are to the substantive post-holders listed. Only where specifically indicated may the delegation be exercised by their deputy.

The approval of the Delegated Financial Limits is reserved to the ICB.

For invoice/purchase order/order/credit memo and journal approval limits see operational authorised signatory list.

Financial Delegations - Contents

Section	Title
1	Capital Projects & Assets
2	Contracts / Tenders
3	Quotations
4	Income Generation and Research & Development Contacts
5	Petty Cash
6	Engagement of Solicitors
7	Payroll Expenditure
8	Losses & Write-Off of Debts
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11	Bank accounts and Payment Methods
12	Fraud and Irregularity
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1~~3~~4	Investments
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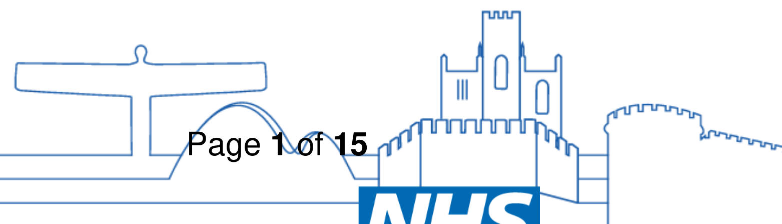


Ref	Responsibility	Delegation Arrangements	Notes
1	**Capital Projects & Assets**		
1.1	Approval of capital business cases including PFI schemes/other schemes and granting, terminating or extending leases: Up to and including £250,000 Up to and including £500,000 Up to and including £5,000,000 except where these may give rise to significant qualitative, reputational or financial risk in which case these must be referred to Finance, Performance and Investment Committee ('Finance Performance & Investment Committee') or ICB for decision. Greater than £5,000,000	ICB Director of Finance ICB Chief Executive **or** ICB Executive Director of Finance Both ICB Chief Executive **and** ICB Executive Director of Finance Finance Performance & Investment Committee	Finance Performance & Investment Committee notes: These fall within the remit of this committee; a) where a budget has already been made available; b) where the scheme of delegation permits; c) subject to compliance with the ICB's financial policies
1.2	Capital expenditure variations over the original business case figure: Up to and including £250,000	ICB Director of Finance	

Ref	Responsibility	Delegation Arrangements	Notes
	Up to and including £500,000 Up to and including £5,000,000 Greater than £5,000,000	ICB Chief Executive **or** ICB Executive Director of Finance Both ICB Chief Executive **and** ICB Executive Director of Finance Finance Performance & Investment Committee	
1.3	Maintenance of the capital asset register	Nominated Finance Officer	Nominated Finance Officer to be determined by the ICB Executive Director of Finance.
1.4	Approval of asset disposals: Where asset has a residual value of less than £100,000 Greater than £100,000	ICB Chief Executive **or** ICB Executive Director of Finance Finance Performance & Investment Committee	The Nominated Finance Officer must be informed of all disposals (whatever their value) to enable the asset register to be updated. Disposals include those items that are obsolete, obsolescent, redundant, or cannot be repaired cost effectively.
2	**Contracts / Tenders**		
2.1	For goods and services up to £25,000 in value For goods and services between £25,000 and relevant UK procurement threshold	Informal price testing (best practice is to obtain 3 quotes) Need at least 3 competitive quotes	Relevant UK procurement thresholds as of 1 January 2022 are: Standard Goods and Services (non-healthcare) = £138,760 Light Touch Regime (health

Ref	Responsibility	Delegation Arrangements	Notes
	Above relevant UK procurement threshold	Formal tender/procurement process to be followed	and social care services) = £663,540 Both inclusive of VAT where applicable
2.21	Financial appraisal of companies identified as potential tenderers	ICB Executive Director of Finance **or** Nominated Finance Officer	Nominated Finance Officer to be determined by ICB Executive Director of Finance.
2.32	Waiver of less than the requisite number of tenders/quotes: For all contracts less than £250,000 (life time value) including Capital projects/works, goods and services For all contracts of £250,000 (life time value) and above	 ICB Executive Director of Finance **or** ICB Finance Director ICB Chief Executive **and** ICB Executive Director of Finance	The reason for waving the requisite number of tenders must be recorded and signed and dated by those with delegated authority.
2.43	Authorisation of single tender/single quote For all contracts less than £250,000 (life time value) For all contracts of £250,000 (life time value) and above	 ICB Executive Director of Finance **or** ICB Finance Director ICB Chief Executive **and** ICB Executive Director of Finance	Where a single tender/single quote is sought or received, the ICB shall as far as practical, determine that the price to be paid is fair and reasonable and that details of the investigation are recorded. Where a single tender/single quote is authorised, the reason for this must be recorded and signed and dated by those with delegated authority. This must

Ref	Responsibility	Delegation Arrangements	Notes
			be reported at the next audit committee.
2.54	Permission to consider late tenders	Individual ICB Executive Directors **and** ICB Director of Finance (or nominated deputy)	
2.65	Signing of contracts, letters of intent or variations - any value (where contract approved in accordance with ICB delegated financial limits) Contracts/variations up to £250,000 (life time value) Contracts/variations up to £1,000,000 (life time value) Contracts/variations over £1,000,000	Individual ICB Executive Directors Individual ICB Director or Senior Manager up to relevant individual delegated financial limit Individual ICB Director or Executive Director (e.g. relevant Director of Place), Individual ICB Executive Director	Where contract/variation appropriately approved in accordance with delegated financial limits.
3	**Quotations**		
3.1	Evaluation of quotations between £25,000 and relevant procurement threshold	ICB Executive Director of Finance **or** ICB Executive Director **or** Nominated Finance Officer	
4	**Income Generation and Research & Development Contacts**		

Ref	Responsibility	Delegation Arrangements	Notes
4.1	Approval of income generation contracts or research and development contracts (including variations & extensions): Less than £250,000 Greater than £250,000	 ICB Executive Director of Finance **or** ICB Finance Director ICB Chief Executive **or** ICB Executive Director of Finance & Executive Director	Those greater than £500,000 must be reported to Finance Performance & Investment Committee for information.
5	**Petty Cash**		
5.1	Authorisation of petty cash payments: Disbursements up to and including £100 Disbursements over £100	 Nominated Petty Cash Officer ICB Executive Director of Finance **or** ICB Finance Director	Nominated Petty Cash Officer to be determined by ICB Executive Director of Finance.
6	**Engagement of Solicitors**		
6.1	Engagement of Solicitors	~~ICB Chief Executive **or**~~ ~~ICB Executive Director of Finance **or**~~ ~~ICB Executive Director~~ Engagement of solicitors must be approved in accordance with the legal services Standing Operating Procedure, which will be maintained by the Executive Director of Corporate Governance, Communications and Involvement.	Approval of relevant legal costs must be in line with individual delegated financial limits.

Ref	Responsibility	Delegation Arrangements	Notes
7	**Payroll Expenditure**		
7.1	Engagement, re-engagement, re-grading employees, (permanent or temporary)	ICB Executive Director	Authorisations must be within the limit of the approved budget and funded establishment.
7.2	Remuneration for substantive staff on VSM contracts or non Agenda for Change e.g. clinicians and non-executives	Remuneration Committee or ICB Board for Remuneration Committee members (except those delegated to NHS England)	In accordance with Scheme of Reservation and Delegation. Taking account of relevant NHS England and DHSC guidance.
7.3	All Off-payroll engagements where: - Cost is less than £245/day - Engaged for less than 6 months - And not in roles of significant influence Where any of the above are not met	ICB Chief Executive **or** ICB Executive Director of Finance **and** ICB Executive Director ICB Chief Executive	
7.4	Authorisation of travel and expenses claims Claims exceeding £1,000 for any single month and/or claims older than 3 months (whatever their value) Expenses of the ICB Chair	Line Managers as outlined in the Authorised Signatory List ICB Chief Executive **or** ICB Executive Director of Finance ICB Chief Executive **or** ICB Executive Director of Finance	

Ref	Responsibility	Delegation Arrangements	Notes
	Expenses of the ICB Chief Executive	ICB Chair **or** ICB Executive Director of Finance	
7.5	Study leave and associated expenses / training expenses	ICB Executive Director **or** ICB Finance Director **and** Line Manager	
7.6	Authorisation of timesheets with a value of less than £2,500 Authorisation of timesheets with a value of £2,500 or over	Line Manager ICB Executive Director **or** ICB Finance Director	No authorisations may exceed the conditions of an individual's contract. Values should be estimated based on number of hours x rate for that grade.
7.7	Authorisation of early retirement, redundancy and other termination payments to staff where there is a cost to the ICB	Remuneration Committee or ICB Board for Remuneration Committee members (except those delegated to NHS England)	Taking account of relevant NHS England and DHSC guidance and any additional approval that may be required.
8	**Losses & Write-Off of Debts**		
8.1	Authorisation of debt write-off and losses: Less than £50,000 £50,000 to £300,000 Greater than £300,000	 ICB Executive Director of Finance **or** ICB Finance Director Finance Performance & Investment Committee ICB Board (and NHS England)	Must be presented to Audit Committee for information. All losses greater than £300,000 must also be approved by NHS England

Ref	Responsibility	Delegation Arrangements	Notes
8.2	Authorisation to refer debts to debt collection agency	ICB Executive Director of Finance **or** ICB Finance Director	Where this course of action risks adverse publicity the matter must first be discussed with the ICB Chief Executive and/or ICB Chair.
9	**Special Payments**		
9.1	As part of the HR process, authorisation of special payments, including: staff compromise agreements; and ex-gratia payments: Up to £10,000 Up to £95,000 £95,000 and over	 ICB Finance Director ICB Executive Director of Finance ICB Chief Executive **or** ICB Executive Director of Finance **and** ICB Chair	All special payments must be reported to Audit Committee. Refer to ICB losses and special payments guide which includes delegated limits. No special payments exceeding delegated limits shall be made without the prior approval of NHS England. Any special payments over £95,000 require NHS England approval along with all special severance and retention payments.
10	**Budgetary Control**		
10.1	Approval of budgets and resources Delegation of budgets Approval to spend	ICB Board ICB Executive Director of Finance Budget Holder/ Manager is permitted to incur costs in accordance with their budgets & authorisation limits	The approval of budgets and resources will usually take place during March for the following financial year

Ref	Responsibility	Delegation Arrangements	Notes
10.2	Approval of budget virements: Up to and including £500,000 Up to and including £1,000,000 Over £1,000,000	 ICB Finance Director ICB Executive Director of Finance Finance Performance & Investment Committee	ICB Finance Director approval relates to budgets delegated to relevant place.
10.3	Approval of transfers from reserves	ICB Executive Director of Finance **or** ICB Finance Director	As above
11	**Bank Accounts and Payment Methods**		
11.1	Opening of bank accounts or changes to banking arrangements	ICB Executive Director of Finance **or** ICB Finance Director	Governing Banking Services only. Must be reported to the next Finance Performance & Investment Committee meeting.
11.2	Signing of cheques for cash, signing of other cheques, and authorisation of electronic payments, cheque and BACs payment schedules	ICB Executive Director of Finance **or** ICB Finance Director **or** Nominated Finance Manager	

Ref	Responsibility	Delegation Arrangements	Notes
11.3	Approval of credit card / payment card arrangements, including opening of any new accounts	ICB Executive Director of Finance	Individual credit card transactions to be approved in line with delegated financial limits.
12.0	**Fraud and Irregularity**		
12.1	Counter fraud and corruption work in accordance with Secretary of State's Directions	ICB Executive Director of Finance **or** ICB Finance Director	In liaison with Local Counter Fraud Specialist, Counter Fraud Operational Service and Police as appropriate
12.2	Investigation of suspected cases of irregularity not related to fraud or corruption	ICB Chief Executive **or** ICB Executive Director & ICB Executive Director of Finance	
13	**External audit – non audit services**		
13.1	Any non-audit services provided by the appointed external auditor must comply with the requirements of National Audit Office (NAO) Auditor Guidance Note 01 (AGN/01). Non-audit services up to £50,000 Non-audit services over £50,000	 ICB Chief Executive **or** Executive Director of Finance ICB Chief Executive or Executive Director of Finance **and** Audit Committee	Any proposed services must comply with NAO AGN/01, including total non-audit services being below 70% of audit services and complying with the prohibited services listed in NAO AGN/01. All non-audit services agreed must be reported to Audit Committee.

Ref	Responsibility	Delegation Arrangements	Notes
143	**Investments**		
143.1	Investment decisions	Refer to individual delegated financial limits for approval of expenditure on administrative and commissioning budgets	
154	**Grants**		
154.1	Decisions to award grants.	Refer to individual delegated financial limits for approval of expenditure on administrative and commissioning budgets	
165	**Healthcare Packages**		
165.1	Approval of Individual Packages of Care (including Continuing HealthCare (CHC, Funded Nursing Care (FNC), S117 health packages, and children's health packages: Up to budget delegation limit Packages above the Commissioning Manager budget delegation limit Packages above the ICB Nurse Director's budget delegation limit	 Commissioning Manager or Senior Manager ICB Nurse Director ICB Executive Area Director **or** ICB Executive Chief Nurse	Individual Health care packages to be considered and awarded in accordance with relevant legislation. Relevant commissioning manager may be employed by ICB, NECS or other partner organisation such as Local Authority or NHS Provider Trust in accordance with relevant placed based delegation arrangements. Relevant budget delegation limits are set out in Financial Limits document and authorised signatory list.

Ref	Responsibility	Delegation Arrangements	Notes
1~~6~~7	**Delegated Primary Care Commissioning Expenditure**		
17~~6~~.1	The ICB shall ensure that any decisions in respect of the Delegated Functions and which exceed the financial limits set out ~~above~~ below are only taken: a) by the individuals set out in column 2 of Table 1 ~~above~~below; and b) following the approval of NHS England (if any) as set out in column 3 of the Table 1 ~~above~~below.	See Table 1 below	NHS England may, from time to time, update Table 1 by sending a notice to the ICB of amendments to Table 1.

Table 1 – Delegated Primary Care Financial Limits		
Decision	**Person / Individual**	**NHS England Approval**
General:		
Taking any step or action in relation to the settlement of a Claim, where the value of the settlement exceeds £100,000	ICB Chief Executive Officer or Executive Director of Finance or Chair	NHS England Head of Legal Services and Local NHS England Team Director or Director of Finance
Any matter in relation to the Delegated Functions which is novel, contentious or repercussive	ICB Chief Executive Officer or Executive Director of Finance or Chair	Local NHS England Team Director or Director of Finance or NHS England Region Director or Director of Finance or NHS England Chief Executive or Chief Financial Officer
Revenue Contracts:		
The entering into of any Primary Medical Services Contract which has or is capable of having a term which exceeds five (5) years	ICB Chief Executive Officer or Executive Director of Finance or Chair	Local NHS England Team Director or Director of Finance
Capital: Note: As at the date of this Agreement, the ICB will not have delegated or directed responsibility for decisions in relation to Capital expenditure (and these decisions are retained by NHS England) but the ICB may be required to carry out certain administrative services in relation to Capital expenditure.		

Financial Limits

1. Introduction

1.1 The tables below set out the financial limits up to which officers of the Integrated Care Board may exercise executive functions. These financial limits form an integral element of the financial governance arrangements for the ICB as part of the detailed operational policies which support the scheme of reservation and delegation and prime financial policies.

1.2 Appendix 1 outlines the delegated limits to be provided to staff in North of England Commissioning Support (NECS) to ensure effective processing of transactions.

2. Administrative Budgets

2.1 Initial budgets and relevant contract values will be reviewed by the Finance, Performance and Investment Committee and approved by the ICB Board prior to the start of the financial year. The following limits will then apply to administrative budgets:

Limit	Authoriser
Over £5,000,000	Integrated Care Board
Up to £4,999,999	~~Finance, Performance and Investment~~Executive Committee
Up to £1,999,999	ICB Chief Executive **and** ICB Executive Director of Finance **and** ICB Chair
Up to £1,000,000	ICB Chief Executive **and** ICB Executive Director of Finance
Up to £250,000	Individual ICB Executive Directors
Up to £100,000	Band 9 and VSM
Up to £50,000	Senior Managers (Band 8b-d)
Up to £10,000	Managers (Band 7 to 8a)

Invoices for less than £250: All invoices for less than £250 in total can be authorised by an approved member of the finance team without any further authorisation being required by relevant budget holders

3. Commissioning Budget and Functions

3.1 Contracts will be agreed at the start of the year through the Executive Committee and approved by the ICB Board.

3.2 Related requisitions will then be processed on the ISFE system for the agreed contract value and relevant invoices will then be processed without further authorisation being required (up to the requisition value).

3.3 Within this framework the following authorisation limits will then operate:

Limit	**Authoriser**
Over £30,000,000	Integrated Care Board
Up to £29,999,999	Executive Committee
Up to £4,999,999	ICB Chief Executive **and** ICB Executive Director of Finance **and** ICB Chair
Up to £2,999,999	ICB Chief Executive **and** ICB Executive Director of Finance **or** ICB Chief Executive **and** Executive Area Directors ~~of Place Based Delivery~~
Up to £1,000,000	Executive Area Directors ~~of Place Based Delivery~~ and Finance Director
Up to £500,000	Individual ICB Executive Directors
Up to £250,000	Band 9 and VSM
Up to £75,000	Senior Managers (Band 8b-d)
Up to £10,000 *Up to £75,000 Individual packages of care only **	Managers (Band 7 to 8a)
Up to £10,000	Nominated Officers for non-contract activity and individual funding requests
Invoices for less than £250: All invoices for less than £250 in total can be authorised by an approved member of the finance team without any further authorisation being required by relevant budget holders	

Notes:

The limits above refer to individual contract values or individual contract variations (cumulative value over the life of the contract/variation, i.e. 3 year contract for £50,000 p.a. would be considered £150,000 in context of limits above). Where expenditure relates to individual packages of care, the limits above will apply to the annual package value.

Values represent total expenditure on each contract/variation (including where relevant any VAT not recoverable by the ICB).

The delegations noted above relate to the use of budgets approved by the ICB and within the individual's own areas of responsibility. Authorisation limits, based on these rules, will only be allocated to staff where this is appropriate to their role. Therefore not all staff at the banding levels listed above will be allocated these authorisation limits.

Managers (Band 7 to 8a) will have approval to agree individual packages of care up to £75,000 pa. This will also apply to relevant Band 6 case managers where agreed by Executive Director of Finance. This includes Continuing Healthcare packages, Funded Nursing Care, Section 117 healthcare, children's packages, joint funded packages.

These limits are also applicable for the approval of tenders, provided the relevant tender process has been fully complied with.

An operational authorised signatory list, confirming the relevant individuals holding delegated authority in line with the limits set out below, will be maintained by the ICB finance team and approved by the ICB Executive Director of Finance. This may include certain individuals employed by NECS to work on behalf of the ICB, in accordance with the delegated limits outlined below.

Relevant senior finance staff will have higher (in some cases unlimited) approval limits within the financial ledger system to enable the processing of high value orders/invoices relating to contracts which have been approved in line with the limits ~~below~~above.

Approval limits for the financial ledger system, including journal authorisation limits, will reviewed and approved by the Executive Director of Finance and included within the operational authorised signatory list. This list will be available for scrutiny by the Audit Committee as required.

Additional authorisation or procedure may be required for non-financial aspects of any planned expenditure or where exceptional arrangements are contemplated. It is the responsibility of the budget holder to ensure that any such authorisation has been obtained or procedure completed in advance of any financial commitment. Examples would be:

- expenditure requiring quotations, tenders or business case approval
- service change requiring clinical approval
- contracts of unusually long duration
- non-employed individuals where there may be taxation or employment rights issues requiring expert HR advice

- ex gratia or compensation payments, which have specific procedural requirements

APPENDIX 1

NECS Delegated Limits

1. Healthcare spend

1.1 Under the ISFE system, formal requisitions should be processed for healthcare payments in order for any payments to be made to providers. It is essential that we agree the boundaries in terms of what NECS can authorise on behalf of the ICB to ensure efficient processing of transactions whilst managing any potential financial risk to the ICB.

1.2 The scheme of delegation for the following key areas is as follows:

Contract Type	Signed contract by ICB?	Authorisation of requisition and receipting of service on a monthly basis	Contract Over / Under Performance
Acute / Community / Mental Health / 999 / PTS / contracts	Yes - Signed standard NHS contract is in place, which includes an agreed monthly payment profile	All requisitions can be processed by contract manager in line with rules as identified in the ISFE. This does not require additional authorisation from ICB.	Relevant NECS staff can authorise additional payment / credit up to £75,000 without additional authorisation from ICB for each contract. Amounts above £75,000 would require approval in accordance with ICB scheme of financial delegation. Excluded from the above is where a service is currently not commissioned from the provider. A variation appropriately authorised in accordance with the ICB scheme of financial delegation is required.
AQP	Yes - Signed standard NHS contract is in place with zero activity and financial value	All requisitions can be processed by contract manager in line with rules as identified in the ISFE. This does not require additional authorisation from ICB.	NECS can authorise additional payment / credit up to the overall budget agreed by ICB. Budgets will be reviewed monthly and reset where appropriate. If budget is exceeded, approval in accordance with the ICB scheme of financial delegation will be required for payment above 2% or £75,000 whichever is the lowest for each service line, e.g. AQP Adult Hearing (not provider level).

Contract Type	Signed contract by ICB?	Authorisation of requisition and receipting of service on a monthly basis	Contract Over / Under Performance
NCAs including PTS NCAs (all other PTS will be covered above)	No signed contract in place.	Requisition not required.	NECS can authorise additional payment / credit up to the overall budget agreed by the ICB. Budgets will be reviewed monthly and reset where appropriate. NCAs with an individual value above £10,000 will require approval in accordance with the ICB scheme of financial delegation. Emergency air ambulances / decompression chambers above £50,000 will require approval in accordance with the ICB scheme of financial delegation. PTS air ambulance/transport above £10,000 will require approval in accordance with the ICB scheme of financial delegation.
Enhanced Services	Yes – signed enhanced service agreement in place	All requisitions can be processed by contract manager in line with rules as identified in the ISFE. This does not require additional authorisation from ICB.	NECS can authorise additional payment / credit up to the overall budget agreed by ICB. Budgets will be reviewed monthly and reset where appropriate. If budget is exceeded, approval will be required for payment above £10,000 for each service line, e.g. minor aliments (not provider level).
Continuing Healthcare Agreements / Individual packages of care (including MH/LD and children's packages)	Yes - Signed standard NHS contract is in place with zero activity and financial value	All requisitions can be processed by contract manager in line with rules as identified in the ISFE. This does not require additional authorisation from ICB.	NECS can authorise additional payment / credit up to the overall budget agreed by the CCG. Budgets will be reviewed monthly and reset where appropriate. Individual continuing care packages above £75,000 (annual value) will require individual approval in accordance with the ICB scheme of financial delegation.
Local Authority Agreements	Yes - Signed section 256	All requisitions can be processed by contract	NECS can authorise additional payment / credit up to the overall monthly budget agreed by ICB.

Contract Type	Signed contract by ICB?	Authorisation of requisition and receipting of service on a monthly basis	Contract Over / Under Performance
	or section75 in place	manager in line with rules as identified in the ISFE. This does not require additional authorisation from ICB.	Budgets will be reviewed monthly and reset where appropriate. Only if the section 75 covers continuing health care, any individual continuing care packages above £75,000 will require individual approval in accordance with the ICB scheme of financial delegation.

2. Non-healthcare spend

2.1 It is suggested that the ICB delegates to NECS sufficient authority to allow NECS to make low value non-healthcare payments on behalf of the ICB. The proposed areas and levels of payment are as follows:

Payment Type	Value of delegated authority
Collaborative fees, blue badges, adoption forms etc	NECS can authorise individual payments up to £100.
Childcare vouchers	NECS can authorise individual payments where the cost to the ICB is up to £100.
Any other incidental expenditure	NECS can authorise individual payments up to a value of £1,000.

Item: 8.1
Enclosure: Appendix 5

Integrated Care Board
EXECUTIVE COMMITTEE – TERMS of REFERENCE

1. Constitution

The North East and North Cumbria Integrated Care Board (NENC ICB) was established by statute on 1st July 2022.

The Board of the NENC ICB has resolved to establish the Executive Committee as a committee of the Board.

2. Authority

The Committee is authorised by the Board to:

- Investigate any activity within its terms of reference
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference
- Commission any reports it deems necessary to help fulfil its obligations
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the

ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any decisions to such groups

For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions, and the SoRD other than the committee being permitted to meet in private

The Committee may not establish any subcommittees without prior Board approval as stated in the Constitution and Scheme of Reservation and Delegation.

