NHS
North East and North Cumbria

Longer and healthier lives **for all**

Annual report & accounts

1 July 2022 – 31 March 2023

Contents

Chair's foreword

Over the past few years, 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 region.

I joined the region almost two years ago as chair of the Integrated Care System (ICS) and then as chair for the Integrated Care Board (ICB). Earlier in my career, I was responsible for the NHS in the former Northern Region, that had a very similar geographical footprint to our present ICS. It has given me a unique opportunity to continue a longstanding passion and commitment in serving the people of the North East and North Cumbria.

So it is with particular pleasure that I introduce this report which sets the main achievements of our first nine months as a new organisation, as well as the challenges we have faced.

We are very proud of our strong partnerships and collaborative working. These have been built on over many years and are pivotal to our journey of delivering a fundamental change – not just to help people to live longer, but to increase their quality of life by making those extra years a time of health and freedom from serious illness.

It is well documented that our region has high levels of unemployment, low levels of decent housing, and significant areas of deprivation. These adverse conditions contribute to some of the starkest health inequalities, early death rates and highest sickness levels in England, driving much of the pressure that health and social care services struggle to manage.

This year we established our Integrated Care Partnership (ICP) - a committee of the ICB and the 14 local authorities from across the North East and North Cumbria which brings together local councils, hospitals, community services, primary care, hospices, and voluntary, community and social enterprise (VCSE) organisations and Healthwatch.

Through this partnership we launched a new and far-reaching plan called *Better health and wellbeing for all*. It sets out how we are working together to help people to stay healthy by addressing the causes of ill health and preventing diseases in the first place, and to improve mental health and wellbeing.

We have set demanding goals for 2030 to tackle the key causes of early death in our region - such as smoking, alcohol, obesity, heart disease, substance misuse and suicide. These goals include raising healthy life expectancy, reducing suicide rates, and

cutting smoking levels from 13 per cent of adults to five per cent by 2030, as well as giving our children and young people the best start in life.

No organisation can tackle these deep-seated problems alone but with the strength of our NHS, local authorities, voluntary, community and social enterprise (CVSE) organisations and other partners, we know we can make a real difference.

We have set out an ambitious vision that foresees all our communities are able to live healthier and longer lives. We are now poised to bring this plan to life and really make it happen, with the ICB and ICP creating a new momentum to do this.

We also want to drive forward even more innovations and harness the pioneering spirit that already exists here.

A new research and innovation partnerships forum will help us to do this whilst working in partnership with National Institute for Health and Care Research, Applied Research Collaborations (NIHR ARC's) and many more.

We are determined to create a 'northern diamond' of innovation, research, and regional economic impact, formed between the university cities of the north, to rival the dominance of the 'golden triangle' of Oxford, Cambridge, and London in the south.

We have already launched and signed up to a Health and Life Science pledge for our region and this year's *Bright Ideas in Health* awards showcased the immense talent and creativity that we have here. It was moving and inspiring to see so many practical and innovative solutions being developed and bringing benefits to help transform health and care for today's patients.

Finally, I wanted to express my deepest gratitude to all our health and care teams both within the ICB and across the region for their support to get us to where we are now, and as we embark on delivering our plan in the years ahead.

I am incredibly proud to be part of a region which has such a rich history of joint working, and a passion and commitment for doing the very best for the people we serve.

Professor Sir Liam Donaldson
Chair

Statement from the Chief Executive

As I write this, our new organisation – the Integrated Care Board (ICB) – is almost one year old, having launched on 1 July 2022.

While we said that things wouldn't change overnight, and our first year would be one of transition for our new organisation, we have much to be proud of and have achieved a lot together in a short space of time.

Early on we set out some key ambitions and values for our organisation which continue to be at the heart of what we do - many of which I hope you can start to see reflected in this report.

A year of challenges

While we knew this year would be a challenging one as we began our recovery from the pandemic, I don't think we imagined we would face a period like the one we have just experienced.

It has been one of significant and sustained pressures on health and care services which hit its peak in the winter, and more recently we have had the challenges of industrial action too.

While we were prepared, and our health and care teams worked tirelessly to ensure the very best care, we know these pressures will inevitably have had an impact on the experiences of our patients and on the wellbeing of our workforce.

I would like to pay tribute to all our teams across health and care, and all the unpaid carers in our communities, who have provided care and support to their families, friends and neighbours. All have gone above and beyond, and their efforts have been extraordinary. We are grateful for the support they all provide and to those who volunteer their time, fundraise, volunteer and make charitable donations to support our NHS and community and voluntary organisations.

Organisational change is also not without its challenges - moving from eight clinical commissioning groups, each with its own established ways of working, to create one organisation, takes time and resilience. My thanks to colleagues who have been part of creating the Integrated Care Board and all who work in it.

I would also like to acknowledge the contribution of colleagues who have moved on to new futures as part of these changes. We are now focused on the development of a new multi-professional clinical leadership strategy which we will drive though our evolving senior leadership team, and the setting up of all the new processes we need to have in place to operate together as an organisation.

Despite these challenges and demands we have made inroads to reduce waiting times, improve access to primary care, innovate and do things differently across the region.

Performance and improvement

Our region's GP surgeries provide more than 1.5 million appointments a month and on one of our busiest days there were a staggering 90,000 appointments.
Despite this, data shows for March that around 75 per cent of appointments were face to face compared to 70 per cent nationally – with many patients preferring phone or online options where these are right for their needs.

Around half of all appointments are with GPs, with wider practice staff like nurses, healthcare assistants, physiotherapists, social prescribers and pharmacists also providing appointments and helping many more patients. This clearly shows the move to a multidisciplinary model of working within general practice in our region.

There's been a huge amount of work across the region to improve access to primary care. Groups of local practices known as primary care networks (PCNs) have added extra appointments outside normal working hours – increasing the number of evening or weekend slots by up to 30 per cent in some areas since autumn last year.

Other innovations to improve patients' access including better telephone systems and triaging, and more online video appointments, seven days a week including early mornings, evenings, and weekends.

Across our pharmacies we are seeing more services being developed that people would have traditionally gone to their GP surgery for.

Most recently this has included treatment for urinary tract infections (UTIs) with more than 15,000 women treated by community pharmacists and a reduction in antibiotic prescribing by 47 per cent. This project has been adopted nationally as part of NHS England's Primary Care Recovery Plan, and the evidence and evaluation from our pilot was a key part of it.

This year saw the publication by NHS England of the Fuller report and the subsequent Primary Care Recovery Plan, which outlines the next steps for integrating primary care focusing on improving access, experience, and outcomes for our communities.

We welcome these reports and have been working through their recommendations as we further develop the way we work. What is clear is that general practice and primary care is a vital and integral part of our health and care system for our patients and there is a clear consensus from this report about what we can do differently.

In planned hospital care, we have virtually eliminated two-year waits for treatment and made significant reductions to the number of people waiting more than 78 weeks. Overall, we perform well compared to other parts of the country for other waiting times such as the A&E four-hour standard and faster diagnosis for cancer.

That said, these are still areas of significant pressure, and we are not where we want to be, with more to do in areas such as neuro-developmental disorder, mental health and ambitious plans to improve the diagnosis time for cancer.

Although media attention has been on delays in ambulance handovers and long waits in A&E, we know these are a symptom of pressure across the health and care system which includes delays in the time it takes for patients to leave hospital after their treatment.

This is why we have a key focus on working together across the region to improve the transfer of care for patients. Additional government funding has helped us start this process of change in health and care organisations across the region – working in partnership to deliver better outcomes for patients, their families and carers, and staff.

We also delivered our biggest flu and COVID-19 vaccination programmes yet, with around 2.3 million vaccines given in the year - no mean feat at a time of pressure and a tribute to the many teams across our region from our hospitals to community pharmacists and GP surgeries.

We continue to work with our Provider Collaborative, which includes our 11 NHS foundation trusts. This collaborative has seen our trusts joining forces to work at scale to tackle waiting times and recovery of services following the pandemic, such as increasing diagnostic capacity, with new community diagnostic centres for our region agreed for north Cumbria, Gateshead and Stockton.

The collaborative also secured £29.7 million of national funding to create a new state-of-the-art sterile drug manufacturing hub. This is just one example of how we are working collectively, joining up resources and sharing expertise, while also creating opportunities and making a positive social impact within our communities.

Quality and learning

Working with partners, we are continuing to look at how we can work together to raise standards so that all services are high quality and delivered safely and effectively at the right time and in the right place.

There is learning for us all from national inquiries such as the Ockenden Review and East Kent Maternity Report, as well as cases and issues which are closer to home including recent reviews and enquiries into quality of care.

In the past year, a number of reports have been published about care provided by Tees, Esk and Wear Valleys NHS Foundation Trust. This included an independent system-wide report into concerns and issues raised relating to the safety and quality of child and mental health services at West Lane Hospital and independent investigations into the care of Christie, Nadia and Emily.

Following an inspection by the Care Quality Commission (CQC), care provided in wards for adults with a learning disability were rated as inadequate. It is heart-breaking to read these reports and clearly devastating for patients and their loved ones. I know those working in mental health services also feel sad when reflecting on these and have been determined to make the improvements required.

These reports do provide us all with an opportunity to learn and take action to improve people's experience and their outcomes and that is the focus of the trust. Our thoughts continue to be with the young people's families, as well as staff who we know are also deeply affected by these incidents.

We are continuing to work together across the region, as there is always more to be done, to ensure everyone gets the right care and is treated with respect and dignity. This includes delivering our children and young people's mental health strategic transformation plan.

Shaping a culture of openness, transparency and a focus on learning and improvement has been a priority for us this year and we will continue to work together with our providers and collaboratives across the region.

The CQC also published separate inspection reports on the North East Ambulance Service and Sunderland and South Tyneside NHS Foundation Trust. Both organisations were rated as requiring improvement. I know the teams in both organisations have been very responsive to the feedback from the CQC and are working hard to deliver the improvements required.

This is why we really do want to be 'the best at getting better'. In September we launched a new learning and improvement community which brings together people with a passion for improvement, innovation and change in health and care. I believe this network is the start of something with the potential to make a huge difference for our patients, communities and colleagues.

Better health and wellbeing for all

People in our region people still die younger and live with illnesses for longer than in other parts of the country. It's a situation we know has been exacerbated by the pandemic and the cost-of-living crisis, and it is having the greatest impact on those

living in our most deprived communities.

One of the core purposes of our Integrated Care Board is to reduce health inequalities and improve outcomes through the lens of their access to and experience of healthcare services. To do this we need to work in partnership with all, which is why a new Integrated Care Partnership for the North East and North Cumbria has been formed. Part of its early work has been to develop a plan about what we are going to focus on in our first year and beyond.

So, together with our Integrated Care Partnership we launched our new ambitious plan called *Better health and wellbeing for all* - which our chair, Professor Sir Liam Donaldson, covers in more detail in his introduction. This plan sets out the key actions we will take to enable our communities to live longer and healthier lives.

Alongside this we have made a commitment to invest £35 million as part of a three-year programme to improve health in some of our most deprived communities.

Working with our directors of public health and local authorities we have a system-wide and multi-agency approach to co-ordinate our efforts to prevent ill health, tackle inequalities and support the NHS to play a greater role in economic regeneration and addressing the social determinants of health.

In our first year we are investing £13.6m to support a range of initiatives across the region, including extra support for the Deep End, a network of GP practices in our most deprived communities, as well as programmes to reduce the harm caused by alcohol and smoking.

Supporting our communities to quit smoking remains one of the single biggest things we can do to improve people's health in our region. This year we joined forces with our directors of public health and agreed to match the funding of all 12 local councils to help create better outcomes for people and support programmes to reduce smoking.

We have also launched an innovative programme to provide extra support for people waiting for surgery who are from clinically and socially vulnerable groups. This *waiting well* programme helps patients make changes to have the best chance of a good outcome after surgery. It's been a truly collaborative programme and shows how we can make innovative use of data to target support for patients who need it the most.

Our wider role in communities

We also hold a much wider role in supporting the economic, social and environmental wellbeing of all our local communities. This year we launched our green plan which sets out our ambitions to be the greenest region in England by 2030, recognising that a healthier planet means healthier people.

With our partners, we are also playing our part in supporting our communities through the cost-of-living crisis, as we know this is impacting on their physical and mental health. I was very open about my concerns, which were raised with Ofgem, about the potential disruption of energy supplies for some of our most vulnerable communities including those who use medical equipment. As part of this we launched a joint campaign with the Association of Directors of Public Health for the North East and our NHS trusts, to encourage people to join their energy supplier's priority services register.

Engagement and involvement of our communities

The voice of the public, patients, families, and carers is vital in all work we do, as are their lived experiences. Healthwatch continues to enable these voices to be heard and we are delighted to welcome their membership of the ICB. We are also pleased to share that we've secured funding to support Healthwatch across our region for the coming year. This support is very much welcomed as the ICB continues to embed engagement and involvement in everything we do.

The best place to train and work

Across our region there is more to do to recruit and retain our staff, ensuring equality for all and supporting our diverse workforce with their physical and mental wellbeing. Work is underway across the region to encourage local people to take up careers in health and social care, with a particular focus on providing equality of access and opportunity.

Our year ahead

As we move from a year of transition to one of delivery, our work will not be without its challenges - but there are also many opportunities for us.

We are taking on further responsibilities including the commissioning of pharmacy, dentistry and optometry services previously managed by NHS England.

As ever we will need to manage our resources wisely and this includes the wellbeing of our workforce. Next year will be tougher with an ask that we reduce our running costs in the Integrated Care Board by 30 per cent. This is against a backdrop of inflation and agreed pay increases. We have worked with our NHS partners to agree a financial plan with NHS England which will see our system with a deficit plan of £49.9m for 2023/24.

We also have some unique challenges in our region which have left us in a position of greater health and care need, made worse by the pandemic and more complex geography which make it more expensive to provide services. The formula for allocation of growth funding means we have seen a reduction in this too - despite the complexities of our region.

Our priority now is to develop a realistic plan and continue our work to develop a medium and long-term financial recovery plan over the next three to five years. We will make the most of opportunities presented through wider public sector reform, greater collaboration between our NHS providers and engaging our wider partners and communities to support more effective and efficient use of healthcare services.

It's good to see that the themes and aspirations for the future of integrated care systems set out in the recent Government's Hewitt Review are already captured in our plans and ways of working. Over the months ahead we will consider this report and seek views from our area integrated care partnerships, Integrated Care Board members and wider partners on how it may influence and determine the way we work.

This year we will celebrate the NHS's 75th birthday and as we reflect on how far we have come; we will be looking to the future too.

We have a balance to strike. While we must deal with the here and now, we will be doing our communities a disservice if we don’t build on the momentum and commitment we have made to tackle long-standing inequalities and poor health. The action we take now will impact future generations in the region. This will be a key focus in the years ahead.

Finally, I would like to give a special mention to our predecessor organisations, our eight clinical commissioning groups. While many of their staff are now part of our new organisation, I would like to thank them for all they have done to care for our communities and for the strong foundations they have built with partners across the region over the past decade.

I have spent a lot of time meeting people and visiting places across the region. What has stood out for me is people's commitment, passion and drive to improve health and care for our communities. I would like to thank all our staff, health and care teams and partners, including the community, voluntary and social enterprise sector, for the vital roles they all play and for their ongoing support. Special thanks are reserved for our patients and the people who live in our region.

I look forward to working with you all in the years ahead.

Samantha Allen
Chief Executive

PERFORMANCE REPORT

Samantha Allen
Chief Executive

Accountable Officer
29 June 2023

Performance overview

NHS North East and North Cumbria Integrated Care Board (ICB) is the statutory decision-making body of the North East and North Cumbria Integrated Care System (ICS). The ICB is responsible for commissioning of health services and effective stewardship of NHS spending for everyone who lives in the North East and North Cumbria.

The performance overview summarises the ICB's purpose, including the way we operate, our structure, objectives and strategy. This section gives an overview of how the ICB has performed against its key objectives since July 2022, and highlights the main risks to achievement and how it mitigates against these risks.

About our Integrated Care Board

As part of a new system of statutory NHS organisations formed on 1 July 2022, our ICB is responsible for meeting the health needs of our population, managing the NHS budget and arranging for provision of health services. The ICB also works locally with health and wellbeing boards in each of 13 local authority areas. The ICB's 'place-based' teams work alongside our 64 primary care networks (PCNs), which are groups of local GP practices, social care teams and other community-based care providers.

Since 1 July 2022, the ICB has had the general statutory function of arranging health services for its population and is responsible for the performance and oversight of NHS services within its ICS. The ICB oversight framework is integrated into the wider ICB cycle of business and this ensures that it is a powerful tool for the achievement of the ICB's strategic and operational aims as articulated in its strategy and operational plan.

During 2022/23 the ICB, on behalf of the Integrated Care Partnership (ICP), has developed its Integrated Care Strategy in line with national guidance. The ICB has operated its oversight arrangements with regard to its statutory duties, its agreed priorities for 2022/23 and the requirements set out in its 2022/23 operating plan which addresses the NHS England Operating Plan Guidance for this year.

The ICB, along with 13 local authorities, forms the statutory committee of the ICP. The ICP is responsible for setting and developing our strategy for health and care in the region. It is an equal partnership between local government and the NHS with a key purpose to align the ambition and strategies of partners across the area to improve the health of our communities.

Our vision, goals and ambition

Our vision is for better health and wellbeing for all. 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 (NENC). We have worked in partnership across the ICP and at local authority level to develop a basic framework to show our vision, goals and enabling actions.

This framework, outlined in Figure 1, provides the structure for our integrated care strategy *Better Health and Wellbeing for all – a strategy for the North East and North Cumbria*, published in December 2022.

The purpose of our integrated care strategy is to provide a strategic direction and agreed key commitments to improve the health and care of people in the region. The strategy is focused 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.

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

We recognise that this is a challenging time for the NHS and social care. 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 are of grave concern for all and impacting significantly on quality of life for our citizens.

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. Work continues on a shared ambition to deliver a programme of health and care improvement that reverses these negative trends and delivers the healthier and fairer lives our patients deserve.

The pandemic has further reduced the life expectancy at birth of our population and focused work is needed to ensure we recover from this position through supporting our providers to recover.

Key issues and risks that could affect delivery of objectives and future performance and plans relate to capacity and workforce challenges continued in July 2022/23 onwards, and services which have been adversely impacted by the pandemic remain in recovery.

Figure 1 Better health and wellbeing for all...our integrated strategy for the North East and North Cumbria

The ICB continues to support its providers in managing these pressures and some improvements have been seen during 2022/23, including a reduction in the number of patients waiting over 104 days and 78+ days. We continue to see a reduction in the number of patients waiting over 62 days for cancer treatment, although work continues to be undertaken.

Specific pressures which could impact delivery of our objectives and future performance include:

- Urgent and emergency care continue to be a significant pressure and we are working hard to increase capacity and operational resilience with a continued focus on ambulance performance and response.
- Ambulance handover delays demonstrated a sustained period of significant pressure over winter in particular.
- Pressures due to high level of attendances mean high bed occupancy continues across the region, and pressures within social care together with health service capacity has meant patients who no longer meet the criteria to reside have had their discharge delayed.
- The total number of patients on waiting lists has grown throughout 2022/23 due to pressures in particular specialties such as spinal, orthopaedics, dermatology and ophthalmology, where demand outpaces capacity (which is limited to specific trusts within the region). Workforce and industrial action have exacerbated pressures, and system-wide collaboration in relation to finance, digital and estates is continuing.
- We are working hard to improve mental health pathways, as well as investing in extra support to meet emotional, mental health and wellbeing needs.
- Lack of continuity of care, and workforce pressures have placed additional pressure on existing staff.
- Increased waiting times have a negative impact on mental health and autism conditions of patients while they are waiting.

Performance analysis

The performance analysis section provides a detailed summary of how the ICB measures its performance; what is sees as its key performance measures; how it checks performance against those measures; and the link between key performance indicators (KPIs), risk and uncertainty.

The section builds on the performance overview, giving a more detailed integrated performance analysis and long-term expenditure trend analysis where appropriate. The section also describes how risks have affected the organisation achieving its objectives; how risks have been mitigated; and likelihood of their impact, including how existing and new risks could affect performance and delivery of plans in future years.

The ICB has a duty to improve its quality of services and this section gives an overarching summary of ICB performance, followed by more detailed analysis in relation to mental health and safeguarding, as well as a review of the steps the ICB has taken to implement its joint local health and wellbeing strategy.

The ICB measures performance utilising a range of performance metrics which are aligned to NHS England's operational planning metrics. These are reviewed and monitored by the ICB. This is underpinned using a statistical process control (SPC) approach which is considered best practice to enable boards and systems to understand where there is significant variation and most risk and therefore focus attention on areas that require improvement support.

The ICB performance assessment encompasses key elements of the 2022/23 operational planning priorities, NHS oversight framework metrics, and the targets as set out in the NHS constitution, noting nationally the impact of the pandemic. The Finance, Performance and Investment and Quality and Safety committees consider the element of risk to achievement of the operational planning priorities within the organisational risk register, so that impact on the quality of care to our patients is minimised.

Performance management is a key element of oversight meetings with our trusts and the frequency of these will be dependent on the NHS oversight framework segmentation of each trust. ICSs and trusts were allocated to one of four ‘segments’ in 2021/22. A segmentation decision indicates the scale and general nature of support needs (ranging from no specific support needs in segment one to a requirement for mandated intensive support in segment four) and influences the oversight arrangements that are established.