3. Purpose

The principal purpose of the Executive Committee is to support the Board 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
- Providing 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
- Implementation of the approved ICB strategies and plans.

The Committee will contribute to the overall delivery of the ICB objectives by delivering its remit as set out in these Terms of Reference.

The Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

4. Membership and attendance

All members of committees and sub-committees that exercise the ICB commissioning functions will be approved by the Chair. The Chair will not approve an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

4.1 Chair and Vice Chair

- Chief Executive (Chair)
- Executive Medical Director (Vice Chair)

4.2 Membership (subject to Chair's approval as above)

- Chief Executive (Chair)
- Executive Director of Finance (or nominated deputy)
- Executive Medical Director (or nominated deputy)
- Executive Chief Nurse (or nominated deputy)
- Executive Area Director ~~of Place Based Delivery~~ - North (or nominated deputy)
- Executive Area Director of ~~Place Based Delivery~~ – South and Central (or nominated deputy)
- Executive Chief Digital and Information Officer (or nominated deputy)
- Executive Director of Innovation (or nominated deputy)
- Executive Chief People Officer (or nominated deputy)
- ~~Executive Director of Strategy and System Oversight~~ (or nominated deputy) Chief of Strategy and Operations
- Executive Director of Corporate Governance, Communications and Involvement (or nominated deputy)
- The Vice Chair will be agreed by the Committee members in the absence of the Chair.

Nominated deputies must be agreed with the Chair. Nominated deputies will have the same rights and responsibilities as members, and where applicable will form part of the quoracy.

4.3 Attendees

Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee may also be attended by the appropriately nominated individuals who are not members of the Committee.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter.

4.4 Attendance

Where a member of the Committee is unable to attend a meeting, a suitable deputy may be agreed with the Chair. Once agreed, that person will have the same voting rights and responsibilities as the member.

Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair (or Vice Chair in his/her absence).

5. Meetings Quoracy and Decisions

The Committee will meet in private, however any aspects relating to the commissioning of delegated primary care services from NHSEI that may have a requirement for public visibility will be managed in a public facing meeting.

The Committee will meet at least 10 times a year and arrangements and notice for calling meetings are as set out in the Standing Orders. Additional meetings may take place as agreed by the Chair (or Vice Chair in his/her absence).

The Board or ICB Chair may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

5.1 Quorum

For a meeting to be quorate a minimum of 50% (six) members is required, and must include the following:

- Chair or Vice Chair
- Executive Director of Finance (or their nominated deputy)
- At least one of the Executive Area Directors ~~of Place Based Delivery~~ (or their nominated deputies), and
- Executive Medical Director or Executive Chief Nurse (or their nominated deputies).

5.2 Decision making and voting

Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote. Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. If a decision is needed which cannot wait for the next scheduled meeting, the chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

6. Responsibilities of the Committee

The Committees responsibilities are as follows:

6.1 Commissioning

- Commissioning of Acute services for the NENC ICB population, including core contracts and other independent sector (private) provision across the Board's commissioning portfolio

- Commissioning primary care services (consistent with delegation from NHS England)

- Commissioning any specialised services not commissioned by NHS England (NHSE) but recognising the need to work with NHSEI in relation to the commissioning of specialised services

- Overseeing significant service reconfiguration to meet the needs of the population and providing assurance to the Board on the proposals.

- The Committee will work in conjunction with the Executive Area Directors ~~of Place Based Delivery~~ to ensure any delegated commissioning arrangements at place (or a wider geographical area) are consistent with the ICB strategies and plans

- Monitoring provider performance to ensure outcomes are met and report material exceptions (to the Board)

- Overseeing the rigorous and ongoing analytical review of the drivers of system pressures, so that solutions to these pressures may be developed with a collaborative approach

- Developing and monitoring a Board approved performance and outcomes framework that will provide assurance to the Board on delivery

- Under the arrangements agreed by the Executive Committee, reviewing ICB performance against the NHS System Oversight Framework

- Ensuring the ICB's response to the ongoing recovery of services as a result of Covid-19 pandemic

- Recommends the ICB's programme budgets to the Board for approval

- Approves ICB programme costs subject to the SoRD and financial delegations and financial limits

- In conjunction with the Finance, Performance, and Investment Committee, overseeing the development of an annual system plan [with partner trusts] to meet the health and healthcare needs of the population within the NE&NC having regard to the Integrated Care Partnership integrated care strategy and place health and wellbeing strategies

- Overseeing the ICB's process for provider contract development

- Ensuring that commissioning activities promote the health and wellbeing of communities across the NE&NC as well as addressing health inequalities, and commissioning activities to ensure cost effective care is delivered

- Promoting collaborative working across all providers in the NE&NC provider landscape

- Approve arrangements for complying with the NHS Provider Selection Regime

- Ensuring that commissioning activities are underpinned and informed through communications and involvement with partners across the ICS and at place to ensure the voice of local populations is heard and understood

- Align public and key stakeholder engagement in the development and implementation of ICB strategies and plans as set out in the ICB's statutory

duties for patient and public involvement, including the duty to consult where required

- Adhering to ICB's process for quality assurance, linking with the ICB Quality and Safety Committee to escalate any areas of concern, to ensure the quality and safety of commissioned services and that quality and safety are central to all of the Committee's functions

- Ensuring that commissioning activities promote the health and wellbeing of communities across the NE&NC as well as addressing health inequalities, and to ensure cost effective care is delivered

- Taking account of collaborative commissioning activities, including those of clinical networks, to consider and make recommendations to the Board as to whether they will have wider contracting/financial across the NE&NC system.

6.2 Corporate

6.2.1 System Control

- Support the Chief Executive to prepare the SoRD, Operating Framework and Operating Structure

- To ensure the ICB fulfils the functions, duties and responsibilities set out in the ICB's Constitution

- Establish a comprehensive system of internal control across the ICB

- To ensure the effective operational management of the ICB in accordance with organisational policies and procedures

- To advise the Board of urgent or emerging strategic issues and risks and recommend an ICB response to the Board

- To ensure adequate arrangements are established in relation to the System Oversight Framework.

- Develops the Organisational Development (OD) Plan and oversees the delivery of the OD Plan

- Managing the ICB's own performance and associated risks (noting that Finance, Performance and Investment Committee monitors financial performance).

6.2.2 People

- Implementation of the people priorities including delivery of the People Plan and People Promise
- Workforce planning and sustainability
- To approve arrangements for staff recruitment, retention, and development
- To advise the Board on compliance with its statutory duties relating to people and employment legislation and to provide the Board performance reports of KPIs relating to people and employment
- WRES disclosure
- Prepare a Code of Conduct for staff for approval by the Board.

6.2.3 Research

- To advise the Board on compliance with its statutory duties relating to section 14Z40 (duty in respect of research).

6.2.4 Policies

- Recommend human resources policies to the Board for approval
- Approve and implement the ICB's complaints policy
- Approve arrangements and for ensuring the ICB has an integrated approach to the management standards of health and safety and has appropriate strategy and policies in place
- Approve and implement the ICB's health and safety policies
- Approve and implement the ICB's information governance policies including handling Freedom of Information requests, ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data

- Approve corporate policies not specifically stated elsewhere (excludes HR or clinical polices)

- ~~Approve ICB Standard Operating Procedures (SOPs).~~

6.2.5 Strategy

- Development, and implementation, of a system-wide strategy and action on data and digital, subject to approval of the strategy by the Board

- Development, and implementation, of a Communications and Engagement Strategy for approval by the Board

- Development, and implementation, of the Equalities and Diversity Strategy for approval by the Board

- Develop and implement an Equality, Diversity and inclusion Action Plan

- Develop and implementation of Primary Care Strategy

- Development of other ICB strategies, not specifically delegated to other committees, for approval by the Board

6.2.6 Governance Assurance Reports

- Receive and monitor Governance Assurance Reports (GAR)

6.2.7 Litigation

- Approve and implement the arrangements for action on litigation against or on behalf of the ICB.

6.2.8 Legal

- Determine arrangements for securing legal advice, where necessary.

6.2.9 Emergency Planning Resilience and Response (EPRR)

- Approve and implement the ICB's arrangements for planning, responding to and leading recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on

incident coordination responsibilities as delegated by NHS England and NHS Improvement.

6.2.10 Conflicts of Interest

- Oversee the ICB's compliance with the management of conflicts of interest as stated in the Constitution and the Standards of Business Conduct Policy/Conflicts of interest policy and procedures.

6.2.11 Risk Management

- Approve and implement the ICB's risk management policy.

- Escalate any issues or risks for inclusion on the corporate risk register as necessary.

Any other operational matter as determined by the Chief Executive, and subject to the SoRD, approved budgets and the Financial Delegations and Limits.

7. Behaviours and Conduct

7.1 ICB values

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

7.2 Conflicts of interest

In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to the NHS guidance on managing conflicts of interest.

Conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Chair and submitted to the Board. If a conflict of interest arises, the Chair may require the affected member to withdraw at the relevant point.

7.3 Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

8. Accountability and Reporting

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The Committee will submit to the ICB Board a decision and assurance report following each Committee meeting, summarising key decisions.

The Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded and submitted to the ICB Board, in private or public as appropriate.

The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

9. Secretariat and Administration

The Committee shall be supported with a secretariat function which will ensure that:

i) The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.

ii) Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.

iii) Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.

iv) Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.

v) The Chair is supported to prepare and deliver reports to the Board.

vi) The Committee is updated on pertinent issues/ areas of interest/ policy developments.

vii) Action points are taken forward between meetings and progress against those actions is monitored.

10. Review

The Committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Version: ~~v1-1~~ **2-0**

Date of approval: **31 January 2023 TBC**

Date of review: ~~1 July 2023~~ **31 January 2024**

Item: 8.1
Enclosure: Appendix 6

Integrated Care Board

QUALITY and SAFETY COMMITTEE – TERMS OF REFERENCE

1. Constitution

The Quality and Safety Committee (the Committee) is established by the North East and North Cumbria Integrated Care Board (the Board) as a Committee of the Board in accordance with its Constitution.

These terms of reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a non-executive chaired committee of the Board, and its members are bound by the Standing Orders and other policies of the ICB.

2. Authority

The Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

The Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

3. Purpose of the Committee

The Committee has been established to provide the ICB 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 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.

The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

4. Membership and Attendance

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than four members of the Committee including two who are Independent Non-Executive Members of the Board (from the ICB). Other attendees of the Committee need not be members of the Board, but they may be.

When determining the membership of the Committee, active consideration will be made to equality, diversity, and inclusion.

The Board has appointed 14 Members of the Committee, as follows:

- Non-Executive Member (Chair)
- Non-Executive Member (Vice Chair)
- Executive Medical Director
- Executive Chief Nurse
- ~~Executive Director of Strategy and System Oversight~~ Chief of Strategy and Operations
- 1 x Partner Member, NHS Foundation Trusts
- 1 x Partner Member, Primary Medical Care
- Director of Public Health or Partner Member, Local Authority
- 1 x Place Director of Nursing (North & North Cumbria)
- 1 x Place Director of Nursing (South and Central)
- 1 x Place Medical Director (North & North Cumbria)
- 1 x Place Medical Director (South and Central)
- ICB Director of Allied Health Professions
- ICB Director of Medicines

Members may ask the Chair to agree a deputy. Those deputies agreed by the Chair will have the same rights and responsibilities as members, and where applicable will form part of the quoracy.

4.1 Chair and Vice Chair

The Committee will be chaired by an Independent Non-Executive Member of the Board. The Chair cannot also be the Audit Committee Chair.~~ or Vice Chair.~~

Committee members may appoint a vice chair from amongst the other ICB Independent Non-Executive Members.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

If a Chair has a conflict of interest, then the vice-chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

4.2 Attendees

Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee may also be attended by the appropriately nominated individuals who are not members of the Committee.

The Board has nominated the following as attendees:

- 2 x registered Healthcare Professionals (e.g. allied health professional, nurse, medic, GP, pharmacist) from providers within the NE&NC ICS boundary
- Healthwatch representative

The Chair may agree other nominated individuals to attend regularly or for specific agenda items.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter.

4.3 Attendance

Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable deputy may be agreed with the Chair.

5. Meetings Quoracy and Decisions

The Committee will meet in private.

The Committee shall meet at least 6 times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

5.1 Quoracy

No business shall be transacted at a meeting unless at least half of the whole number of core members is present to include at least one Non-Executive Member, either the Executive Medical Director or the Executive Chief Nurse and at least one other additional clinician.

In the event that a meeting of the committee is not quorate, the Chair can decide that the meeting will progress, but where decisions are required, they will be deferred to the next meeting when the committee is quorate.

5.2 Decision making and voting

Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a ‘virtual’ basis through the use of telephone, email or other electronic communication.

6. Responsibilities of the Committee

The responsibilities of the Committee will be authorised by the ICB Board. It is expected that the Committee will:

a. Be assured that there are robust processes in place for the effective management of quality and safety

b. Scrutinise structures in place to support quality, clinical effectiveness, and safety; planning, control and improvement programmes, to be assured that the structures operate effectively, and timely action is taken to address areas of concern

c. Agree and put forward the key quality priorities that are included within the ICB strategy/ annual plan, including priorities to address variation/ inequalities in care

d. Oversee and monitor delivery of the ICB key statutory requirements in relation to quality; safety and clinical effectiveness

e. Review and monitor those risks on the Board Assurance Framework and Corporate Risk Register which relate to quality, and high-risk operational risks which could impact on care. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner

f. Oversee and scrutinise the ICB's response to all relevant (as applicable to quality) directives, regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHS England and other regulatory bodies / external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained

g. Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all sites

h. Oversee and seek assurance on the effective and sustained delivery of the ICB quality improvement programmes

i. Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by NHS and independent contractors and place

j. Receive assurance, including through the Patient Safety Incident Response Framework, that the ICB identifies lessons learned from all relevant sources, including, serious untoward incidents requiring investigation, never events, safety alerts, complaints and claims and ensures that learning is disseminated and embedded

k. Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and associated metrics, and that it learns from Trusts' Learning From Deaths (LFD) reports (including coronial inquests and LFD reports)

l. To be assured that people drawing on services are systematically and effectively involved as equal partners in quality activities

m. Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children

n. Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control

o. Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services

p. Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines safety and controlled drugs

q. Review Patient Group Directions to ensure appropriate governance is in place (before approval by the ICB Medical Director)

r. Have oversight of and approve the terms of reference and work programmes for the groups reporting into the Committee (e.g. System Quality Groups, Infection Prevention and Control, NENC Local Maternity and Neonatal System, Safeguarding Partnerships/ Hubs, Clinical Reference Groups etc)

s. Approve arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes

t. Approve clinical, quality and safety policies

7. Behaviours and Conduct

7.1 ICB values

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

7.2 Equality and Diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

8. Accountability and Reporting

The Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded and submitted to the ICB Board, in private or public as appropriate.

The Chair of the Committee shall report to the Board (public session) after each meeting and provide a report on assurances received, escalating any concerns where necessary.

The Committee will advise the Audit Committee on the adequacy of assurances available and contribute to the Annual Governance Statement.

The Committee will receive scheduled assurance reports from its delegated groups. Any delegated groups or sub committees would need to be agreed by the ICB Board.

9. Declarations of Interest

All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

10. Secretariat and Administration

The Committee shall be supported with a secretariat function which will ensure that:

i) The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.

ii) Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.

iii) Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.

iv) Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.

v) The Chair is supported to prepare and deliver reports to the Board.

vi) The Committee is updated on pertinent issues/ areas of interest/ policy developments.

vii) Action points are taken forward between meetings and progress against those actions is monitored.

11. Review

The Committee will review its effectiveness at least annually and complete an annual report submitted to the Board.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Version: 2-0
Date of approval: 31 January 2023 TBC
Date of review: 31 January 2024

Item: 8.1
Enclosure: Appendix 7

Integrated Care Board

FINANCE, PERFORMANCE, AND INVESTMENT COMMITTEE – TERMS OF REFERENCE

1. Constitution

The NHS North East and North Cumbria Integrated Care Board (NENC ICB) was established by statute on 1st July 2022.

The Board of the NENC ICB has resolved to establish the Finance, Performance, and Investment Committee as a committee of the Board.

2. Authority

The Committee is authorised by the Board to:

- Investigate any activity within its terms of reference
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference
- Commission any reports it deems necessary to help fulfil its obligations
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any decisions to such groups

For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions, and the SoRD other than the committee being permitted to meet in private.

The Committee may not establish any subcommittees without prior Board approval as stated in the Constitution and Scheme of Reservation and Delegation.

3. Purpose

The Finance, Performance, and Investment Committee will contribute 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.

The Finance, Performance, and Investment Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

4. Membership and attendance

4.1 Chair and vice chair

The Finance, Performance and Investment Committee will be chaired by an Independent Non-Executive Member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee. The Chair cannot also be the Audit Committee Chair.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

4.2 Membership

Members will possess between them knowledge, skills and experience in accounting, risk management, internal, external audit; and technical or specialist issues pertinent to the ICB's business. When determining the membership of the Committee, active consideration will be made to diversity and equality.

The Board will appoint no fewer than four members of the Committee including two who are Independent Non-Executive Members of the Board.

Membership of the Committee will comprise:

- ICB Non Executive Member (Chair)
- ICB Non Executive Member (Vice Chair)
- ICB Executive Director of Finance (or nominated deputy)
- One of the ICB Executive Area Directors (or nominated deputy)
- ICB Chief of Strategy and Operations (or nominated deputy)
- ICB Executive Medical Director (or nominated deputy)
- ICB Board NHS FT Partner Member x 2 (or nominated deputy)

Nominated deputies as shown above must be agreed with the Chair. Nominated deputies will have the same rights and responsibilities as members, and where applicable will form part of the quoracy.

4.3 Attendees

Attendees may include the ICB place Directors of Finance. Other Provider sector representatives may be invited to attend, as required.

At the invitation of the Chair, the ICB Audit Committee Chair may be invited to attend as a non-voting attendee on an adhoc basis. This will be kept under review to ensure attendance at the Committee does not compromise the role of the Audit Committee Chair in ensuring appropriate oversight and assurance of the work of the Committee.

Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee may also be attended by the appropriately nominated individuals who are not members of the Committee.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter.

4.4 Attendance

Where a member of the Committee is unable to attend a meeting, a suitable deputy may be agreed with the Chair. Once agreed, that person will have the same voting rights and responsibilities as the member.

Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

5. <u>Meetings Quoracy and Decisions</u>

The Committee will meet in private.

The Finance, Performance, and Investment Committee will meet at least 10 times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

The Board, Chair or Chief Executive may ask the Finance, Performance, and Investment Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

5.1 Quorum

For meetings to be quorate a minimum of 50% members is required, including the Chair or Vice Chair and ICB Executive Director of Finance or nominated representative.

If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

5.2 Decision making and voting

Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote. Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. If a decision is needed which cannot wait for the next scheduled meeting, the chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

6. Responsibilities of the Committee

The Committee's duties can be categorised as follows:

Financial framework:

- to recommend the strategic financial framework of both the ICB and ICS system to the Board for approval and monitor performance against it.
- to recommend for approval the System Collaboration and Financial Management Agreement to both the ICB Board and NHS provider organisations.
- to consider and support the development of system approaches to new payment models, to incentivise appropriate system behaviours and to support the achievement of agreed outcomes.
- to develop the financial information systems and processes to be used to make recommendations to the Board on ICB financial planning in line with the strategy and national guidance.
- to ensure health and social inequalities are taken into account in financial decision-making.

Resource allocation:

- to develop an approach (consistent with the Scheme of Reservation and Delegation and in accordance with financial delegations and financial limits) to distribute ICB resources to drive agreed change based on the ICB strategy.

- to agree proposals for the deployment of system wide transformation funding.

- to recommend the ICB non-programme budgets (running costs) to the Board for approval.

- approval of variations to annual planned budgets (Board/Committee/Individual in accordance with Financial Delegations and Limits).

- approval of variations to non-programme contracts.

- to identify and allocate resources where appropriate (consistent with the Scheme of Reservation and Delegation and in accordance with financial delegations and financial limits) to address finance and performance related issues that may arise within the context of the approved ICB financial framework.

- to consider and advise on system priorities for investment and disinvestment, utilising evidence based outcome data to support decisions.

- Ratification of pooled budget arrangements relating to commercial sponsorship and joint working with the pharmaceutical industry.

National framework:

- to advise the ICB on any changes to NHS and non-NHS funding regimes and consider how the funding available to the ICB can be best used within the system to achieve the best outcomes for the local population.

- to oversee ICB system financial submissions.

- to ensure the required preparatory work is scheduled across the system to meet national planning timelines.

Financial monitoring information:

- to develop a reporting framework for the ICS as a system of bodies to articulate the financial position and financial impacts (both short and long-term) to support decision making.

- to agree common approaches across the system wherever possible such as financial reporting, estimates and judgements.

- to oversee the development of financial and activity modelling to support the ICB priority areas.

- to develop a medium and long-term ICB and ICS system financial plan which demonstrates ongoing value and recovery for approval by the Board.

- to maintain oversight of the underlying ICB and system run rate and advise on actions to improve.

- to develop an understanding of where costs sit across the system, system cost drivers and the impacts of service change on costs, utilising available national tools and data sources to support evidence based decisions.

- to ensure appropriate information is available to manage financial issues, risks and opportunities across the ICS.

- to manage financial and associated ICB and system risks by developing and monitoring a finance and estates risk register, and to escalate to the Corporate Risk Register as appropriate.

Financial performance:

- to oversee the management of the ICB and system financial targets, to agree and monitor performance against remedial actions as appropriate.

- to agree key outcomes to assess delivery of the ICB and system financial strategy.

- to monitor and report to the Board both ICB and overall system financial performance against national and local metric, highlighting areas of concern and proposing actions to address risk at both organisational and system level.

- to monitor and report to the Board key service performance metrics which should be taken into account in assessing the financial position.

- reviewing ICB financial performance against the NHS System Oversight Framework.

Productivity and efficiencies:

- to drive a system wide productivity and efficiency strategy and to ensure system efficiencies are identified and monitored across the ICS, in particular where

opportunities for ICS partners working together across organisations can be leveraged.

- to ensure ICB efficiencies are identified and monitored and are clearly linked into opportunities at system level.

- to ensure financial resources are used in an efficient way to deliver the organisational and system objectives.

- to review exception reports on any material breaches of the delivery of agreed system efficiency improvement plans including the adequacy of proposed remedial action plans.

Communication:

- to co-ordinate and manage ICB communications on financial issues with stakeholders internally and externally.

- to develop an approach with partners, including the Integrated Care Partnership, to ensure the relationship between cost, performance, quality and environment sustainability are understood.

Capital:

- to co-ordinate development of the system estates strategy in conjunction with system estate leads and plan to ensure it properly balances clinical, strategic and affordability drivers, for approval by the Board.

- to monitor the system capital programme to ensure the system lives within the agreed capital envelope and take action to ensure that it is appropriately and completely utilised.

- to develop plans to ensure effective oversight of future prioritisation and capital funding bids.

Risk Management:

- Escalate any issues or risks for inclusion on the corporate risk register as necessary.

NHS Constitution waiting times standards and related NHS England Operational Planning Guidance performance requirements:

- to gain assurance that the ICB has effective plans in place to deliver all of the performance requirements set out in the NHS England extant operational planning guidance.

- to gain assurance that the ICB has robust and effective operational planning systems in place (including demand and capacity) for delivering contract levels of activity.

- to gain assurance that the ICB has, robust and effective performance management systems in place relating to delivery of the access targets.

- to gain assurance that controls are in place, and operating effectively, to mitigate the risks to the successful delivery of access targets.

- to ensure that the Board is informed of significant issues, underperformance, deviation from plans and to provide assurance on action being taken.

- to gain assurance that agreed recovery plans are being implemented in a timely fashion and delivering the required outcomes.

7. Behaviours and Conduct

7.1 ICB values

Members will be expected to conduct business in line with the ICB values and objectives. Members, and those attending the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

7.2 Conflicts of interest

In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to the NHS guidance on managing conflicts of interest.

Conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Chair and submitted to the Board. If a conflict of interest arises, the Chair may require the affected member to withdraw at the relevant point.

7.3 Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

8. Accountability and Reporting

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The chair & vice chair are non executives.

The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

The Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded and submitted to the ICB Board, in private or public as appropriate.