NHS England holds the responsibility to review and change segmentation. Oversight of trusts in segment one and two is led by the ICB, and oversight of trusts in segments three and four is undertaken by NHS England in partnership with the ICB.

During 2022/23, NHS England initiated a process by which trusts were allocated to tiers in relation to their elective and cancer backlog positions. Trusts which were placed in tier one have regular escalation meetings initiated by the NHS North East and Yorkshire regional team, and trusts placed in tier two have similar meetings initiated by the ICB.

During 2022/23, the ICB has had four trusts placed under the tier escalation process for cancer and two trusts in escalation for elective backlogs. All trusts continue to see improvements through this process, and only one trust now remains under escalation for elective care.

The ICB continues to support trusts in managing pressures, and some improvements have been made since July 2022, in particular the reduction of patients who have been

waiting over 104 days and 78+ days, and a reduction in the number waiting over 62 days for cancer treatment.

Performance summary

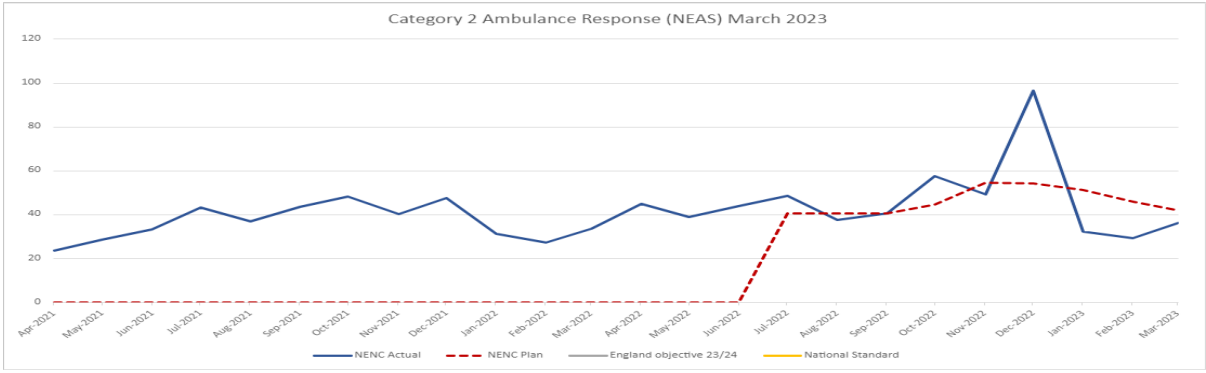
Urgent and emergency care: what we set out to achieve

The ICB continues to focus UEC resources to improve responsiveness and build additional capacity in the community. A key aim for 2022/23 and beyond is to ensure greater resilience in the system, resulting in improved ambulance response times, ensuring patients are seen in the right place at the right time by the right person, improved hospital flow and discharge processes by reducing bed occupancy and effectively managing system flow.

2022/23 performance summary and mitigations

Accident and emergency March 2023	>4 hr waits (95% national standard)	NENC 75.1%
Ambulance response March 2023	Cat 2 mean response (18m national standard) (NEAS)	NEAS 36.2m

- A key area of work continues be the reduction of inappropriate variation through a learning and improvement approach.
- NEAS ambulance response times were very long in November and December 2022, but improved significantly between January and March 2023.
- Work continues as a system to improve handover delays within our providers, address workforce pressures and reduce the number of patients who no longer meet the criteria to reside within our hospitals to ensure improved system flow.



Delivery and risk into 2023/24

Work continues into 2023/24 to expand and join up new types of care outside of hospital to provide a safe and efficient alternative to inpatient care through the expansion of virtual ward pathways. This work will support patients who would otherwise be in a hospital to receive acute care and treatment in their own home, to prevent avoidable admissions into hospitals and enable early supported discharge out of hospital.

Primary and community care: what we set out to achieve

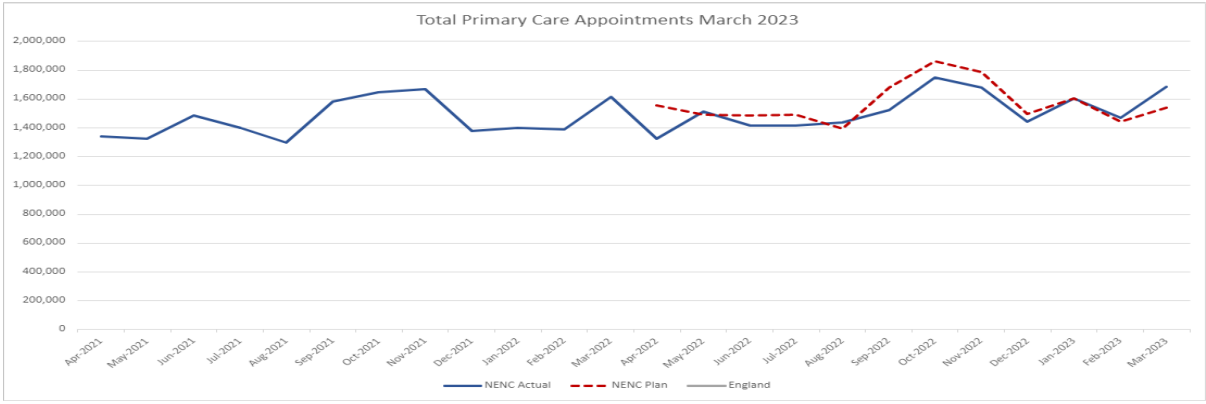
Although more appointments are being provided in general practice, challenges remain for some patients in getting access to the appointments they need. A key objective for 2022/23 has been to support primary care providers to increase capacity and the number of appointments provided, and to get the most out of the capacity and resources that are available.

The ICB is committed to delivering community health crisis response services as well as reablement care within two days of referral to patients who are judged to need it. Urgent community response (UCR) services provide urgent care to people in their homes which helps to safely avoid hospital admissions and enable people to live independently longer.

2022/23 Performance summary and mitigations

Primary care appointments	1.54m appointments NENC operational plan target	1.68m Mar 2023
2-hour urgent community response	70% National Standard	74% Jan 2023

- GP appointment numbers continue to increase and NENC area has met its plan to deliver more appointments in 2022/23.
- UCR standard has been achieved in NENC with coverage in all clinical conditions with the exception of unpaid carer.
- Work is underway to understand and reduce barriers for PCNs and to increase employment in general practice.



Delivery and risk into 2023/24

Delivery of general practice services has become more challenging. Patient demand is increasing and becoming more complex, while the availability of workforce is limited. Work is underway to understand and reduce barriers for PCNs and to increase employment in general practice in 2023/24. The focus remains on increasing UCR referrals including from 999/111 and care homes. A significant increase in activity for UCR is anticipated in 2023/24.

Elective care: what we set out to achieve

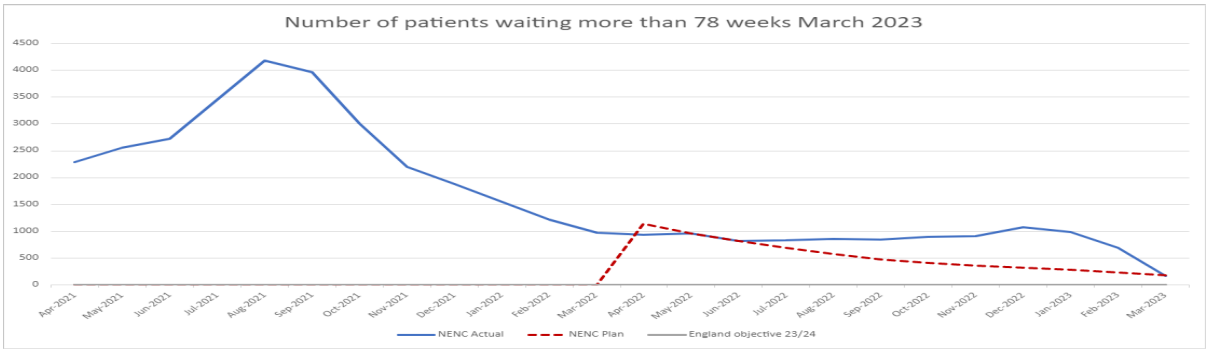
Work is underway to develop an overarching longer term elective care strategy in NENC. In 2022/23, a key aim has been to eliminate long waiting times for elective care, reduce unwarranted variation, transform outpatients, and ensure specialty-based development work in high volume pressured specialties such as dermatology and ophthalmology across our system.

2022/23 performance summary and mitigations

***Patients waiting >104 weeks* March 2023**	30 NENC operational plan target March 23 National Standard 0	NENC 20 Mar 23
Patients waiting > 78 weeks March 2023	180 NENC operational plan target March 23	NENC 169 Mar 23

Patients waiting >52 weeks March 2023	National target zero by March 2025	NENC 7084 Mar 23

- Waiting lists continue to increase across NENC, although more recently in 2022/23 this trend is stabilising.
- Individual trust pressures are variable, with specific pressure in spinal, orthopaedics, dermatology and ophthalmology.
- Specialty-based work delivery and improvement plans and alliances are in place.
- Processes for short term mutual aid are being implemented.
- NHSE support and national work on outpatients to identify improvements are underway.



Delivery and risk into 2023/24

The NENC area did not meet the national standard to eliminate 78+ week waiters by the end of March 2023, due to pressure in spines (which is a national issue), but the agreed plan was met.

Work continues through the tier 1 elective meetings with NHSE to monitor trajectories to clear 78+ week waiters and 104+ waiters throughout 2023/24. Workforce and industrial action risks to elective activity are being managed by executive teams within NENC.

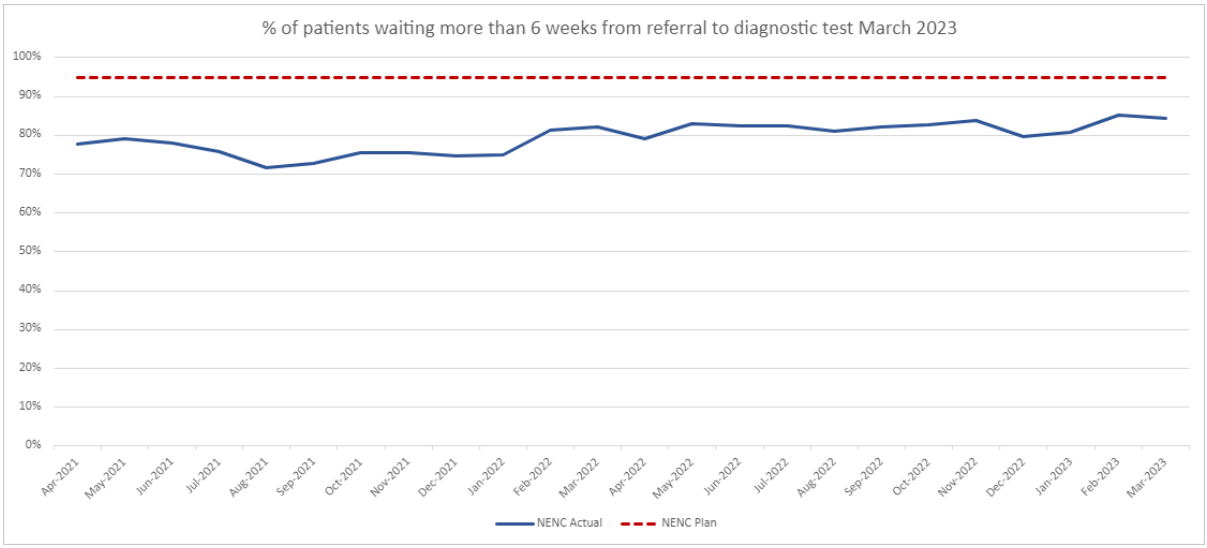
Cancer and diagnostics: what we set out to achieve

NENC ICB and the Northern Cancer Alliance (NCA) aim to speed up cancer pathways, increase diagnostics capacity, reduce waiting times and improve operational performance. Early diagnosis is key to increasing survival rates and reducing variation in treatment for our cancer patients. This in turn will improve patient experience and quality of life, hence reducing health inequalities in cancer services.

2022/23 performance summary and mitigations

Patients waiting >62 days **March 2023**	NENC operational plan standard: 960 patients waiting >62 days by March 2023.	NENC: 952 Mar 23
Faster diagnosis standard	75% within 28 days National Standard.	NENC: 80% Mar 23
Patients waiting <6 weeks for a diagnosis test March 2023	95% National standard	NENC: 84.3%

- NENC achieved the planned reduction in the number of patients waiting over 62 days for cancer treatment, although cancer backlog remains above 2019/20 levels. The main specialities demonstrating cancer backlog are gastrointestinal patients and urology patients.
- NENC achieved the faster diagnosis standard October-March 2022/23. This has compared favourably to national performance.
- The number of patients waiting over six weeks for a diagnostic test in NENC is below the required standard in 2022/23, with particular pressures in MRI and echocardiography where pressures are seen nationally.
- NENC trusts have diagnostic recovery plans in place with a focus on mutual aid for diagnostics with large backlogs.



Delivery and risk into 2023/24

- There has been significant provider effort in backlog reduction for cancer treatments which is to be sustained into 2023/24.
- Challenges remain at tumour-specific level.

- Best practice is shared among providers.
- Support continues from the Northern Cancer Alliance and NHSE, with local oversight processes from NENC ICB and NHSE.
- An improving position for the diagnostics standard is expected throughout 2023/24. Recovery of the diagnostics standard is expected by March 2025 through implementation of key diagnostic strategies, to identify new models of working and expansion in training.

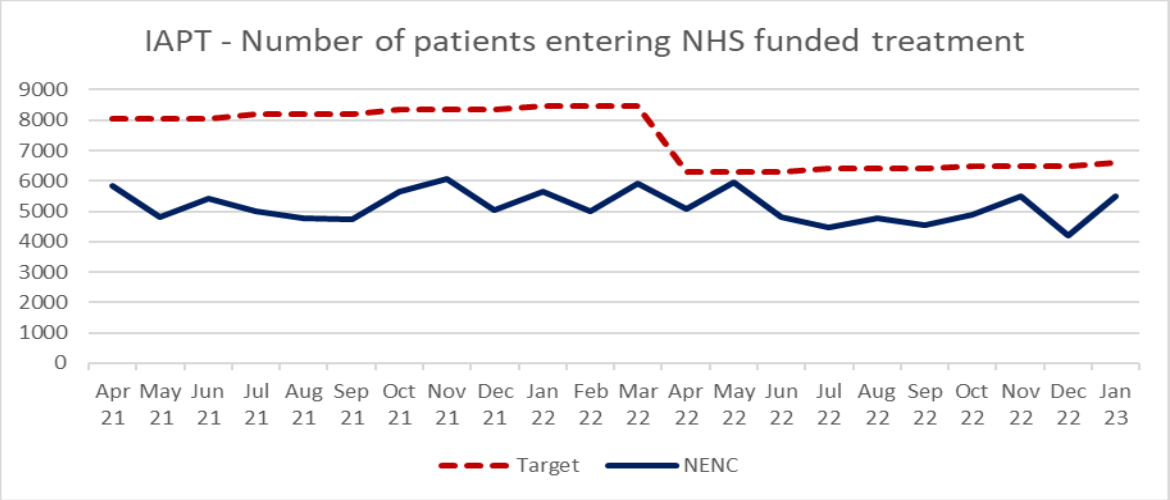
Mental health and people with learning disability and autism: what we wanted to achieve

As a region we are committed to reducing health inequalities of people with mental health problems, people with a learning disability and autistic people. Improving waiting times for adults and young people for mental health services is key, as well as ensuring there is more support to meet emotional, mental health and wellbeing needs through improved access to psychological therapies. Reducing the reliance on inpatient setting and beds for adults and children and young people with a learning disability is a key aim.

2022/23 performance and mitigations

Improving access to psychological therapies	NENC operational plan 70,751 for February 23 YTD	NENC: 54,315 February 2023 YTD
Dementia diagnosis rate March 23	66.7% national standard	NENC 67.9%
Improve access to mental health support for CYP	53,341 NENC operational plan standard Feb 23	53,510 Feb 23
CYP eating disorders – routine within 4 weeks	95% National standard by Mar 24 91.1% NENC operational plan target Dec 22	74.3% Dec 22
CYP eating disorders – urgent within 1 weeks	95% National standard 90% NENC operational plan Dec 22	89.9%
Reduce reliance on inpatient care for people with learning disabilities – ICB adults	NENC operational plan - 57 by March 2023	NENC 83 March 23

- Improving Access to Psychological Therapies (IAPT) rates continued to be sporadic and below plan and target through 2022/23, though numbers have started to increase and are more in line with pre-pandemic numbers.
- NENC aims to improve inclusivity and outcomes of people with mental health needs, sharing learning and driving innovation to improve access. Actions include publicity, single point of access, ethnic minority workshops, waiting list and DNA initiatives, as well as exploring recruitment opportunities.
- The COVID-19 pandemic has impacted on trajectories for planned reduction of patients within inpatient beds for learning disabilities.
- Within NENC we have robust regional monitoring led by the NENC Transformation Hub which supports the learning processes in place to understand patient flow, understanding where admissions come from, and to support discharges. This is being enhanced by the new joint regional approach with the Association of Directors of Adult Social Services (ADASS) to ensure joint working on delivery, and engagement with care and housing providers.



Delivery and risk into 2023/24

Challenges have remained in the delivery of key ambitions in 2022/23 for mental health and for people with learning disabilities and autism. The ICB is working hard to improve mental health pathways for our patients, as well as investing in extra support to meet emotional, mental health and wellbeing needs. The ICB is making progress in improving services with further work underway to address variation within the region.

NENC oversight

During 2022/23, the ICB has published an oversight framework which provides a comprehensive set of arrangements for effective oversight of NHS services within the ICB and the management of risk. The purpose of the oversight arrangements is to facilitate the delivery of the ICB's statutory duties and strategic priorities.

This has been achieved through scrutiny of all relevant indicators and the agreement of remedial action where necessary, including the deployment of additional support arrangements. The oversight framework is a comprehensive framework and includes arrangements for the oversight of delivery of all elements of the ICB's statutory duties and strategic and operational priorities, incorporating all the measures of success included within the NHS oversight framework.

Oversight within the ICB is examined through the lens of the overall ICB, provider trusts, 14 local 'places', primary care providers and programme and clinical networks. Place and programme oversight is future development scheduled for 2023/24.

The ICB works with colleagues from the NHS England regional team to initiate rapid performance review meetings with relevant providers to understand issues of concern and agree preventative and/or improvement actions with a view to heading off formal designation within the national tiering system.

These meetings are focused on identifying and deploying high-quality support to aid rapid performance improvement. In addition, the ICB works with trusts within the key strategic programmes to drive performance improvement via service improvement and the deployment of programme investment, for example via the Urgent and Emergency Care Programme, the Cancer Alliance, and the Strategic Elective Board.

Statement of activities

The statement of activities section outlines the ICB's main areas of work and highlights of our workstream priorities and key achievements July 2022 – March 2023.

In line with national requirements for all integrated care systems (ICS), we have developed a new operating model framework and revised governance arrangements. As a new NHS organisation, it was essential to take a very transparent approach to the development of our initial operating model, ensuring good engagement throughout.

We have invested time and effort into our development and transition programme and our key development principles are aligned to:

- Maximise opportunity for standardisation in the interest of efficiency
- Arrangements must be affordable and within running costs
- Subsidiarity based on the consideration of standardisation and efficiency
- Ensure simplicity and clarity on accountability to the ICB

Our operating model describes:

- How we deliver our objectives within the ICS
- How we deploy our people and resources to support decision making

- How we make decisions, and who makes them
- How we assure ourselves that we are meeting our objectives

Our new and evolving operating model will continue to support the delivery of the ICS.

Partnership working

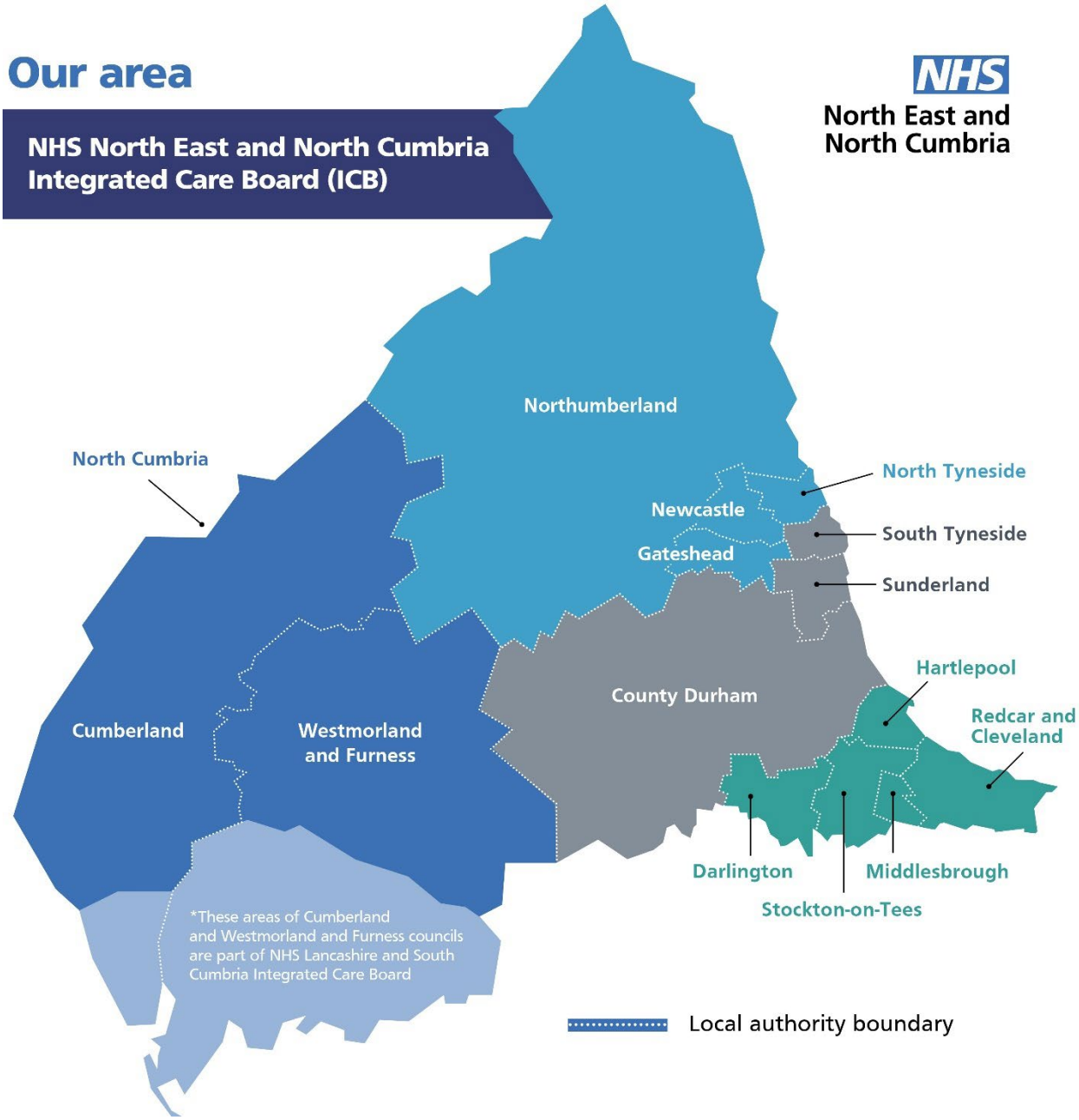
We have worked closely with our partners to ensure our governance and partnership arrangements are fit for purpose to improve the health and care outcomes of our population. We have engaged with our partners throughout our development journey, regularly briefing and working with Health and Wellbeing Boards, Overview and Scrutiny Committees, Healthwatch organisations and patients' groups, and our Voluntary Community Social Enterprise (VCSE) partnership.

The detail of our governance and partnership arrangements has been considered through a Joint Management Executive Group (JMEG) of senior leaders from across the NHS, local authorities and wider partners which has met regularly over the past two years. The feedback from JMEG has helped us to develop our ICB constitution and board membership, our Integrated Care Partnerships, and our arrangements for delegating ICB functions and resources to each of the fourteen local authority 'places' within the North East and North Cumbria.

We have committed to working together through a single overarching ICP alongside four area ICP arrangements. These area 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 continue to focus on the importance of working at local authority level to:

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



Our ICP covers the largest resident population in England at just under three million people (2021 census) and covers a large and diverse geography – from cities and towns to rural and coastal communities.
The ICP as part of ICS is a new and evolving way of working across the NENC 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 ICB is also part of this system, as 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, for the specialised commissioning of dentistry, optometry and pharmacy.

Better health and wellbeing for all

The purpose of our ICS is to provide a strategic direction and agreed key commitments to improve the health and care of people in the NENC. 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 development the strategy, jointly chaired by a local authority and an 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.

We drafted our strategy during October, and on 26 October 2022 published the first draft and a survey to enable members of the public and stakeholders to give their 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 was invaluable in developing the final version of the strategy. *Better health and wellbeing for all – a strategy for the North East and North Cumbria* was published December 2022 with a clear focus on:

- Our case for change
- Strengths to build on
- Our vision, goals and ambition
- Longer and healthier life expectancy
- Fairer outcomes
- Best start in life for children and young people
- Improving health and care services
- Enabling strategies
- Delivering the strategy

Joint Forward Plan

The Joint Forward Plan is a national requirement for all ICBs and partner Foundation Trusts covering the period 2023/24 – 2028/29. NHS England published national guidance on developing Joint Forward Plans in December 2022 and January 2023. Joint Forward Plans should demonstrate how the ICB and its partner trusts:

- intend to arrange and/or provide NHS services to meet their population's physical and mental health needs
- will deliver of the NHS Mandate and NHS Long Term Plan in the area
- will meet the legal requirements for ICBs

Our Joint Forward Plan is organised to support the key commitments made in the Better health and wellbeing for all strategy. As part of our Joint Forward Plan, we have developed action plans including:

- the integrated care strategy goals
- the integrated care strategy enablers
- each local authority Place or groups of Places
- key service areas, e.g., urgent and emergency care

The actions plans are intended to address the immediate priorities and key deliverables, but also the longer-term transformation/development priorities. Wherever possible the plans been developed in partnership, often through an existing integrated care system wide workstream or clinical network. Action Plans include:

- Key Deliverables – what we will deliver, and by when
- Measures of impact – how we are delivering measurable improvement to services and outcomes.

Action Plans are informed by:

- Health and Wellbeing Plans, Joint Strategic Needs Assessments and the ICP integrated care strategy
- NHS National Operating Plan ambitions 2023/24, NHS Long-Term Plan and relevant National guidance.

Like all ICBs and partner NHS Trusts across England, this is our first Joint Forward Plan, it will be reviewed and updated annually. The first updated version will be published in March 2024, and then updated again every subsequent March. The updated plan each year will be informed by:

- Our implementation over the previous year. Our maturing partnerships, integration and/or aligned programmes of work.
- Our learning, as we seek to be the 'best at getting better'.
- Changes in the needs of the population, national policy, good practice and legislation.
- The views of service users and communities, partners and partnerships including Health and Wellbeing Boards.

Emergency preparedness, resilience and response

As part of the NHS, the ICB needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. This is referred to as emergency preparedness, resilience and response (EPRR).

The Civil Contingencies Act (2004) requires NHS organisations and providers of NHS-funded services to show that they can deal with such incidents while maintaining services.

The 2022 Health and Care Bill amended the 2004 Civil Contingencies Act (CCA) to designate ICBs as “Category 1 responders”, which means that they are at the core of an emergency response and therefore subject to the full set of civil protection duties under the CCA which includes coordinating the activities of all providers of NHS funded healthcare to plan for and respond to emergencies.

As a Category 1 responder, the ICB must:

- Assess the risk of emergencies occurring and use this to inform the ICB and consider system contingency planning
- Have in place a single incident response plan that sets out how the ICB will respond to any significant, critical or major incident in and out of hours
- Have a risk-based single business continuity plan that sets out how the ICB will continue to provide its core and critical functions in response to a disruption to service provision
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance co-ordination
- Cooperate with other local responders to enhance co-ordination and efficiency.

In addition to meeting legislative duties, the ICB is required to comply with guidance and framework documents, including but not limited to:

- NHS England Emergency Preparedness, Response and Resilience framework
- NHS England Core Standards for Emergency Preparedness, Response and Resilience
- NHS England Business Continuity Framework

The ICB is committed to developing and maintaining prepared, and resilience services by taking a proactive approach to EPRR. To ensure that the ICB is able to deliver its core statutory function, since 1 July 2022 it has focused on transitioning into a Category One

organisation by developing new ways of working to ensure an integrated resilience function able to respond to any emergency across the NENC Integrated Care System.

The ICB is working closely with all NHS Accountable Emergency Officers (AEOs) and their EPRR leads, as well as with a range of multi-agency partners including representing the NHS at the Cleveland, County Durham and Darlington, Cumbria and Northumbria Local Resilience Forums (LRF).

Training and exercising is a critical component of delivering the ICB's statutory responsibilities with a rigorous and robust programme being delivered to ensure that all staff who would support any incident or scenario hold the relevant qualifications and competencies to effectively undertake that role.

The ICB will continue to participate in training events and multi-agency 'table top' and 'live' exercises to determine the effectiveness of specified functions, to support individuals and test roles within a safe environment, acting on feedback via a robust debriefing process to maximise organisational learning.

During 2022/2023 it has been necessary for the ICB EPRR team to provide system co-ordination, oversight and leadership to a significant number of operational pressures, outbreaks of infectious disease, industrial action, business continuity and critical incidents. This has ensured that the ICB develops and maintains planned and resilient services for residents and patients that meet the statutory and mandatory duties as set out in the Civil Contingencies Act 2004 and the NHS England Framework 2015.

Workstream priorities and key achievements

Mental health, learning disabilities and autism

The ICB and its partners have spent much of the year developing a broad and inclusive Mental Health, Learning Disability and Autism (MHLDA) Collaborative. We already have a strong track record of working together under the NENC Mental Health, Learning Disabilities and Autism programmes and the Specialist Services Partnership. We have taken this further by developing a broad inclusive collaborative with the involvement of all stakeholders, ensuring experts by experience and their families are equal partners.

The collaborative will be a vehicle for:

- Delivering integrated planning and service provision on behalf of the ICS
- Promoting family and individual leadership
- Integrating the planning and commissioning of specialised and local services to reduce fragmentation across pathways
- Delivering transformation at scale on behalf of the ICS and importantly through place-based partnerships and delivery
- Delivering the long-term plan for mental health
- Driving up quality and improving experience

The MHLDA Collaborative will:

- Have a firm relationship with inclusive place-based partnerships, who will determine the needs of the local population
- Strengthen the role of the citizens who use services and their families, the local authority and in the voluntary, community and social enterprise sector both at scale and place-based transformation
- Ensure deep involvement and listen and learn at all levels from citizens who use services, families, carers
- Drive collaboration of MHLDA expertise to enable workforce development
- Be accountable for delivery to the statutory organisations we plan and deliver

The MHLDA Collaborative will engage and form part of both place and system development by:

- Working with partners at place across health and care, commissioning and provision
- Being active members of the ICS, where we work with our wider system partners to achieve our vision
- Focusing on delivering improved outcomes, reduction in health inequalities and the provision of sustainable service
- Reducing bureaucracy and ensuring enabling faster decision making

Throughout 2023/24, we will work with local system leaders to further develop our partnerships to ensure strategic links to north and south partnerships and ultimately to the Mental Health Learning Disabilities and Autism Collaborative Executive Board and ICB and our North and South Mental Health Strategic Partnerships are now in place.

The ICB will be establishing a Mental Health, Learning Disability and Autism Subcommittee during April 2023 which will build on our long-established relationships developed through the Mental Health Steering Group.

Main deliverables and aspirations for the workstream

- Establish and maintain links to the sponsors of each of the priority area and enabling work streams
- Facilitate proportionate, useful, relevant evaluation and research outputs to inform mental health priority workstreams
- Utilise funding provided in 2022/23 and provide scrutiny and oversight
- Set up of a mechanism to facilitate delivery of broader dissemination across multiple partners both within and outside the NHS
- Explore the development of a wider network group for sharing of evaluations related to mental health

Achievements during the year

- Terms of reference reviewed and revised
- Continuation of monthly evidence and evaluation group meetings
- Forward plan of presentations for a dedicated 'learning and sharing' section of the meetings
- Independent evaluation of the group conducted by Quintessential to review what had worked well and areas for improvement
- Workshop organised and facilitated to invite people to share their thoughts about the group and their needs. A thematic review of the workshop outcomes was conducted and a review of the evaluation report recommendations was carried out to inform future strategy (outputs are available on the mural board)
- Exploring links with other regional developments/networks that focus on evaluation to minimise any potential duplication and inform how to proceed with future strategy
- An Oversight Group established to provide scrutiny and decision making around funding decisions
- Protocol and documentation for accessing evaluation funding drafted, based on the NENC ICS 'Evaluation Framework' document
- Three projects funded which directly relate to priority areas

- Process established for utilising the remaining funding in a way that best meets the needs of priority/enabling groups by addressing any evaluation gaps and needs
- Mural online whiteboard has been developed to scope evaluations that currently exist relating to each priority/enabling workstream and to identify needs/gaps and to enable the sharing presentations that have been delivered to the group.

Mental health spending

The Mental Health Investment Standard (MHIS), set by NHS England, requires all ICBs (and formerly CCGs) to increase their planned spending on mental health services by a greater proportion than their overall increase in budget allocation each year.

The ICB reports compliance against the MHIS on a monthly basis throughout the year. All former CCGs were required to publish a statement after the end of the financial year to state whether they consider that they have met their obligations regarding the MHIS, as well as appointing an independent, appropriately qualified reporting accountant to carry out a reasonable assurance review on the MHIS compliance statement.

The former CCGs considered that the MHIS was achieved for 2021/22 and the ICB has reported achievement of the MHIS for the 12 months to 31 March 2023, with total growth in mental health spend of 6.77% during the year.

The table below summarises mental health spend as a proportion of total programme allocations for both 2021/22 and 2022/23:

Financial years	**2021/22 £'000**	**2022/23 £'000**
Mental health spend	591,972	632,047
CCG / ICB programme allocation	5,851,687	5,989,569
Mental health spend as a proportion of CCG / ICB programme allocation	10.12%	10.55%

Notes:

- *2021/22 figures reflect the total mental health spend and allocations of the former CCGs*
- *2022/23 figures represent the full 12 months to 31 March 2023, including 3 months of former CCGs and 9 months of ICB expenditure*
- *Mental health spend reflects expenditure falling within the scope of MHIS*

Learning disability and autism workstream

To reflect the importance of the learning disability and autism programme, the scale of the ICS, and the challenges we face as a system, the ICB has invested in a newly created dedicated programme team working in partnership with people, local authorities, trusts and other stakeholders.

Main deliverables and aspirations for the workstream

The programme team focused on the following priority areas:

- Delivery of *Building the Right Support,* a national plan to develop community services and reduce reliance on inpatient care
- Co-production and the working together strategy
- Workforce development

Our region is a high user of hospital-based provision, with our main provider trusts being Tees, Esk and Wear Valley and Cumbria, Northumberland and Tyne and Wear. However, we remain committed to reducing the reliance on hospital provision by continually developing enhanced community services and good care and support for people with a learning disability and autistic people.

NHS England has commissioned a senior intervenor to work with the ICB for an expected duration of 12 months to provide support to the system. The programme will focus on a group of people who are clinically ready for discharge and the senior intervenor will provide support and advice where there are barriers to discharge.

The key areas of focus are:

- Children and young people
- Developing community infrastructure
- Quality of care and support
- Autism
- Health inequalities
- Working together strategy
- Workforce development

Local maternity and neonatal system

The Local Maternity and Neonatal System (LMNS) has continued its journey for maternity and neonatal services across NENC to become safer, more personalised, kinder, professional and more family friendly. We are committed to improving quality and safety through becoming an effective learning health system capitalising on the unique digital opportunities within our ICB.

Our ambition is to be the safest place to be pregnant, give birth and transition into parenthood – with all women who use maternity and neonatal services receiving the best care possible. Our commitment to reducing health inequalities and unwarranted variation is crucial to this.

Main deliverables and aspirations for the workstream

The LMNS deliverables for 2022/23 fall under three overarching areas:

- Pandemic recovery
- Ockenden report
- Transformation

Achievements during the year

- David Purdue, the ICB's Executive Chief Nurse, took over the role of LMNS senior responsible officer on 1 September 2022
- Clinical leadership is provided by Professor Steve Robson as Obstetric Clinical Lead and Jane Wall, Midwifery Clinical Lead. There are plans in place to secure Neonatal Clinical Leadership
- Completion of a capacity and capability self-assessment against a national framework and development of an action plan that supports improved function and performance and further amends and strengthens the governance of the LMNS within the ICB. The self-assessment included the five domains of system leadership, governance, co-production, insight and data and transformation.
- Maternity Voices Partnerships (MVPs) are multidisciplinary independent advisory groups, consisting of a team of women and their families, commissioners and providers working together to review and contribute to the development of local maternity and neonatal care. The LMNS has 10 MVPs and each has received an annual budget with an annual workplan outlining local priorities
- Recruited two additional service user voice representatives (SUV) for the LMNS Board who have oversight and facilitate wider support and development for the local MVPs
- Ensured patient and public voice representation on all LMNS subgroups and clinical expert groups. This is a major step forward to ensure that the service user voice is at the heart of everything we do

- Published the NENC LMNS Equity and Equality Plan on 30 September 2022. This was one of only three nationally to be rated as 'excellent'. The plan was co-produced by a wide range of partners from across NENC and a project group including three service users was established to drive forward development of the plan.
- The plan will be updated regularly as we continuously strive to ensure that the NENC is the safest place to be pregnant, give birth and start parenthood. We have committed to produce an equity and equality annual report at the end of each year so that we can monitor progress over time.
- Published our Digital Maternity Strategy - our digital maternity vision is 'to improve the quality and safety of maternity care using data and digital solutions as part of a learning health system'.
- All providers continue to embed and deliver the seven immediate and essential actions (IEAs) identified in the interim Ockenden report. The LMNS and MVP representatives joined the regional NHS England maternity transformation team to undertake an Ockenden assurance visit to all eight provider trusts in NENC
- Reviewed the maternity clinical dashboard and developed additional analytics to compare one or more indicators between appropriate providers
- Utilised additional funding for four enhanced midwifery continuity of carer teams to provide an enhanced model of continuity of carer for women living in the most deprived 10% of neighbourhoods, with the funding being used for a maternity support worker dedicated to meeting the additional needs of these women.

Children and young people safeguarding

Child Health Wellbeing Network

The Child Health Wellbeing Network works to the priorities defined by the system and delivers on NHSE's Children and Young People's (CYP) Transformation Programme. 2022-23 was a fabulous year when much of its foundation work started to become established. This has included:

- Delivered 7 huddles (webinars to share good practice) and a Health Inequalities Showcase event
- Over 40 projects were presented in our Health Inequalities Showcase resource published in May 2022
- Our membership increased to over 1700 system-wide members and over 80 networks
- We completed our first Digital Apprentice role with charity NE Youth and recruited two apprentices in partnership with Middlesbrough Council
- Launched our Healthier Together website and mobile app giving families assured NHS pathways for their children's illnesses. **Worried about group A Strep?**

page and video created within a day, with over 58,000 users on the site in December compared to just over 4,500 in November.

- Creation of cost-of-living resources section on the Healthier Together website, as part of our Tackling Respiratory Illness in Poverty Together (TRIPT) call to action in response to the fuel crisis
- Youth Mental Health First Aid training – more than 350 people trained in the two-day qualification by VCSE colleagues in our local communities
- Focus on long term conditions including baseline publications on epilepsy, transitions, and asthma, and a nationally supported Asthma Podcast
- Secured external funding for the second phase of STAR, a dance intervention in schools with family support and appointed a new Arts and Creativity Advisor.

Network priorities	**Top ten priorities**
	1. Voice of CYP 2. Mental health 3. Poverty 4. Additional needs and vulnerability 5. Inequalities and access 6. Strong start in life 7. Health promotion 8. Family support 9. Childhood illness 10. Data, digital and communication

The ICB has established effective arrangements to ensure the statutory requirements as outlined in the third NHS England Safeguarding accountability and assurance framework (SAAF) published in July 2022 are fully met

The ICB Executive Director of Nursing is the safeguarding portfolio lead and chairs the ICS Health Safeguarding Executive (HSE): this Executive Group sets the priorities and provides the expertise and leadership from Provision and Commissioning partners across North East North Cumbria ICS. NENC ICB Joint Forward Plan also highlights the HSE priorities of cared for children, domestic abuse, self-neglect, and transitional safeguarding.

The HSE facilitates strong partnership working and builds on what is working well, and works to share knowledge and provide a North East North Cumbria view on key safeguarding issues to deliver a cohesive health voice into the Safeguarding

Partnerships and Adult Boards. The HSE is a formal subcommittee and reports directly into the NENC ICB Quality Committee

In each the area Directors of Nursing are responsible for taking a lead role in working in partnership with each Local Authority, Police, and wider safeguarding partners to fulfil all the ICB statutory and legislative duties to safeguard and promote the welfare of children and adults. NENC ICB has in place key designated leaderships roles for safeguarding, cared for children, child deaths, mental capacity/deprivation of liberty and Prevent with time and appropriate support to achieve these roles

Cancer alliance workstream

Across NENC Cancer Alliance developments are encouraged and supported as a way to bring together our local senior clinical and managerial leaders who represent the whole cancer patient pathway across our specific geography.

Launch of a breast pain pathway

The NENC Breast Managed Clinical Network (MCN) in collaboration with primary care clinicians, secondary care imaging and breast clinicians, the public and Northern Cancer Alliance (NCA) introduced a Breast Pain Pathway (BPP) for the diagnosis and treatment of patients with breast pain only.

Patients with breast pain only, are unlikely to have breast cancer and can be treated without the need for imaging but do need good symptom management. The BPP provides an effective alternative to the current symptomatic breast service and reduce demand in urgent cancer pathways. In NENC, an estimated 2000 people per year with breast pain only, could be seen and treated without the need for the anxiety or worry of being referred on a cancer pathway.

Teledermatology pathway for skin cancer

Teledermatology is now in place across all four skin cancer service providers across the NENC, giving us whole population coverage. Skin cancer teledermatology pathways allow for triage of suspected cancer referrals by a dermatologist and ensuring timely upgrade of routine referrals to the cancer pathway.