9. Secretariat and Administration

The Committee shall be supported with a secretariat function which will ensure that:

i) The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead

ii) Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements

iii) Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary

iv) Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept

v) The Chair is supported to prepare and deliver reports to the Board

vi) The Committee is updated on pertinent issues/ areas of interest/ policy developments

vii) Action points are taken forward between meetings and progress against those actions is monitored.

10. Review

The Committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Version: v2-0
Approved by Board: 31 January 2023 TBC
Review Date: January 2024

Item: 8.1
Enclosure: Appendix 8

Integrated Care Board
AUDIT COMMITTEE – TERMS of REFERENCE

1. Constitution

The Audit Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These terms of reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB

2. Authority

The Committee is authorised by the Board to:

- Investigate any activity within its terms of reference
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference
- Commission any reports it deems necessary to help fulfil its obligations
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice.

For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference other than the Committee being permitted to meet in private.

The Committee may <u>not</u> establish any subcommittees without prior Board approval as stated in the Constitution and Scheme of Reservation and Delegation.

3. Purpose

To contribute 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 will be 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.

The Committee has no executive powers, other than those delegated in the scheme of reservation and delegation and specified in these terms of reference.

4. Membership and attendance

4.1 Chair and Vice Chair

In accordance with the Constitution, the Committee will be chaired by an independent non-executive member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

The Chair of the Committee shall be independent and therefore may not chair any other committees. In so far as it is possible, they will not be a member of any other committee.

The Committee will agree the vice chair from amongst its members. However, the vice chair must be an independent non-executive member of the Board.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

4.2 Membership

The Committee members shall be appointed by the Board in accordance with the ICB constitution.
The Board will appoint no fewer than four independent members of the Committee including at least two non-executive members of the Board. Other independent members of the Committee need not be non-executive members of the Board.

Members will possess between them knowledge / skills / experience in accounting, integrated governance, risk management and internal control, internal / external audit, and technical or specialist issues pertinent to the ICB's business. When determining the membership of the Committee, active consideration will be made to diversity and equality.

Neither the Chair of the Board, nor employees of the ICB will be members of the Committee.

4.3 Attendees

Only members of the Committee have the right to attend committee meetings however meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

- Executive Director of Finance or their nominated deputy
- Chief Executive to discuss at least annually with the Committee the process for assurance
- Representatives of both internal and external audit
- Individuals who lead on risk management and counter fraud matters
- Other relevant attendees as agreed by the Committee Chair

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board, secondary and community providers.

The Chair of the ICB may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

4.4 Attendance

Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

4.5 Access

Regardless of attendance, external audit, internal audit, local counter fraud and security management providers will have full and unrestricted rights of access to the Committee.

5. Meetings, Quoracy and Decisions

The Committee will meet in private.

The Committee will meet a minimum of four times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

5.1 Quorum

For a meeting to be quorate, a minimum of two independent non-executive members of the Board are required, including either the Chair or Vice Chair of the Committee.

If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those members present agree, but no decisions may be taken.

5.2 Decision-making and Voting

Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.
Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis in consultation with one other member of the Committee (i.e. a quorum) through the use of telephone, email or other electronic communication.

6. Responsibilities of the Committee

The Committee's duties can be categorised as follows:

6.1 Integrated Governance, Risk Management and Internal Control

- To review the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the ICB's activities that support the achievement of its objectives, and to highlight any areas of weakness to the Board

- To recommend SFIs, financial delegations* and limits to the Board for approval. *The financial delegations include approval of Non-Audit Services

- To recommend the Scheme of Reservation & Delegation to the Board for approval.

- To ensure that financial systems and governance are established which facilitate compliance with Department of Health and Social Care' s Group Accounting Manual

- To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of the ICB's objectives, the effectiveness of the management of principal risks

- To have oversight of system risks where they relate to the achievement of the ICB's objectives

- To ensure consistency that the ICB acts consistently with the principles and guidance established in Her Majesty's Treasury's Managing Public Money

- To seek reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness

- To identify opportunities to improve governance, risk management and internal control processes across the ICB.

6.2 Internal audit

To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved

- Approving the appointment of Internal Auditors

- Review and approval of the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework

- Considering the major findings of internal audit work, including the head of internal audit opinion, (and management's response), and ensure coordination between the internal and external auditors to optimise the use of audit resources

- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation

- Monitoring the effectiveness of internal audit and carrying out an annual review.

6.3 External audit

To review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit

- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan

- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee

- Reviewing all external audit reports, including to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses

- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

6.4 Other Assurance Functions

To review the findings of assurance functions in the ICB and consider the implications for the governance of the ICB.

To review the work of other committees in the ICB, whose work can provide relevant assurance to the Committee's own areas of responsibility.

To review the assurance processes in place in relation to financial performance across the ICB including the completeness and accuracy of information provided.

To review the findings of external bodies and consider the implications for governance of the ICB. These will include, but will not be limited to:

- Reviews and reports issued by arm's length bodies or regulators and inspectors: e.g. National Audit Office, Select Committees, NHS Resolution, Care Quality Commission; and

- Reviews and reports issued by professional bodies with responsibility for

the performance of staff or functions (e.g. royal colleges and accreditation bodies).

6.5 Counter Fraud

To assure itself that the ICB has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet NHS Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of work in these areas.

To review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans, provide direct access and liaison with those responsible for counter fraud, review annual reports on counter fraud, and discuss NHSCFA quality assessment reports.

Ensure that the Counter Fraud Service provides appropriate progress reports and that these are scrutinised and challenged where appropriate.

To be responsible for ensuring that the counter fraud service submits an annual report and self-review assessment, outlining key work undertaken during each financial year to meet the~~NHS Standards for Commissioners, Fraud, Bribery and Corruption~~ Government Functional Standard 013 Counter Fraud: NHSCFA requirements.

To report concerns of suspected fraud, bribery and corruption to the NHSCFA.

The Committee recommend the ICB's counter fraud and security management arrangements to the ICB Board for approval.

6.6 Freedom to speak up

To review the adequacy and security of the ICB's arrangements for its employees, contractors and external parties to raise concerns, in confidence, in relation to financial, clinical management, or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

6.7 Information governance (IG)

To receive regular updates on IG compliance, including uptake and completion of data security training, data breaches and any related issues and risks.

To review the annual senior information responsible officer report, the submission for the data security and protection toolkit and relevant reports and action plans.

To receive reports on audits to assess information and IT security arrangements, including the annual data security and protection toolkit audit.

To provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.

6.8 Financial reporting

To monitor the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.

To ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as the completeness and accuracy of the information provided.

To review the annual report and financial statements (including accounting policies) before submission to the Board focusing particularly on:

- The wording in the governance statement and other disclosures relevant to the terms of reference of the Committee
- Changes in accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements
- Significant judgements in preparing of the financial statements
- Significant adjustments resulting from the audit
- Letter of representation; and
- Qualitative aspects of financial reporting

6.9 Conflicts of interest

The Chair of the Committee will be the nominated Conflicts of Interest Guardian.

The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

6.10 Management

To request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the ICB as they may be appropriate to the overall arrangements.

To receive reports of breaches of policy and normal procedure or proceedings, including such as suspensions of the ICB's Standing Orders, in order provide assurance in relation to the appropriateness of decisions and to derive future learning.

6.11 Communication

To support communications on governance, risk management and internal control with stakeholders internally and externally as required.
To develop an approach with other committees, including the Integrated Care Partnership Board, to ensure the relationship between them is understood.

6.12 Auditor Panel

In order to meet the requirements of the Local Audit and Accountability Act 2014, the Committee shall also perform the role of the Auditor Panel for the ICB. The Chair and members of the Committee will also be the Chair and members of the Auditor Panel.

The Auditor Panel shall:

- advise the Board on the maintenance of an independent relationship with external auditors;
- advise the Board on the selection and appointment of external auditors;
- if asked advise the Board on any proposal to enter into a limited liability agreement.

To ensure the activities of the Auditor Panel are distinctive to the other activities of the Committee, the Chair of the Auditor Panel shall arrange separate Auditor Panel meetings as required, ensure minutes of meetings are formally recorded and submitted to the Board and provide a separate annual report to the Board of the panel's activities and decisions.

7. Behaviours and Conduct

7.1 ICB Values

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

7.2 Conflicts of Interest

In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to the NHS guidance on managing conflicts of interest.

Conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Chair and submitted to the Board. If a conflict of interest arises, the Chair may require the affected member to withdraw at the relevant point.

7.3 Equality and Diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

8. Accountability and Reporting

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The minutes of meetings shall be formally recorded and submitted to the ICB Board in private.

The Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

The Committee will provide the Board with an annual report, timed to support finalisation of the accounts and the governance statement. The report will summarise its conclusions from the work it has done during the year specifically commenting on:

- The fitness for purpose of the assurance framework
- The completeness and 'embeddedness' of risk management in the organisation

- The integration of governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements; and
- The robustness of the processes behind the quality accounts.

9. Secretariat and Administration

The Committee shall be supported with a secretariat function which will ensure that:

I. The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead

II. Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements

III. Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary

IV. Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept

V. The Chair is supported to prepare and deliver reports to the Board

VI. The Committee is updated on pertinent issues / areas of interest / policy developments

VII. Action points are taken forward between meetings and progress against those actions is monitored.

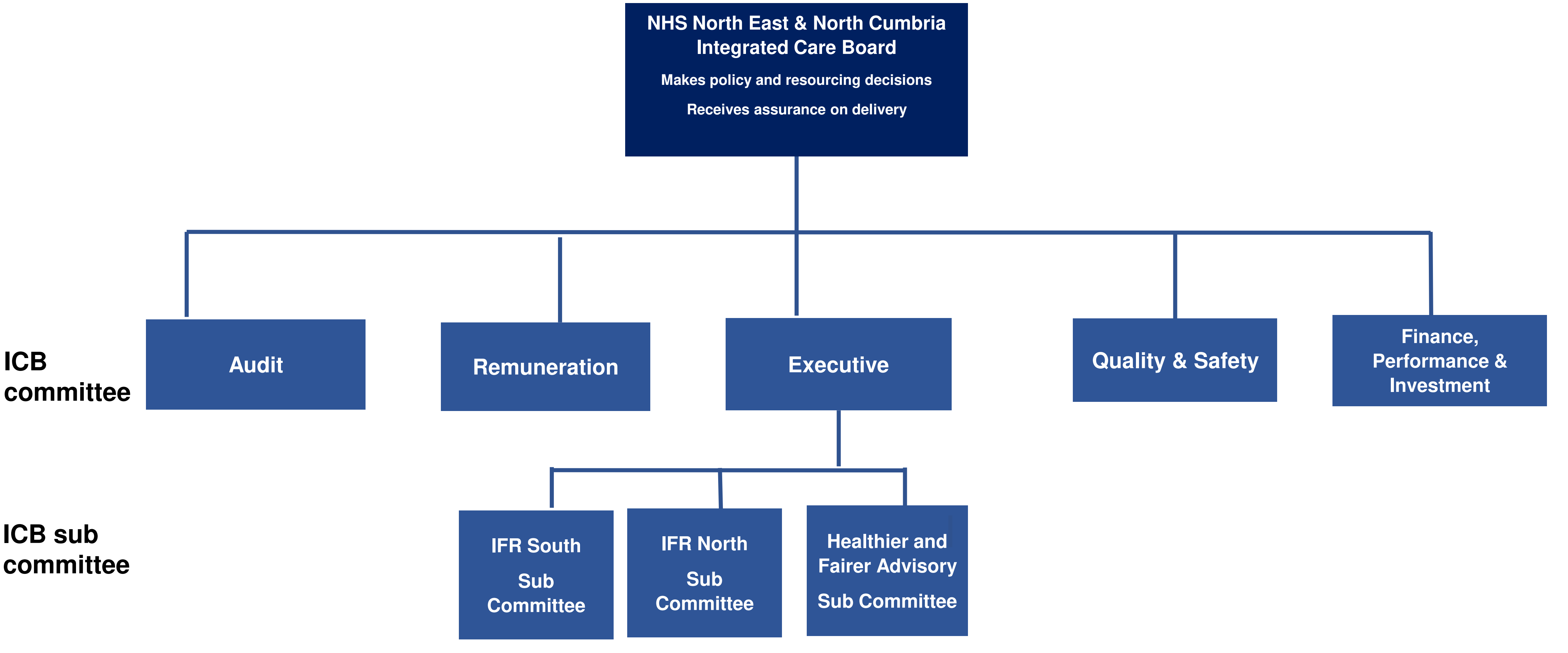
10. Review

The Committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Version: v2-0
Date of approval: 31 January 2023 TBC
Date of review: 31 January 2024

ICB OPERATING MODEL – GOVERNANCE v2-0



Committees or sub committees may also establish groups where decision making is restricted to the financial limits and financial delegations of the most senior member present. These do not required the approval of Board and are not itemised on this chart.

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

NORTH EAST AND NORTH CUMBRIA ICB BOARD MEETING

31 January 2023

Report Title:	**Highlight report and minutes from the Executive Committee meetings held on 15 November and 13 December 2022**

Purpose of report

To provide the Board with an overview of the discissions and decisions at the Executive Committee meetings in November and December 2022.

Key points

The key points from the meetings include the following:

- Redesign of the involvement and engagement model in County Durham
- Integrated care partnerships (ICPs) in North and North Cumbria
- Developing a learning and improvement system
- Winter plan for system resilience
- NECS strategic partnership and delivery plan
- Future support for asylum seekers
- Hospital discharge funding

The confirmed minutes from the meetings held on 15 November 2022 and 13 December 2022 are attached at Appendix 1 and Appendix 2 respectively.

Risks and issues

The Committee discussed the ICB risk register, noting the existing risks and the mitigating actions being put in place to address these, and following a discussion, identified the following risks and issues:

- A risk to be added to the risk register in relation to the healthcare needs of asylum seekers.

Assurances

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The Committee also received a number of items for assurance and these included:						
• An integrated delivery report – a high level overview of the key metrics across the system and internal to the ICB, covering access, experience, outcomes, people and finance • A finance update report – an overview of the current financial position • ICB Development Plan updates on progress in relation to agreed actions • A risk management report – an overview of the ICB's current risk register and movement of risks.						
Recommendation/Action Required						
The Board is asked to: • Receive the highlight report and confirmed minutes for the Executive Committee meetings held on 15 November and 13 December 2022 for assurance.						
Acronyms and abbreviations explained						
NENC ICS – North East and North Cumbria Integrated Care System NENC ICB – North East and North Cumbria Integrated Care Board NENC – North East and North Cumbria NECS – North East Commissioning Support ICP – Integrated Care Partnership NHSE – NHS England CCG – Clinical Commissioning Groups EPRR – Emergency Planning, resilience and Response Framework						
Sponsor/approving director	Samantha Allen, Chief Executive					
Report author	Deborah Cornell, Director of Corporate Governance and Involvement					
Link to ICB corporate aims (please tick all that apply)						
CA1: Improve outcomes in population health and healthcare						✓
CA2: tackle inequalities in outcomes, experience and access						✓
CA3: Enhance productivity and value for money						✓
CA4: Help the NHS support broader social and economic development						✓
Relevant legal/statutory issues						
Health and Care Act 2022						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**		**N/A**	✓
If yes, please specify						
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**	

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Key implications	
Are additional resources required?	Identified as part of the committee minutes.
Has there been/does there need to be appropriate clinical involvement?	Yes as part of the Executive Committee membership.
Has there been/does there need to be any patient and public involvement?	Not applicable as highlight report only.
Has there been/does there need to be partner and/or other stakeholder engagement?	Not applicable as highlight report only.

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Executive Committee Highlight Report

Introduction

The principal purpose of the Executive Committee is to support the Board by:

- Overseeing the day-to-day operational management and performance of the Integrated Care Board (ICB) in support of the Chief Executive in the delivery of her duties and responsibilities to the Board
- Provide a forum to inform ICB 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
- Implementation of the approved ICB strategies and plans.

The Committee will contribute to the overall delivery of the ICB objectives by delivering its remit as set out in its terms of reference.

Summary report

The Executive Committee, chaired by Samantha Allen, Chief Executive, met on 15 November and 13 December 2022.

The key points to bring to Board's attention from each meeting are set out below.

15 November 2022

- **Redesign of the involvement and engagement model in County Durham:** work was underway to develop a joint working arrangement between the ICB and local authority to work more closely with the community and voluntary sectors. This work would be linked to the ICB's strategic priorities to ensure delivery of the ICB's statutory duties in relation to patient and public involvement.
- **Integrated care partnerships (ICPs) in North and North Cumbria:** this was a key focus in both areas to establish the area ICPs (one for the North area and one in North Cumbria) and it was expected that the first meetings would take place during November. The membership of these were discussed to ensure it was appropriate and included the right representation from partners.
- **Developing a learning and improvement system:** the Committee received an update on the second system wide engagement workshop that had taken place on 2 November 2022. The event was highly successful and well attended, highlighting a number of priorities for the system to work together on. A discussion took place around the resources needed to support this work and a further event was being planned with the Executive Team for early in January 2023.
- **Winter plan for system resilience:** the plan set out the proposed engagement across all partners within the Integrated Care System, along with detailed operational plans to manage system pressures and focussing on three priority areas. A letter had been received from NHS England asking for a baseline assessment from the ICB on this.

13 December 2022

- **NECS strategic partnership and delivery plan:** the Committee received an update on the ongoing developing strategic partnership between the ICB and NECS. Discussions were underway in relation to developing the service level agreement in partnership and a number of key points raised during the meeting to ensure the good relationship with NECS was maintained.

- **Future support for asylum seekers:** the report set out the potential issues and challenges in relation to the number of asylum seeker hotels in North Cumbria. Concerns were raised around the long-term approach going forward, particularly in relation to the shortfall in funding for providing additional health support to this cohort of people. The Committee noted this was not an issue specific to North Cumbria and a longer term plan was needed to address these issues. It was agreed further work would be undertaken and a risk added to the register around this.
- **Hospital discharge funding:** an update was given on the proposed approach to how this money would be used. A number of conversations had taken place with the relevant director of adult social services around this, using the same formula as the local authorities. A taskforce was to be established to oversee this piece of work, with links into the learning and improvement work.

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Appendix 1

North East and North Cumbria Integrated Care Board

Executive Committee

Minutes of the meeting held on Tuesday 15 November 2022, 09:00hrs at Joseph Swan Suite, Pemberton House, Colima Avenue, Sunderland

Present:	Samantha Allen, Chief Executive (Chair) Nic Bailey, Interim Executive Director of Place Based Delivery (North) Claire Riley, Executive Director of Corporate Governance, Communications and Involvement Graham Evans, Executive Chief Digital and Information Officer Dave Gallagher, Executive Director of Place Based Delivery Jacqueline Myers, Executive Director of Strategy and System Oversight Dr Neil O'Brien, Executive Medical Director David Purdue, Executive Chief Nurse Aejaz Zahid, Executive Director of Innovation
Apologies for absence:	Annie Laverty, Executive Director of People David Chandler, Interim Executive Director of Finance
In attendance:	Phil Argent, Director of Finance (North) Deborah Cornell, Director of Corporate Governance and Involvement Kate Hudson, Director of Finance (Central) Holly Kitching, Deputy Director of Nursing, STSFT Rachel Mitcheson, Director of Place (Northumberland) Gillian Sheppard, Executive Assistant (minutes)

EC/2022/66 Welcome and introductions

The Chair introduced Holly Kitching, Deputy Director of Nursing, South Tyneside and Sunderland NHS Foundation Trust, who is currently shadowing the Executive Chief Nurse.

EC/2022/67 Apologies for Absence

Apologies of absence was noted for David Chandler, Interim Executive Director of Finance and Annie Laverty, Executive Director of People.

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EC/2022/68 Declarations of interest

A declaration of interest was declared by the Executive Medical Director for agenda 14.2. The Chair confirmed he may be present in the room throughout the discussion but unable to participate in any decision making.

EC/2022/69 Minutes of the previous meeting (11 October 2022 - enclosure 1)

It was AGREED that the minutes accurately reflected the meeting with the following exception:

RESOLVED:
The Executive Committee **AGREED** that the minutes from the 11 October 2022 meeting were a true and accurate reflection.

EC/2022/70 Matters arising from the minutes and action log

The action log was reviewed and specific updates provided on the log.

EC/2022/71 Notification of urgent items of any other business

There were no urgent items of business identified.

EC/2022/72 Central and South Place Based Delivery Report

The Executive Director of Place Based Delivery (Central and Tees Valley) provided a brief summary of the decisions made at recent local delivery groups with the following key points highlighted:

- The County Durham Care Partnership Executive had proposed to redesign the involvement and engagement function across health and social care with an increased focus on use of the Community/Voluntary sector. There would be further opportunities to link engagement work more closely with the NHS

- The Middlesbrough urgent care centre was due to go live w/c 14/11/2022 but had been delayed for approximately a week to accommodate a Care Quality Commission (CQC) visit to the hospital.

- The CQC visited South Tees NHS Foundation Trust (STFT) week commencing 7 November and although no formal feedback was available at present, the initial indication is positive.

- A draft version of the business case for the replacement of theatres at the Friarage Hospital was complete, a further update would be provided at the December meeting.

- The reprovision of Shotley Bridge hospital through the New Hospitals Programme would go ahead, a letter of support from the North East and North Cumbria Integrated Care Board (the ICB) would be needed. Further information will be provided to the Comms team on timings once known.

- The Carnall Farrar work with North and South Tees Foundation Trusts to agree a model for greater collaboration continued. The 10-week programme and costs had previously been agreed at Executive Committee, a further request had been received for the ICB to support and approve an additional 2 weeks to complete the work at an additional cost of £29k. Support for this was given by the Committee.

There were no items requiring approval from the Committee as all decisions on the log remained within financial delegation limits.

The Executive Director of Nursing requested for place-based reports to include a quality element and suggested that a section providing feedback on quality issues from all other committee members was included.

A discussion took place regarding the engagement and involvement work in County Durham detailed within the report. It was acknowledged that there would be differences in approaches and partnerships, but it was essential that all places operated and mobilised in line with the ICB's involvement strategy. The Director of Corporate Governance and Involvement confirmed that she was currently working with involvement leads to agree the work to be delivered at place to ensure the ICB meets its statutory duties.

RESOLVED:
The Executive Committee **NOTED** the content of the report, including the extension to the Carnall Farrar work and the associated cost.

EC/2022/73 North and North Cumbria Place Based Delivery Report

The Interim Executive Director of Place Based Delivery (North and North Cumbria) provided a brief summary on issues considered and decisions made at each Place with the following key points highlighted:

- A key focus continued to be developing the Integrated Care Partnerships (ICPs) and place-based governance. The expectation was to hold the first of the new Area ICP meetings in November to consider the proposed

terms of reference, membership and draft North East and North Cumbria health and care strategy

- There was a concern about the fragility of primary care services in North Cumbria and the local place team was working with North Cumbria primary care services in terms of their infrastructure and resilience and their future needs

- A request had been received from Northumbria Primary Care (NPC) requesting the realignment of their North Tyneside GP practices into a single NPC primary care network. Conversations were ongoing as a range of factors and impact need to be considered carefully

- A formal notice was received on 17 October 2022 from The Manor House, Whickam, to de-commission nursing care beds and move the home fully to an elderly mental infirm and general residential home. The provider had indicated this was due to the financial challenges to deliver good quality nursing and ongoing recruitment difficulties

- The development of a sleep station service was being considered across the North places to support people who struggle to sleep. The affordability of this service across Northumberland, and the need for recurrent funding, may mean consideration for flexible commissioning. An update would be provided to the committee in due course as to the relative priority of this for funding and also the potential for a wider NENC service.

- The number of Children Looked After (CLA) was increasing and all systems were struggling with meeting the statutory requirements for health assessments, including in fostering and adoption. The SEND reinspection had taken place in Newcastle with a number of improvements seen since the last inspection but with further improvement required in a smaller number of areas.

There were no items requiring approval from the Committee as all decisions on the log remained within financial delegation limits.

The Executive Chief Digital and Information Officer advised that the majority of the work on IT migration in North Cumbria from North Cumbria Integrated Care (NCIC) to North of England Commissioning Support (NECS) had taken place successfully.

A discussion took place on the general feedback from the proposed ICPs across the system. There were ongoing discussions to ensure the membership of each ICP is appropriate. As they were not formal decision-making committees some local authority (LA) leaders may feel this is more appropriate for their Health and Wellbeing Board (HWBB) chair or lead

member to be the LA representative. In North Cumbria there is concern that the same people will sit on both the Place Based meetings, HWBB and the ICP, therefore consideration is needed as to whether the role for the ICP is clear.

The Executive Director of Strategy and System Oversight referred to the £350k Winter Support for Hospital Discharge on the decisions and assurance log and explained that there were many actions to prioritise in the winter action plan and clarity was needed on what was spent at place and spent centrally.

Action:
The Director of Finance (North) to provide clarity on how the winter plan fund was being managed and what has been committed to spend. The financial plan was to include detail on Place and Central spend and any other funds that would be made available.

The Chair asked for confirmation of how the contents of the place-based reports were being communicated to the wider staff in the ICB. The Executive Director of Corporate Governance, Communications and Involvement confirmed a summary of the Committee was circulated within the staff 'Pulse' newsletter.

RESOLVED:
The Executive Committee **NOTED** the content of the report, including the action relating to the financial work plan for winter plan.

EC/2022/74 SIRO Cyber Awareness and Assurance Report

The Executive Chief Digital and Information Officer provided a further update in relation to the Ransomeware attack.

The cyber-attack took place on 4 August 2022 against the software provider 'Advanced' which had a direct impact on a number of health care and social care services. It was noted that this was not a direct attack on the NHS.

A number of systems were taken offline immediately at the time of the attack and quickly re-established, with the exception of a system used by mental health trusts, Carenotes.

The risks and issues contained in the report was summarised. NHS England national IMT and the National Cyber Security were awaiting the full forensic report from the incident. Further information on lessons learnt will also be provided to the committee as they become available for consideration.

The Chair asked if there was a plan in place for the ICB to mitigate the risks identified. In response, it was noted that there was an ongoing

programme of work with the Senior Information Risk Owner (SIRO), which included updating the ICB Board on the three key cyber risks via the corporate risk register. The Strategic Head of Infrastructure, Security and Technology would be responsible for developing the plan.

RESOLVED:
The Executive Committee **NOTED** the content of the report and the ongoing programme of work with the SIRO.

EC/2022/75 Proposed Oversight Framework and Memorandum of Understanding with NHS England

The Executive Director of Strategy and System Oversight provided an update on the oversight framework which had previously been presented to the Committee for consideration in October 2022.

The framework had now been shared fully across the system to include provider chief executives and chief operating officers. Discussions with executive directors of place and finance and the Executive Chief Nurse had been refined accordingly.

It was acknowledged that the proposed oversight arrangements may take some time to be accepted by all partners within the system but should be enacted the remainder of the year; a review will take place in 2023/24.

Further detail was needed on all current meetings taking place with providers, information has been shared with senior leadership groups and it was agreed to include directors of place in these discussions.

Action:
The Executive Director of Straegy and System Oversight to raise the reset of all provider meetings at the Senior Leadership meeting on Wednesday 23 November 2022.

RESOLVED:
The Executive Committee **APPROVED** the Oversight Framework and AGREED to include this as an agenda item at the Senior Leadership meeting on 23 November 2022.

EC/2022/76 Developing a Learning and Improvement System Update

The Executive Director of Innovation updated the Committee on the first system wide engagement workshop delivered on 21 September 2022. The event was successful, with a number of areas of priorities highlighted by participants for the system.

A follow-on webinar took place on 2 November 2022 via Zoom which was attended by approximately 300 people and was very well received. A

date had been set for 10 January 2023 for an executive team strategy workshop with Helen Bevan, NHS Horizons to give executive directors the opportunity to support the development of the strategy and to help map out the seven key priorities identified from these events.

To continue the momentum, it was requested that the Executive Team support the development of a learning and improvement system and establish the resources required to build the workplan, including the use of additional resource outside of the original budget to support future virtual engagement events via Zoom. The original funding agreed covered recruitment of a number of team members to support the work for the first year of the programme, but to expedite the development of the work changes to recruitment were proposed from the original plan.

A conversation took place regarding the need to understand the long-term plans of the project and what it hoped to achieve which will assist conversations regarding the request for further resource. It was noted that any request for further resource and funding away from the approved business case must be submitted to the Committee for further consideration. It was suggested that the Executive Team Strategy workshop be prioritised and held at an earlier date with fewer participants if necessary.

In relation to the purchase of a Zoom licence for virtual engagement events, it was noted that MS Teams was in use throughout the NHS and has the functionality to support large scale virtual events and would be more efficient to continue its use.

Action:
The Executive Director of Innovation to bring forward the Executive Team Strategy workshop scheduled for 10 January 2023.

Th Executive Director of Innovation review the business case and changes to revenue requirements to be resubmitted to Executive Committee for consideration.

RESOLVED:
The Executive Committee **REJECTED** any additional revenue requirements from the original business case submitted for the development of a Learning and Improvement System. A new business case would need to be submitted to Executive Committee for consideration.

EC/2022/77 ICS Winter Plan for System Resilience

The Executive Director of Strategy and System Oversight presented the ICB winter plan for system resilience for information only. The plan was prepared with wide engagement across all partners in the Integrated Care

System (ICS). The report detailed the plans to manage the operational system pressures throughout the winter period in three key priority areas:

- Increase clinical triage and use of non-Emergency Department pathways
- Increasing access to urgent primary care
- Improving discharge and patient flow

The Chair referred to the letter received from NHS England in October 2022 detailing the requirements of all organisations throughout winter and asked for detail on the baseline of the ICB to enable prioritisation in key areas.

A discussion took place on the data that was available across organisations for two hour responses, urgent treatment centres and the metrics from national data but it was acknowledged that that there is a shortage in resource to pull this information together to provide a baseline on performance. It was agreed that further resource is needed to progress this work further with a need to have project management in place and an underpinning financial plan to support the work.

Action:
The executive directors to meet urgently and discuss the resource available in the ICB to support the Director of Transformation, System Wide on winter planning.

RESOLVED:
The Executive Committee **NOTED** the content of the report and subsequent action to urgently discuss the resource available to support winter plans.

EC/2022/78 Winter Assurance Framework

The Executive Director of Strategy and System Oversight presented the ICB winter assurance framework for information only. This report will also be presented to the ICB Board on 29 November 2022.

RESOLVED:
The Executive Committee **NOTED** the content of the report.

EC/2022/79 Proposed Model for Managing Freedom of Information Requests, Ministerial Briefings and Parliamentary Enquiries

The Executive Director of Corporate Governance, Communications and Involvement introduced the new procedures to manage correspondence

received from Members of Parliament, ministerial briefings, patient complaints, Freedom of Information and subject access requests.

It was acknowledged that the process had not been working seamlessly in the past but the new procedures would improve this going forward with appropriate timelines in place and retraining provided to staff. There would be regular updates brought to the Committee and directors of place would be included in responses to any specific issues within their respective places to ensure they were informed.

RESOLVED:
The Executive Committee **NOTED** the new procedures outlined in the report.

EC/2022/80 Secure Data Environment (SDE) – NHS Funding Proposal

The Executive Chief Digital and Information Officer provided an update on the NENC proposal for £10m to NHS England (NHSE) for the regional Secure Data Environment (SDE) development. The proposal was to be a national 'wave 1' region with accelerated funding.

Some initial feedback from NHSE had been received on 11 November 2022 but was subject to a publication/communication embargo. In the meantime, the ICB team would continue to liaise with the NHSE SDE team in relation to next steps.

The full report and SDE outcomes would be published in approximately two weeks.

RESOLVED:
The Executive Committee **NOTED** the contents of the report.

EC/2022/81 Ongoing support to NENC ICB COVID-19 Vaccination programme – options papers

The Executive Medical Director presented a report to update the Committee on the current vaccination programme. The report proposed a model to ensure effective delivery of COVID-19 and flu vaccine programmes to March 2024 and the funding to resource this.

At present the COVID-19 vaccination programme in the NENC ICS was provided by Newcastle Upon Tyne Hospitals NHS Foundation Trust (NUTH) through a lead provider contract funded by NHSE until 30 March 2023. From 1 January 2023, NUTH had indicated that it no longer wished to continue with the coordinating function but was willing to remain as the conduit for national funding up to 31 March 2023.

It was highlighted that the preferred option, which supported the continuation of the System Vaccination Operations Centre (SVOC) service, was detailed in section 6 of the report.

A general discussion took place and it was agreed to support the proposal detailed in 'option 3, sub-option C' in principle, subject to further conversations with NHSE to confirm the resource that would be delegated to the ICB and the allocation given to support the 2023/24 programme.

A question was raised in relation to the Vaccination Committee's position within the ICB governance structure and it was agreed that further clarity was required.

Action:
The Director of Corporate Governance and Involvement to clarify where the Vaccination Committee is positioned within the ICB governance structure.

The Chair thanked Stewart Findlay, the report author for the work detailed in the report.

RESOLVED:
The Executive Committee **AGREED** to the support 'Option 3, sub-option C' in principle subject to further conversations with NHSE to confirm the ICB's allocation and resource for 2023/24**.**

EC/2022/82 ICB Programme Plan Highlight Report

The Executive Director of Strategy and System Oversight briefly summarised the report which provided assurance of progress against all key objectives and milestones for the ICB during 2022/23.

It was agreed to continue working through the current model until closedown, or until a Portfolio Management Office (PMO) is in place.

RESOLVED:
The Executive Committee **NOTED** the contents of the report**.**

EC/2022/83 Finance update

On behalf of the Interim Executive Director of Finance, the Director of Finance (Central) presented a high-level update for the NENC ICB and the ICS for the period to 30 September 2022, with the key points from the report highlighted.

The ICB was currently reporting a forecast outturn deficit of £5.8m, prior to expected retrospective central funding of £11.46m relating to the Primary Care Additional Roles Reimbursement Scheme (ARRS). Once

this funding was received, the ICB would report a forecast surplus of £5.6m against a planned surplus of £2.6m. The additional £3.0m surplus would offset a forecast deficit across relevant NHS providers, resulting in a balanced financial position across the ICS.

There were pressures in mental health for the Section 117 packages and continuing healthcare, however these were partially offset through underspends on prescribing costs and use of programme reserves.

The financial plan of the ICB required an overall efficiency target of £48.4m and the ICB was on track to deliver this.

There was a small underspend forecast on running costs due to vacancies and contingencies not being used. There was a potential recurring pressure on running costs which would need to be managed in future years.

Whilst a balanced position was forecast at month 6, it was highlighted that there were substantial risks to be managed across the ICS totalling £95m. Most of the risks would be mitigated by a range of non-recurring measures, but there was a potential unmitigated risk of £39m for the ICS. This included a specific risk across the providers due to the pay award impact of £15-20m.

The ICB would be working with ICS providers to understand their underlying position. A workshop was taking place on 18 November 2022 to understand what the assumptions were at month six, with a follow up session later in November 2022.

A question was raised in relation to running costs and if vacancy control was needed at this point. In response it was stated that no discussions had taken place but further work may be required to determine overall running costs.

It was noted that there may be over reliance on certain providers to provide efficiency targets and this could be discussed further to ensure all providers consider efficiency targets required.

Action:
The Director of Finance (Central) to circulate a further update on running costs and budget update via email by end of December 2022.

RESOLVED:
The Executive Committee **RECEIVED** the finance update and **NOTED** the risk on running costs and need for budget control.

EC/2022/84 Integrated Performance Delivery report

Item: 8.2.1

The Executive Director of Strategy and System Oversight briefly summarised the integrated quality and performance report and the key changes highlighted:

- **Urgent and Emergency Care (UEC)** – pressures were building due to high level of attendees, high bed occupancy, and NEAS response times with an escalation in 12 hour breaches.

- **Elective care** – there had been a reconfirmation of trajectories with acute Trusts in 78+ and 104+ week waits. The number of patients waiting over 78 weeks was currently over the NENC plan. Trusts had recently been asked to confirm their plans for the end of March 2023. Most providers had confirmed they could meet their plans with the exception of NUTH, who had confirmed they could achieve their plan of 180. For 104+ week waits, most providers had confirmed they could eliminate the list by June 2022, with exception of NUTH due to complex spinal surgeries.

- **Diagnostics more than 6 weeks**– performance for the 15 key diagnostic tests was stable.

- **Cancer**: the NENC was not achieving the 75% faster diagnosis target, currently standing at 74.3%, it was noted there was a variation in performance across the trusts. There was a focus for trusts on cancer performance through Tier 1 and 2 cancer meetings in collaboration with NHSE.

- **MH/Autism**: *to note that the data had not been updated in month due to changes within the NHSE publication.* There was a pressure on services overall, with an increase in waiting times for the Improving Access to Psychological Therapies (IAPT) service with 38% of patients waiting 90 days between their first and second appointments. The Committee was advised that there was a newly appointed Director of Transformation (Mental Health, Learning Disabilities and Autism) within the ICB and there would be a focused programme of work on transformation resources and priorities across places.

It was suggested that national data on children elective waiting list should be included in future reporting and out of area information.

A query was raised regarding the work in improving collaboration and efficiencies to reduce the 104+ week waits(ww). It was confirmed that discussions had taken place with NUTH and all avenues for treatment had been investigated but would look to move degenerative work to alternative centres. Work continued on the complex cases, currently 30 patients at over 104+ww. It was confirmed that further detail would be included in future reporting.

RESOLVED:
The Executive Committee **RECEIVED** the report for assurance.

EC/2022/85 Continuing Healthcare Fees – Northumberland Place

The Director of Finance (North) and the Director of Place (Northumberland) presented the report outlining the proposed approach to managing the continuing healthcare (CHC) dispute in Northumberland place.

The background and context of the previous arrangement was briefly summarised, wherein Northumberland Clinical Commissioning Group (NCCG) had a Section 75 partnership with Northumberland Council. A new three-year contract had been entered into in April 2021 with Northumberland care home providers. The negotiation included a challenging behaviour premium of £100 per week for patients that had been assessed as requiring additional staff support.

Northumberland had a total number of residential and nursing beds of 2891 with 459 vacancies (84% occupancy rate), and there had been a general fall in occupancy during the COVID-19 pandemic.

Care North East (CNE) represent the minority of care providers in Northumberland during fee and contracts discussions with councils and the NHS. It was reported that CNE had submitted a legal letter to Northumberland challenging the fee setting process for 2022/23. Full details of the process of engagement and challenging behaviour premium was outlined in section 4 of the paper.

It was acknowledged that the prices and premium paid differs in each local authority area. A range of options were outlined for the Committee to consider:

1. Option 1 – Continue with the current arrangement in Northumberland

2. Option 2 – Pay an interim premium payment

3. Option 3 - Agree to review approach to all CHC fees and premiums**.**

A general discussion took place in which all options were considered. It was acknowledged that this was a complicated process to resolve and required a detailed piece of work to understand the split of vacancies between nursing care and CHC cases. Any work would need to be completed quickly to prevent legal challenges or lengthy legal issues.

RESOLVED:
The Executive Committee **NOTED** the proposed approach to managing the CHC dispute in Northumberland place and **AGREED** to:

- Option 1 and Option 3 and not providing an interim payment
- To support a Task and Finish Group to review the approach to all CHC fees and premiums across the whole ICB sponsored by Executive Directors of Finance and Nursing. A proposal and specialist resource to update in December meeting
- To manage cases in Northumberland on a case-by-case basis**.**

EC/2022/86 Delegation of Specialised Service Commissioning to ICBs

The Executive Director of Strategy and System Oversight summarised the approach that had been taken for the delegation of specialised services to the ICB from NHSE.

ICBs were to have their readiness assessed by NHSE prior to delegation being approved. All ICBs were expected to go through the Pre-delegation Assessment Framework (PDAF) process in quarter three of 2022/23 even if they had opted to form a joint commissioning arrangement from April 2023 and take on full delegation a year later in April 2024. It was proposed that the NENC ICB would form a joint committee with NHSE from April 2023, establishing a joint commissioning arrangement and full delegation in April 2024.

Currently NHSE was the accountable commissioner for 154 specialised commissioning services, approximately 65 of which identified as appropriate to delegate to ICBs. It was acknowledged that the detail for a joint committee was unclear at this stage as delegation would not take place until 2024, therefore it was assumed a shadow arrangement would be in place. In response, it was noted that the governance structure of the joint committee would need to be reviewed before any agreement could be given.

There was a need for further due diligence work and to look at internal ways to manage commissioning across the ICB. Further clarity was needed to understand if the work around specialised commissioning would be delegated to regional level or whether it was hosted by one ICP. It was noted that the due diligence was a significant piece of work and the ICB did not have the staffing resource to support this.

Action:
The Chief Executive to discuss staffing resource shortage for the due diligence work in specialised commissioning with the regional team.

RESOLVED:
The Executive Committee **AGREED** the following recommendations outlined in the report as follows:

- The current direction of travel with proposed delegation of specialised service commissioning
- Delegate responsibility of PDAF submission to the Executive Director of Strategy and System Oversight
- Review governance arrangements and establish and progress a joint committee.

EC/2022/87 NHS England Clinical Network Staff Transfer to the NENC ICB

The Interim Executive Director of Place Based Delivery (North and North Cumbria) presented the report outlining the proposed transfer of staff from five of the NHSE Clinical Networks working within the ICB area, these included:

- Maternity and Perinatal Mental Health
- Mental Health
- Northern Cancer Alliance
- Learning Disability and Autism
- Physical Health and Long-Term Conditions

The funding for the clinical networks was via national funding programme, with staff employed within NHSE, with the exception of Learning Disability and Autism Network which was already funded by the ICB.

It was reported that there were a number of risks associated with the transfer of staff, including potential programme funding cuts and the ICBs running cost allowance.

A general discussion took place regarding the impact the transfer of staff would have on the ICB, with regards to estate implications, cost of additional IT requirements, increase in running costs to ensure the services continued to run effectively and additional freedom of information requests that this work would generate. The request to transfer the staff in all five networks was agreed in principle subject to an amendment to running allowance for full head costs and overhead costs. It was envisaged that the networks would sit in the directorate of either the Executive Chief Nurse or the Executive Medical Director.

Action:
The Interim Executive Director of Finance to review running allowance adjustment for clinical network staff transfer.

The Executive Chief Nurse to update the Committee in December on timelines and any HR implications with transfer of staff in the five clinical networks.

RESOLVED:
The Executive Committee **AGREED** in principle to the transfer of the five clinical networks and their staff to the ICB subject to:

- Further clarification of secure funding sources and actual staff costs with NHSE was required with final sign off delegated to the Interim Executive Director of Finance.

EC/2022/88 Strategy and Partnerships

There were no items for this section.

EC/2022/89 Corporate Risk Register

The Executive Director of Corporate Governance, Communications and Involvement presented an updated position on the risks facing the organisation for the period 30 September to 8 November 2022 for information and assurance.

A question was raised if all risks were accurately reflected on the report as there was an absence of detail on capacity and PMO.

Action:
The Director of Corporate Governance and Involvement to amend the risk register to include risks associated with capacity and the absence of PMO within the organisation.

RESOLVED:
The Executive Committee **NOTED** the contents of the report for information and assurance.

EC/2022/90 Recommended addendum to the Scheme of Reservation and Delegation to IFR

The Director of Corporate Governance and Involvement presented the report for information and assurance.

The initial Scheme of Reservation and Delegation (SoRD) was approved by the ICB Board on 1 July 2022. During a recent review of the SORD it was identified that delegated authority to approve individual funding requests has not been specified.

An interim process had been put in place to enable the Executive Medical Director to approve requests until the addendum to the SORD was been ratified.

RESOLVED:
The Executive Committee **APPROVED** the recommendation to the ICB Board for a retrospective addendum to the SoRD from 1 July 2022**.**

EC/2022/91 Items of Any Other Business

There were two items of additional business:
- System Development Funding (SDF) 2022/23
- EPRR Core Standards Annual Assurance Process

System Development Funding 2022/23 – October update

A declaration of interest was declared by the Executive Medical Director for the agenda item. The Chair confirmed he may be present in the room throughout the discussion but unable to participate in any decision making.

The Executive Director of Place Based Delivery (Central and Tees Valley) provided an update regarding the Primary Care System Development Fund (SDF) allocated to NENC ICS for 2022/23 and the proposals for allocating the funding.

Prior to the formation of the ICB, a small task and finish group had been established to investigate the multiple funding streams and to put forward proposals for the allocation of funding across the ICS. There had been regular updates provided to the ICS Primary Care Strategy Group.

The recommendation was to continue supporting the continuation of the development of draft proposals ahead of the confirmation of funding and publication of the SDF and General Practice IT (GPIT) Funding Guidance.

A question was raised regarding online consultations, it was explained this related to video consultations and further detail could be obtained if needed. A further question was raised regarding how the developing fund was to be communicated to primary care. It was explained that the information would be communicated through Primary Care Networks, GP practices linked to GP Teamnet and GP Federations.

RESOLVED:
The Executive Committee **APPROVED** the recommendations outlined in the report.

EPRR Core Standards Annual Assurance Process

The Executive Director of Strategy and System Oversight provided an update regarding the outcome of the annual NHS England (NHSE) EPRR Core Standards annual self-assessment for 2022-23 for the NENC ICB and the process undertaken with provider organisations.

The ICB had undertaken the self-assessment process against the NHSE EPRR core standards. Following completion of this process the ICB then participated in a peer review workshop with other ICB's within the North East and Yorkshire region.

The ICB had assessed itself as partially compliant, however assurance was given that rigorous and robust plans were in place to manage any incidents in line with its category 1 responsibilities. The areas identified as requiring further action were:

- Business continuity management
- Training of staff in line with a training needs analysis to ensure staff were update to date in their response role – to note the Emergency Planning Manager would commence in post in January 2023
- A need to review the risk register to consider mitigating actions on EPPR.

The individual trusts across the ICB had completed the NHSE template and undertaken a peer review with another trust. There had been positive feedback received in this process with all trusts either fully or partially compliant.

A question was raised whether further assurance was needed for the peer review evidence submission and declared compliance levels. It was confirmed all hard copy evidence could be obtained if required and spot checks could be carried out as necessary. It was confirmed there was a good history of compliance submission from the trusts in previous years.

RESOLVED:
The Executive Committee **NOTED** the update and **ENDORSED** the submission to NHSE as part of the NHSE EPPR annual assurance process for 2022/23.

The meeting closed at 13:05

Signed:

Item: 8.2.1

Position: **Chief Executive (Chair)**

Date: **13 December 2022**

Appendix 2

North East and North Cumbria Integrated Care Board

Executive Committee

Minutes of the meeting held on Tuesday 13 December 2022 10.40am at Joseph Swan Suite, Pemberton House, Colima Avenue, Sunderland

Present:	Samantha Allen, Chief Executive (Chair) Nic Bailey, Interim Executive Director of Place Based Delivery (North and North Cumbria) David Chandler, Interim Executive Director of Finance Graham Evans, Executive Chief Digital and Information Officer Dave Gallagher, Executive Director of Place Based Delivery (Tees Valley and Central) Jacqueline Myers, Executive Director of Strategy and System Oversight Neil O'Brien, Executive Medical Director David Purdue, Executive Chief Nurse Claire Riley, Executive Director of Corporate Governance, Communications and Involvement Aejaz Zahid, Executive Director of Innovation
In attendance:	Andrea Brown, Executive Assistant (minutes) Stephen Childs, Managing Director (NECS) Deborah Cornell, Director of Corporate Governance and Involvement Ewan Maule, Director of Medicines and Pharmacy

EC/2022/92 Welcome and introductions

The Chair welcomed the Managing Director of NECS to the meeting and confirmed that agenda Item 12.1 'NECS – Strategic Partnership and Delivery Plan' would be considered as the first main item of business. It was also noted that the meeting would be held in person with one attendee dialling in via MS Teams.

The Committee agreed that the meeting would also be recorded for minuting purposes only.

EC/2022/93 Apologies for Absence

Apologies for absence were received from Annie Laverty, Executive Chief People Officer.

EC/2022/94 Declarations of Interest

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

EC/2022/95 Minutes of the previous meeting held on 15 November 2022

RESOLVED:
The Executive Committee **AGREED** that the minutes from the 15 November 2022 meeting were a true and accurate record.

EC/2022/96 Matters arising from the minutes and action log

Please see separate action log for updates provided.

EC/2022/97 Matters Arising

- Continuing Healthcare Update – Task and Finish Group: The Executive Chief Nurse confirmed that mapping sessions with NECS were ongoing and included discussions on high-cost panels and also care home fees. It was expected that the proposal would be complete by January 2023.

- NHS England Clinical Network Staff Transfer to NENC ICB Update: The Executive Chief Nurse confirmed that progress was slow and there had been some issues receiving information which were being followed up via routes to be able to progress.