Embedding the pathway across the Cancer Alliance was based on learning from County Durham and Darlington Foundation Trust (FT) who were one of the first to implement this new technology which is now a national recommendation for all skin cancer services.

Non-specific symptoms pathway

In 2022/23 the NCA was able to support the final three trusts (Northumbria, Gateshead and North Cumbria) within NENC to establish Non-Specific Symptoms (NSS) pathway. This means that 100% of our population has access to these rapid access pathways, providing GPs with a service that will hold a patient until a definitive diagnosis is determined removing the need for multiple referrals.

The NSS pathways are often supported by skilled navigators who work closely with patients to move them rapidly through the diagnostic process reducing anxiety, improving compliance, and greatly improving the overall patient experience. There are multiple models working across the NENC and we anticipate that close to 1,000 patients per quarter will be referred across all these pathways by the end of next year.

Faecal immunochemical testing (FIT)

NCA has implemented a combined abdominal symptoms pathway across its geography that has the FIT test as an integral part of the pathway. Acceptance and adherence to this pathway has contributed to the early achievement of the 80% deliverable for FIT (December 2022 82% - NCA top performer nationally against this deliverable).

Data collection at the two labs providing the FIT service is comprehensive and regularly used to audit performance and the provision of the FIT tests has already transitioned to business as usual in NENC.

Achievement of the 28-day cancer waiting times standard

Faster Diagnosis is a key element to achieving the 2019 NHS Long-Term Plan ambitions for cancer. One element of this workstream is the delivery of the 28-day Faster Diagnosis Standard (FDS), which ensures patients are diagnosed or have cancer ruled out within 28 days of being referred urgently by their GP for suspected cancer.

This means that for anyone diagnosed with cancer, their treatment can begin as soon as possible. It also means that patients who do not have cancer can have their minds put at rest quickly. The NENC has been a high performer against the FDS in 2022/23, consistently being in the top three cancer alliances in the country.

Our achievement is due to significant improvement work in our trusts implementing the national best practice timed pathways and putting non-specific symptoms pathways in place. Whilst as a system we know that there are some site-specific pathways and some trusts that need further work to achieve this standard, the current position which has been achieved against a backdrop of increased referrals into most cancer pathways has been a great foundation to build on in 2023/24.

Cancer workforce

In 2022/23, the NCA developed a Cancer Workforce Strategy incorporating recommendations in the Long-Term Plan, NHS People Plan and the National Cancer Workforce Plan which outlines NCA's plans to grow and upskill the cancer workforce.

Within the NCA we have identified that a significant percentage of our current Clinical Nurse Specialist (CNS) workforce will be retiring over the next three years. To address this predicted workforce gap, the NCA is participating in two very different approaches to improving the supply of CNSs.

The first initiative is a two-year collaborative workforce development programme between NCA, Macmillan Cancer Support, Health Education England, Yorkshire Cancer Alliances and provider trusts across North East Yorkshire.

This programme started in October 2022 to support aspirant band 5 nurses to meet the capabilities and competencies of a band 6 cancer CNS, with participants being supernumerary for the first six months while focusing on academic and observational learning. An evaluation of this model will be undertaken at the midpoint of training and at the end of year two.

Our second initiative was the Cancer Nurse Internship Programme, originally developed by South Tyneside and Sunderland Foundation Trust, with South Tees Foundation Trust subsequently participating in this approach. This model gives nurses (bands 5 and 6) the opportunity to leave their ward environment for one day per week for 12 months to work as part of a specialist cancer multi-disciplinary team, through the provision of clinical placements across a variety of cancer specialties.

Participants are accredited at academic level six through completion of a 'Principles of Integrated Practice in Cancer and other Long-Term Conditions' module, delivered through self-directed distance learning with the University of Teesside.

Musculoskeletal (MSK) alliance

The Musculoskeletal (MSK) Alliance core membership consists of clinical and managerial leadership from each trust in NENC. In addition, there is representation from subspecialty group clinical leads such as hips, knees, spine and wider stakeholder representation from physiotherapy leads, intermediate MSK services, commissioners, and the independent sector.

The alliance plays a key role across the following areas:

1. Empowering the networks to make change
2. Providing relevant data and data support - Provision of focused data across the established networks will allow greater concentration on areas of variation and increased performance and patient outcomes
3. Supporting mutual support and movement of cases and surgeons
4. Acting as a conduit to support discussion between local teams and ICS, regional and national teams and initiatives.
5. Increasing awareness of variability and outcomes within teams and supporting the spread of best practice
6. Reducing low volume procedures, and promoting highly specialised care when needed. This will provide equity of access for patients and reduce variation in access and outcomes, resulting in providing better care for patients
7. Improvement collaboratives
8. Sharing data/sharing ideas
9. Supporting the dovetailing of secondary care with primary and intermediate care initiatives
10. Streamlining referral pathways / mechanisms

An example of current and future projects

Funding has been acquired for Patient Reported Outcome Measures (PROMS) and perioperative care projects, with a keen focus on better experience for patients and in supporting elective recovery.

- Expanding the use of the open outcomes tool to collect and analyse the patient reported outcome measures (PROMS). This will be used to assess the quality of MSK care from the perspective of the patient, thereby supporting patient self-management. It is also expected to contribute to reducing waiting times to first appointment, as clinic appointments for follow-up could be reduced
- Perioperative care: high level AI software will read the available data (e.g. previous comorbidities/blood results) and indicate to pre-assessment teams whether a patient could be considered for a particular provider or hospital. Conditions such as risk of complications (e.g. a heart attack) can be predicted with more accuracy than current clinical preassessment models. It is intended this will lead to fewer complications at hospitals without high level support, fewer hospital transfers and higher risk patients
- May decide not have surgery after all (80% risk of complication or over). This has been made available to trusts.

Personalised care key achievements

Personalised care is a key part of the NHS Long Term Plan. We have embraced a 'whole system' approach which has enabled us to work with a variety of services across the health, social care, public health and community spectrum to be integrated around the individual in order to deliver better outcomes and experiences.

Project	Key Achievements
NENC-wide	
Patient Activation Measure (PAM)	Funded and commissioned licences for use of the PAM, with support from Academic Health Science Network. Licences to be offered out to services across NENC to support tailored interventions for people, aiming to address health inequalities and ensure appropriate use of healthcare resource. Working collaboratively with Waiting Well programme as initial roll out pathway.
Training for staff in Primary Care Networks (PCN) - personalised care roles	Worked in partnership with voluntary, community and social enterprise providers to fund and commission training for social prescribing link workers and health and wellbeing coaches, to ensure they meet the requirements of new national competency frameworks.
Personal Wheelchair Budgets (PWB)	Established PWB Task and Finish Group, with engagement from all wheelchair services across NENC. Focus on improving consistent PWB offer and accurate data collection.
Personal Health Budgets (PHB)	Engaged with NECS to develop proposal for additional capacity to work with places to address issues relating to data collection and processes linked to PHB offer, with an aim of improving the offer and ensuring groups with a legal right to a personal health budget receive an assessment and option of a PHB.
Personalised care in trust contract	Specific wording relating to the delivery of personalised care and support planning and shared decision making were included in Schedule 2M of the trust contract for 2022/23.
Expansion of personalised care workforce development project manager role	North Cumbria used previous personalised care programme funding to establish a dedicated Personalised Care Workforce Development Project Manager. The post holder has successfully trained over 300 staff in North Cumbria in personalised care approaches, and agreement has been reached to expand this post across NENC in 2023/24. This supports the workforce development trajectory of the NHS Long Term Plan.

Project	Key Achievements
Support for supervision and development of PCN-based personalised care ARRS staff	Worked with social prescribing associates and workforce development project manager to develop a comprehensive training matrix to support PCNs and personalised care ARRS staff. Additional funding secured via Health Education England for supervision and support offer for next 12 months.
Place-based examples	
North Cumbria	Personalised Anticipatory Care pilot underway, working in collaboration with Ageing Well network, Year of Care partnerships and two PCNs. Piloting a care and support planning approach to people in the anticipatory care cohort. Feasibility study being led by Northumbria University.
Northumberland	Targeted PHB offer for people with mental health issues and in receipt of s117 aftercare.
Newcastle	Year of Care and support planning approach in all GP practices. Piloting social prescribing link worker role in additional areas e.g. hospital discharge/Emergency Department; development of a pilot for peer leaders in weight management services
Gateshead	Development of link worker and peer support roles to enhance the service offer for people living with mental health issues.
North Tyneside	Funding used to expand Admiral Nurse service to provide a more personalised service to people with dementia and their families / carers.
South Tyneside	Anticipatory care and prevention models being tested to target services at most vulnerable cohorts.
Sunderland	Well-established PWB offer across Sunderland
County Durham	Targeted programme focused on supported self-management for people with learning disabilities and diabetes.
Tees Valley	Development of Personalised Care Project Manager role to work into trusts – now out to advert. Personalised care principles embedded in palliative and end of life care service design. Piloted NHS@home with volunteer practices, embedding personalised care approaches and supported self-management.

Physical health and long-term conditions network

We have established focused networks with individual workplans aligned to key areas of work relating to physical health and long-term conditions care management and support as outlined below:

- CVD Prevention Clinical Network
- Lipids Clinical Network
- Diabetes Clinical Network
- Diabetic Foot Care Clinical Network
- Vascular Clinical Network
- Integrated Stoke Delivery Network
- Cardiac Network
- Respiratory and Post COVID Networks

Diagnostic programme workstream

We are well aware of the potential benefits of the establishment and robust management of earlier diagnostic testing closer to home for our local population. We want to achieve earlier diagnoses for patients through easier, faster, and more direct access to the full range of diagnostic tests so we can understand and treat patients' symptoms, reduce hospital visits/patient hospital diversion and improve our contribution to NHS's net zero ambitions by providing multiple tests at one visit.

Our headlines

- Secured in excess of £95m of capital funding investment for 2022/23 – 2024/25 for diagnostic equipment, digital diagnostics and community diagnostic centres
- Around 9% growth in diagnostic tests delivered in 2022/23 compared to 2021/22
- Reduced the number of patients waiting more than six weeks for a diagnostic test by 12% (as at January 2023)

Community Diagnostic Centres (CDC)

- Business cases for four new hubs to go live in 2023/24 approved (totalling £65.5m over two years)
- Approximately 140,000 diagnostic tests delivered in 2022/23

Endoscopy

- Developed a demand and capacity model that has been recognised by the national team and replicated across the North East and Yorkshire region.
- Review of ICS Endoscopy Services published, and work plan developed.
- Secured £5.5m capital funding for additional rooms, upgrading of estate to meet JAG accreditation and kit to support additional capacity and training.

Imaging network

- Imaging workforce strategy signed off by the imaging network and Diagnostic Programme Board
- Significant progress with the workforce strategy action plan (see diagnostic workforce section)
- Establishment of the NENC Imaging Academy, funded by Health Education England (HEE)
- Agreement on a hub and spoke service model for interventional radiology. Established Interventional Radiology working group, presented future network plan to Diagnostic Programme Board and entered second stage of the project
- Created a development plan to guide the network through network maturity levels
- Redefined imaging strategy for the next three years
- Secured £6m capital funding for increase in imaging kit and software upgrades for MRI scanners
- Established an Auto Imaging (AI) group

Pathology network

- Created a development plan to guide the network through network maturity levels
- Refresh of pathology network structure including re-establishing Network Board and introducing Pathology Network Management Group
- Refresh/creation of network documents including MOU and network risk register
- Implementation of network-wide pathology quality reporting. Reviewed and updated clinical governance structure through Quality Management Group
- Established point-of-care testing (POCT) speciality reference group
- Commissioned project to develop options for the pathology network operating model, currently underway.

Physiological Measurement

- Participated in national data collection for cardiorespiratory services, gastro intestine physiology and neurophysiology.
- Initiated conversations with clinical teams about the development of physiological science networks in line with national strategic direction.

Performance

- Agreement of the NENC diagnostic performance improvement plan with trust-level improvement trajectories.

Diagnostic capital investment

Programme	Trust	2022/23	2023/24	2024/25	Total	Purpose
Imaging	Total funded	£2,868,400.00	£2,445,788.00		£5,314,188.00	Purchase of equipment, including CT,MRI &Ultrasound
	Total awaiting approval		£78,392.00	£1,604,436.00	£1,682,828.00	
Endoscopy	Total funded	£5,538,045.00				Expansion of capacity, upgrade of estates. Accreditation & purchase of equipment for diagnostics & training
Community Diagnostic Centre	Total funded	£13,240,000.00	£52,256,000.00	£0.00	£65,496,000.00	Four new CDC hubs - Working, Metro Centre & Bishop Auckland
Digital	Total funded	£6,674,000.00	£6,775,00	£4,280,000.00	£17,729,000.00	Imaging home reporting, imaging sharing, I Refer, CDS, LIMS & interoperability & digital pathology.
Other		£1,000,000.00				Urology investigation unit - additional cancer monies.
Diagnostic Programme total	Total funded	£29,320,445.00	£61,476,788.00	£4,280,000.00	£95,077,233.00	
	Total awaiting approval	£0.00	£78,392.00	£1,604,436.00	£1,682,828.00	

Diagnostic workforce

- Development of a three-year diagnostic workforce strategy (2022-25) in line with the NHS People Plan, NHS Long Term Plan, Sir Mike Richards: Recovery and Renewal and the National Cancer Workforce Plan that addresses the current workforce challenges facing diagnostic services.
- Paper on pathology, imaging and endoscopy workforce capacity needs over the coming five years and recommendations to address those gaps.
- Radiology nursing workforce project where the group was able to review, identify and develop opportunities related to recruitment, advanced roles, education, students, job descriptions, and marketing.
- Engaged and liaised with acute trusts to identify potential funding streams and utilise Health Education England (HEE) funding effectively for workforce projects. Six acute trusts in the region were successful in the NHSE 2022/23 bid for international recruitment of diagnostic radiographers. NENC was successful in receiving funding for practice educators and imaging navigator funding for 2022/23.
- A significant amount of progress has been made towards the imaging strategy and the delivery for the radiologist workforce, the radiographer workforce, the reporting radiographer workforce, the sonography workforce, and the support worker workforce.
- Successfully collaborated and built relationships across teams with HEE, universities and providers to support an increase in training capacity and clinical placements.
- Conducted a scoping exercise with cardiac network for the role of support worker. Additionally, carried out a scoping exercise with lead sonographers in the network to discuss current issues with the workforce, steps taken by trusts, shared learning, and areas for regional or national assistance.

Pathology workforce

- Established a Workforce Reference Group (clinical and scientific) to oversee, facilitate and support delivery of the pathology workforce strategy, reporting to the ICB's pathology governance structure.
- Attracted and facilitated spend of £240,000 of HEE funding to upskill 60 pathology support staff to professional registration through additional level 6 qualifications: developing staff and providing a pipeline for band 5 practitioner vacancies.
- Secured £1 million HEE funding for a Biomedical Science Training Academy project. Introduced new ways of working through a networked approach to training and practice educator roles, harmonised job descriptions and an increase in professionally registered staff (20).
- Introduced the first cohort of level 2 apprentices into the NENC pathology workforce. Working with HEE this has been achieved in collaboration with widening participation teams to increase diversity in our workforce, reduce turnover in band 2 staff and develop a ‘grow your own’ pipeline in the scientific pathology workforce.
- Increased capacity for training and development of staff to move from band 5 practitioner level to band 6 specialist level through a national project of webinars supported by the Institute of Biomedical Science.
- Developed a pathology-focused network careers group hosting an inaugural online careers webinar for Biomedical Science Day 2022. The event attracted students and teachers from nine schools and colleges across the network (intentionally kept local) with an aim to showcase careers in pathology.

Digital radiology/digital image sharing

- Agreement on the final regional Global Work List (GWL) functionality.
- Completion of PID and sign off on project.
- Regional contract development and sign off including the agreement of contracted payment milestones.
- Implementation of GWL solution at all three proof of concept sites.
- Enabling solution access to trusts across the locality.

Digital pathology/digital slide scanning and image sharing

- Procurement and roll out of digital scanners taking region to a minimum of 60% scanning capability.
- Implementation of digital PACS solution at majority of trusts across the region, with the remaining two currently undergoing testing.
- Supporting and enabling trusts who are live with digital scanning to conduct digital MDTs across the region.

Regional diagnostic reporting

- Procurement of regional COSD reporting solution.
- Regional contract development and sign off.
- Implementation at one trust currently in UAT stage.
- Obtained agreement from all trusts that regional COSD templates will be used for reporting.
- Established a regional clinical reporting group to focus on the future and design of regional reporting across the locality.
- Regional sessions conducted to review COSD reporting templates to standardise for the region.

Digital diagnostics funding

- Coordinated and facilitated spend of £6.5m allocated to the ICS for 2022/23 to support digital diagnostic programme of work.
- Established teams within each organisation with representation from pathology, haematology, radiology, finance and procurement to work with regional ICS team to manage spend.
- Currently supporting procurement of work stations, digital scanners to support 100% scanning capability across the region and to ensure the region is aligned and has updated ICE solutions in line with the programme.

Ageing well workstream

It's all about people. People who may need support and those who plan and offer it! Older people are often the most likely to use health and care services as well as the most likely to have their needs unmet. Demand for these services is increasing, with unhealthy ageing and changes in demographics.

We all have the potential to live longer and better at home if we are supported to be 'age-healthy' and are offered services (when needed) that are 'age-friendly' at or close to our homes.

The health and care needs of people in our region continue to increase because of a growth in our ageing population and greater numbers of people living with long-term conditions. All areas in our ICS have seen an increase in the 65+ population. This is more marked in rural areas, with Northumberland and North Cumbria having 'hyper-ageing' populations.

Ageing well transformation is based on true integrated partnerships between health, local councils, social care and voluntary sector colleagues to better support and promote independence and improved quality of living for people throughout their lives.

This approach is at the core of the integration agenda and original 10-year NHS plan. To achieve this, the aim is to promote interdisciplinary team working, offering personalised proactive and responsive care and support based on what matters to people, to keep them as independent as possible in their own homes and communities.

The Ageing Well Network is a collaborative partnership between the ICB and the Academic Health Science Network and has been in place since 2018. The ethos is very much around 'primacy at place' within specific working groups that have an 'enabling' function to allow place-based design and delivery. The programme operates through a network approach, bringing together people from all sectors to facilitate knowledge generation, translation and dissemination across our region.

We have identified five 'at scale' priority areas, aligned to national commitments and the goals set out in the ICP's *'Better Health and Wellbeing For All'* strategy**:**

- **Urgent community response**: Providing urgent care to people in their own homes within two hours if their health suddenly deteriorates
- **Proactive care (formally known as anticipatory care):** Enabling proactive and personalised care and support for people living with frailty and/or multiple long-term conditions.
- **Enhanced health in care homes:** Enabling proactive care and support to residents and their families.
- **Community health services digital:** Driving forward digital transformation with community health services to improve patient care.
- **Enhanced care for older people workforce competency framework**: Supporting the workforce to provide enhanced care at home.

Digital data and technology

Establishment of the ICB included the appointment of an Executive Chief Digital and Information Officer. This highlighted the critical importance of digital, data and technology for the ICB's transformation ambitions.

The ICB digital and information directorate was established during the latter part of 2022, and key digital, data and technology appointments were made for a range of strategic heads/directors and chief clinical information officers. Each role is aligned to the existing ICS digital strategy themes:

- **Essentials** - getting the basics right and working together
- **Improving** - an integrated health and care system needs digitally mature organisations and a digitally capable workforce
- **Connecting** - continuing to connect the region's health and care IT systems. Through secure sharing of information, we are improving quality and safety of care

- **Empowering** - by using digital technologies where appropriate, we will empower people to be partners in their own health and care needs
- **Learning** - through use of reliable, up-to-date information, data and research we can proactively respond to the needs of our population

Throughout the year, the ICB coordinated delivery of a range of system-wide digital, data and technology programmes, while existing ICS governance arrangements were updated in line with the emerging ICB.

Example programmes include but are not limited to:

- Digital first primary care
- Digital elective recovery
- Digital diagnostics (digital pathology, radiology and laboratory information management systems)
- Population health management
- Maternity
- Community/anticipatory care

Furthermore, a series of Academic Health Science Network (AHSN) - supported digital transformation projects were delivered during the period. These relate to digital inclusion, covering policy reviews and digital inclusion forum activities, and a digital skills working group along with a digital device repurposing initiative. This is of particular importance given the significant challenges of 'digital poverty'.

A great deal of AHSN-led work also focused on digital solutions within regional care homes, and the care home sector as an integral and critical part of the heath and care system. As such, digitising and integrating, systems, data and processes will form a key part of the regional interoperability agenda.

The AHSN also undertook a range of innovative work around a digital pioneers programme, with the creation of a digital champions, a digital innovation hub and aspects of communities of practice.

A separate AHSN report is outlines this significant area of work in more detail. From a people development perspective, the NENC Informatics Skill Development Network was formally launched at a public event on 22 September 2022. It was created from regional services originally set up to support finance and procurement skills developments, and is thus able to exploit exciting areas of best practice and learning.

Given the emerging challenges in the digital data and technology workforce nationally, our Executive Chief Digital and Information Officer was asked to co-chair the National Digital Workforce Board to assist with creation of a digital data and technology workforce plan.