  The Interim Executive Director of Finance had allocated a member of the finance team to support the process and would use the Cancer Alliance as the pilot for that piece of work. It was noted that the original transfer included Maternity Clinical Network but

this should remain with NHS England under the Regional Chief Nurse. However, the Regional Chief Nurse was keen that this was also transferred to the ICB so discussions around that were ongoing. Currently, this would not be included in the process.

- Tactical On-Call Cover Proposal – Update on consultation process with staff: The Executive Director of Strategy and System Oversight advised that the consultation process had been concluded and a proposal had been made to move to four tactical rotas from January 2023, giving people two weeks' notice. The rota would be populated through to the end of 2023 and relevant training being implemented to support those on-call.

  Although staff at Band 8d were not required to cover the rota, the contractual changes had been made for resilience in the future. It was noted that there was still some work to do to operationalise the rotas, including discussions with doctors as on-call provision was not included in their contracts either.

  The Executive Medical Director advised that the phase 2a appointments process was nearing completion and, although there had been a couple of appeals during the matching process, which were resolved, all of the available posts would be filled. The appointment of the Director of Allied Health Professionals would commence in January 20223 and would oversee the appointments of the multi-professional leads. Overall the process had gone reasonably well and all contracts would commence on 1 January 2023. The Chair recognised the considerable amount of work undertaken and commended all those involved.

As previously agreed, the Committee considered Agenda Item 12.1 NECS – Strategic Partnership and Delivery Plan as the next item of business.

EC/2022/98 North of England Commissioning Support (NECS) – Strategic Partnership and Delivery Plan

The Executive Director of Strategy and System Oversight introduced the report which provided an update on the developing strategic partnership between the ICB and NECS. Discussions continued with regarding the service level agreement (SLA) arrangements being developed as well as a proposed series of service reviews to be undertaken to define the new service models following the assimilation of various CCG arrangements into the SLA with NECS.

The Committee welcomed the NECS Managing Director, who advised that the relationship between the ICB and NECS was a particularly special one as the NENC region was the base for NECS. It was explained that NECS had not before been in a position to offer as much

as it had done over the last 12 months, reporting a funded resource in excess of £2.3m this year to provide services without charge to the ICB. NECS would endeavour to sustain this as long as the relationship with the ICB could be maintained.

The NECS Managing Director noted that in 2013, NECS was paid £60m but now delivered more services than in 2013 and for £34m funding.

The report set out how the partnership would work in the future to build on the positive relationships already in place.

During discussion, the following points were noted:

- The response from NECS in relation to funding challenges over recent years had been extremely helpful and had worked more in partnership
- NECS would only look to grow their business where there was a desirable demand to do so and a key business move, but would not detract from the high quality of services provided to the ICB
- There was a need to determine how and where those relationships would be developed
- Appendices had not been circulated with the report so these would be issued as they included detail around the SLA Management Group
- A structured approach to the work and services between the organisations to be taken
- A reference made to the reshaping of services and, if there was an element of the services provided by NECS, this was to be highlighted as soon as possible so it could be included in the discussions from the onset
- Thinking around investment and the operating model to be encouraged
- A strategic overview of all services would be key to the success of the partnership
- A detailed forecast of all the service lines to be provided
- A review of the operating model in quarter four to be undertaken improve the next steps; and
- A summary to be provided to staff and for the website regarding the ICB relationship with NECS as it would be beneficial for staff to understand the links. This would also be included in Pulse.

ACTIONS:
The Committee Secretary to circulate of the appendices to the report, omitted from the agenda pack

The Committee Secretary to add a twice- yearly update to the cycle of business to monitor the SLA and the relationship between the ICB and NECS

The Executive Director of Corporate Governance, Communications and Involvement to ensure a summary to be included in the Pulse and on the ICB website to promote the work with NECS and the strengthening strategic partnership.

RESOLVED:
The Committee **APPROVED** the principles for the management of the NECS SLA, as set out in table 1 and, in particular, the two principles highlighted in the main body of the report relating to a resource commitment and NHS England's in-housing process.

The Committee **AGREED** to the formation of a NECS Service Level Agreement Management Group and a schedule of planned service reviews to be developed, including their purpose and potential outcomes.

At 11.12am, the Managing Director of NECS left the meeting and did not return.

EC/2022/99 Notification of urgent items of any other business

Three items of any other business were notified to the Chair for discussion under that agenda item:

1. Hospital discharge (Executive Chief Nurse)
2. Strike action (Executive Director of Strategy and System Oversight); and
3. Winter pressures (Executive Director of Strategy and System Oversight).

EC/2022/100 Integrated Place Based Delivery Report (Central and South)

The Executive Director of Place Based Delivery (Central and South) provided a brief summary of the decisions made at recent local delivery groups with the following key points highlighted:

- The Directors of Place in Tees Valley had established a joint working group with the Tees Directors of Public Health representing the five places within Tees. The group met for the first time in November 2022

and considered a standardised process to support the development of the five individual joint strategic needs assessments across Tees Valley. The next meeting of the group would take place in January 2023.

A query was raised regarding winter funding and how the the numerous requests for winter support in certain areas, e.g., urgent and emergency care, were being managed. It was explained that every area received £4m in allocated winter funds from NHS England. Since COVID-19, this money would sit with providers with three areas of priorities chosen for that money to support.

There were no items requiring approval from the committee as all decisions on the log remained within financial delegation limits.

RESOLVED:
The Executive Committee **NOTED** the content of the report**.**

EC/2022/101 Integrated Place Based Delivery Report (North and North Cumbria)

The Interim Executive Director of Place Based Delivery (North and North Cumbria) advised that there was nothing in particular to highlight from the report on this occasion and there were no items requiring approval from the Committee as all decisions on the log remained within financial delegation limits.

RESOLVED:
The Committee **NOTED** the content of the report.

EC/2022/102 ICB Programme Plan Update

The Executive Director of Strategy and System Oversight introduced the report which provided visibility of the current ICB programme plan and assurance on progress against key deliverables. The interim assurance process from the relevant leads was also included with the proposals and the further actions needed to streamline the process and outputs. Feedback was sought from the Committee on the plan and any further actions.

Monthly updates for each area of the plan were requested from director leads, following which a commentary and RAG (red, amber, green) rating was provided along with any requests for change in scope. The plan reflected the 15 key priority areas and delivery milestones. Key headlines from the plan included:

- Following the inaugural meeting of the Integrated Care Partnership (ICP) in September, the governance and operating model for the four

area ICPs had been agreed, with the standard terms of reference and membership also being concluded. The overarching ICP governance and operating model was to be confirmed at the strategic ICP meeting in December with the first meetings of the area ICPs in their new format early in 2023

- The draft ICP Health and Care Strategy was developed with involvement from a broad range of system stakeholders and the strategy was on track to be signed off by the ICB Board on 16 December 2022
- The Oversight Framework was approved by the ICB Executive Committee and the action was now complete; and
- Nine key actions had been classified as 'amber' (experiencing obstacles), all of which had mitigations in place.

Two change requests were included in section 23 of the plan as follows:

1. Agreement of the four tactical on-call rotas (one for each ICP area) but the completion date to be revised from 1 November 2022 to 3 January 2023 to allow for reasonable notice for the new rotas; and
2. A request to remove the line 'review place-based governance model and implement final arrangements' as this is a duplicate the actions within 'place governance and roadmap' at line 13.

RESOLVED:
The Committee **NOTED** the content of the report and **AGREED** the two change requests as described in section 3 of the report.

EC/2022/103 ICS Operational Team Update

The Executive Director of Strategy and System Oversight introduced the report which outlined the background to the creation of the Operational Team meeting and its function. Reports and updates which were routinely shared at the Operational Team meetings would be incorporated into other governance streams within the ICB. It was proposed, therefore, to stand down this meeting as agreed on 10 November 2022 and associated reports/issues previously discussed would be incorporated into other ICB governance streams.

RESOLVED:
The Committee **NOTED** the contents of the report**.**

EC/2022/104 Developing a Learning and Improvement System - Update

The Executive Director of Innovation introduced the report which provided an update on outcomes from initial NENC-wide engagement and to review the Learning and Improvement System phase 1 budget. Further to the learning event held on 21 September 2022, a follow-up webinar had taken place on 2 November 2022 which enabled a further 150 participants to join the learning and improvement community.

The report also noted that programme staffing had been reviewed with a £56k reduction in associated costs delivered through efficiencies and internal secondments.

The Executive Chief Digital and Information Officer asked if NECS was the only option considered at this stage and if universities or graduates, for example, could also be utilised. The Executive Director of Innovation advised this had not been considered at that point but would be going forward.

The Executive Team was encouraged to attend the workshop planned on 10 January 2023.

RESOLVED:
The Committee **NOTED** the progress being made to deliver the strategic aim of establishing a learning and improvement community.

EC/2022/105 Operational Resilience Update

The Executive Director of Strategy and System Oversight introduced the report which provided a monthly update on the progress made against the Board Assurance Framework (BAF) and a benchmark against the 'Going Further for Winter' letter published on 18 October 2022.

A discussion took place around the BAF and the need to ensure that it was aligned to the NHS England BAF and the ICB's organisational BAF. Some risks around capacity and recruitment were noted and a suggestion made to consider some 'return to practise' recruitment communications.

The Chair asked how the six national and three local metrics were being measured across the system and suggested that more work would be required before full assurance could be reached. It was explained that there was not a business intelligence (BI) function across the ICB which made it difficult to analyse the amount of data available. It was agreed that the Executive Chief Digital and Information Officer would contact NECS to discuss what would be needed to provide a live document of how the system was performing. Prior to the discussion with NECS, it would be beneficial to discuss as a team what exactly would be needed.

ACTION:

The Executive Director of Strategy and System Oversight would urgently arrange a call to discuss the BI resource available and the detailed analysis of the data required to provide further assurance.

RESOLVED:
The Committee **NOTED** the content of the report.

It was agreed to consider item 15.1 Any Other Business (Hospital Discharge £500m) as the next item of business.

EC/2022/106 Any Other Business (Hospital Discharge £500m)

The Executive Chief Nurse referred to an email circulated to the Committee prior to the meeting which detailed the proposed approach to splitting the discharge funding. A number of conversations had taken place with the relevant directors of adult social services about how to do this. It was confirmed that this had been done using the same formula as the local authorities.

A number of schemes had been used to base this on, for example within workforce, with a requirement to have a discharge to assess process in place. This required sign off by 16 December 2022 with reporting to commence, with set metrics, from 30 December 2022. This would be added to the nine-winter metrics.

The template for social care had not yet been released but would need to be completed to report how many new packages were being delivered each week.

The Interim Executive Director of Finance explained that the funding was likely to form part of the Better Care Funds (BCFs) which would be responsible for the financial governance that would be received as part of a Section 75 agreement.

Place directors had been asked to provide the details for their own areas. The Chair suggested that the Executive Chief Nurse establish a taskforce to oversee all of this as soon as possible and asked that the Executive Director of Innovation be linked in to ensure the learning and improvement network was also up to speed on this.

ACTION:
The Executive Chief Nurse to establish a taskforce to oversee this process.

RESOLVED:
The Committee **RECEIVED** the update for assurance.

EC/2022/107 Finance Update

The Interim Executive Director of Finance introduced the report which provided an update on the financial performance of the NENC ICB and NENC ICS in the financial year 2022/23 for the period to 31 October 2022.

The ICB was currently reporting a forecast outturn deficit of £5.5m, prior to expected receipt of additional funding from NHS England of £11.2m to cover costs associated with the primary care Additional Roles Reimbursement Scheme (ARRS). Once this funding had been received, the ICB would report a forecast surplus of £5.7m against a planned surplus of £2.6m. The additional £3.0m surplus would offset a forecast deficit across relevant NHS providers, resulting in a balanced financial position across the ICS.

A question was raised in relation to running costs and if vacancy control and if the implications of the phase 2a consultation would deliver some efficiencies. It was reported that some ICBs were undergoing external recruitment but that this would likely be met with some challenge so it was recommended that internal secondments were undertaken in the interim until running costs could be confirmed following the implementation of all structures across the ICB.

It was noted that employment processes were taking between two to three months which could cause additional gaps and risks when staff left or retired. The NECS contract would also need to be considered as part of this as a number of NECS staff work within the ICB which ultimately impacted on the running costs for the ICB.

The Chair asked that the risk be noted and further work undertaken as priority to work out how this could be mitigated. The Interim Executive Director of Finance reported this work had started, with executive directors meeting with finance colleagues to discuss vacancies.

The SLA with NECS could also provide a number of opportunities so would need to link this in with the operating model. In the short term, all executive directors were to work through all vacancies in their teams and establish which roles were essential and link this into the operating model discussion.

ACTION:
Executive Directors to provide details of the functions within their directorates and all vacancies to the Executive Director of Strategy and System Oversight. A session would be arranged once the information had been received to consider the overall picture.

RESOLVED:
The Committee **RECEIVED** the report for assurance and **NOTED** the latest year to date and forecast financial position for 2022/23, with a number of financial risks to be managed across the system.

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EC/2022/108 Integrated Delivery Report

The Executive Director of Strategy and System Oversight noted the report which provided an ICS overview of quality and performance and advised that there were no further updates to the report as presented.

The integrated delivery report was structured around the 2022/23 planning priorities and linked to the NHS Oversight Framework (NHS OF) which applied to all ICSs, NHS trusts and foundation trusts. The purpose was to provide oversight of delivery of the NHS Long Term Plan commitments, the NHS People Plan and operational planning priorities. The report provided the NENC position in relation to the 2022/23 planning priorities and the themes set out in the 2022/23 NHS OF.

RESOLVED:
The Committee **RECEIVED** the report for assurance.

EC/2022/109 Commissioning

There were no items for consideration on this occasion.

EC/2022/110 Risk Management Report

The Executive Director of Corporate Governance, Communications and Involvement introduced the report which provided an updated position on the risks facing the organisations for the period 8 November to 28 November 2022.

Three new risks had been identified within the reporting period and were detailed within the report. The Governance Team were currently working to clarify the details around these risks.

RESOLVED:
The Committee **RECEIVED** the risk register for assurance.

EC/2022/111 Governance of the NENC Medicines Committee

The Chair welcomed the Director of Medicines and Policy to present eh report which sought approval for the establishment of an NENC Medicines Committee and ratification of its recommendations to-date.

The proposed Medicines Committee met in both September and October 2022 but had not yet been formally established and had no delegated authority to make decisions. Therefore, the Committee was asked to consider approval of the following:

- Terms of reference of the Medicines Committee and Sub-Committee, with the level of delegated authority detailed in the report
- The decisions recommended at the September and October 2022 meetings as detailed in the report
- Open publication of the draft minutes from the September and October 2022 meetings on the website; and
- To accept the views of the Medicines Committee regarding the ICB executive proposal on NENC compliance with NICE technology appraisals as detailed in the report.

The proposed Medicines Committee also requested £1.6m as a delegation limit to prevent all decisions being presented to this Committee. The Director of Corporate Governance and Involvement highlighted that the establishment of the proposed Medicines Committee (which would be a subcommittee of this Committee and not a Board Committee) was reserved to the Board and its establishment and any level of delegation would have to be approved by the Board. The Executive Committee (as the parent Committee) would need to make a recommendation to the Board to establish this as a subcommittee.

Although the Committee agreed in principle with the proposals, it was disappointing to note that the Governance Team had not been asked to consider the proposals or asked for guidance on the appropriate process for this type of request. It was agreed that the Director of Corporate Governance and Involvement would be asked to reposition the proposal.

It was also clarified that if urgent decisions were needed relating to medicines optimisation, this could be done via email and in line with agreed levels of delegation, and ratified formally at the next meeting of this Committee to avoid any potential delays in patient care.

At 12.26pm, Neil O'Brien left the meeting.

The quoracy of the proposed Medicines Committee needed a further review which would be supported by the Governance Team.

At 12.28pm Neil O'Brien re-entered the meeting.

ACTION:
The Director of Medicines and Policy and Director of Corporate Governance and Involvement to review the governance process needed to establish a medicines optimisation subcommittee and report back to the Committee at its meeting in January 2023.

RESOLVED:
The Committee **CONSIDERED** the establishment of a medicines optimisation subcommittee for formal approval by the Board following the

outcome of the governance review; and **AGREED** to receive a further update on this following the governance review at its meeting in January 2023.

EC/2022/112 Health and Safety Policies

The Executive Director of Corporate Governance, Communications and Involvement introduced the report which presented a number of policies for approval following a request by the Board to review all policies again within the first six months of the ICB's establishment. A forward plan of had been developed and the reviewed policies would be presented using a staggered approach throughout the financial year.

The following health and safety policies had been reviewed by the subject experts, with any amendments outlined within the report:

- Driving at Work Policy
- Fire Safety Policy
- Health and Safety, Fire and Security Strategy
- Health and Safety Policy
- Moving and Handling Policy
- Physical Security Policy
- Provision and Use of Work Equipment; and
- Violence and Aggression Abuse Policy.

RESOLVED:
The Committee **APPROVED** the review and updated of the suite of health and safety policies.

EC/2022/113 Individual Funding Request Policy, Panel Terms of Reference and Standard Operating Procedure

The Executive Medical Director introduced the report which provided an updated policy and key documentation to support the individual funding Request (IFR) process.

Some discussion took place around the policy amendment for IVF for couples with children from previous relationships. It was noted that a letter had been received from North Tyneside Council and a Member of Parliament about this issue.

RESOLVED:
The Committee **APPROVED** the Individual Funding Request Policy (Appendix 1 to the report); **APPROVED** the Individual Funding Request Panel terms of reference (Appendix 2 to the report); and **APPROVED** the Individual Funding Request Standing Operating Procedure (Appendix 3 to the report).

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EC/2022/114 Items of Any Other Business

There were three items of additional business:

- Winter Pressures – previously discussed under minute number EC/2022/105
- Hospital Discharge – previously discussed under minute number EC/2022/106; and
- Strike Action – minute detailed below

Strike Action update

The Executive Chief Nurse provided an update in relation to the planned strike action. A meeting had taken place with the Regional Chief Nurse around consistency in relation to derogation and the different approaches being taken across the country. There was concern around emergency and paediatric departments.

Although services were usually quieter on Christmas Day, there was still major concern about service provision. The seven provider trusts impacted by the strike action would be joining an emergency call at 5.00pm that day with colleagues across the region to consider how to get some consistency in terms of approach.

It was reported that Newcastle Upon Tyne Hospitals NHS Foundation Trust would have two picket lines, one at the main entrance to the RVI. There would also be a picket line at the Freeman Hospital, Northumbria Specialist Emergency Care Hospital in Cramlington, North Tyneside General Hospital and the Queen Elizabeth Hospital Gateshead.

There should only be six people on each picket line but it was noted that the Royal College of Nursing was encouraging more to join.

A detailed discussion took place to ensure all teams had the relevant input to the system throughout this process. It was agreed for a call to take place on Friday 16 December 2022 at 8.30am to discuss any issues.

ACTION:
The Executive Chief Nurse to stand up a call at 8.30am on Friday 16 December 2022 to discuss any issues highlighted as a result of the strike action

RESOLVED:
The Committee **RECEIVED** the update for assurance.

The meeting closed at 12:45

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Signed:

Position: **Chief Executive (Chair)**

Date: **10 January 2023**

Item: 8.2.2

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

NORTH EAST & NORTH CUMBRIA ICB BOARD MEETING

31 January 2023

Report Title:	Highlight report from the Quality and Safety Committee held on the 15 December 2022

Purpose of report

To provide the Board with an overview of the discussions at the meeting of the Quality and Safety Committee held in December 2022.

Key points

The Committee considered a number of issues and supporting papers including:

- Patient story process
- Terms of reference and cycle of business
- Involvement and engagement updates
- Clinical quality exception report
- Complaints quarterly report
- Establishment of a Medicines Safety Committee
- Developing the ICB Safeguarding Strategy
- NENC Valproate programme

Risks and issues

Members suggested that risk reporting be provided at each meeting (previously it was suggested a quarterly report).

The Committee will continue to receive and review the corporate risks aligned to the quality and safety portfolio to provide assurance to the Board that the quality and safety risks contained within the corporate risk register reflect the current environment.

Assurances

- The clinical quality exception report and other supporting reports provide the Committee with a range of data and assurance sources.

Recommendation/action required

The Board are asked to note the Quality and Safety Committee highlight report for December 2022.

Acronyms and abbreviations explained	
N/A	
Sponsor/approving director	Eileen Kaner, Chair of the Quality and Safety Committee and Non-Exec Director
Report author	Neil Hawkins, Head of Corporate Affairs

Link to ICB corporate aims (please tick all that apply)	
CA1: Improve outcomes in population health and healthcare	X
CA2: tackle inequalities in outcomes, experience and access	X
CA3: Enhance productivity and value for money	X
CA4: Help the NHS support broader social and economic development	X

Relevant legal/statutory issues						
Health and Care Act 2022						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	**X**	**N/A**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	**X**
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**	**X**

Key implications	
Are additional resources required?	None at this stage – membership and terms of reference of the Committee are under review.
Has there been/does there need to be appropriate clinical involvement?	Appropriate clinical representation within the membership of the Committee. Terms of reference to include representation from Nursing Directors and Medical Directors.

Has there been/does there need to be any patient and public involvement?	N/A
Has there been/does there need to be partner and/or other stakeholder engagement?	N/A

Quality and Safety Committee highlight report – December 2022

Summary report

The Quality and Safety Committee, Chaired by Eileen Kaner, met on the 15 December 2022 and considered a number of issues and supporting papers including:

Terms of reference and cycle of business – the Committee considered the current terms of reference and agreed that further discussions and work would be required to refine the membership of the Committee. Discussions included representation from the Medical Directors at Place. Medical Directors will be reinstated onto the Committee to mirror representation of Nursing Directors to ensure appropriate geographical coverage and local knowledge of current issues. Consideration is being given to including social care representation within the Committee membership, and public/lay representation. The terms of reference will remain on the agenda and any suggested amendments will be brought to the Board for approval. Additions to the cycle of business concerning patient stories, safeguarding and bi-monthly risk reporting were recommended and noted.

Patient story process - the Committee were provided with an update on the patient story process which had been embedded into the Engagement Strategy. Further work was required with a communications campaign under development which would include animation, supporting materials and social media. In summing up, it was noted that the principle was important, sometimes complex and care will be needed to ensure the process was not used as a platform for grievances but to record and learn from lived experience.

Delivering our people and involving communities strategy (and involvement and engagement update) – the Committee received an update on the strategy and work to progress the ICB's involvement and engagement work. Discussions noted the importance of using multiple methods and approaches, to reach out to less heard groups, to children and young people, and the use of citizens panels. The report was received for information and assurance.

Integrated Quality and Performance Report – the Committee received a report concerning key quality and performance indicators, including data never concerning events, serious incidents and infection rates. Risks and assurances around independent providers, workforce pressures (sickness at some trusts above the national average with high turnover rates), 104 week wait for spinal surgery, ambulance response times, cancer 62 week waits were all provided within the report. In addition, 14 never events were reported within the reporting period for investigation.

Complaints – Quarter 2 report - the report provided assurance that the ICB had fulfilled its statutory responsibilities regarding complaints management, including an overview of the issues raised in complaints/concerns during the quarter along with learning for the ICB following complaint investigations. The KPIs for acknowledging and responding to complaints had all been met. The ICB will soon take on responsibility for other primary care services from NHS England (ophthalmology, dentistry and pharmacy), so it is envisaged numbers of complaints may rise in future in line with this additional scope (not as a result of a lessening of quality).

Establishment of a Medicines Safety Committee – the Committee received a report recommending that the ICB establish a Medicines Safety Committee. The Committee approved the recommendation of the formation of a Medicines Safety Committee - to be considered by the ICB Board. The sub-committee is proposed to sit jointly under the Quality and Safety Committee and Medicines Committees. Terms of reference will be developed before considering further.

Developing the ICB Safeguarding Strategy – An overview into the steps of this important piece of work were given noting that the ICB needed to be held to account to deliver against its statutory functions including prevention and strategic workforce planning. The terms of reference for a new Health and Safeguarding Executive Group had been developed which would be established as a formal sub-committee of the Quality and Safety Committee. The Board approval process would be discussed once the terms of reference were completed. It was noted that safeguarding partnership arrangements would continue at place. The focus of a new executive group was to assure safeguarding partners as well as the ICB Board and NHS England that the appropriate safeguarding arrangements were in place.

Sodium Valproate – the Committee also received a presentation concerning the use of Sodium Valproate in people of childbearing potential across North East & North Cumbria. Assurance was given that the numbers were being reviewed and compliance with the care package was being monitored and reviewed. Across NENC there were 1583 people of child bearing potential that were prescribed valproate at present and could be at some type of risk. Half of these had been biologically excluded. Of the coding in the GP practices only 12% across NENC had been coded as having this care package in place. The Committee sought assurance around data recording given the low coding rates and this will be further explored as part of the work moving forward.

Item: 8.2.2

North East and North Cumbria Integrated Care Board

Quality and Safety Committee meeting held on 20 October 2022 from 10.00-11.30am via MS Teams.

Minutes

Present: Professor Eileen Kaner, Independent Non-Executive Member (Chair)

Hannah Bows, Independent Non-Executive Member (Vice Chair)

Siobhan Brown, Director of Transformation, Systemwide for Jacqueline Myers

Ken Bremner, Foundation Trust Partner Member

Professor Sir Liam Donaldson, ICB Chairman

Ann Fox, Director of Nursing

Maureen Grieveson, Director of Nursing

Dr Saira Malik, Primary Medical Services Partner Member

Ewan Maule, Director of Medicines

Rajesh Nadkarni, Foundation Trust Partner Member

Dr Neil O'Brien, Executive Medical Director

David Purdue, Executive Chief Nurse

Dr Mike Smith, Primary Medical Services Partner Member

David Thompson,

In Attendance:

Kirstie Atkinson, Clinical Quality Manager/Interim Head of Quality & Patient Safety (Newcastle/Gateshead)

Neil Hawkins, Head of Governance Newcastle/Gateshead Place

Tony Roberts, Director of NEQOS

South Tees Hospitals NHS Foundation Trust

Jan Thwaites (minutes)

QSC/2022/10/01 Welcome and Introductions

Introductions were given, it was explained that Hannah Bows, Independent Non-Executive Member would be the Vice Chair of the meeting going forward.

It was noted that the ICB was in a year of transition and the membership may change over time, representation from social care needed to be included and any changes to be recommended to the ICB Board.

The meeting today did not require any decision making but there was a lot of information to be processed which was important for the ICB and also the local population. The members were requested to be really mindful of safety and 'do no harm' and think about quality. To ensure the committee had the time and space to ensure public was at its at heart and to drive quality forward.

QSC/2022/10/02 Apologies for absence

Apologies were given by Jeanette Scott, Director of Nursing, Annie Laverty, Executive Chief People Officer, Louise Mason-Lodge, Director of Nursing, Jacqueline Myers, Executive Director of Strategy and System Oversight and Tom Hall, Local Authority Partner Member (Designate)

QSC/2022/10/03 Declarations of Interest

The following interests were declared.

Dr Rajesh Nadkarni, Foundation Trust Partner Member noted that he sat on the GMC advisory panel which looked at Doctors health issues.

Mr Purdue noted that he worked for the CQC as an Executive Assessor and also worked as a health inspector of Wales.

RESOLVED: The interests were accepted.

QSC/2022/10/04 Opening Address

Sir Liam explained that constitutionally he could not attend every meeting but would be happy to hold a seminar at some point to update on both national and international quality issues.

In relation to context the committee needed to decide their positioning on and how strategic they wanted to be.

The position on risk need to be considered to ensure that the correct decisions on risk were made. To also bear in mind that ultimately one day the question could be asked who knew what and when and what was done about it.

Were the committee responsible for the quality in all organisations or just responsible for the quality programme led at a systemic level. If required Sir Liam could assist in a discussion with Trusts over what was or was not the leading edge in relation to quality. It was noted that the Foundation Trusts had been used to working in an autonomous way in the past which included inconsistent reporting of serious incidents, with CCGs not being in the position to have the proper oversight of this area of quality and safety.

Sir Liam gave suggestions on programme areas such as the ICB needed to launch major programmes in quality and safety and had offered to help with a patient safety programme.

There was already an established learning and improvement community programme led by Annie Laverty. The first meeting had been held which needed to continue. The challenge was if the approach would be to skill people in quality improvement and empower them to do place based projects which they considered to be important and priorities or direct and co-ordinate some regional action or a mixture of the two. A special programme on patients and carers was suggested as this was a major part of the quality agenda in all healthcare systems. Working more closely with patients and families was essential.

It was important to work out what the quality and safety synergies would be with other programmes - for instance work on a clinical strategy between the FT and the ICB and how quality would be embedded in that. Do cardiology departments operate to a best practice standard? Or was this not the remit for the ICB, was it just to ensure that the Trusts had good quality programmes.

Questions were put as to workforce - was it up to the ICB to educate and upskill people with the tools for quality assurance and improvement. Did the ICB have any legitimacy in the role of social care of was this for the local authority only?

Assessment, metrics and data were not as strong as they should be in the NHS – were they being measured correctly? Did we need to join any international benchmarking schemes to enable comparisons in performance?

In regard to patient experience data, how much do the ICB use these patient reported outcome measures to look at qualitative survey data and what would he FTs say if gathering these data on their organisations.

In regard to culture were there ways to have surveillance to spot in advance and issues for example the recent reporting from CQC.

The Chair thanked Sir Liam for his opening address and noted that his comments set out a wide canvas following on from this transition phase. The agenda would

reflect lived perspectives and the membership would look to include both young and older public representatives and also representatives from voluntary organisations. To also put patients at the heart of all that the ICB undertook.

QSC/2022/10/05 Terms of Reference Review

The terms of reference for the committee were discussed.

It was explained that at a recent Audit Committee meeting it had been suggested that the Chair of the Quality and Safety Committee would be invited to be the Vice Chair of that meeting. It was noted that due to this committees Terms of Reference this was not possible.

The membership currently lacked representation of social care; this issue would be taken back to the ICB board for a recommendation to be included for future meetings.

In relation to page 6 reference to patient group directions being reviewed to ensure appropriate governance was in place. This also fell under the remit of the ICB Medicines Committee which it was felt to be a more appropriate place for them to be reviewed. Any future issues would be highlighted in the medicines overview report.

Action: It was agreed to remove the patient group directions section from this committee's terms of reference.

It was suggested that all 4 area Directors of Nursing should be in attendance and for clarity to ensure titles are aligned and representative of each area. Also to make it explicit around having patient safety partners from provider organisations.

Action: To invite all Directors of Nursing to the meetings.

It was explained that the System Quality Group (SQG) had been the NHS England (NHSE) and CCG approach to quality and had been previously called the Quality Surveillance Group which will be co-chaired by Mr Purdue and Jane Robinson.

Any issues from the SQG would be reported to the Regional Quality Group to ensure no duplication.

Action: An organogram to be produced to distinguish the quality structure.

A comment was made that the terms of reference could not be confirmed until there was a clear idea of what the focus of the committee was. There was a need to revisit them earlier than the noted yearly review. The Foundation Trusts would be looking for a degree of transparency on who was doing what which had not at this point been confirmed. It was suggested that the committee give a view on what was expected of it i.e. effective robust processes and take learning from other areas and use collectively then test this with the ICB board after being discussed by Sir Liam and Mr Purdue.

Action: The Chair to formulate a response for her report to the ICB board for discussion on the terms of reference and the confirmation on what was expected from the Foundation Trusts.

Action: To ensure space at next meeting to discuss the terms of reference.

There were some important areas to look at with challenge but need the guidance of some terms of reference going forward.

It was noted that the NHSE Operating Framework clarified some of the areas that ICBs and NHSE were responsible for. A group to be arranged to look at the terms of reference.

Action: A group to be arranged to look at the terms of reference – this should include Mr Bremner, a representative from mental health, primary care, social care, the Chair and the Head of Governance.

RESOLVED: The terms of reference were received.

QSC/2022/10/06 Cycle of business

The cycle of business for the committee was discussed.

This had been drafted at a point in time and was a work in progress. It had been built on previous activity from the CCGs as a starting point but did not touch on areas such as strategic views, forward looking and deep dive elements.

There were regular items such as the clinical quality exception reports and annual reports for complaints, safeguarding, LeDeR and serious incidents along with items for assurance.

It was noted that the draft document was helpful but there was a need to be proactive and not reactive, to monitor items on a more regular basis and change or prevent where remit allows. To continue to add into the cycle of business on a regular basis and to include a social care element.

The following to be included:

- Patient experience to be added to each meeting for instance a patient story (both positive and negative)
- A regular complaints report

It was agreed to make amendments to the cycle of business and pick up regular themes. An edited version to be brought to the meeting in December. It was important to think about not only health but wider care.

Action: An edited version of the cycle of business to the December meeting.

RESOLVED: The cycle of business was received.

QSC/2022/10/07 Overview of Agenda

Item: 8.2.2

Key issues and clinical quality exceptions were highlighted in this presentation, these included the following areas:

Healthcare Acquired Infections (HCAI)

MRSA 4 cases since April with 3 hospital-onset and 1 community-onset

C.difficile 278 cases across the region since April 2022 with 4 Foundations Trusts (FTs) exceeding their year to date thresholds.

The biggest issues were C.difficile and MRSA.

Infection Prevention and Control (IPC) had increased due to Covid19, all providers had signed up to a set of principles in terms of the management of Covid IPC. These were being reviewed regionally although this may differ at place. One of the main issues at the moment with Covid was the lack of testing which made it difficult for the provider organisations to manage this.

The community and care home IPC provision would be reviewed and support would be provided.

In terms of C.difficile rates South Tees had been the biggest outlier, throughout the pandemic a lot of organisations had cancelled their deep clean programmes. South Tees had recommenced their deep clean programme in each patient area.

An antimicrobial system wide approach had been taken, this was being managed.

In regard to never events 14 had been reported year to date with South Tees being an outlier. There were opportunities to share practice across the system by looking at local procedures.

In terms of serious incident reporting it was explained that high reporting was a positive as it showed that organisations were willing to share information.

It was noted that Newcastle Hospitals had a high number of pressure ulcer incidents for which they had reported each and everyone. There was a need for all organisations to increase their reporting of incidents.

In relation to falls there had been a dramatic increase during the pandemic due in part to a lack of staffing and lack of visiting. The highest reporter of falls had been Gateshead FT due in part to the setup of the wards having all individual rooms which made observations of patients more difficult.

In terms of self-harm the highest reporters were Tees, Esk and Wear Valley (TEWV) and Cumbria, Northumberland, Tyne and Wear FT (CNTW). A lot of support work was being put into TEWV.

In regard to maternity a lot of focussed work would be undertaken in this area.

The 60-day timeframe was no longer a requirement under the NHSE SI Framework/PSIRF. The timeframe was suspended during COVID and has since been permanently removed. Trusts provided regular updates on their open cases and reasons for delays via Quality Review Group & NENC ICB SI panels.

A piece of work had been undertaken to look at the overdue incidents.

In terms of quality PSIRF and what that means would be in place by September 2023.

Four sub ICP quality groups had been set up to look at the sharing and learning from incidents and never events. There was social care representation at these meetings looking at thematic reviews and how the system was being affected.

One of the key pieces of work to focus on would be harm reviews across the system to understand the areas of most risk. These included the following:

- Waiting for an emergency response
- Waiting in an ambulance
- Overcrowding in ED
- Waiting for discharge
- Being discharged to the wrong place

It was explained that anyone waiting over 3 days for discharge should be classed as a serious incident.

A joint outcomes framework with the Local Authority would be agreed.

In terms of workforce risk issues there had been 1 care home that would be changing over from nursing to residential as cannot engage any staff. The 21 residents were having to be found alternative provision. The Directors of Nursing were asked to look at quality in care homes and assessments of quality but need to look at staffing provision also. Once this piece of work had been undertaken the resulting report would be brought to this committee.

In regard to the North East Ambulance Service (NEAS) independent enquiry, a chair had been appointed and staff interviews were underway. The timescale for completion was the end of this year. Support continued to be offered to NEAS from the QRG/ ICB system.

Good progress had been made against the 7 Ockenden essential actions with 3 organisations being rated green and the other areas were around informed consent and around how we get patient views of services. There was a strong maternity voices partnership across the ICB.

Following a CQC inspection North Tees had been invited to join the national maternity support programme and STSFT had been invited to join the national workforce programme.

The East Kent report had been published with 4 key areas highlighted – these included poor performance units to be identified, giving care with compassion and kindness, team working with a common purpose and responding to challenge.

A review had been undertaken of the Local Maternity Neonatal Services (LMNS) and how this worked.

The number of falls were increasing this was down to deconditioning where patients lost confidence after lockdown in homes and in hospitals. There were excellent programmes looking at this. It was noted that those falls which were serious incidents were falls that resulted in harm.

In relation to care homes some were not wishing to continue with care home nursing beds due to the difficulties in workforce recruitment. Focus was on the Covid capacity tracker which looked at the number of beds across the system, the information not shown was the staffed beds. A question was raised on this gap in the system and what could be done to refine this tracker. In response it was noted that the Local Authorities had a better system where they had daily calls to care homes to collate staff levels, how many staffed beds there were.

The Chair noted that if the Local Authority were doing something well should they be invited to this meeting.

Action: Mr Purdue to have a conversation with NECS as they support the tracker information.

One of main aims as an ICB was to reduce inequalities in outcomes access and experience and improve outcomes - this lens needed to run through our quality and safety reporting too.

In regard to SI reporting primary care had their own central reporting system and only report on the central reporting system when there was a cross system issue. There may be a need for a piece of work in primary care to make more robust. In response it was noted that PSIRF would be looked at to introduce across the whole system.

In relation to infection control and respiratory infections and how they could overwhelm the primary care system – was this to be monitored as would be a massive issue particularly the impact on workforce. In response this could be monitored from a ICB perspective and coded to look at infection rates.

A comment was made to be clear on the data presented to this committee with the need to understand the implications and the need for data to be more robust and consistent. There was a need to share where there were exceptions.

<u>Patent Safety Incident Responses Framework (PSIRF)</u>

PSIRF had been published in August 2022 to replace the Serious Incident Framework and was a major component of patient safety strategy. This was a mandatory and contractual requirement under the NHS Standard Contract for all organisations.

The framework focussed on the learning from patient safety incidents not on compliance. This was not mandatory for primary care but may be of real interest. There was a 12 month implementation plan which commenced in August.

The implementation plan was highlighted noting that the 1st 3 months looked at the system and associated requirements and documentation. Organisations were required to complete a patient safety profile

There were 4 components of the framework:

- compassionate engagement and involvement
- application of a range of system based approaches
- considered and proportionate responses
- supportive oversight focussed on strengthening response system

There were a lot of supporting documentation with the output of a patient safety incident policy and plan.

There was a system based approach to learning with the framework based on System Engineering Initiative for Patient Safety (SEIPS) methodology.

It was important to move away from a blame culture and look more to system thinking with the learning not focussing on root cause analysis.

The ICB should appoint a lead to collaborate with providers, oversee and support the effectiveness and support the co-ordination of cross-system learning responses. It was important to look at who was asking for assurance from provider organisations as it was not the wish for them to be inundated for assurance, this needed to be a system approach.

It was confirmed that the ICB lead would be Maureen Grieveson.

It was explained that Maureen would make contact with the Directors of Nursing in provider organisations. It was hoped that in working in this way the question would only be asked once and then cascaded through regional and NHSE contacts – to bring national speakers to learning events to share learning across the patch.

A comment was made on the fundamental shift re reporting and learning – there was a need to know if there was a particular organisation which may not meet the timescale of transition and what could be done to support them. It was noted that preventative work would come from learning across the system rather than individuals.

A question was raised as to what extent under this agenda the committee relied on the views for assurance of external bodies for example the CQC. Would this be used as one of main areas of assurance and don't replicate. There may be an opportunity to focus on systems rather than organisations to align them and use their work rather than replication. It was confirmed that the CQC were moving to system inspection and not individual organisations.

RESOLVED: The overview was received.

QSC/2022/10/08 Risk Register

The purpose of the report was to provide the Quality and Safety Committee with some suggested risks facing the ICB which aligned to the quality and safety portfolio.

The main risks had been assessed, there was a need to add on workforce as the biggest issue across the system for patient safety and to also encompass social care.

A process was being worked through to amalgamate legacy risks and to capture the new organisations risks, looking at different tiers of risk not just at a corporate level and ensure assurance was in place.

New risks had been included which would be presented at the next meeting which included maternity workforce pressures and the funding element of maternity services.

In regard to risk 0006 access to mental health following on from the learning and improvement event where it was acknowledged that children's mental health response was the biggest priority – should this be separated out from adult services. Some were issues rather than risks and how the ICB should articulate and show this.

The residual risk around ambulance delays should be more clearly defined and were too low – the risk had not been mitigate down, think of how to illustrate this.

Action: The children and adults risks should be separated out and the residual risk to be altered also to include the residual risk in relation to ambulance delays. Maternity workforce should be a standalone item on the risk register.

In relation to the risk 0011 prescribing, the committee should concentrate this on the quality aspect and the financial aspect should be reviewed elsewhere.

RESOLVED: The Risk Register was received.

QSC/2022/10/09 Clinical Quality Exception Report

The report provided an overview on a range of quality measures relating to providers across the North East and North Cumbria Integrated Care System (NENC ICS) and assurance that actions were taken, where appropriate.

RESOLVED: The Clinical Quality Exception Report was received.

QSC/2022/10/10 National Cancer Patient Experience Survey 2021

The report provided an overview of the key findings from the National Cancer Patient Experience Survey (2021) for NENC ICS and Acute Trust Providers which had been published in July 2022. The report had been presented to the ICB and the acute trusts across the region. The response rate for the ICB for 6 of the trusts were either at or above the national response rate.

The report showed the scoring for the ICS for each of the trusts, overall the ICS had 50 questions where they were a positive outlier.

Question 59 showed the overall position where patients had a positive experience.

The areas which had less positive comments where on diagnoses not explained to patients, positive long term effects not being explained, family not fully informed on care needs at home – these were not negative responses but collectively information to patients was not as robust as it should be. What was being done about this.

It was explained that each survey had been discussed in detail at quality improvement group meetings and any actions taken forward.

It was agreed that these were important areas, assurance was given that the trusts do give detailed responses to the surveys and were picked up in the Quality Review Groups at a local level where they were looked at in detail but it was also agreed that these issues should be brought back to this committee.

RESOLVED: The National Cancer Patient Experience Survey 2021 was received

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QSC/2022/10/11 GP Patient Survey 2021

The report provided an overview of the headline findings and results from the National GP Patient Experience Survey (2022) for NENC ICS.

The survey had been conducted between January and April this year after a rise in Covid cases which may have impacted on patients overall experience. The response rate for the ICB was 34% which was above the national average of 29.1%.

The results were available at an individual GP practice level and also an ICS level. The report covered the key headlines from the ICS report.

RESOLVED: The GP Patient Survey 2021 was received.

QSC/2022/10/12 Quality and Safety of inpatient services

A letter had been received from Claire Murdoch, National Director, Mental Health in regard to the quality and safety of mental health, learning disability and autism in patient services.

The letter came out following the BBC Panorama programmes. The Executive Chief Nurse had written to both Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) and Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) to gain assurance and received good assurance in return. All individual private providers had also been asked to provide assurance. The NHSE Nurse for Direct Commissioning had been asked for a report that could be shared with the team and providers. The work was ongoing around closed cultures.

RESOLVED: The Quality and Safety of inpatient services was received.

QSC/2022/10/13 NEQOS Regional Mortality

The report provided surveillance of hospital mortality using mortality metrics (like the Summary Hospital-level Mortality Indicator), the use of mortality case note reviews, currently within hospitals but with the aim of extending along care pathways and the scrutiny provided by Medical Examiner Services.

There were 3 types of assurance around mortality

- statistical approaches
- case note review of deaths
- medical examiners or referral to coroners

On the statistical side there was an issue in that the way that SHMI was calculated was likely to change to exclude hospices which would change the outlier status. The system had not been designed to work through a pandemic therefore the assurance was less than normal.

In regard to case note reviews all hospitals undertook this but would like to do this along the pathway of care. There was a role for the ICB to assist with this process.

In relation to Medical Examiners development of these services was going ahead and there was a need to report how foundation trusts were getting on delivering this service.

Mortality was discussed at the System Quality Group (SQG), the Regional Mortality Oversight Group and at this committee. Guidance was requested on what and where the committee thought this information should be presented. It was confirmed that the wider strategic elements and oversight should be presented to this meeting especially around the medical examiner but the data should also be shared at the SQG.

Action: To hold a discussion around what reporting was to be presented at both this meeting and the SQG.

RESOLVED: The NEQOS Regional Mortality report was received.

QSC/2022/10/14 Medicines Overview

The report informed the committee of the current priorities relating to medicines, the emerging governance structures and proposals for strong links between the medicines and quality and safety agendas.

There was a significant overlap between Quality and Safety and Medicines, the paper proposed methods by which close links remained between the two committees. This was a starting point and would evolve.

Action: It was proposed that the minutes from the Medicines Safety Committee and an annual report be brought to this committee.

A question was raised in relation to the place based delivery groups - does that include any reporting into area ICP quality groups. It was confirmed that the place based delivery groups were primarily about delivering against prescribing objectives and would feed into existing place based quality routes.

Concerns had been raised in general practice around the supply of medicines, and the risk of patients not receiving their medication.

The risk on the risk register it was noted was too vague and needed to reflect these issues. A summary was being prepared on these issues and would be brought back to a future meeting.

The committee discussed the content of the interim report and provide guidance on how links between the medicines committee and quality and safety may be established

RESOLVED: Medicines Overview report was received.

QSC/2022/10/15 Any other business

Public representation for this committee would be discussed on the agenda for the December meeting.

To embed the meetings in patient experience

A question was raised in relation to the terms of reference that the meeting would meet in private – could the reports be shared outside of the meeting.

Action: The Executive Chief Nurse would look at the constitution of the ICB and report back to the meeting.

QSC/2022/10/16 Date and time of next meeting

Thursday 15 December 2022, 10.00-12.00.

Signed:

Date: 15.12.22

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

NORTH EAST AND NORTH CUMBRIA ICB BOARD MEETING

31 January 2023

Report Title:	**Highlight report and minutes from the Audit Committee meeting held on 12 January 2023 and 13 October 2022, respectively**

Purpose of report

To provide the Board with an overview of the discissions at Audit Committee on 12 January 2023 and approved minutes from Audit Committee on 13 October 2022.

Key points

The key points from the meetings include:

- ICB Risk Management
- Data Security & Protection Toolkit 2022/23
- Annual Accounts & Annual Report Timetable
- Scheme of Reservation and Delegation and Standing Financial Instructions
- ICB Finance Update
- Financial Sustainability Checklist Action Plan
- Internal Audit Progress Report
- Counter Fraud Update Report
- External Audit Progress Update - 3 month CCG Accounts to 30/06/2022
- External Audit Progress Report - ICB Audit

The confirmed minutes from the meeting held on 13 October 2022 are attached at Appendix 1.

Risks and issues

The Audit Committee discussed the ICB risk register as part of its business cycle and welcomed the detailed report. The committee suggested that the top 3 ICB risks should be flagged as a matter of course by the ICB in its reports to Board and its committees.

Assurances

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The purpose of Audit Committee is to receive assurances on the adequacy and effectiveness of internal control across the ICB and in doing so provide Board with assurance. The Audit Committee received several assurance reports at its meeting on 12 January 2023 and did not identify any material concerns with the assurances received.

Recommendation/Action Required

The Board is asked to:

- Receive approved minutes for the Audit Committee meeting held on 13 October 2022 for assurance.
- Receive the highlight report for the Audit Committee meeting held on and 12 January 2023 for assurance

Acronyms and abbreviations explained

ICB – Integrated Care Board
DSP Toolkit - Data Security & Protection Toolkit
SoRD - Scheme of Reservation and Delegation
SFIs - Standing Financial Instructions
HFMA - Healthcare Financial Management Association

Sponsor/approving director	Claire Riley, Executive Director of Corporate Governance, Communications, and Involvement
Report author	Irene Walker, Head of Governance

Link to ICB corporate aims (please tick all that apply)

CA1: Improve outcomes in population health and healthcare	✓
CA2: tackle inequalities in outcomes, experience and access	✓
CA3: Enhance productivity and value for money	✓
CA4: Help the NHS support broader social and economic development	✓

Relevant legal/statutory issues

Health and Care Act 2022

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

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Key implications	
Are additional resources required?	N/A
Has there been/does there need to be appropriate clinical involvement?	N/A
Has there been/does there need to be any patient and public involvement?	N/A
Has there been/does there need to be partner and/or other stakeholder engagement?	N/A

Item: 8.2.3

Audit Committee Highlight Report

Introduction

The purpose of Audit Committee is to receive assurances on the adequacy and effectiveness of internal control across the ICB and in doing so provide Board with assurance.