As the ICB continues to develop as a system convener, the ICB System Coordination Centre (SCC) became operational on 1 December 2022. This was built on a range of regionally available digital and data services assets, and aims to provide regional oversight and coordination at times of system pressure and during critical incident activities.

During December 2022, the ICB developed an expression of interest to become one of the Sub National Secure Data Environment (SNSDE) regions. This was successful and the ICB was announced as one of eleven regions to receive national funding, supporting development of an outline business case for a further two-year funding programme. At the time of writing, this review and approval process was still ongoing.

During the early part of 2023, the ICB progressed into the final stages of establishing and implementing a regional Analytics Leaning Programme (or Analytics Academy). This aims to provide an enhanced analytical skills development opportunity to the regional analytics and business intelligence community.

During 2022, the ICB also commissioned the AHSN and Collective Impact Agency to understand work taking place around the region, how issues relating to digital exclusion impact on people’s health and share best practice. This work forms part of the region’s drive to prioritise digital inclusion and examines some of the policies and literature around digital inclusion and digital healthcare across the UK.

The report's findings will form a significant part of the revised NENC digital data and technology strategy.

In addition, the Board received a presentation on the use and development of information systems for the work of the Integrated Care Board. This described the direction and development of the planned information and data services that will underpin and enable a more data-driven decision-making way of working.

On International Women’s Day, the ICB announced its commitment to support the Shuri Network with membership expansion and promotion of Shuri Digital Fellowships within the region.

Communications and engagement are a key part of our ambitions to share, learn and promote best practice. Our awareness and engagement approach includes publication of a monthly digital newsletter, updating system members on the wide range of innovations, programmes and transformations underway.

Eye care alliance

There is an ever-increasing demand for hospital eye services. Ophthalmology represents approximately 8% of all outpatient attendances (2021/22) and 10% of the elective waiting list (March 2022), while the COVID-19 pandemic has also had a significant impact.

The eye care alliance meets bi-monthly, is clinically led, and has excellent stakeholder participation. There is input from clinical and non-clinical secondary care as well as community optometrists, commissioners, patient groups and the third sector.

Its aims are to work collaboratively to improve waiting times and plan eye care provision, recognising that access to high quality eye care is essential to quality of life.

The alliance's key objectives are:

1. Improve population eye health
2. Reduce health inequality
3. Influence decision-making about how healthcare services are delivered regionally
4. Develop standardised pathways end to end
5. Encourage self-management where clinically appropriate
6. Optimise the use of key enablers such as digital technology

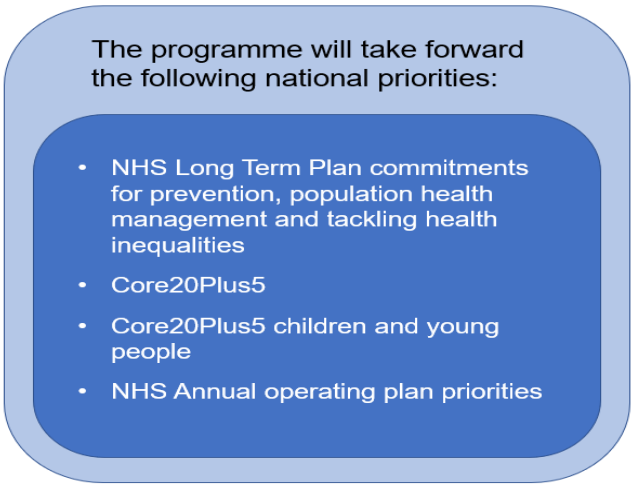
Four objective groups (cataract, glaucoma, medical retina and emergency eye care) are working towards achieving these objectives, to ensure everyone in NENC has access to high quality eye health care.

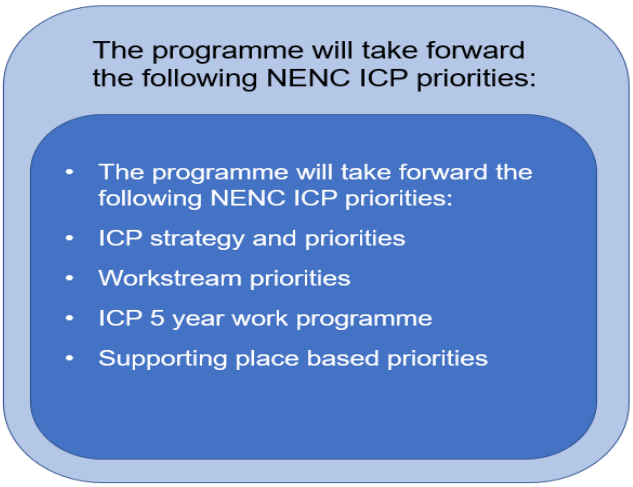
Healthier and fairer programme

Healthier and fairer is a system-wide, multi-agency, ICS-wide approach to coordinate efforts to prevent ill health, tackle inequalities and support the NHS to play a greater role in economic regeneration and addressing the social determinants of health.

The programme is an excellent example of system partners working together with a collective purpose and aim.

Key priority areas – national and regional





The healthier and fairer programme builds on system-wide working over the years across the NENC area. This includes:

- The Population Health and Prevention Board
- The Health Inequalities Advisory Group
- The Deep End Steering Group
- Links and direct engagement with wider ICS workstreams and priority programmes to develop and embed a focus on population health and tackling inequalities

Examples of programme impact are aligned to:

- Waiting well – life is worth living
- Using population health management approaches to truly understand our population and its needs
- Tobacco Dependency Treatment Service – available in all trusts

Population health management

Our Population Health Management (PHM) approach builds on a data-driven methodology to help plan and deliver care that maximises our impact in achieving health outcomes and reducing health inequalities. It includes looking at wider determinants of health and working with partners to make best use of collective resources.

Our aim is to embed PHM approaches across the ICB, provider collaborative, local and PCN levels to support a fundamental shift from reactive to proactive care for our communities, supporting delivery of the ICB vision as well as the ambitions set out in the NHS Long Term Plan and NHSE Operational Planning Guidance.

Our PHM strategy and delivery framework supports the ICB's ambition to move towards 'thriving' status on the PHM maturity matrix. We want to create the knowledge, skills and culture to support embedding PHM as a way of working across NENC, working across the three core capabilities for PHM (intelligence, infrastructure, interventions and incentives).

Workforce programme

The North East and North Cumbria covers a large geography with a rich and diverse demography, which impacts and influences our plans and approach. We take account of the needs and aspirations of our workforce to effectively provide services at scale or locally at place or community level, having regard to population health and care needs and taking all opportunities available to address health inequalities through all workstreams and projects.

The recovery of our workforce following the COVID pandemic is the most important aspect of our work. Successful recovery of services depends on having a healthy, supported and engaged workforce and our planning, work programmes and deliverables recognise this.

Our workforce programmes cover all service areas: mental health, learning, disability and autism, community health, primary care, social care, voluntary and hospital services taking account of everybody involved whether paid or unpaid, including family and other care givers.

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 workforce. 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. Additionally, an estimated 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. In August 2021 alone, the NHS lost 560,000 days to sickness and absence due to anxiety, stress, and depression. Our ICS area is not exempt from these challenges. Some organisations are experiencing severe challenges in the recruitment and retention of staff.

Our vision for the region is for the NENC to be the best place to work in health and care, with a focus on wellbeing and population health, delivered by an adaptable and flexible workforce. To this end, the workforce programme focusses on five key priorities, all aligned to the People Plan and looking to mitigate the challenges and pressures we are facing:

1. Supply, including enabling local people to be able to access employment and career structures and pathways in our local services
2. Retention, health, and wellbeing of our workforce which is all about looking after our people
3. Equality, diversity, and inclusion, ensuring that we have a diverse workforce which reflects our community demography and offers equality of access and opportunity to all, actively encouraging people from all walks of life to take up careers in health and care services
4. System development and leadership
5. Workforce redesign

There has been a huge amount of work undertaken to support our existing workforce and to encourage local people to take up careers in health and social care, with a particular focus on providing equality of access and opportunity. This has included encouraging some of the most disadvantaged people in our communities to take up training and employment opportunities.

Our work is undertaken system-wide (regionally), at an integrated care partnership level and within local communities. The work is undertaken by a range of partner organisations from the public, private, academic, and voluntary sectors working together in collaboration. The voluntary sector plays an important role in supporting individuals of all ages and from all walks of life to take up employment in health and care.

Set out below are some examples and short case studies of regional and local workforce activities:

Mini-scrubs study

Helping students think about, prepare for, and pursue career aspirations is an essential element of secondary and tertiary education across England. In 2017, the Department for Education launched its careers strategy, making a landmark decision to focus on primary education.

It was therefore agreed by partner organisations in the north of our region, using funding from Health Education England (HEE), to introduce children to ideas about the work they might want to do in the future. Each primary, first and special school throughout Gateshead, Newcastle, North Tyneside and Northumberland received a gift

of clinical-quality health and social care ‘mini-scrubs’ and role profile information during the first half of the autumn 2022 term.

Each pack consisted of 32 individual scrubs and matching cloth hats embroidered with the name of a role, agreed between partners to depict roles across our health and care provision. They were manufactured by the Northumbria Healthcare Manufacturing and Innovation Hub.

The scrubs covered the following 25 professions: administrator; biomedical scientist; care assistant; catering assistant; chef; clinical skills teacher; dietitian; doctor; finance manager; gardener; healthcare support worker; IT technician; midwife; nurse; nursing home manager; nutritional support worker; occupational therapist; physiotherapist; porter; psychiatrist; pharmacist; psychologist; radiographer; social worker; surgeon. They were accompanied by role profile resources, produced in partnership with relevant professionals.

Health and social care is a key priority sector of growth in the North East and as such we have a responsibility to engage with our potential future workforce from a young age, to allow primary school students to connect their learning with their future. This is vital to ensure the health and care sector is fully resourced.

There are more than 350 jobs and careers in health and care, more than any organisation in the world; many people do not realise the range of opportunities and so a sample of different roles were selected to represent the variety.

The roles covered a range of qualification levels and entry routes to motivate and excite students, encouraging further discussions with peers, teachers, and families. By doing so, there will be a link between learning in the classroom and the real world, while challenging gender stereotypes and helping them understand the health and care sector beyond the classroom.

Diagnostic workforce

We are looking to increase the capacity of our diagnostic workforce to meet increasing demands, and to staff the planned new diagnostic hubs. We have developed a three-year diagnostic workforce strategy, as well as an understanding of pathology, imaging and endoscopy workforce needs over the coming five years and plans to address those gaps.

Our radiology nursing workforce project reviewed, identified, and developed opportunities related to recruitment, advanced roles, education, students, job descriptions and marketing. We have six acute trusts in the region which were successful in the NHSE 2022/23 bid for international recruitment of diagnostic radiographers.

NENC was successful in receiving funding for practice educators and imaging navigators for 2022/23. A significant amount of progress has been made towards the imaging strategy and work in relation to the radiologist, radiographer, reporting radiographer, sonography, and support worker workforces.

We successfully collaborated and built relationships across teams with HEE, HEIs (universities) and providers to support an increase in training capacity and clinical placements. We conducted a scoping exercise with the cardiac network for the role of support worker. Additionally, we carried out a scoping exercise with lead sonographers to discuss current issues with workforce, steps taken by trusts, shared learning, and areas for regional or national assistance.

Cancer workforce

In 2022/23 the Northern Cancer Alliance (NCA) developed a cancer workforce strategy incorporating recommendations in the Long-Term Plan, NHS People Plan and the National Cancer Workforce Plan which outlines NCA's plans to grow and upskill the cancer workforce.

Within the NCA we have identified that a significant percentage of our current Clinical Nurse Specialist (CNS) workforce will be retiring over the next three years. To address this predicted workforce gap, the NCA are participating in two very different approaches to improving the supply of CNSs.

The first initiative is a two-year collaborative workforce development programme between NCA, Macmillan Cancer Support, Health Education England, Yorkshire Cancer Alliances and provider trusts across North East and Yorkshire. This programme commenced in October 2022 to support aspirant band 5 nurses to meet the capabilities and competencies of a band 6 Cancer CNS with participants being supernumerary for the first six months focusing on academic and observational learning.

The NCA have part-funded a programme lead for this workforce initiative and will continue to engage with learners, mentors and stakeholders. An evaluation of this model will be undertaken at the midpoint of training and at the end of year two.

The second initiative is the Cancer Nurse Internship Programme, originally developed by South Tyneside and Sunderland Trust with South Tees Trust subsequently participating in this approach. This model gives nurses the opportunity to leave their ward environment for one day per week for 12 months at Agenda for Change band 5 or 6, to work as part of a specialist cancer multi-disciplinary team, through clinical placements across a variety of cancer specialties.

Participants will be accredited at academic level 6 through completion of the 'Principles of Integrated Practice in Cancer and other Long-Term Conditions' module, delivered through self-directed distance learning with the University of Teesside. HEE has funded this initiative to date and following initial positive feedback of this approach NCA will support this development further in 2023/24 and an evaluation will take place.

'Step into health' recruitment event

Step into health is made up of NHS organisations which have pledged their support to the programme. Through Step into Health, members of the armed forces community can connect to the NHS organisations and set up training opportunities, placements, and application support.

The programme has been identified as an ICS priority and regular meetings have been set up for colleagues in eight of the 11 local foundation trusts to bring colleagues together to discuss work around the programme.

After several weeks in the planning stage, a Veteran Support Partnership recruitment event took place in Catterick on 22 November 2022. The event was organised by the NHS Business Services Authority in partnership with Step into Health with support from the ICS Workforce Team. The Career Transition Partnership was there on the day as well as a representative from Skills for Care alongside the following NHS organisations.

- Newcastle upon Tyne Hospitals
- Harrogate Integrated
- Health Education England
- Harrogate and District
- North East Ambulance Service
- South Tees Hospitals
- North Tees and Hartlepool
- Northumbria Healthcare

Jobs for everyone

A unique careers education opportunity was offered to primary school children in Tees Valley, following discussion by the ICS Workforce Team, with colleagues in South Yorkshire ICS, who developed the programme.

The programme is aimed at the very youngest pupils – reception and year 1 – and was offered as a free of charge trial which introduced over 20 different health and social care job roles, in a fun and engaging package.
Resources include classroom activities, role play, junk modelling and singing as well as a chance to meet the workers.

Evidence tells us that children make decisions about the roles that are open to them by the age of 7. This provides an opportunity to challenge stereotypes and raise aspirations.

Schools in Tees Valley were encouraged to get in touch. A high volume of schools came forward expressing their interest. Over 40 responses were received for the five free places, so we chose schools on a first come, first served basis. The first school to make contact from each local authority area was invited to take part.

The project has evaluated well in South Yorkshire schools, where it was originally developed and piloted, and an application has been agreed via the ICB workforce team to secure funding to deliver across the region in 30 schools, 10 of which will be in Tees Valley.

Widening participation internship project

The purpose of this initiative is to provide a co-ordinated approach across higher education institutions and health and care employers to support attraction and retention ambitions. It aims to attract and retain undergraduate students studying in the region, encouraging them to take paid employment as a sandwich or placement year, providing a route into employment where meaningful relationships have been formed to support talent management and future workforce planning.

The senior programme manager has been working with all universities in the area to establish courses that have placement requirement/option and broker those needs with employers. Working on already established relationships, the senior programme manager has reached into non-health programmes such as human resources, digital/ICT, finance, business, communications, facilities and leadership.

Meetings have taken place with internship placement leads to understand degree programmes that link into non-clinical role internships and understanding of the process for advertising and recruiting of internship roles on the universities' portals.

NHS trusts, local authorities, primary care networks, hospice and social care employers have engaged with the project, and work is ongoing within corporate areas to encourage internship posts, develop job descriptions and support recruitment processes. The most interest has been from digital, finance and HR roles. Successful recruitment has taken place for a software developer role at St. Oswald's Hospice, with a Northumbria University student starting the role in June.

Pathology workforce

- Secured £1 million HEE funding for a Biomedical Science Training Academy Project.

Key project aims:

- 20 Health and Care Professionals Council (HCPC) registered individuals with 12 months recent employment in an NENC pathology laboratory: **Decreased vacancies and local recruitment.**
- A network training package for the Institute of Biomedical Science (IBMS) registration portfolio: **Improved quality**
- A platform of online resources for use beyond the project trainees: **Increase training capacity**
- A standardised trainee band 5 Job Description: **Improved retention**
- A proof of concept for new ways of training: **Biomedical Science 'academy'.**
- Project lead and other new roles targeted at planned leavers: **Supports retention**
- Proof of concept of new roles: **New roles**
- Wider impact on band 2 staff: **Decreased in turnover**
- Introduced the first cohort of level 2 apprentices into the NENC pathology workforce. Working with HEE this has been achieved in collaboration with widening participation teams to increase diversity in our workforce, reduce turnover in band 2 staff and develop a 'grow your own' pipeline in the scientific pathology workforce.
- Increased capacity for training and development of staff to move from band 5 practitioner level to band 6 specialist level through a national project of webinars supported by the Institute of Biomedical Science, professional body for Biomedical Science.
- Developed a pathology focused network careers group hosting an inaugural online careers webinar for Biomedical Science Day 2022. The event attracted attendees (students and teachers) from 9 schools and colleges across the network (deliberately kept local) with an aim to showcase careers in pathology in this region.
- Attracted and facilitated spend of £240,000 of HEE funding to upskill 60 pathology support staff to professional registration through additional level 6 qualifications: developing staff and providing a pipeline for band 5 practitioner vacancies.

Research engagement and network development

Research and innovation key achievements

We are currently developing a research and innovation strategy, co-produced with a range of partners including provider organisations, academia, industry, NIHR research infrastructures and the AHSN.

This builds on the work already delivered as the ICB took on three statutory research duties during 2022-23. It has also seen co-ordination and alignment of a number of key research and innovation partners across the system with ICB priorities – in particular, the NECS Research and Evidence Team, the NIHR Local Clinical Research Network, the Applied Research Collaborative, and the AHSN.

The Research and Evidence Team at the North of England Commissioning Support (NECS) is commissioned and supervised by the ICB to deliver a range of research support services, including research governance, research training, knowledge mobilisation, managing excess treatment costs, and service evaluations.

This provides assurance to the ICB that research is conducted in line with HRA requirements, and that evidence is both developed and used across the system. Research and evaluation projects that have resulted in direct service improvements include an Evidence Synthesis project, a review of LeDeR reports, an ICS alcohol mapping project, new discharge pathways (in end of life care), a pharmacy workforce review, and a direct UTI pharmacy pilot – which has now been commissioned nationally.

The management of NIHR research capability funding was also handled by the NECS research and evidence team on behalf of the ICB. This was administered to several pilot and feasibility projects in line with national and system research priorities. These include work around alcohol policy, school meals, group consultations, primary care workforce developments, and evaluations of new approaches to managing specialist conditions in primary care. Many of these projects have already had a direct impact on service delivery, policy change, and often progress to larger scale research projects – supporting new funding into the system.

The Local Clinical Research Network have recruited over 2,500 patients across the system in 2022-23, with recruitment seen in every speciality and every provider. The Applied Research Collaborative have also delivered research projects covering areas such as enabling methodologies, inequalities and marginalised communities, integrating physical and mental health, knowledge mobilisation and implementation sciences, and multi mobility, ageing, and frailty.

Improving diversity of representation in research

Mental health services for children and young people are experiencing a significant rise in demand across the country. The NENC health and care system has identified this as a key priority to address for the region.

To help reverse this trend, developing a deeper understanding of the experiences of children and young people across the region; the underlying causes of increasing mental health issues; interactions with the health and care system; and the evaluation of interventions (healthcare or non-healthcare) is essential. This is particularly important in relation to the diversity of communities and levels of deprivation in the region and addressing limitations in how representative recruitment to research has typically been, particularly for children and young people.

Following a successful bid in November 2022, NENC are amongst 17 ICBs to receive the Research Engagement and Network Development award (for approximately £100k) from Research England to support new models of community engagement which have potential to improve representative recruitment to research.

The NENC ICB, along with key partners, will utilise these funds to develop a programme of work with the voluntary, community and social enterprise sector focusing on research into the mental health needs of children and young people as follows:

- Seek to gain a better understanding of the levels of participation and diversity in research amongst this population across the region and identify the barriers to participation.
- Seek to grow the involvement and capacity of voluntary and community sector organisations with strong community relationships to help facilitate more tailored and creative approaches to engaging children and young people in research.
- Enable VCSE organisations to engage with children, young people and/or families around health research including their understanding of and views on health research, and barriers and enablers to being part of research.

The programme will support up to two VCSE organisations in each of the four integrated care partnership areas (up to eight organisations) to co-design a programme of engagement with their respective communities and develop an evaluation plan to monitor the outcomes of each approach.

Through this programme, the project partners aim to:

- Utilise and build on the current work of research co-ordinators in Voluntary Organisations' Network North East (VONNE) and Cumbria Council for Voluntary Services (CVS) who are supporting the development of improved relationships between research and the VCSE sector, and empowering

VCSE organisations to harness and direct research opportunities to increase opportunities and amplify the voice of the communities they support.

- Map previous work across the region aligned with increasing diversity in research participation in teams, to avoid duplication, build on existing expertise and capacity, and learn from what has or has not worked.
- Examine what diversity exists within current research network structures across the NENC region and wherever feasible, adopt learning from previous initiatives.
- Identify barriers to VCSE organisations becoming involved in research work (especially in relation to CYP mental health) and build on previous learning which led to the development of Research Design Service (RDS) toolkits to support research engagement in the VCSE sector.
- Enable and support the development of community-suggested ways of addressing the barriers to research engagement/participation.