Summary report

The Audit Committee, chaired by David Stout, Non-Executive Director, met on 12 January 2023.

The key points to bring to Board's attention from the meeting are set out below.

ICB Risk Management

The Audit Committee received the ICB's corporate risk register which contained 19 risks with a residual risk of 12 (or higher) these are classed as high or extreme. One corporate risk has increased in score in the period 13 October to 21 December, i.e. the risk that delayed ambulance handovers impact negatively on patient safety and patient flow. The report to committee also listed place risks with a residual score of 12 or above. The committee was satisfied with the arrangements for managing risk at this stage in the ICB's development.

Data Security & Protection Toolkit 2022/23

All NHS organisations are required to complete a DSP Toolkit each year. The DSP Toolkit is an online self-assessment tool that enables NHS organisations to measure their performance against the data security and information governance requirements mandated by the Department of Health and Social Care, notably the ten security standards set by the National Data Guardian (NDG) in 2016.

The committee received a report outlining the timetable for the ICB to submit its Data Security & Protection Toolkit 2022/23 and discussed with internal audit the arrangements for the audit of the toolkit. No issues were identified at this stage of the process.

Annual Accounts & Annual Report Timetable

The committee reviewed the draft timetable for the submission of the ICB's annual accounts & annual report by 30 June 2023 and agreed an action to consult on whether additional meetings of the Audit Committee and Board were required to assure and approve the submission of the Accounts and Annual Report 2022/23 (including Q1 reports 2022/23 from the 8 former CCGs). Alternatively, existing meetings may be rescheduled.

Scheme of Reservation and Delegation and Standing Financial Instructions

The North East and North Cumbria Integrated Care Board's Scheme of Reservation and Delegation (SoRD), Standing Financial Instructions (SFIs), Financial Delegations and Financial Limits were all approved by Board on 1st July 2022 and form part of the ICB Governance Handbook.
The committee was advised that as part of a process of ongoing review of the documents, several proposed amendments had been identified to ensure the documents remain fit for purpose.

The Audit Committee reviewed the proposed amendments to these documents and agreed to recommend them to Board for approval.

ICB Finance Update

The report indicated that_The ICB is currently reporting delivery of key statutory duties, including delivery of expected surplus position.

Financial Sustainability Checklist Action Plan

The committee was advised that as part of the 2022/23 planning round, NHS England introduced a requirement for all NHS organisations (including ICBs) to complete a self-assessment against the Healthcare Financial Management Association (HFMA) checklist *'Improving NHS financial sustainability: are you getting the basics right?* and engage their internal auditors to review it.

The report includes a summary of the average self-assessment scores which were submitted to NHS England in December 2022 (in line with national requirements).

A large number of actions were identified as part of the self-assessment which have been incorporated into an action plan. Most actions are either complete or are in progress and on track to be delivered within initial planned timescales. A small number of actions are in progress but potentially at risk of being completed later than the initial planned deadline although no significant issues have been identified and work is in progress to complete all actions.

Internal Audit Progress Report

The Head of Internal Audit advised the committee that progress against plan had been steady and no concerns are raised. There were no changes are requested to the programme of work.

Work was complete on the HFMA finance checklist, and a draft report had been issued on the tenders waivers analysis.

Counter Fraud Update Report

The 2022/23 risk-based work plan is aligned to the NHS Counter Fraud Authority requirements and sets out the range of activity the ICB is committed to delivering through the AuditOne counter fraud team between ICB establishment on 1 July 2022 and 31 March 2023. The report provided the committee with a status update against planned.

External Audit Progress Update - 3-month CCG Accounts to 30/06/2022

Committee was advised that following the delay in establishment of Integrated Care Boards until 1 July 2022, separate statutory accounts for the former CCGs need to be prepared, and audited, for the 3-month period to 30 June 2022. Previous CCG external audit contracts have been extended to cover the audit of the 3 month accounts.

External Audit Progress Report - ICB Audit

Following a procurement process, Mazars were appointed as external auditors of the ICB.
Their report to the committee, provided an update on progress on the external audit for 2022/23. Planning work is about to commence in the New Year (January/February 2023) and the Audit Strategy Memorandum is expected to be presented to the Audit Committee at the meeting in April 2023.

Appendix 1

Item: 8.2.3

North East and North Cumbria Integrated Care Board
Audit Committee

Minutes of the meeting held on Thursday 13 October 2022 at 10:00hrs
Via MS Teams

Present: David Stout, (Chair) Non-Executive Director
Eileen Kaner, Non-Executive Director
Jon Rush, Non-Executive Director

In attendance: Carl Best, Associate Director (AuditOne)
Simon Clarkson, Counter Fraud Specialist (AuditOne)
David Chandler, Interim Executive Director of Finance
Deborah Cornell, Director of Governance and Involvement
Richard Henderson, Director of Finance
Preetha Kumar, Associate Director of TRA (AuditOne)
Claire Riley, Executive Director of Corporate Governance, Communications and Involvement
Martyn Tait, Counter Fraud Specialist, (AuditOne)
Susan Sweeney, Executive Assistant (minutes)

AC/2022/10/01	**Welcome and introductions** The Chair welcomed everyone to the inaugural meeting of the Audit Committee.
AC/2022/10/02	**Apologies for Absence** There were no apologies received.
AC/2022/10/03	**Confirmation of Quoracy** The Chair explained that due to other commitments the meeting would only be quorate until 11:30hrs and added that he would ensure that any items requiring a decision would be discussed before the meeting was no longer quorate.
AC/2022/10/04	**Declarations of interest** There were no declarations of interest declared.
AC/2022/10/05	**Audit Committee Terms of Reference: appointment of Vice Chair**

	Deborah Cornell advised that the Committee was required to appoint a Vice Chair which needed to be one of the Non-Executive Director members, but added it was not good practice for this to be the Chair of the Finance, Performance and Investment Committee. Eileen Kaner said that she was the only current option but stressed that due to her other commitments within the Integrated Care Board (ICB) a conversation would need to take place regarding her responsibilities. The Chair said he was aware of conversations underway regarding adding another independent member to the audit committee. Deborah Cornell confirmed that discussions were ongoing with Human Resources (HR) to recruit to this post. The Chair suggested two options for cover should he not be able to attend future meetings: 1. Eileen Kaner, Non Executive Director to deputise as Chair 2. A person to deputise as Chair be decided on the day of the meeting. Option 2 was decided to be the best option until a Vice Chair was in post and a reminder given that the Chair would need to be a non Executive member of the Board. Deborah Cornell informed the Committee that the Standard Financial Instructions (SFIs) which currently sat with the Finance, Performance and Investment Committee would need to move to the Audit Committee as there was a risk that there could be potential two different outcomes if considered at both meetings. Martyn Tait requested a rewording of section 6.5 'Counter Fraud' section of the audit committee terms of reference. An amendment in paragraph 4 (page 8) should be changed from NHS Standards for Commissioners' to 'NHS Functional Standards'. **Action:** **Deborah Cornell to amend the audit committee terms of reference, section 6.5, paragraph 4 to read 'NHS Functional Standards' and not 'NHS Standards for Commissioners'.** **<u>RESOLVED:</u>** The Committee **AGREED** to the proposals for a Vice Chair and the amendment to the Terms of Reference.
AC/2022/10/06	**Confirmation of Appointment of External Auditors** David Chandler informed the Committee that Mazars had been confirmed as the ICB's external auditor but as this was a recent decision, they were unable to join the meeting today due to the short notice. Cameron Waddell, Partner and Jim Dafter, Senior Manager of Mazars will be included in all future meeting invites. **<u>RESOLVED:</u>**

	The Committee **NOTED** the appointment of External Auditors to the ICB.
AC/2022/10/07	**Confirmation of Appointment of Internal Audit/ Counter Fraud** David Chandler asked the Committee to ratify the appointment of Audit One as the Internal Auditors and advised that the ICB would be a member of the Consortium, which is a continuation from the Clinical Commissioning Groups (CCGs). **RESOLVED:** The Committee **NOTED** the appointment of internal audit and counter fraud to the ICB.
AC/2022/10/08	**Freedom to Speak up: Raising Concerns (Whistleblowing) Policy** Deborah Cornell presented the raising concerns (whistleblowing) policy which for information, this policy has already been approved by the ICB Board. There will be some minor amendments made to the policy which includes a typo on page six and names will be added where they have been omitted. Jon Rush pointed out that the policy still referred to Lay Members instead of Non-Executive Directors which will also need to be updated. Carl Best also queried about the reporting line under section 1.3 and asked whether a local link needed to be added. After discussion, committee members agreed that a local link should be added. **Action:** **Deborah Cornell to request the updating of the Raising Concerns (Whistleblowing) Policy to include a local link under section 1.3.** **RESOLVED:** The Committee **NOTED** the policy with the recommended amendments.
AC/2022/10/09	**Corporate Risk Register** Eileen Kaner sought clarification that the direct reporting of the specifics of the risks was to the Board whereas assurance that it is being managed is undertaken by the Audit Committee. The Chair agreed that it was. Carl Best advised that Audit One's contribution will be on the year-end statement and that they will provide assurance that processes are being adhered to. **RESOLVED:** The Committee **RECEIVED** the Risk Register and recognised the review work that needs completing.
AC/2022/10/10	**ICB Finance update**

	David Chandler reminded the committee that the purpose of the finance update was to provide assurance that strong financial governance arrangements are in place and that the ICB is compliant with those arrangements; that there are no losses or special payments that the Board need to be aware of; that the ICB has appropriate systems and controls around debt recovery; and that the tendering and contracting procedures are being followed. The key areas of the report was summarised for the period to 31 August 2022 (month 5). The Chair mentioned that in terms of the arbitration process for NHS Property Services they are starting to gain momentum in other parts of the country. David Chandler confirmed that across the previous CCGs, some of these have already been resolved and there is a good relationship with the Director of NHS Property Services and advised that the ICB was not on the arbitration list to the best of his knowledge. The Chair expressed his appreciation as reputationally this would not be good for the ICB. **<u>RESOLVED:</u>** The Committee **RECEIVED** the Finance Update Report *10:43hrs – Jon Rush left the meeting, the meeting remained quorate.*
AC/2022/10/11	**Financial Sustainability Checklist** Richard Henderson provided a brief overview of the self-assessment the ICB is required to complete against the NHS England Financial Sustainability Checklist. Carl Best advised that the work has already commenced and that Audit One are supporting all of their clients with this. However, clarification needs to be sought as some NHS Foundation Trusts are scoring themselves as a 'one' because they do not do something that meets the requirement but do something similar, whereas others are scoring themselves a 'five' for the same reason. Richard Henderson emphasised that this exercise is worth doing to identify a range of actions but advised that it has been difficult due to the timing with the ICB being a new organisation. It would also be beneficial completing this again in a year from now to compare how far the organisation has come. **<u>RESOLVED:</u>** The Committee **RECEIVED** the NHSE Financial Sustainability Checklist for information.
AC/2022/10/12	**External Audit Annual Reports 2021/22 for the 8 former CCGs** Richard Henderson informed the Committee that the external audit annual reports for the 8 former CCGs are shared for information, stating that there were seven unqualified opinions for income and expenditure and one qualified

	opinion which was for North Cumbria CCG, otherwise there were no significant issues carried over. **RESOLVED:** The Audit Annual reports were **RECEIVED** by the Committee
AC/2022/10/13	**Draft Operational Internal Audit Plan 2022/23** Carl Best explained that the draft 2022/23 operational internal audit plan had been brought to the meeting today to seek approval and shared the main points with the Committee, noting that work had already commenced. The Chair asked whether AuditOne was confident that they could deliver the plan before the end of the year. Carl Best confirmed that the plan would be completed. Claire Riley expressed thanks to the AuditOne team for their support over the recent months. **RESOLVED**: The Committee **AGREED** the draft Operational Internal Audit Plan 2022/23.
AC/2022/10/14	**Internal Audit Charter 2022/23** Carl Best shared the AuditOne Charter and Protocol with the Committee advising that this is a standard that they are applying to all of their clients on an annual basis David Chandler commented that the Consortium arrangement was valuable to the ICB and helps to receive a high-quality service hosted by an NHS Body and the Charter was a good example of that approach. **RESOLVED:** The Committee **AGREED** to sign up to the Internal Audit Charter for the current year.
AC/2022/10/15	**Counter Fraud Progress Report – inc Annual Work Plan 2022/23** Martyn Tait provided the Committee with an overview of the activity that the ICB is required to deliver with the support of the AuditOne Counter Fraud team, such as understanding the fraud risks, providing fraud awareness, and setting protocols with key staff groups. Simon Clarkson shared the Fraud Risk work that has been undertaken, the priority being sending the message to all staff on how to report or seek advice if they believe fraud is being committed. Martyn Tait provided an update on one of the investigations that they have (0067). One of the subjects was invited for a voluntary interview under caution at a police station this week; however, it was decided that they required further legal advice so this did not go ahead. The Committee will be kept updated on this matter.

	RESOLVED: The Committee **RECEIVED** the Progress Report and **AGREED** the Annual Work Plan for the current year
AC/2022/10/16	**Counter Fraud Annual Reports 2021/22 for the 8 former CCGs** Martyn Tait advised that the Counter Fraud Annual Reports 2021/22 from the 8 former CCGs, which were approved by the Chief Finance Officers in the former CCGs, had been brought for information only with nothing significant to raise. **RESOLVED:** The Committee **RECEIVED** the Reports for information.
AC/2022/10/17	**Annual programme of business** The Chair advised that this item will set out what is intended to be discussed at future meetings and will be kept under review, with any items to be emailed to Deborah Cornell directly. **RESOLVED:** The Committee **RECEIVED** the Annual Programme of Business
AC/2022/10/18	**Any other business** Deborah Cornell advised the Committee that work is ongoing regarding the Individual Funding Request (IFR) decision making process which she will report back on in due course. The Chair suggested having a brief agenda item at the end of each meeting to review how the meeting went and suggest any improvements.
AC/2022/10/19	**Date and time of next meeting** Thursday 12 January 2023 at 10:00hrs – 12:00hrs Pemberton House, Sunderland **Close**: 11:27hrs

Signed:

Position: Chair
Date: 12 January 2023

Item: 8.2.4

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

NORTH EAST AND NORTH CUMBRIA ICB BOARD MEETING

31 January 2023

Report Title:	**Finance, Performance and Investment (FPI) Committee Chair Highlight report**

Purpose of report

To provide Board members with an overview of items considered and discussed at the FPI committee

Key points

- A summary of the highlights from the November, December and January FPI Committee meetings

Risks and issues

Financial

- There are a number of potential financial risks to manage in 2022/23, including growth in prescribing costs and independent sector activity pressures in the ICB along with pressures associated with the pay award and other cost pressures impacting the wider ICS position. Unmitigated financial risk across the ICS was assessed at £35m at month 8, with work continuing across the system to manage the potential risk.

- Work is ongoing to review planning guidance and develop financial plans for 2023/24, however the 2022/23 financial position across the ICS includes significant non-recurring benefits which will present a significant financial challenge to developing a balanced plan for 2023/24. Initial estimates indicate a significant recurring deficit across the ICS.

- There is also a risk to delivery of the ICS capital position in 22/23 given the current forecast pressure although this is reducing.

- NHS England have developed a protocol for changes to in-year financial forecasts which sets out a process for organisations and systems to follow where forecasts may deteriorate from plan. This will require careful management in both delivering the in-year position and in agreeing financial plans across the system for 2023/24.

Item: 8.2.4

Performance
Whilst there are a number of performance issues across the ICB, the two main ones are as follows:

- Category 2 Ambulance response times
- Clearing the 78 week waiting lists

Assurances

- For the Board to gain assurance that the FPI Committee is undertaking the relevant discussions and approvals in line with its Terms of Reference

Recommendation/action required

The Board is asked to:

- Note the contents of the committee highlight report;
- Receive the approved November and December minutes for information

Item: 8.2.4

Acronyms and abbreviations explained						
Sponsor/approving director	David Chandler, Interim Executive Director of Finance					
Report author	Richard Henderson, Director of Corporate Finance Jen Lawson, General Manager					
Link to ICB corporate aims (please tick all that apply)						
CA1: Improve outcomes in population health and healthcare						
CA2: tackle inequalities in outcomes, experience and access						
CA3: Enhance productivity and value for money						✓
CA4: Help the NHS support broader social and economic development						✓
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**	✓
If yes, please specify						
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**	✓
Key implications						
Are additional resources required?	N/A					
Has there been/does there need to be appropriate clinical involvement?	N/A					
Has there been/does there need to be any patient and public involvement?	N/A					
Has there been/does there need to be partner and/or other stakeholder engagement?	N/A					

Item: 8.2.4

Finance, Performance and Investment (FPI) Committee Highlight Report
Introduction
The purpose of the FPI Committee is to provide oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable, system financial plan. The committee reviews and scrutinises the financial performance of both the ICB and NHS organisations within the ICB footprint, as well as having an overview of overall operational performance and investments.
Summary report
The FPI Committee, chaired by Jon Rush, Non-Executive Director, has met on 3 November and 1 December (approved minutes attached). It also met on 5 January, albeit that these minutes will not be approved until the next meeting scheduled for 2 February, hence why they are not circulated with this report. As the Board received an update at its meeting on 29 November regarding the FPI Committee meeting held on 3 November, this update will cover the meetings held on 1 December and 5 January. <u>1 December 2022</u> The Committee were provided with a summary of the ICB Oversight Framework for information and assurance. The new oversight arrangements are now moving into implementation phrase Meetings would commence with Directors of Place and Trusts later in December 2022. The Committee also reviewed, at a high level, the Integrated Quality and Performance report, focusing on the most recent unpublished data following the report at the Board on 29 November. Updates from the Interim Executive Director of Finance included the Financial position for the ICB for the period to 31 October; historic surpluses, risk management report and the NHS England overspend protocol. <u>5 January 2023</u> The Committee reviewed the financial position of the ICB and wider ICS for the period to 30 November 2022 and received an update from the interim Executive Director of Finance on the latest forecast position for the year and ongoing work with partner organisations to manage remaining financial risks. Although a number of potential financial risks remain, a balanced financial position across the ICS is expected. Updates were also received from the Executive Director of Strategy and Operations and interim Executive Director of Finance on the 2023/24 national planning guidance published by NHS England. This included the Operational Plan priorities and key measurable objectives which the ICS will focus on, along with the latest expected financial allocations and payment

arrangements for elective activity. The ICB is expected to receive the lowest % growth in England and significant financial challenges are expected for 2023/24.

The arrangements and timescales for developing and agreeing 2023/24 plans was discussed with further updates to be provided to future Committee meetings and to the Board.

Recommendation

The Board is asked to:

- Note the contents of the committee highlight report;
- Receive the approved November and December minutes for information

North East and North Cumbria Integrated Care Board
Finance, Performance and Investment Committee

Minutes of the meeting held on Thursday 3 November 2022, 10:00hrs at Joseph Swan Suite, Pemberton House, Colima Avenue, Sunderland

Present:	Jon Rush, Chair Nic Bailey, Interim Executive Director of Place Based Delivery David Chandler, Interim Executive Director of Finance Dave Gallagher, Executive Director of Place Based Delivery Eileen Kaner, Vice Chair Jacqueline Myers, Executive Director of Strategy and System Oversight Rajesh Nadkarni, Executive Medical Director, CNTW Neil O'Brien, Executive Medical Director David Purdue, Executive Chief Nurse
Apologies for absence:	Samantha Allen, Chief Executive Ken Bremner, Chief Executive, South Tyneside and Sunderland NHS FT Graham Evans, Executive Chief Digital and Information Officer Annie Laverty, Executive Director of People Aejaz Zahid, Executive Director of Innovation
In attendance:	Richard Henderson, Director of Finance Jennifer Lawson, Governance Lead David Stout, ICB Audit Committee Chair Gillian Sheppard, Executive Assistant (minutes)

FPI/2022/11/01	**Welcome and introductions** The Chair welcomed everyone to the Finance, Performance and Investment Committee (FPIC) meeting.
FPI/2022/11/02	**Declarations of interest** There we no declarations of interest declared. The Chair highlighted that should a specific conflict of interest be evident during the course of the meeting for the two Provider representatives, they will be dealt with by the Chair as and when they occur.
FPI/2022/11/03	**Minutes of the previous meeting (6 October 2022 - enclosure 1)** It was AGREED that the minutes accurately reflected the meeting with the

	following exception: Page 5; item Review Terms of Refence; 4th paragraph - "to recommend SFIs and financial delegations and limits to the Audit Committee for consideration and subsequent recommendations where appropriate". This task is to be deleted from the terms of reference and be included in Audit Committee responsibilities. **Action:** **To delete reference of SFIs in the terms of reference (ToR) and to include as a responsibility for Audit Committee.**
FPI/2022/11/04	**Matters arising from the minutes** There were no matters arising from the minutes.
FPI/2022/11/05	**Action log updates (enclosure 2)** The action log was reviewed with the following updates provided: **FPI/2022/09/01**: Jacqueline Myers said the discussion of the committee membership is ongoing and will be brought to the Executive team meeting on 08/11/2022 for further consideration. A further update will be provided at the December meeting. **FPI/2022/10/09/02**: Jacqueline Myers confirmed amendments to the ToR are complete and include a section on Performance. **Agreed action closed.** **FPI2022/06/01:** Jon Rush agreed to link with Richard Henderson and amend ToR as discussed. This will be circulated to all non executive members for consideration and approval ahead of being presented to the ICB Board on 29/11/2022 for final ratification. A discussion took place on the possible need for representation at the committee from local authority and social care. It was agreed that current membership remain until the ICB has fully formed and Place Based governance arrangements have been confirmed. It was agreed that this will be considered in a review of the committees ToR in March/April 2023. **Action:** **ToR membership of the FPIC be reviewed in March 2023 and to consider representation from local authority and social care. To be added to the Forward Plan.**
FPI/2022/11/06	**Notification of urgent items of any other business** There were no urgent items of any other business raised.
FPI/2022/11/07	**ICB Performance position update (enclosure 3)**

	Jacqueline Myers presented a high-level update on the integrated quality and performance report for the North East and North Cumbria Integrated Care Board (ICB) and the Integrated Care System (ICS). The focus of all future integrated reports will be on performance, with the quality element being discussed in more detail at the Quality and Safety Committee. Jacqueline Myers asked committee members on their opinion of the report as it is a current work in progress with the content and format of the report evolving. It was agreed that although the integrated performance report will be presented to different committees, they will each have a different focus, therefore a fully integrated performance report was preferred with key highlights pulled out at each meeting and an executive summary provided relevant to each committee. *Neil O'Brien arrived 10:35hrs* The key exceptions within the report were highlighted: • **Primary care:** the increase in overall activity of demand continues and is rising, with GP appointment levels at pre-pandemic levels. The DNA rates as a proportion of all appointments remain high at 4.7% in August 2022, but this is reflected in the national average. • **Urgent and Emergency Care (UEC):** the system as a whole is seeing unprecedented levels of pressure and the ICS system is working to increase capacity and operational resilience ahead of additional winter pressures. This is a specific area of focus for the ICB. • **NEAS ambulance response times:** the response times are longer than the national standards, although Category 1 target of 7 mins response is being met. Category 2 targets are not being met and September performance showed a worsening position of 40:45mins response compared to the 18 mins standard. It was noted that the standard was not met anywhere within England. • **Ambulance handover delays:** the performance is static and hours lost is rising due to crews waiting resulting in approx. average of 61 hours lost per day in October 2022. • **A&E 4 hour wait:** in September 2022 the expected standard of 95% patients treated/discharged in ED had not been met, this is currently 75.8% compared to 63.3% nationally. There is an increase in the number of patients waiting over 12 hours following decision to treat in ED, to 909 patients. • **Length of stay:** patients residing in hospital over 7 and 21 days has continued to increase, particularly for patients who do not meet the criteria to reside (patients need package of care before discharged) is at 16.6% (acute bed base as patients need a package of care before discharge) against target level of 9.2% across the system. This does not reflect previous seasonal patterns which puts pressure on the emergency

	department and an increase in hospital stay; this is a national issue. • **Bed occupancy:** this has increased to 91.9% in October 2022 for general and acute, the standard of which is 85%. David Stout asked if the target of 9.2% of criteria to reside was achievable across the system. David Purdue said there is variation across the Trusts in the NENC system, some of which are below target. Specific work is taking place with North Cumbria and South Tees Trusts to address this, some of the issue is related to the domiciliary care market within these two areas. Nic Bailey said this was compounded by patients' choice and not moving from hospital until their place of choice is found. A national mandate had been issued previously to patients in hospital to advise they may need to be discharged from hospital to an alternative venue until their place of choice has been confirmed. **Action:** **David Purdue to investigate if the discharge mandate is being followed with patients receiving routine letters advising on the criteria to reside in hospital.** Rajesh Nadkarni asked what process was in place so the committee can be assured that all actions are taken to resolve any issues raised and any key areas of difficulty are highlighted. Jacqueline Myers said there are strategic programmes in place addressing priorities, one of which is specific to UEC and a summary of the actions that have been delivered can be provided in a future report, for example the winter resilience plan. Further detail on developing metrics which are related to actions being taken can also be shared in future reports to assure the committee. **Action:** **Future performance reports to summarise metrics on actions taken across the ICB to address key issues and include additional narrative to provide assurance.** David Stout asked for assurance that the ICB performance management system in place was fit for purpose and queried how this was accomplished. Jacqueline Myers said the delegations for performance management are reserved to the Executive Committee and an oversight framework has been developed and awaiting ratification at the November meeting. The ICB does not have full delegation of the framework, but each Trust is signed a set of metrics and it is the ICBs responsibility to deliver accountability arrangements. **Action:** **Jacqueline Myers to share the oversight framework presented to ICB Executives to this committee in December 2022.**

| | Jacqueline Myers continued to highlight the following exceptions of the report.