Project Activity	Outputs
Mapping activity to understand what research is currently live or upcoming across the ICS footprint, what is in the pipeline and what current activity and opportunities there are for communities to participate in research	• Report on levels and diversity of/research engagement and participation • Create a bespoke version of the online survey to identify barriers to research participation.
Mapping activity to understand what community groups and VCSE organisations are in the area relevant to CYP mental health and which of those are specifically interested in research, and whether there are existing targeted approaches to increase engagement	• Identify communities and local VCSEs that can support engagement with identified research opportunities • Create a programme of support for each area ICP, including award criteria • Identify a methodology to monitor and evaluate growth in local participation in research
Target diverse communities to get involved in specific research activity	• 7 VCSE organisations across the 4 area ICPs funded to run a co-designed engagement programme in respective communities
Monitor and evaluate the growth of the research network and its activities	• Overall project management, coordination of activities, organisations and tracking of outputs

Project Activity	Outputs
	• Monitor and evaluate growth in community engagement and interest in research

Research and innovation partnership forum

In November 2022 we collaborated with AHSN in hosting our first Research and Innovation Partnership Forum, which brought together over 100 leaders from the health and care services, local authorities, NIHR infrastructures and all six universities.

The purpose of the forum was for all parties to understand how they can work better together and with the evolving ICB. Through a series of workshop activities all participants had an opportunity to develop a framework through which core strategic objectives for the ICB research and innovation strategy evolved.

Health and life sciences pledge

The ICB Executive Director of Innovation worked closely with the AHSN in launching the Health Life Science Pledge for the NENC region in March 2023. This joint commitment is to encourage, enable and empower stakeholders from academia, industry, local authorities, the community and the health and care sector to support the with the following:

1. Supporting the reduction of health inequalities
2. Improving and increasing research and innovation investment
3. Promoting economic growth to become recognised as an exemplar/centre of excellence for health and social care innovation

For more details, visit: www.hlspledge.org.uk

Improving quality

Quality governance

The ICB has set up quality structures to support place-to-board oversight, based on National Quality Board guidance.

We have established Integrated Place reports, with a standardised quality agenda to ensure a consistent approach. Learning and areas for escalation feed into the ICP quality groups, co-chaired by the Director of Nursing and Medical Director, focused on

patient experience, patient safety and clinical effectiveness. Key learning from these four meetings and areas for escalation are discussed at the Non-Executive Director (NED) chaired sub–board Quality and Safety Committee.

In addition to this we have an ICB System Quality Group. Based on best practice guidance from the National Quality Board, this reviews a wider than health-focused review of quality across the system. Co-chaired by the ICB Executive Chief Nurse and one of the local authority Directors of Adult Social Care, this meeting includes all regulators and colleagues from HEE and reviews quality concerns across all health and social care providers, escalated from place discussions. Items for learning or escalation are discussed at the Regional Quality Group, chaired by NHSE.

Safeguarding

The ICB has developed a Strategic Safeguarding Group, ensuring a standardised approach to processes across the 13 'places'. A heat map of our safeguarding practice has been completed and key learning shared across the ICB.

Continuing health care (CHC)

With a set of guiding principles developed and shared with partners, 2023/24 will be a year of transition to standardise processes. High-cost panels have been set up to review spending and ensure good governance. CHC is managed through a Strategic CHC Group chaired by the Deputy Chief Nurse and supported by the four area leads for CHC. The group has local authority representation and will be the vehicle for the transformational change programme.

Personalisation

The ICB has commissioned a piece of work to look at increasing the uptake of Public Health Budgets (PHBs) and Public Wheelchair Budgets (PWBs) within NECN. Several challenges have been identified with regard to these services, including:

- A lack of awareness and understanding among commissioners of the different types of PHBs, how to implement them, what they can and can’t be used for and the underpinning personalised care and support planning process
- Implementing mechanisms and governance for managing PHBs at a local level, including robust data collection
- Block contracts hindering the use of funds in a different and more personalised way for those eligible
- Support for families who take on PHBs, such as how to manage any employed staff

- These historically sitting with social care in the form of direct payments, so health colleagues have limited involvement and knowledge the ICB will develop a strategy to promote and increase the uptake of Personal Health Budgets (PHBs) and Personal Wheelchair Budgets (PWBs) across the system and to develop a strategy for robust data collection systems.

Learning Disabilities Mortality Review (LeDeR)

The LeDeR Governance Group is chaired by the Executive Chief Nurse and is a subgroup of the Quality and Safety Committee. Regional oversight arrangements include NHSE/I sampling to assure quality of reviews. Local governance arrangements will feed into the area Quality and Safety Groups and, for local authorities, Health and Wellbeing Boards, to ensure that the people who can affect the necessary improvements understand the issues that need to be addressed. The ICB is responsible for ensuring:

- That LeDeR reviews are completed for their area
- That actions are implemented to improve the quality of all mainstream services for people with a learning disability, to reduce health inequalities and premature mortality
- That local actions are taken to address the issues identified in reviews
- That recurrent themes and significant issues are identified and addressed at a more systematic level.

Special education needs and disabilities (SEND)

A strategic group has been developed to review the current provision of SEND across the ICB. The current heat map produced shows us as Amber against the standards. There is a workplan in place to ensure consistency across the ICS, with key areas relating to accessible date, governance and workforce.

Peer review meetings are taking place every six months with the regional teams. The Hartlepool Partnership has been inspected with the new inspection regime, and learning from this is being shared across other areas.

Maternity

The Local Maternity and Neonatal System (LMNS) is now fully staffed and has a development plan in place. The LMNS published its equity plan, which has received very positive feedback from the national team. All provider CNST plans were reviewed by the senior clinical team in the LMNS to provide an independent overview of submissions. These were then signed off prior to being submitted by the provider trusts.

The LMNS plans to continue Ockenden visits and all trusts will have assurance visits between September and October. The single maternity plan has been published and a planning event with key stakeholders will take place. The ICB is developing plans for a Maternity Alliance, bringing all partners together to ensure a prioritised plan is delivered for women and babies.

Children and young people

The ICB works closely with partners to ensure the voice of children and young people is heard, through engagement with the voluntary sector and local authority partners. The ICB works closely with the regional CYP team to align our priorities. The ICB plans to develop an alliance model of CYP services to ensure a coordinated approach to meet the needs of our children and young people.

Engaging people and communities

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

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

Specialist advice and external benchmarking is obtained from the Consultation Institute. This support ensures that all engagement and consultation work undertaken by the ICB follows best practice.

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

Each project has a specific bespoke involvement plan which sets out objectives, tactics and resources required.

We have a robust process in place to ensure that patients' views are considered for the services we commission, to help evaluate current service delivery and to help shape how future services will work. This includes a toolkit for staff to use when undertaking service change, and guidance on mechanisms and techniques that can be used to ensure patient views are captured. Advice and guidance are also available from ICB involvement leads, who support involvement across the whole region.

Annual involvement and engagement report

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

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

We undertake demographic monitoring to ensure inclusive participation across the region and that the nine protected characteristics of the Equality Act 2010 are covered. The ICB's annual involvement and engagement report details all the ways we work with local people to improve access, service delivery and quality. It also includes evidence of local people acting as a catalyst for innovation and change.

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

The annual involvement and engagement report provides a summary and demonstrates the range of some of the key patient and community engagement activities during 2022/23. This report demonstrates how the involvement of patients and public has influenced decisions the ICB has made.

Innovative ways to listen

- Involvement toolkit
- Citizens' panel
- Storyteller process
- Raising awareness of involvement in the ICB
- Secure data environment

Shaping services through listening

- Respite services for people with learning disabilities
- Waiting well
- Post-Covid syndrome
- Affordable transport for care leavers
- Integrated quality strategy accross health and care system

Collaborative listening

- Northern Cancer Alliance oncology service review
- Integrated approach to review local advocacy services
- Co-producing a new health resource for teenagers and young people
- Co-production with parent carers of children and young people with SEND-North Tyneside
- Co-production training review

Working with our communities

- Working with Healthwatch
- Community mental health transformation
- Health Inequalities Fund
- Equalities, health inequalities, and vaccinations
- DigitalMe - giving a voice to volunerable people
- Listening forums

Supporting quality improvements in primary care

- Urgent care services
- Enhanced GP access
- Urgent Community Response
- GP commissioning engagement
- Identifying penicillin allergies
- Maternity clinics for covid and flu vaccination

Waiting Well

Eight areas across the region received funding to deliver a programme of support for patients awaiting non-urgent surgery.

The *Waiting Well* programme aims to engage with patients to support them to adopt healthier lifestyles whilst waiting for surgery. It is hoped that not only will this help prepare them for surgery and recovery but will also inspire patients to continue healthier lifestyle choices in the long term.

Patients who fall into any of the following categories will be eligible for the programme - living in a deprived community, having a learning disability, having uncontrolled diabetes or obesity, and/or current smoker/user of preoperative opiates.

To explores perception of Waiting Well, we carried out a piece of engagement with stakeholders and members of the public during a three-month period from December to March, gathering the opinions of 200 individuals. The engagement also linked with Healthwatch across the region to help listen to thoughts from local communities.

The engagement helped us to understand perceived barriers and benefits of the programme, as well as explore the ideal Waiting Well programme. This information is being used to help develop the programme, plan future engagement and support the development of information materials.

Integrated urgent care in South Tees

We carried out a public engagement between August and October 2022 on proposals to introduce a new model of urgent care in Middlesbrough and Redcar and Cleveland. The proposals included a new Integrated Urgent Treatment Centre at The James Cook University Hospital, GP Out of Hours to be relocated to The James Cook University Hospital and increased opening hours at Redcar Primary Care Hospital.

Proposals included a standardised offer, so that wherever a patient lives in Tees Valley, they will have the same access to the same high standard of urgent care around the clock.

The engagement consisted of a survey, public meetings, and targeted engagement with the local community. Please click here to read the findings of this engagement. This report will help inform the next steps and development of proposals to ensure services are equipped to best meet the needs of the local population.

Respite services for people with learning disabilities

Elmville provided short break respite services to people with learning disabilities in South Tyneside. The centre was temporarily closed for safety reasons in 2020 due to

the COVID -19 pandemic and the families using Elmville were contacted to establish what other support they needed.

To understand the needs of patients and their carers, what was important to them, and their thoughts on Elmville and other short break services, we carried out a piece of engagement in May 2022. This information will be used to help inform future service provision.

The work was led by the ICB and South Tyneside and Sunderland Trust, with support from a specialist involvement and communications agency, and the learning disability charity Twisting Ducks.

Conversations with service users, families and carers began in November 2022, continuing to March 2023. Engagement included:

- Initial contact with 18 families to understand communication needs and conversation preferences of patients.
- Survey with parents and carers of service users
- Workshop sessions with patients and their family members
- System-wide workshop with wider stakeholders to feedback what service users and families had shared
- Final feedback workshop held with families and patients to summarise the learning and discussions from the system-wide workshop
- Conversations with individual families who could not attend the event

As part of this engagement work, we developed a video to demonstrate how we have engaged with service-users with learning disabilities, including individuals with complex communication needs. This is available on YouTube.

Integrated Care Board – communities and people

As we began greater collaborative working arrangements, we have worked together with involvement leads across the region to develop stronger partnership arrangements. We held conversations with our stakeholders to understand what has worked well for involvement, what could work better, and in an ideal world, how the ICB can deliver excellence through involvement.

This information was used to develop the ICB's principles, aspirations, and framework for involvement. This framework has been built on conversations with our stakeholders, and a shared commitment to continue to involve patients, public, carers, and wider stakeholders in shaping, evaluating, and improving the services we commission.

Integrated care strategy

The NHS, local authorities and the community, voluntary and social enterprise sectors came together to develop a plan to improve health and care in the North East and North Cumbria.

The *better health and wellbeing for all* plan sets out how we will reduce inequalities, improve experiences of health and care services and improve the health and wellbeing of people living and working in our region by 2030 and beyond, as well as the steps that will be taken to make these ambitions into reality.

To ensure that stakeholders, partners, and members of the public had the opportunity to help shape this strategy, – we welcomed people's views through an online survey between 27 October and 25 November 2022.

Additionally, individuals and organisations were able to submit a direct response. Valuable feedback was received from stakeholders, and this was used to help finalise the strategy. The engagement findings report is available on the ICB website.

Involvement strategy

The ICB's involvement strategy was produced in co-production with partner organisations. Based on research with partner organisations, the strategy is based around the following five themes:

We will reach out to people to involve them in the right way to increase participation.

We will promote equality and diversity and encourage and respect different beliefs and opinions.

We will take the time to plan for involvement, including how we can work with partners, and feeding back.

We will continue to build on our partnership relationships, in particular to ensure knowledge and capability is shared for the future.

We will use a range of best practice involvement methods including both on-line and off-line methods.

This strategy – available on the ICB website - ensures that we have a clear plan to meet legal duties to engage and consult the public and also the pledges set out in the NHS constitution.

The strategy was also produced as an easy read version, and in British Sign Language.

Listening to lived experience

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

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

An animation has been developed to help collect patient stories which has been included on the ICB website, shared with Healthwatch and wider stakeholders, and promoted through social media.

Working with our communities

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

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

We also work with a wide range of other voluntary and community organisations. This helps us to reach and involve our diverse populations in shaping local health services.

Developing a citizens' panel

The ICB commissioned some research to scope out a future citizens' panel engagement model. This explored the benefits, drawbacks, and resource requirements of differing models of citizen engagement, providing recommendations on an approach that will meet future needs.

Stakeholders told us they felt citizens' panels were a good method of engagement that has proven effectiveness within health care, and specifically within ICB structures. The

report summarised some recommendations, including practical considerations for running and managing a panel. This information is being used to develop a plan for operational delivery of a panel in 2023/24. The report is available on the ICB website.

Working in co-production

Co-production is a way of working with people and communities in equal partnership. It is an approach to decision making and service design, rather than a specific method of engagement. It stems from the recognition that if organisations are to deliver successful services, they must understand the needs of their users and engage them closely in the design and delivery of those services.

Co-production offers the opportunity for professionals and service users to work together to ensure that service delivery connects to lived experiences and is therefore meaningful and effective.

The ICB is committed to working with people and communities at the earliest stages of conversations, acknowledging that people with lived experience, carers, and community stakeholders are expertly placed to advise on what support and services will make a positive difference to their lives and what is needed for their communities. We champion this way of working and are leading this way of working as an ICB.

We commissioned an independent research company to develop bespoke co-production training for staff and wider partner organisations. The main objective was to develop a co-production training toolkit which is practical, easily understood, and accessible for staff and stakeholders to implement. The research had the following key objectives:

- Preliminary research to understand thoughts about co-production, any barriers that may exist and how they would like training to be delivered.
- Develop and deliver initial training that was cognisant of this understanding, worked to overcome any barriers and was delivered according to staff preferences.
- Evaluate this training with training participants to understand how it could be improved.
- Develop and evaluate the final toolkit. This is a stand-alone resource for co-production that can be iteratively developed by staff to reflect their learning as co-production becomes embedded in routine practice.

Find out more about how we work to involve people on the ICB website.

Reducing health inequality

Our vision is to become the most equitable and inclusive ICB, creating fairer outcomes for all.

The ICB has appointed a Director of Health Equity and Inclusion to lead on our public sector equality duty and deliver beyond legal duties. To demonstrate performance against equality of service delivery KPIs and metrics, we will report and deliver against the NHS Workforce Race Equality Standard, the NHS Workforce Disability Equality Standard and the Gender Pay Gap.

Our mission is to create an environment, workplace and system where our people feel that they belong, are listened to, invested in, and valued – where they receive equity of treatment, opportunity and representation, in their work and at all levels of the ICB.

We have begun our journey to embed equality, diversity and inclusion (EDI) into the fabric of the ICB, its delivery and policies to become the best place to work in health and care in England.

Our equality, diversity and inclusion objectives are:

1. **Improved EDI capability and knowledge** - we will improve our equality, diversity and inclusion capability and knowledge, by providing our people with opportunities for learning, experiences and development at all bands and professions.
2. **Be legally compliant and confident**
3. **Be consciously inclusive** - we will listen and work with our people to build psychological safety and improve their lived experience, to create the best workplace environment, providing them with the opportunities to perform at their best.

To continue to promote and enhance equity of service delivery we currently have a one-year interim EDI Strategy 2023/24 which secured board sign off in March 2023, which has started to deliver against the above three objectives. One future-focused action is to shape and co-create a system-wide 5-year EDI Strategy with our providers and partners.

Our interim strategy aims for EDI to become a universal indicator of how we respect and value our workforce, with an inclusive and fair culture in which we can develop metrics by which leadership at all levels is judged. The ICB has specific responsibilities to fulfil (as outlined below) and will continue to develop and evolve its approach during 2023/24.

The Equality and Human Rights Commission (**EHRC)** advises that a board sets strategic direction, reviews performance and ensures good governance of the organisation.

The **Messenger** report (2022) states: "A *step-change is needed in the way the principles of equality, diversity and inclusion are embedded as the personal responsibility of every leader and every member of staff."*

The **Messenger** report also states: *"There is widespread evidence of considerable inequity in experience and opportunity for those with protected characteristics, of which we would call out race and disability as the most starkly disadvantaged."*

Our three key actions to understand and reduce health inequalities within the ICB are:

1. Recruit to a dedicated post to lead on health inequalities across the ICS
2. Create a health inequalities academy which is funding specific projects to tackle health inequalities
3. Tackle health inequalities for staff, as well as wider communities and public.

These actions fall within the newly created programme infrastructure of the 'healthier and fairer' advisory group, which reports directly into to the Executive Committee, with three workstreams focusing on prevention, healthcare inequalities, and the NHS contribution to the social economic inequalities.

Each workstream has a focus on elements of the Core20PLUS5, with a senior responsible officer and a programme manager to support and report on deliverables on a regular basis.

Primary care achievements

The majority of NHS patient interactions are delivered in primary care, through general practice, dentistry, optometry and community pharmacy. Some parts of our region are struggling to maintain their primary care services due to severe workforce shortages, particularly of 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 (2022) makes a range of recommendations for the improvement of primary care. During 2022/23 the primary care team has had the opportunity to review the Fuller stocktake and identify the potential it can offer our system and our patients.

Adopting an approach to integration and focusing on outcomes for patients is at the centre of our transformation agenda. The ICB has undertaken an initial baseline assessment of delivery and opportunity which identifies the elements that offer both stability to primary care delivery, and the positive outcomes that can be achieved by ensuring providers across our local systems work together through collaboration to transform services and improve the health and wellbeing of our communities.

Following this baseline assessment, a programme of work will encompass the delivery plan for primary care and include key transformation programmes:

- Enablers and strengthening the infrastructure to support delivery
- Focus on improving the experience of service users when accessing primary care
- Alignment with the ageing well, mental health and out of hospital care
- Urgent care delivery and interface between providers

Aligning delivery across the ICB will take the form of an action plan, creating a NENC Fuller blueprint with the aim of creating a prospectus which describes our offer to providers, stakeholder organisations and our population.

Early developments include:

- Initial engagement on our Fuller blueprint
- Developing a framework for local areas to consider best practice that demonstrates early success and opportunities on which we can build
- Designing enablers to support innovation through planning and prioritisation – raising awareness of what our providers need to create opportunities for change

Following publication of the ICS strategy, an engagement process was undertaken to understand the key priorities and themes that are important to local primary care stakeholders. Through January and February 2023, local primary care teams alongside the Primary Care Transformation Team engaged with a range of system partners including primary care contract holders (GPs, dentists, pharmacies, optometrists), primary care networks (PCNs), GP federations, local medical, pharmaceutical, dental and optometry committees, as well as Healthwatch).

There was a good response to the engagement exercise and some clear themes identified. These themes have formed the basis for production of a Forward Plan for Primary Care in 2023-24 and beyond. This will set out how we work with system partners to stabilise and build resilience in primary care as well as support key change and transformation programmes.

Since July 2022, the Primary Care Transformation Team has been working with NHS England colleagues to ensure the ICB is ready to receive the delegation of pharmacy,

optometry and dentistry (POD) services, as well as services such as clinical waste, occupational health, translation and interpretation, and secondary care dental services.

All these functions transferred to the ICB on 1 April 2023, and the NHSE staff who currently deliver them are due to transfer from 1 July 2023. A formal delegation agreement supported by memoranda of understanding has been signed to accept the delegation.

An ICB and NHSE operational group consisting of subject matter experts was convened to manage actions required to support the transition. These will continue until the staff transfer on 1 July. Complaints, MP enquiries and Freedom of Information requests associated with POD and general practices will also transfer to the ICB on 1 July 2023. The ICB has hosted two development sessions with the NHSE teams in support of the transition, and further sessions are planned prior to and post-transition of staff.

A primary care operating framework has been developed for all primary care functions, including new sub-committees to ensure appropriate governance to support decisions in respect of these contractor groups. NHSE has published its new Primary Care Assurance Framework against which the ICB will be monitored, and plans are currently being drawn up to provide assurance.

The North East and North Cumbria Primary Care Collaborative has been set up to create an interface between primary care, the ICB and our wider system partners.

It is more important than ever that general practice is represented in strategic and operational planning and delivery. Regionally, clinical directors, GP federations and local medical committees have come together to create a focused interface with system partners and commissioners on key priorities.

Through the Primary Care Collaborative, we will establish a structure to ensure primary care has a strong voice in the health and care system and ensures the views of practices, PCNs, GP federations and local medical committees are at the heart of all discussions around the delivery of stable, high-quality services. The functions and interface are described in a memorandum of understanding, while a stakeholder engagement plan is also planned.

Environmental matters

The climate crisis is a health emergency – one of the biggest health challenges faced by humanity. Our health and care system is committed to playing its part in tackling climate change, and launched its Green Plan in July 2022.

This three-year plan sets out targets and actions to meet the sustainability challenge through a programme of activity and by exploiting synergies between member

organisations. A healthier environment means healthier people, and healthier people have a lower impact on the environment by requiring less treatment and/or fewer medicines.

The NHS has committed to reaching carbon net zero in response to the profound and growing threat to health posed by climate change. The Health and Care Act 2022 has placed new duties on NHS bodies including foundation trusts and integrated care boards to contribute towards statutory emissions and environmental targets. The NHS has set out top level targets for carbon emissions as follows:

- 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 ('NHS carbon footprint plus'), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.[1]

We aim to go beyond this and have a vision of being England's greenest region by 2030. As an enabler to meet the vision and align our ambition with climate science and the majority of local authorities in the region, the ICB and its members will have to cut their carbon footprint at a faster rate than the NHS national targets of 2040/2045.

Our key work programmes

As part of our Green Plan we will monitor key indicators in relation to the net zero target, working at place with anchor institutions as well as developing system-level oversight with the appropriate representation from all partners.

As a health and care system, we are committed to developing a consistent approach with our partners in the public and voluntary sectors to sustainability, recycling, improving air quality and carbon reduction, as well as increasing access to green spaces.

We are part of a cross-sector coalition working to enable our vision. Our Green Plan has identified a range of key targets and actions for delivery to support the following key focus areas which reflect the priority action areas in 'Delivery a Net Zero NHS' strategy:

- People
- Sustainable healthcare
- Travel and transport
- Energy
- Waste and the circular economy
- Supply chain and procurement
- Greener estates and adaptations
- Clean air

[1] Delivering a Net Zero NHS https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/

These priority action areas form the basis of our sustainability working groups across the region where key stakeholders work collaboratively to deliver our regional ambitions.

Financial review

For 2022/23, funding allocations were set at ICB level for the full year. Prior to the ICB's establishment on 1 July 2022, CCG financial positions were monitored in aggregate against the overall ICB allocation.

All CCGs received an allocation equal to resource consumed for the three-month period to 30 June 2022. The ICB on establishment was allocated the remaining full year funding allocation to be utilised over the remaining nine months of 2022/23.

This is shown in the table below:

	Programme allocation £'000	**Running Cost allowance £'000**	**Total funding allocation £'000**
Total initial ICB funding allocation	6,454,768	57,406	6,512,174
Resource consumed by CCGs	(1,550,584)	(13,641)	(1,564,225)
Balance of initial funding available to ICB	**4,904,184**	**43,765**	**4,947,949**
Additional in-year allocation adjustments	222,223	3,662	225,885
Total ICB funding for nine-month period	**5,126,407**	**47,427**	**5,173,834**

Further details on the ICB's financial position, together with the wider ICS position, can be found in the finance reports presented to Board, which are published as part of Board papers on the ICB's website.

Financial targets and performance for the period

The ICB has a number of financial duties under the NHS Act 2006 (as amended). Performance against these duties is reported in note 20 of the annual accounts and is summarised in the table below.

Unlike commercial companies which make a profit or loss, ICBs are set resource limits within which they must contain net expenditure for the year. There are separate resource limits set for revenue and capital expenditure, with revenue expenditure limits further split between programme spend and running costs ('administration').

ICB financial performance is reported on an in-year basis. As can be seen from the table below, all relevant financial duties were met for 2022/23.

Target	Target Met?
Revenue resource use does not exceed the amount specified in Directions ICBs are required to manage overall revenue expenditure within the revenue resource limit (the 'break-even duty'). For 2022/23, the ICB delivered an overall surplus of £2.744m.	✓
Revenue administration resource use does not exceed the amount specific in Directions A separate running cost allowance is provided to all ICBs to cover the administrative costs of running the ICB. There is a requirement to manage administrative costs within this allowance. Total running costs for the nine months amount to £42.010m, which was within the running cost allowance of £47,427m.	✓
Capital resource use does not exceed the amount specified in Directions The ICB is required to manage capital spending within the capital resource limit. The ICB received no direct capital resource during the year and incurred no capital expenditure.	✓

An underspend has been delivered in administrative spend during the period which has allowed additional funding to be spent on frontline healthcare services.

The overall ICB surplus of £2.744m was planned in order to offset deficits in NHS provider trusts within the system.

Efficiencies totaling £48.461m (compared to a plan of £48.433m) were delivered by the ICB during the period, which has supported delivery of the overall financial position. This has included particular efficiencies in medicines optimisation and in delivery of individual packages of care.

Other financial targets

The ICB, along with other system partners, also has a shared responsibility for achievement of financial balance at an ICS level. The ICB has worked collectively with partners to manage financial risks across the system in line with the agreed approach to system financial management. This has included monthly review of the financial

position and potential financial risks, with targeted actions agreed during the period to successfully mitigate and manage risks, enabling delivery of a surplus position.

For 2022/23, the overall ICS financial position was a surplus of £56.163m, compared to a planned break-even position. This predominantly reflects additional income received by one of the provider trusts late in the year following settlement of a court case relating to building quality issues.

The ICB agreed a joint capital resource use plan for the year along with partner NHS Foundation Trusts, which is published on the ICB website, along with the plan for 2023/24. Although the ICB received no direct capital resource, overall capital expenditure across the ICS for 2022/23 was managed within the agreed ICS capital allocation.

Compliance with Better Payment Practice Code

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

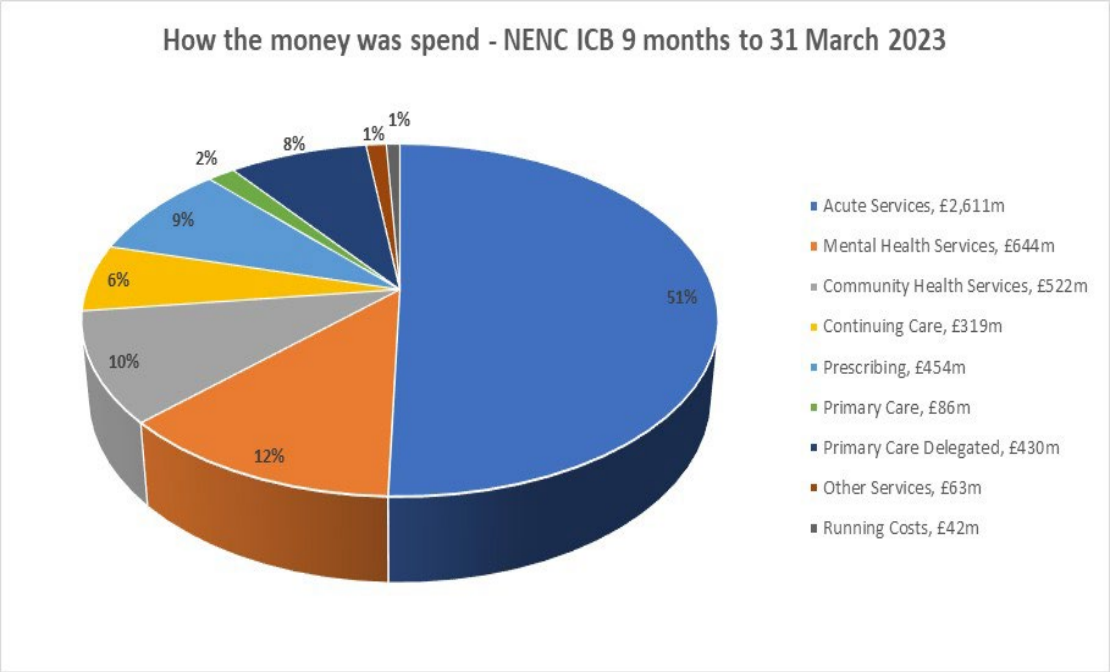
The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms.

Details of compliance with the code are given in note 5 to the annual accounts.

Performance against the target is monitored by the ICB monthly with performance maintained at over 95% of invoices paid within 30 days of receipt, measured against both total invoice value and overall volume of invoices.

How was the money spent?

The ICB works hard to ensure that the revenue allocation it receives is spent wisely, and that it supports the aim of commissioning high quality healthcare while ensuring effectiveness and value for money. The chart below shows how the ICB funding allocation was utilised in 2022/23.



Looking ahead

The 2022/23 financial position includes significant non-recurring efficiencies and benefits across both the ICB and wider ICS, including substantial additional non-recurring funding from NHS England.

The non-recurring nature of these savings contributes to a considerable financial challenge to develop balanced financial plans for 2023/24.

Financial allocations have been confirmed for 2023/24 which show the NENC ICB receives lower than average growth funding, due to being deemed to be over target allocation and having a lower population growth.

Additional financial pressures have also been identified for 2023/24, particularly relating to excess inflationary pressures over and above national planning assumptions.

All these factors combine to present a significant risk to the delivery of a balanced financial position for 2023/24.

Considerable work has been undertaken during 2022/23, across both the ICB and in collaboration with NHS provider trusts across the ICS, to develop financial plans for 2023/24. Initial draft plans developed in February 2023 indicated an overall deficit position across the ICS of £410m. Intensive work has been undertaken across the system to review positions and identify further mitigations, including ICB-led reviews with individual provider trusts. This has included:

- Review of all funding allocations,
- Review and challenge of cost assumptions across all organisations,

- Identification of additional stretch efficiencies
- Review of planed investments and potential non-recurring opportunities
- Improved productivity on elective care

This is reflected in the final plan submitted on 4 May 2023 showing an overall ICS deficit of £50m, including an overall planned surplus for the ICB of £30m.

Work continues to review plans and seek to identify further mitigations and recurring efficiencies to both support delivery of planned positions and reduce potential risks associated with the plan.

Work has also commenced with partners across the ICS around the development of a medium-term financial plan and strategy to address underlying recurring deficits across the system.

ACCOUNTABILITY REPORT

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

Accountable Officer
29 June 2023

Accountability report

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations. It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 July 2022 to 31 March 2023, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate governance report

Directors' report

Director profiles

Membership of the ICB Board is summarised in table xx below. Profiles of members are given on the ICB website.

Composition of ICB Board

The membership of NHS North East and North Cumbria Integrated Care Board is set out in the constitution. The composition of the ICB Board from 1 July 2022 (the date the ICB was established) to 31 March 2023 is shown in table xx below.

Membership of NHS North East and North Cumbria Integrated Care Board

All members were in post from ICB establishment on 1 July 2022 until 31 March 2023, unless shown.

Position	Name	Gender	Status
Chair	Professor Sir Liam Donaldson	Male	Voting
Chief Executive	Mrs Sam Allen	Female	Voting
Executive Chief of Strategy and Operations	Ms Jacqueline Myers	Female	Voting
Executive Chief People Officer	Mrs Annie Laverty	Female	Voting
Executive Area Director (North & North Cumbria)	Mr Mark Adams (from 1/7/2022 to 24/11/2022), and Mrs Nicola Bailey (interim from 5/9/2022)	Male/ Female	Voting
Executive Area Director (Central & South)	Mr Dave Gallagher	Male	Voting
Executive Chief Digital and Information Officer	Professor Graham Evans	Male	Voting
Executive Chief Nurse (from 18/7/2022)	Mr David Purdue	Male	Voting
Executive Director of Corporate Governance, Communications & Involvement	Mrs Claire Riley	Female	Voting
Executive Director of Finance	Mr Jon Connolly (from 1/7/2022 to 24/11/2022), and Mr David Chandler interim from 5/9/2022 and permanent from 24/3/2023	Male	Voting
Executive Director of Innovation	Mr Aejaz Zahid	Male	Voting
Executive Medical Director	Dr Neil O'Brien	Male	Voting
Foundation Trust Partner Member	Mr Ken Bremner	Male	Voting
Foundation Trust Partner Member	Dr Rajesh Nadkarni	Male	Voting
Independent Non-Executive Member Patient and Public Involvement	Dr Hannah Bows	Female	Voting

Position	Name	Gender	Status
Independent Non-Executive Member	Professor Eileen Kaner	Female	Voting
Independent Non-Executive Member	Mr Jon Rush	Male	Voting
Independent Non-Executive Member (Audit)	Mr David Stout	Male	Voting
Local Authority Partner Member	Mrs Catherine McEvoy-Carr	Female	Voting
Local Authority Partner Member	Mr Tom Hall	Male	Voting
Local Authority Partner Member (from 10/1/2023)	Cllr. Shane Moore	Male	Voting
Local Authority Partner Member	Mrs Ann Workman	Female	Voting
Primary Medical Services Partner Member	Dr Saira Malik	Female	Voting
Primary Medical Services Partner Member	Dr Mike Smith	Male	Voting
North East and North Cumbria Voluntary Organisations Network North East (VONNE) Representative	Jane Hartley	Female	Non-Voting
North East and North Cumbria Healthwatch Representative	Mr David Thompson	Male	Non-Voting

Committees, including Audit Committee

Membership of the Audit Committee

The Audit Committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.

The duties of the Committee are driven by the organisation's objectives and the associated risks. The Committee will agree an annual programme of business; however this will be flexible to new and emerging priorities and risks.

Audit Committee

Position	Name	Gender
Audit Committee Chair and Independent Non-Executive Director	Mr David Stout	Male
Audit Committee Member and Independent Non-Executive Director	Professor Eileen Kaner	Female
Audit Committee Member and Independent Non-Executive Director	Mr Jon Rush	Male

Membership of the Executive Committee

The Executive Committee reports directly to the ICB Board and assists the Board in its duties by overseeing the day-to-day operational management and performance of the ICB, in support of the Chief Executive in the delivery of his/her duties and responsibilities to the Board; provides a forum to inform ICB strategies and plans and in particular the committee undertakes any commissioning and planning activity on behalf of the Board, helping to secure continuous improvement of the quality of services; and implementation of the approved ICB strategies and plans.

Executive Committee

Position	Name	Gender
Chief Executive	Mrs Sam Allen	Female
Executive Chief of Strategy and Operations	Ms Jacqueline Myers	Female
Executive Chief People Officer	Mrs Annie Laverty	Female
Executive Area Director (North & North Cumbria)	Mr Mark Adams (from 1/7/2022 to 24/11/2022), and Mrs Nicola Bailey (interim from 5/9/2022)	Male/ Female
Executive Area Director (Central & South)	Mr Dave Gallagher	Male
Executive Chief Digital and Information Officer	Professor Graham Evans	Male
Executive Chief Nurse	Mr David Purdue	Male
Executive Director of Corporate Governance, Communications & Involvement	Mrs Claire Riley	Female
Executive Director of Finance	Mr Jon Connolly (from 1/7/2022 to 24/11/2022), and Mr David Chandler interim from 5/9/2022 and	Male

Position	Name	Gender
	permanent from 24/3/2023	
Executive Director of Innovation	Mr Aejaz Zahid	Male
Executive Medical Director	Dr Neil O'Brien	Male

Membership of the Remuneration Committee

The Remuneration Committee reports directly to the ICB Board and assists the Board by confirming the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including board members) but excluding non-executive Board member and excluding the Chair.

Remuneration Committee

Position	Name	Gender
Independent Non-Executive Member (PPI)	Dr Hannah Bows	Female
Independent Non-Executive Member	Professor Eileen Kaner	Female
Independent Non-Executive Member	Mr Jon Rush	Male

Membership of the Finance, Performance, and Investment Committee

The Finance, Performance, and Investment Committee reports directly to the ICB Board and contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan.

Finance, Performance, and Investment Committee

Position	Name	Gender
Executive Director of Finance	Mr Jon Connolly (from 1/7/2022 to 24/11/2022), and Mr David Chandler interim from 5/9/2022 and permanent from 24/3/2023	Male
One of the Executive Area Directors	Mr Dave Gallagher	Male
	Mr Mark Adams (from 1/7/2022 to 24/11/2022), and Mrs Nicola Bailey (interim from 5/9/2022)	Male/Female

Position	Name	Gender
Vice Chair and Independent Non-Executive Member	Professor Eileen Kaner	Female
Executive Chief of Strategy and Operations	Jacqueline Myers	Female
Executive Medical Director	Dr Neil O'Brien	Male
Chair and Independent Non-Executive Director	Mr Jon Rush	Male
Foundation Trust Partner Member	Mr Ken Bremner	Male
Foundation Trust Partner Member	Mr Rajesh Nadkarni	Male

Membership of the Quality and Safety Committee

The Quality and Safety Committee reports directly to the ICB Board and assists the Board by providing assurance that is delivering its functions in a way that delivers high quality safe patient care in commissioned services and secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care.

The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care.

Quality and Safety Committee

Position	Name	Gender
Non-Executive Member (Chair)	Professor Eileen Kaner	Female
Non-Executive Member (Vice Chair)	Professor Hannah Bows	Female
Executive Medical Director	Dr Neil O'Brien	Male
Executive Chief Nurse	David Purdue	Male
Executive Chief of Strategy and Operations	Jacqueline Myers	Female
Foundation Trust Partner Member	Ken Bremner	Male

Position	Name	Gender
Primary Medical Care Partner Member	Dr Saira Malik	Female
Local Authority Director of Public Health or Partner Member	Tom Hall	Male
Director of Allied Health Professions	Maria Avantaggiato-Quinn	Female
Director of Medicines	Ewan Maule	Male
Place Director of Nursing (North)	Richard Scott	Male
Place Director of Nursing (North Cumbria)	Louise Mason-Lodge	Female
Place Director of Nursing (Central)	Ann Fox / Jeanette Scott (job share)	Female
Place Director of Nursing (South)	Jean Golightly	Female

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

Register of interests

The ICB has arrangements in place for the effective management of conflicts of interest. Details of company directorships and other significant interests held by members of the board and committees are recorded in the register of interests. The ICB's guidance on managing conflicts of interest is available here. The register of interests is also available at this link.

Personal data related incidents

There were no personal data related incidents reported to the Information Commissioner's Office in the period 1 July 2022 to 31 March 2023.

Modern Slavery Act

North East and North Cumbria ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Statement of accountable officer's responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of NHS North East and North Cumbria Integrated Care Board and of its income and expenditure, Statement of Financial Position and cash flows for the financial period.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England.

NHS England has appointed the Chief Executive to be the Accountable Officer of NHS North East and North Cumbria Integrated Care Board. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding NHS North East and North Cumbria Integrated Care Board's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as

amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS North East and North Cumbria Integrated Care Board's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Governance statement

Introduction and context

NHS North East and North Cumbria Integrated Care Board is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended). NHS North East and North Cumbria Integrated Care Board's statutory functions are set out under the National Health Service Act 2006 (as amended).

The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

Between 1 July 2022 and 31 March 2023, the ICB was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the ICB's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in the ICB's Accountable Officer Appointment Letter.

I am responsible for ensuring that the ICB is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the ICB as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the board is to ensure that the ICB has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it.

ICB constitution

The ICB has a fully compliant constitution, approved by NHS England, available here.

ICB governance structure

The ICB's governance structure is available here.

ICB Board

The Board met five times in the period 1 July 2022 to 31 March 2023. The main items of business were:

- Approval of Constitution and Standing Orders
- Approval of Governance Handbook
- Establishment of Board Committee Structure and Appointment of Chairs
- Adoption of Key Policies and High-Risk Area Strategies
- Confirmation of Special Lead Roles
- Appointment of Founder Member for the Integrated Care Partnership
- Integrated Delivery
- Integrated Care System (ICS) 2022/23 Plan
- Finance Reports
- Annual Budgets
- Health, Inequalities and Sustainability
- CCG Closedown and Due Diligence
- Urgent and Emergency Care – Operation Resilience Plan
- Ockendon Report – Immediate Actions Review
- Safeguarding and Learning from Life and Death Reviews of People with Learning Disabilities and Autism
- Vaccination Plan
- Roadmap to Placed Based Learning
- Risk Management Strategy
- 2021/22 Annual Reports from Former Clinical Commissioning Groups (CCGs)
- Learning Disabilities and Autism: Building the Right Support
- ICB Oversight Framework
- ICB Operational Resilience – Winter Delivery Plan
- NHS England Commissioning Delegations – Pharmacy, Optometry, & Dentistry (POD) and Specialised Commissioning
- Establishing the Integrated Care Partnership
- Healthier and Fairer Advisory Group
- Integrated Care Strategy

- The Use and Development of Information Systems for the use of the ICB
- Managing and Improving Hospital Discharge: A System Overview
- Maternity and Neonatal Services in East Kent Independent Investigation
- Learning and Improvement System
- Equality, Diversity and Inclusion Strategy
- Operational Plan and Joint Forward Plan 2023/23
- Draft Financial Plan and Budgets 2023/24
- Board Assurance Framework

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

The Board met five times for development sessions times in the period 1 July 2022 to 31 March 2023. The main items of business were:

- Working as an Integrated Care Board
- (Four Weeks in): assessment of the health and care landscape in the North East and North Cumbria
- Moving forward to establish priorities and strategy
- Reflections on the board's needs, support structures and future development steps
- Overview of system risk appetite and board assurance framework
- Risk scenario discussions
- Introduction and overview to the Equality, Diversity and Inclusion Strategy duties
- Building leadership for inclusion initiative (BLFII) – NHS England
- Development of the ICB strategy
- Maternity and neonatal services in East Kent independent investigation
- Overview of the Strategic Coordination Centre for the ICS

The main function of the Board is to ensure that the ICB has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it.