• **Elective care:** the total number of patients on the waiting list for routine elective treatment continues to rise in contrary to the national ask that overall waiting lists size does not increase.
• **104+ww:** there is a national ask to eliminate 104+ww for all NENC providers by June 2022. Most providers have confirmed they can meet this request with the exception of NUTH due to an issue with complex spinal surgery which is a national issue. A discussion has taken place with NUTH and all avenues for treatment have been investigated but will look to move degenerative work to alternative centres and continue work on the complex cases, currently 30 patients at over 104+ww.
• **78+ww:** the number of patients waiting over 78 weeks is currently over the NENC plan. Trusts have recently been asked to confirm their plans for the end of March 2023 and have confirmed they can meet the national ask of zero, with the exception of NUTH, who have confirmed they can achieve their plan of 180.
• **52+ww:** the number of patients continue to increase and are above planned levels. The restoration of elective volumes is struggling to achieve the 104% increase in activity that was requested. This is a national issue and though there are transformation opportunities in outpatient pathways the challenge is capacity in the system compared to the demand.

Jon Rush asked what impact it could have on the receipt of Elective Recovery Fund (ERF) if the 104% increase in activity target was not met. Richard Henderson confirmed that providers have been advised to work on the assumption there is no clawback on ERF funding in month 7 returns.

Jacqueline Myers said she has requested a plan of actions taken and modelling of impact of the waiting list from Lynn Simpson, Chair of the Elective Recovery Board and will present this to a future committee when available.

Action:
Jacqueline Myers to share information on the plan of actions taken and modelling of impact on the waiting list from the Elective Recovery Board at a future meeting.

• **Diagnostics >6wks:** performance for the 15 key diagnostic tests have shown a slight improvement and is below the requirement of 1% patients having to waiting longer that 6wks.

11:15hrs Jennifer Lawson arrived

• **Cancer**: the NENC are not achieving the 75% faster diagnosis target, currently standing at 74.3%, it was noted there is a variation in performance across the Trusts. There is a focus for Trusts on cancer performance through Tier 1 and 2 cancer meetings in collaboration with |

	NHSE. • **MH/Autism**: *to note that the data had not been updated in month due to changes within the NHSE publication.* There is a pressure on services overall, with an increase in waiting times for the IAPT service with 38% of patients waiting 90 days between their 1st and 2nd appointments. There is a newly appointed Director of Transformation (MH/LD & Autism) within the ICB, Kate O'Brien, and there will be a focused programme of work on transformation resources and priorities across places. Rajesh Nadkarni commented that the demand on MH/LD bed occupancy has been at over 100% for a number of years, particularly for those out of areas and needing detention and said this information is missing within the data presented to the committee. **Action:** **Jacqueline Myers/Kate O'Brien to work with Rajesh Nadkarni to include MH/LD specific information to the performance pack for future committees.** *11:30hrs Rajesh Nadkarni left the meeting* **RESOLVED:** The committee **RECEIVED** the report for assurance and **AGREED** that an identical integrated performance report will be presented to each committee, but the executive summary narrative may change dependent on the committees focus.
FPI/2022/11/08	**ICB Financial position update (enclosure 4)** Richard Henderson presented a high-level update for the North East and North Cumbria Integrated Care Board (ICB) and the Integrated Care System (ICS) for the period to 30 September 2022, with the key points from the report highlighted. The ICB is currently reporting a forecast outturn deficit of £5.8m, prior to expected retrospective central funding of £11.46m relating to the Primary Care Additional Roles Reimbursement Scheme (ARRS). Once this funding is received, the ICB will report a forecast surplus of £5.6m against a planned surplus of £2.6m. The additional £3.0m surplus will offset a forecast deficit across relevant NHS providers, resulting in a balanced financial position across the ICS. There are movements across some organisations. The total ICS financial position at month 6 was a £39k forecast surplus for the year with a movement of £3m between ICB and providers. One provider has moved from a planned £5.6m surplus to a breakeven position, which was partially offset by another provider improving its forecast outturn by £2.6m. The

	improvement in the ICB forecast position included a £1m rebate agreed with NECS along with slippage on reserves and other non-recurrent measures. Within ICB budgets, there is a significant overspend of £13m on acute services, mainly due to the Independent Sector providers activity where additional Elective Recovery Fund (ERF) income was anticipated but as a system overall targets have not been delivered. There are pressures in Mental Health for the S117 packages and Continuing Healthcare, these are partially offset through underspends on prescribing costs and use of programme reserves. There is a small underspend forecast on running costs, due to vacancies and contingencies not being used, there is a potential recurring pressure on running costs which will need to be managed in future years. The financial plan of the ICB required an overall efficiency target of £48.4m and the ICB is on track to deliver this. Whilst at M6 a balanced position is forecast it was highlighted that there are substantial risks to be managed across the ICS totalling £95m. Most of the risks will be mitigated by a range of non-recurring measures, but there is a potential unmitigated risk of £39m for the ICS. This included a specific risk across the providers due to the pay award impact of £15-20m. David Stout asked if the £39m unmitigated risk will increase throughout the year as providers identify additional problems and if conversations were taking place to address this. Richard Henderson said the impact of the pay award was now known and that risk was not expected to increase. There was a potential for additional risks to be identified but it was felt the position presented here was a realistic estimate of potential pressures identified through conversations with providers. In response to an earlier question from Rajesh Nadkarni asking how the ICB risks totalling £18m were being mitigated, David Chandler noted this was through a combination of slippage on budgets and other non-recurring measures. Neil O'Brien asked what preparation work was being carried out in relation to the non-recurrent funding and potential cuts for future years. David Chandler said this will be more than a financial challenge and there will be conversations at Chief Executive level of providers and within the finance community to agree any action to be taken to produce balanced plans going forward. Information on funding for 2023/24 was expected to be received in the next few weeks and it was recognised that there is a lot of pressure in the system. Neil O'Brien queried the high cost of Independent Sector (IS) activity and asked if conversations were taking place across the NENC on an exit strategy

	for when ERF ceases and IS reliance may not possible. David Chandler acknowledged the IS are paid on a Payment by Results (PbR) basis and there is a need to work collaboratively across the ICS with a cohesive planned strategy to manage activity appropriately across both IS and NHS providers; this would need to take account of relevant contractual frameworks. Jacqueline Myers said there is a need to understand how referrals into the IS is done, whether this is from patients waiting over 2 years for treatment or direct referrals from GPs to ensure there is no increase in health inequality in the service. A model of activity needs to be considered and included as part of the financial plan. **Action:** **Jacqueline Myers to work with commissioning leads and begin a conversation with the Executive team regarding potential extraction from the ERF recovery process and use of the Independent Sector.** JM asked if consideration would be given as part of the financial plan submission for 2023/24 within the ICB allocations for the work needed around health inequalities related to population. David Chandler said he is expecting a version of ERF to be included in the 2023/24 financial plan but as yet the detail is unknown, this is a risk for the ICB. There is also ongoing work taking place with a proposed allocations task and finish group to review the NENC ICB allocation. **RESOLVED:** The committee **RECEIVED** the report for assurance.
FPI/2022/11/09	**Proposed Allocations Task & Finish Group update (enclosure 5)** Richard Henderson provided a brief update on the findings and recommendations from a task and finish group following a review of the ICBs allocation for 2022/23. The ICB allocations for 2022/23 was announced in January 2022 where it was identified that the NENC ICB was considered to be 'overfunded' by 6.5% against target allocations for Core Programme allocations, resulting in a lower uplift in growth funding for the financial year. The latest national allocation formula showed a reduction overall for general and acute services. The Allocation Task & Finish group was established to explore this and to consider any actions that could be taken as there is a risk that the NENC ICB may not receive a fair share of national funding to providers services to the population. The task and finish group consisted of members from finance leads across NENC ICB, foundation trusts, business intelligence leads, analyst support and public health consultant. This group has undertaken a series of meetings to explore potential hypothesis in relation to the reduction in the relative need for

	general and acute services and identified two areas for further exploration: • Use of secondary diagnosis codes in NENC foundation trusts • Appropriateness of use of secondary diagnosis codes to determine relative need of population It is proposed to establish a formal Resource Allocation Group, with two further sub-groups to support the delivery of any recommendations. It is not expected that either of the groups will have decision making capability, they will be chaired by a Director of Finance and make recommendations to this committee. The proposed sub-groups will: • **Coding Improvement Group** – oversee improvements in coding across NENC to reduce variation and improve diagnostic data used for allocation purposes and population health decision making in the ICB • **Technical Allocation Group –** oversee the technical aspects in relation to developing resource allocation methodologies for use within the ICB/ICS as well as supporting national resource allocation methodological improvements where appropriate. A general discussion took place where it was agreed that there is a need to improve the quality of coding due to variations across the system, and presents an opportunity to work collaboratively and collectively to improve data and be given a fair share of the allocation. Jennifer Lawson noted the incorrect wording within the paper as any sub committee would need approval at ICB Board level. The FPIC is able to approve a task and finish group with a specific time limit detailed. It was agreed that the Groups being proposed were, in effect, time limited Task and Finish Groups Jacqueline Myers requested the membership of the sub-groups be expanded to include strategy and planning team members. **Action:** • **Terminology within the paper to be corrected and reference to subcommittee amended to task and finish group with set end time date.** • **Membership of the subgroups to be expanded and include members of the strategy and planning team.** • **Terms of Reference for the Allocation Task and Finish Group to be presented to FPIC in December 2022 for approval.** **RESOLVED:** **The committee APPROVED all recommendations proposed within the paper to review the NENC ICB allocations for 2022/23.**
FPI/2022/11/10	Any Other Business

	A discussion took place on the frequency of the meetings and the time required to complete an integrated report with the most up to date information and consideration there may be a need for the committee to move to bi-monthly. Jon Rush suggested the committee meetings will remain monthly at this moment in time until used to the data presented and the frequency will be reviewed again in March 2023, along with the Terms of Reference. David Purdue requested the ICB governance risks to finance be reviewed at the December 2022 committee. **Action:** **ICB Governance risk review to be added to the FPIC forward plan on a quarterly basis**.
FPI/2022/11/11	**Review of the Meeting** Date of the next meeting confirmed as 10:00hrs on Thursday 1 December 2022 at Pemberton House.

Signed: J. Rush

Position: Chair

Date: 01 December 2022

North East and North Cumbria Integrated Care Board
Finance, Performance and Investment Committee

Minutes of the meeting held on Thursday 1 December 2022, 10:00hrs at Joseph Swan Suite, Pemberton House, Colima Avenue, Sunderland

Present:
Jon Rush, Chair
Nic Bailey, Interim Executive Director of Place Based Delivery
Ken Bremner, Chief Executive, South Tyneside and Sunderland NHS FT
David Chandler, Interim Executive Director of Finance
Dave Gallagher, Executive Director of Place Based Delivery
Eileen Kaner, Vice Chair
Lucy Topping, Deputy Locality Director, NHSE
Rajesh Nadkarni, Executive Medical Director, CNTW

Apologies for absence:
Samantha Allen, Chief Executive
Graham Evans, Executive Chief Digital and Information Officer
Annie Laverty, Executive Director of People
Jacqueline Myers, Executive Director of Strategy and System Oversight
Neil O'Brien, Executive Medical Director
David Purdue, Executive Chief Nurse
Aejaz Zahid, Executive Director of Innovation

In attendance:
Richard Henderson, Director of Finance
Jennifer Lawson, Governance Lead
David Stout, ICB Audit Committee Chair
Gillian Sheppard, Executive Assistant (minutes)

FPI/2022/12/01	**Welcome and introductions** The Chair welcomed everyone to the Finance, Performance and Investment Committee (FPIC) meeting.
FPI/2022/12/02	**Apologies for absence** Noted above.
FPI/2022/12/03	**Declarations of interest** There we no declarations of interest declared. The Chair highlighted that should a specific conflict of interest be evident during the course of the meeting for the two Provider representatives, they will be dealt with by the Chair as and when they occur.

FPI/2022/12/04	**Minutes of the previous meeting (3 November 2022)** It was AGREED that the minutes accurately reflected the meeting.
FPI/2022/12/05	**Matters arising from the minutes** There were no matters arising from the minutes
FPI/2022/12/06	**Action log update** The actions were reviewed and updates provided on the action log.
FPI/2022/12/07	**Notification of urgent items of any other business** There were no urgent items of any other business raised.
FPI/2022/12/08	**ICB Oversight Framework** Lucy Topping provided a brief summary of the ICB Oversight Framework for information and assurance. This document has been presented and approved at the November 2022 ICB Executive Committee where the responsibility of maintaining effective operational oversight arrangement will remain. The new oversight arrangements are now moving into implementation phrase with the first meeting with Directors of Place and Trusts taking place on 12 December 2022. It was noted that the arrangements are more comprehensive than previously in place and may take time to embed by all partners in the system. David Chandler said the wording was incorrect in item 6.4 ICB Oversight Financial Arrangements of the current document as the Finance, Performance and Investment Committee is supported by a monthly ICS finance meeting which includes directors of finance from both the ICS and the ICB, where the financial position is reviewed collectively. **ACTION: Lucy Topping to amend the wording of section 6.4 ICB Financial Oversight Arrangements within the framework documentation, to clarify that the FPIC is supported by a monthly ICS finance meeting which includes directors of finance from both the ICS and the ICB, where the financial position is reviewed collectively.** Ken Bremner asked if the oversight arrangements was a live process or if smaller cohort of testing was being carried out with NUTH. He said that the amount of data requested needed to be proportionate for the level of tiering the organisation is placed in and feedback will be given once a number of the meetings has taken place. Lucy Topping confirmed that the process is being tested in advance with NUTH ahead of Q4 meetings with all other Trusts, and much of the data is being taken from each organisations tier related meeting.

FPI/2022/12/09	**ICB Performance position update** Lucy Topping presented a high-level update on the integrated quality and performance report for the North East and North Cumbria Integrated Care Board (ICB) and the Integrated Care System (ICS). The report was presented to the ICB Board on 29 November 2022, therefore only the changes within the last month on recent unpublished data was highlighted. • **Elective care** – there are a number of Trusts that are identified as national outliers, which is significant and unusual for the ICS. Recent changes include South Tees coming out of tier 2. North Cumbria has made significant progress in the number of patients waiting beyond 62 days for cancer treatment, this was 331 people in September to 148 people as at 20 November 2022. This significant progress has meant that North Cumbria will move from tier 1 to tier 2 with an element of support still in place. • **North Tees** - has been moved into tier 2, there are some data issues with possible unintentional double counting of cancer patients. The Cancer Alliance is working with the trust to ensure visibility of patients is maintained but not double counted. • **County Durham and Darlington** – has been identified as a trust on the ~~on~~ national watch list due to the deterioration of their 78ww position. They are currently at 179 against a plan of 132 and the number is increasing in recent weeks. National colleagues may contact the trust directly regarding this and any support needed. The ICB will be notified if the national team ~~will~~ contact the trust. • **NUTH** – is in tier 2 for both cancer and long waits. There has been some progress made but significant challenges remain and work is ongoing. All trusts are undertaking work to address the waiting list challenges but continuing to review their pathways, maximise the use of the independent sector and obtain support from other trusts to address these challenges. All Trusts and provider collaboratives within tier 1 and tier 2 have been asked to complete a self-assessment with Elective Recovery Board sign off detailing the arrangements that should be in place. • **Urgent and Emergency care** – there is little change in month and pressures are continuing with a high number of patients waiting 12 hrs from decision to admission into emergency department. Trusts are giving assurance that patients are as safe as possible during any delay. • **Ambulance handover delays** – this continues, with three Trusts reporting more that 140hrs lost as a result of handover delays which then impacts on ambulance response times. • **Mental Health and Learning Disabilities** – currently unable to update

	this as there is a problem nationally with the postcode data and unable to pinpoint the geography of the patient. Trusts have been approached to take part in 100 day discharge challenge, similar to the improvement process in acute trusts. • **Perinatal Mental Health access** – the standards are not currently being met and a detailed analysis is to be carried out to understand the issues. A general discussion took place on the focus for the committee between finance and performance, and it was agreed reports provided for the committee need to have an oversight of the whole system with a clear focus on how performance data relates to the financial pressures and risks to organisations and the action that can be taken to support this. Ken Bremner suggested that future performance update reports are clear which constitutional standards for trusts are still live and which are there for information. **RESOLVED:** The committee **RECEIVED** the report for assurance.
FPI/2022/12/10	**ICB Financial position update (enclosure 4)** David Chandler presented a high-level update for the North East and North Cumbria Integrated Care Board (ICB) and the Integrated Care System (ICS) for the period to 31 October 2022, with the key points from the report highlighted. There is a forecast overspend of £26m on capital spending across the ICS, which is linked to the Capital Departmental Expenditure Limit (CDEL) allocation. Collaborative work with the providers to review relevant capital plans will continue. The ICB is currently reporting a forecast outturn deficit of £5.5m, prior to expected retrospective central funding of £11.2m relating to the Primary Care Additional Roles Reimbursement Scheme (ARRS). Once this funding is received, the ICB will report a forecast surplus of £5.7m against a planned surplus of £2.6m. The additional £3.0m surplus will offset a forecast deficit across relevant NHS providers, resulting in a balanced financial position across the ICS. The main ICB financial pressure is in acute Independent Sector (IS) activity related to the elective recovery programme and CHC and high-cost packages of care. There are potential risks to the wider ICS financial position at month 7 of £35m, this is associated with the pay award of £20m alongside risks relating to general cost pressures and delivery of cost savings in a number of trusts totalling £15m. There will be a meeting in mid December 2022 with ICS Directors of Finance to discuss surplus and deficits in more detail. The pay award will impact on providers forecast and risk, therefore the ICB is

	in discussions with ICB Directors of Finance to work out worse case assessment scenarios and will feedback to NHSE the impact on organisations forecasts.
FPI/2022/12/11	**Historic Surpluses** David Chandler provided a brief summary of the background to CCG historic surplus and deficit position, in brief: • All CCGs were expected to deliver a cumulative surplus of at least 1% of funding allocation, which carried forward from one year to the next • At the end of 2021/22 the cumulative surplus across the eight former CCGs in the NENC totalled £38.16m • The 1% requirement amounted to £50.563m, leaving a net cumulative deficit of £12.4m as the opening position for the ICB. • NHSE have advised the deficit position of £12.4m can be written off if the ICB breaks even for 2 years. • A number of CCGs had historical agreements in place with NHSE guaranteeing drawdown in future years, which total £17.5m for future draw down, subject to business cases, national affordability and approval. The main risk to the ICB is the cumulative deficit of £12.4m will be reinstated if a break-even position is not delivered over the next two financial years. This will be challenging and therefore to manage any risk it would be beneficial to bring the monies into the system as soon as possible to protect existing services. A discussion took place on the recommendations within the paper, and it was agreed that the draw down needs to occur in year one. The historical agreement guaranteeing CCG drawdown should be ringfenced to ensure each area and local community is resourced properly, but this could be reviewed by the ICB to ensure overall financial stability. **ACTION: David Chandler to give advance notice to NHSE that the NENC ICB plan for 2022/23 will incorporate the £17.5m guaranteed drawdown from CCG historical agreements.**
FPI/2022/12/12	**Risk Management Report** The FPIC received the risk management report for assurance, noting that there are five risks in total, three of which was transferred from former CCG risk registers and two new risks after a recent review of the register. The risks will be reviewed on an ongoing basis and will report back to the committee on a quarterly basis. If any risk increases this will be raised each month within the finance update. In response to a query, Jen Lawson confirmed that the threshold of risks being escalated to ICB Board is 12 and above, therefore risk NENC004 and

	NENC0031 has been discussed at Board. Lucy Topping referred to risk NENC007 'Delivery of NHS Constitutional Standards' and suggested this should be amended to include operational planning performance commitments given the potential risk to organisation reputation. **ACTION: Lucy Topping to discuss with Jacqueline Myers to potential need to include operational planning performance commitments for risk NENC007 'Delivery of NHS Constitutional Standards' and update if necessary.**
FPI/2022/12/13	**FPIC Terms of Reference** Jon Rush summarised the reviewed FPIC terms of reference and the proposed new membership discussed, this would include: • Chair – non executive director (Jon Rush) • Vice Chair – non executive director (Eileen Kaner) • Executive Director of Finance (David Chandler) • Executive Director of Strategy and System Oversight (Jacqueline Myers) • Executive Director of Place Based Delivery (Dave Gallagher) • Executive Medical Director (Neil O'Brien) • ICB Board NHS FT Partner Member x 2 (or nominated deputy) For quoracy there will be 50% of membership to attend, plus Chair/or Vice Chair and Executive director of Finance (or nominated deputy) to attend, with the name of a confirmed deputy required in advance of the meeting. Dave Gallagher said a conversation had taken place at a recent executive director meeting and confirmed that he will cover FPIC, whilst Nic Bailey will attend the Quality and Safety Committee and deputise for FPIC when required. **ACTION: Gillian Sheppard to obtain nominated deputies details in advance of each meeting.** All committee members agreed in the suggested changes. **DECISION: FPIC members agreed to the amended terms of reference and to submit these to ICB Board for agreement and ratification.** Jon Rush confirmed that the FPIC will operate on the above membership and quoracy until formally signed off at ICB Board.
FPI/2022/12/14	**FPIC Cycle of Business** The focus of January 2023 meeting will be on the 2023/24 planning guidance and month 9 update.

FPI/2022/12/15	**Any Other Business** **Overspend protocol** David Chandler provided a brief summary of the NHSE/I document detailing the protocol for changes to in-year revenue financial forecast. This information will be included in the finance update at January's committee. The paper details the number of steps an ICS needs to take should an organisation need to make a formal declaration to NHSE of a change in their outcome position. The paper details the process the system needs to follow and the timeframe required for completion of actions to fit with the monthly reporting timetable. Each relevant organisation must submit to the system a board assurance statement (BAS) signed by the chair, chief executive, chief financial officer, and a non-executive director such as the finance committee chair. There are consequences that need to be considered for any provider reporting a forecast deterioration to plan which will include a double lock sign off process for any revenue investments above £50,000 with sign-off required by the provider and the ICB. Should an ICB go out of balance then there is a triple lock sign-off process for any revenue investments above £100,000 with sign-off required by the organisation, system and NHS England regional team. It was noted that this new process will cause difficulty in planning with a possibility of organisations making conservative financial forecasts and a disincentive to deliver any planned underspends in the next financial year. David Chandler said there is a need to work out what the policy means in practice, how it is to operate and understand the consequences. The concerns of the ICS will be fed back to the report author at NHSE (Simon Curry) and the ICS Directors of Finance will meet in December 2022 to discuss ways of working across organisations and how to respond to the policy.
FPI/2022/12/16	**Review of the Meeting** Date of the next meeting confirmed as 10:00hrs on Thursday 5 January 2023 at Pemberton House, Sunderland. Close 12pm

Signed: J. Rush

Position: Chair

Date: 05 January 2023