We have reported on our corporate governance arrangements by drawing upon best practice available. During the year, the board has continuously considered and reviewed the effectiveness of each of its meetings to seek evidence of constructive challenge, contributions beyond member disciplines, behaviour, pace and enthusiasm.

We continuously monitor our process for managing conflicts of interest to ensure any actual or potential interests are managed effectively and robustly. The ICB has robust processes in place to manage conflicts of interest and has not had any breaches at the

time of writing this statement. The declarations of interest register is publicly available on the ICB's website.

The Board has held regular development sessions throughout the year to continuously review, develop and enhance its continuous learning and effectiveness.

The sessions covered a range of key topics such as:

- Working as an Integrated Board and assessing the health and care landscape
- Establishing strategy and priorities, including financial planning
- System risk appetite and board assurance frameworks
- Overview of equality, diversity and inclusion strategy and duties
- Building Leadership for Inclusion Initiative (with NHS England)
- A review of maternity and neonatal services (with Dr Bill Kirkup)
- Development of an Integrated Care System Strategic Coordination Centre
- Financial planning for 2023/24
- Learning and preparing for the Care Quality Commission inspections
- An overview of patient safety, patient experience and the practicalities of improving the safety of care in the North East and North Cumbria

Having reviewed the effectiveness of the Board's governance framework and associated guidance, I consider that the organisation has followed and applied the principles and standards of best practice.

Executive Committee

The Executive Committee is a committee of the NHS North East and North Cumbria Board. It was in operation throughout the 9-month period from 1 July 2022 to 31 March 2023.

The committee was established on 1 July 2022 and remains in place. The membership, purpose, roles and responsibilities of the committee are set out in its terms of reference available at this link.

The committee reviewed its effectiveness during its first 9 months of operation and concluded that the organisation has followed and applied the principles and standards of best practice. The Committee has continued to explore improvements to its effectiveness and efficiency of management to ensure that the meetings are productive and committee member time is effectively utilised.

New processes have been put in place to support this and ensure all essential business is conducted appropriately and provide assurance to the Board on delivery of its delegated functions. The annual review has identified the Committee has delivered its responsibilities as set out in its terms of reference.

The Executive Committee met eight times in the period 1 July 2022 to 31 March 2023.

The main items of business were:

- Terms of Reference including:
  - Executive Committee and Establishment of Sub-Committees
  - Urgent and Emergency Care Strategic Board and Local A&E Delivery Boards
- Integrated Delivery
- Finance Reports
- Financial Sustainability Checklist
- Governance Assurance including Governance Map & Cycle of Business
- Policy Reviews including:
  - Corporate Policies
  - HR Policies
  - Health and Safety Policies
  - Investment Business Case Policy
  - Continuing Healthcare and Safeguarding Policies
  - Individual Funding Request Policy, Panel Terms of Reference and Standard Operating Procedure
  - Policy for the Development and Authorisation of Patient Group Directions
- Community Diagnostics
- Fuller Stocktake
- Priority Areas
- Placed Based Delivery
- Tees Valley Integrated Urgent Care
- Business Cases
- Procurement Exercises and Strategies
- Information Governance
- Risk Management
- Cyber Event
- Senior Information Risk Officer (SIRO) Cyber Awareness and Assurance Report
- Secure Data Environment (SDE) – NHSE Funding Proposal
- Urgent and Emergency Care Network Governance
- Developing a Learning and Improvement System
- Tactical On Call Rota
- Continuing Healthcare Fee Setting
- 2022/23 Capital Plans
- ICB Development Plan

- Winter Planning
- Immunisation Programmes (Children's, COVID -19 & Flu)
- COVID Medicine Delivery Unit
- Review of Health Inequalities Arrangements
- Proposal for the Health Inequalities Targeted Funding Allocation
- Learning Disabilities and Autism: Building the Right Support
- NECS Customer Board Meeting
- General Practice Enhance Access
- Proposed Oversight Framework and Memorandum of Understanding with NHSE
- Corporate Risk Register
- Proposed Model for Managing Freedom of Information Requests, Ministerial Briefings and Parliamentary Enquiries
- Delegation of Pharmacy, Optometry, & Dentistry (POD) services and specialised commissioning
- NHSE Clinical Network Staff Transfer to the NENC ICB
- System Development Funding
- EPPR Core Standards Annual Appraisal Process
- Research and Evidence Report 2022/23
- Compliance with NICE Technology Appraisals
- Governance of the Medicines Sub Committee
- Recommendation from Sub Medicines Committee
- HR Service Review Case for Change
- Complex Care Packages
- Primary Care Workforce Underspend for 2022/23
- Operational Plan 2023/24
- Diagnostics Programme Allocation to the ICB
- Triangulation of Patient Voice

Remuneration Committee

The Remuneration Committee is a committee of the NHS North East and North Cumbria Board. It was in operation throughout the 9-month period from 1 July 2022 to 31 March 2023.

The committee was established on 1 July 2022 and remains in place. The membership, purpose, roles and responsibilities of the committee are set out in its terms of reference available at this link.

The committee reviewed its effectiveness during its first nine months of operation and concluded that the organisation has followed and applied the principles and standards of best practice.

The annual review has identified the Committee has delivered its responsibilities as set out in its terms of reference.
The Remuneration Committee met seven times in the period 1 July 2022 to 31 March 2023. The main items of business were:

- Remuneration of Executive Members
- Remuneration of Medical Directors
- Remuneration of Partner Members
- Tactical on call rota allowance
- Additional Independent Non-Executive Members
- Exit and Severance Business Cases
- Executive Director Pay Reviews
- Executive Director Role Changes

Finance, Performance and Investment Committee

The Finance, Performance and Investment (FPI) Committee was established by the ICB Board on 1 July 2022 and has met seven times during 2022/23. A year end committee effectiveness survey was completed by members and attendees asking their views on how effective the committee had been in its inaugural year. There had also been a thorough review and amendments to the Committees Terms of Reference (TOR) to ensure that they were effective, as well as regular 'bitesize' learning and development sessions prior to the majority of the meetings; covering topics contained within the TOR.

Following consideration of the results and suggested improvements, the committee agreed to refine the reports to reduce duplication across committees, review meeting frequency and hybrid meeting arrangements to maximise the time and effectiveness of members, continue with individual and committee development opportunities for members into 2023 in terms of their committee role and responsibility.
The main items of business were:

- Financial Position Update
- Terms of Reference
- Oversight Framework
- Performance Position Update
- Risk Management Report
- Overspend Protocol
- Financial Planning Update 2023/24
- Operational Planning Guidance Update 2023/24 – Performance
- Operational Planning Submission 2023/24 update
- Resource Allocation Group - Terms of Reference

Audit Committee

The Audit Committee is a committee of the NHS North East and North Cumbria Board It was in operation throughout the 9-month period from 1 July 2022 to 31 March 2023.

The committee was established on 1 July 2022 and remains in place. The roles and responsibilities of the committee are set out in its terms of reference available at this link.

The committee is comprised of three independent non-executive directors:

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

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

The Audit Committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.

The duties of the Committee are driven by the organisation's objectives and the associated risks. The Committee agrees an annual programme of business; however this is flexible to new and emerging priorities and risks.

The ICB's external auditors, internal auditors and counter fraud attend the Audit Committee as does the ICB Executive Director of Finance, Director of Finance, and the Executive Director of Corporate Governance, Communications, and Involvement (or her deputy).

The Audit Committee meets quarterly and on each occasion the Audit Committee Chair extends an invitation to the internal and external auditors to meet with him privately prior to the ICB officers joining the meetings. The Chair was present at all meetings. The Audit Committee was established by the ICB Board on 1 July 2022 and met twice during 2022/2023.

Following these meetings a survey was circulated to Audit Committee members and attendees asking their views on how effective the Committee had been in its inaugural year. The feedback was positive, and respondents concurred that the Committee had quickly established itself and that it had performed effectively.

Following consideration of the survey results and suggested improvements the committee agreed to continue to pursue the appointment of another independent member it was agreed that it was a priority of the committee to increase its capacity by

appointing a vice chair and a fourth independent non-executive member. The committee agreed to continue with hybrid meetings, some in person some by video conferencing depending on the content of the agendas. This way of working would be reviewed again in the future.

The Audit Committee's main activities between 1 July 2022 and 31 March 2023 were:

- Review of its Terms of Reference
- Confirmation of Appointment of External Auditors
- Confirmation of Appointment of Internal Auditors / Counter Fraud
- Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy
- Corporate Risk Register
- Finance Update
- Financial Sustainability Checklist
- External Audit Annual Reports 2021/22 for the 8 Former CCGs
- Internal Audit Operational Audit Plan 2022/23
- Internal Audit Charter 2022/23
- Counter Fraud Progress Report including Annual Workplan 2022/23
- Counter Fraud Annual Reports for the 8 Former CCGs
- Audit Committee Annual Programme of Business
- ICB Risk Management
- Data Security and Protection Toolkit 2022/23
- Annual Accounts and Annual Report 2022/23 Timetable
- Scheme of Reservation and Delegation and Standing Financial Instructions
- Internal Audit Progress Reports
- External Audit Progress Reports
- Counter Fraud Updates

Quality and Safety Committee

The Quality and Safety Committee was operational throughout the first year of the ICB's operation and met three times during 2022/23. The Committee is responsible for ensuring the appropriate governance systems and processes are in place to commission, monitor and ensure delivery of high quality, safe patient care in services commissioned by the ICB. It provides assurance to the Board about the quality of the services being commissioned, and the overall risks to the organisation's strategic and operational plans.

The committee's terms of reference are described in a document separate to the ICB constitution and are available on the ICB's website. Throughout its first year of operation the Committee has focused on refining its terms of reference and membership to reflect the scope of the responsibilities within the Committee's remit and to ensure it has the appropriate representation to provide assurance to the Board.

The committee membership were also asked to complete a year end effectiveness survey to gather feedback from members to guide future work and improvements. The survey sought views on the terms of reference; meeting frequency; meeting Chairing arrangements; the skills and experience of its members; management of conflicts of interest; meeting papers/information format; and Committee successes and improvements to consider.

The majority of members agreed the terms of reference were appropriate noting that time has been taken to review and agree these – which was an important step/process. Whilst most members agreed that the meeting frequency seemed appropriate there are challenges with such a full agenda and being able to give sufficient time to each agenda item. Whilst the Committee has dedicated significant time to reviewing the terms of reference and membership of the Committee, some members still feel we need to continue to focus on the balance of skills and experience to ensure appropriate representation of e.g., providers and commissioners.

The main items of business were:

- Terms of Reference
- Cycle of Business
- Key issues – clinical quality exception report
- Patient Safety Incident Response Framework (PSIRF)
- Risk Register
- Clinical Quality Exception Report
- National Cancer Patient Experience Survey 2021
- GP Patient Survey 2022
- Quality and Safety of Inpatient Services
- NEQOS Regional Mortality
- Medicines Overview
- Public Members / Lay Representation
- Patient / Carer Stories
- Reflection on Meeting Process / Content
- Patient Story Process
- PPI Report
- Q2 Complaints Report
- Medicines Safety Committee Terms of Reference
- NENC Valproate Project
- ATAIN and Transformational Care – Maternity Incentive Scheme
- Place Quality and Safety Group Minutes
- System Quality Group Minutes
- Quality Review Group Minutes
- Medicines Committee Minutes
- Storyteller Protocol
- Patient Involvement and Experience Update
- Establishment of Sub-Committees;
    - Quality and Safety Committee

    - Place Quality and Safety Group
    - Safeguarding Health Executive Group
    - Antimicrobial Resistance and Healthcare Associated Infection Sub-Committee
- Integrated Delivery Report
- Directors of Nursing Top Risks
- ICB Maternity CNST Return
- Reflections on ICB Development Session with Bill Kirkup
- Excess Mortality and The Summary Hospital-Level Mortality Indicator
- Flu Update
- Care Quality Commission, Review of ICS Providers

Sub-committees

Sub-committees are established by the board and their link to their parent committees is shown on the ICB's governance structure, and their terms of reference are shown in the scheme of reservation and delegation available here.

Attendance records for NHS North East and North Cumbria (Integrated Care Board) and committees

Attendance records for NENC ICB and Committees 1st July 2022 – 31st March 2023

			BOARD		EXECUTIVE COMMITTEE		REMUNERATION COMMITTEE		FINANCE, PERFORMANCE & INVESTMENT COMMITTEE		AUDIT COMMITTEE		QUALITY AND SAFETY COMMITTEE	
Surname	**Forename**	**Post Held**	**No. of Meetings Held**	**No. of Actual Attendance**	**No. of Meetings Held**	**No. of Actual Attendance**	**No. of Meetings Held**	**No. of Actual Attendance**	**No. of Meetings Held**	**No. of Actual Attendance**	**No. of Meetings Held**	**No. of Actual Attendance**	**No. of Meetings Held**	**No. of Actual Attendance**
Donaldson	Sir Liam	Chair	**5**	**5**										
Allen	Sam	Chief Executive	**5**	**5**	**8**	**7**								
Adams	Mark	Executive Director of Place-Based Delivery (North & North Cumbria) **Left ICB November 2022**	**5**	**1**	**8**	**1 X 1 deputy**			**7**	**0**				
Avantaggiato-Quinn	Maria	Director of Allied Health Professionals											**3**	**1**
Bailey	Nicola	Interim Executive Area Director (North & North Cumbria) **In post from November 2022**	**5**	**2**	**8**	**7 X 1 deputy**			**7**	**3**				
Bows	Dr Hannah	Independent Non-Executive Member (PPI)	**5**	**4**			**6**	**5**					**3**	**3**
Bremner	Ken	Foundation Trust Partner Member	**5**	**4**					**7**	**4**			**3**	**1**
Chandler	David	Executive Director of Finance **(interim November 2022 to February 2023)**	**5**	**4**	**8**	**7 x 1 deputy**			**7**	**6**				
Connolly	Jon	Executive Director of Finance **Left ICB November 2022**	**5**	**1**	**8**	**1**			**7**	**1**				
Evans	Professor Graham	Executive Chief Digital and Information Officer	**5**	**4**	**8**	**6 x 1 deputy**								
Fox	Ann	Director of Nursing											**3**	**3**
Gallagher	Dave	Executive Area Director (Central & South)	**5**	**5**	**8**	**8 x 2 deputy**			**7**	**5**				
Golightly	Jean	Director of Nursing											**3**	**1**
Grieveson	Maureen	Director of Nursing											**3**	**2**

			BOARD		EXECUTIVE COMMITTEE		REMUNERATION COMMITTEE		FINANCE, PERFORMANCE & INVESTMENT COMMITTEE		AUDIT COMMITTEE		QUALITY AND SAFETY COMMITTEE	
Surname	**Forename**	**Post Held**	**No. of Meetings Held**	**No. of Actual Attendance**	**No. of Meetings Held**	**No. of Actual Attendance**	**No. of Meetings Held**	**No. of Actual Attendance**	**No. of Meetings Held**	**No. of Actual Attendance**	**No. of Meetings Held**	**No. of Actual Attendance**	**No. of Meetings Held**	**No. of Actual Attendance**
Hall	Tom	Local Authority Partner Member	5	5									3	0
Kaner	Professor Eileen	Independent Non-Executive Member	5	5			6	4	7	5	2	2	3	3
Laverty	Annie	Executive Chief People Officer	5	4	8	5 x 1 deputy								
Malik	Dr Saira	Primary Medical Services Partner Member	5	4									3	2
Mason-Lodge	Louise	Director of Nursing											3	2
Mcevoy-Carr	Catherine	Local Authority Partner Member	5	2 1 x deputy										
Moore	Cllr Shane	Local Authority Partner Member	5	0										
Myers	Jacqueline	Executive Chief of Strategy and Operations	5	5	8	8			7	6 x 1 deputy			3	1 x 1 deputy
Nadkarni	Rajesh	Foundation Trust Partner Member	5	5					7	6			3	2
O'Brien	Dr Neil	Executive Medical Director	5	5	8	8			7	5			3	3
Purdue	David	Executive Chief Nurse	5	4	8	7 x 2 deputy							3	3
Riley	Claire	Executive Director of Corporate Governance, Communications & Involvement	5	5	8	8								
Rush	Jon	Independent Non-Executive Member	5	4			6	6	7	7	2	2		
Scott	Jeanette	Director of Nursing											3	2
Scott	Richard	Director of Nursing											3	2
Smith	Dr Mike	Primary Medical Services Partner Member	5	5									3	3
Stout	David	Independent Non-Executive Member (Audit)	5	4							2	2		
Workman	Ann	Local Authority Partner Member	5	3										
Young	Julia	Director of Nursing											3	2
Zahid	Aejaz	Executive Director of Innovation	5	5	8	7								

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Corporate Governance Code. However, we have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the code we consider to be relevant to the ICB and best practice.

Discharge of statutory functions

NHS North East and North Cumbria has reviewed all the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that the ICB is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all the ICB's statutory duties.

Risk management arrangements and effectiveness

Effective risk management is an integral part of the work of the ICB in delivering against its aims, objectives and strategic priorities in the stewardship of public funds. The ICB's risk management strategy sets out the organisation's approach to risk and the management of risk in fulfilment of its overall objectives. The principles are consistent with those within the NHS England's (NHSE) risk management framework and NHSE's risk management strategy.

The ICB acknowledges that risks will arise during the commissioning of health services and tackling health inequalities in an innovative and effective way, but that taking risks can bring benefits and opportunities when managed appropriately. The ICB does not aim to create a risk-free environment, but rather one in which risk is appropriately identified and routinely managed via embedded structures and processes, to enable it and partner organisations to provide safe, high quality, and value for money services for the North East and North Cumbria.

Key elements of the strategy include:

- Clear statements on the responsibilities of the Board and its sub committees as well as individual accountability for delivery of the strategy.
- Clear principles, aims and objectives of the risk management process.

- Clear processes for the management of risk in commissioned services, partnership working and delivery of the quality, innovation, productivity and prevention programme.
- A clearly defined process for assessing and managing risks, including implementation and dissemination of the framework for all staff.
- Details of the approach to be undertaken to assess and report risks, including incident reporting, serious incidents and safeguarding.
- Confirmation of the arrangements for reporting and managing risks through the risk register process.
- Arrangements for monitoring and review of the framework.

As a newly established organisation, the process for embedding risk management in the activities of the ICB has involved:

- Development of the risk management framework with a supporting strategy and procedures.
- Development of a Board Assurance Framework.
- Establishment of a committee structure with clear accountabilities for risk management.
- Development of a robust incident reporting system through staff are actively encouraged to report incidents to help identify risks.
- Putting in place a clear policy and process for staff to raise concerns in relation to potential fraud risks.

Risk assessment

The risk management strategy is supported by a standard operating procedure that sets out a clearly defined process for:

- Risk identification,
- Risk assessment,
- Managing risks through the risk register process.

The risk management strategy defines levels of control or influence over risks depending on the source and type of risk acknowledging that there are risks that are fully or partially within its sphere of control (financial, operational regulatory, compliance), there are occasions where the source of a risk event may be external. While the ICB is unable to prevent such external events, it will focus management efforts on the identification and mitigation of the impact, for example by putting contingency plans in place.

The ICB uses a standard matrix methodology in the application of a risk rating to ensure a consistent approach to the prioritisation of risks and effective targeting of resources. Risks are assessed using the consequence and likelihood of the risk occurring, giving an overall

rating of extreme, high, moderate or low. The rating is recorded against the risk and managed via a series of controls and actions with progress monitored via the ICB's governance processes.

The ICB recognises the risk that fraud, bribery and corruption pose to its resources. This risk is included in the corporate risk register with an appropriate internal risk owner identified. Operational management and recording of detailed fraud, bribery and corruption risks will be carried out by the ICB's counter fraud provider and as agreed in the counter fraud workplan and using a bespoke fraud, bribery and corruption risk planning toolkit. Regular reports will be provided to the Audit Committee or equivalent to ensure effective executive and non-executive level monitoring of fraud, bribery and corruption risks.

Key risks managed from 1 July 2022 to 31 March 2023:

- Widespread challenges to recruitment nationally and particularly of clinical and social care staff could impact on the delivery of safe services and lack of access to specific services driving up waiting times and leading to poorer outcomes for patients.

- Without robust planning for surges, business continuity incidents and outbreaks, there would be significant rises in demand across the healthcare sector leading to inability to deliver core services.

- That delayed ambulance handovers impact negatively on patient safety and patient flow.

- Challenge of meeting the needs of refugees and asylum seekers placed in the North East and North Cumbria without appropriate provision could lead to worsening of health conditions and impact on sustainability of services.

- Failure to achieve NHS Constitutional Standards for our patients.

- Commissioned services are not of sufficiently high quality.

- Delivery of robust and credible financial plan and failure to achieve financial balance.

- Access to mental health services for adults and for children and young people resulting in delays to appropriate treatment and leading to crises.

- Inappropriate antimicrobial prescribing leading to increased resistance that threatens the effective prevention and treatment of infections.

- The transfer of responsibility for commissioning of pharmacy, optometry and dentistry (POD) services from NHS England to the ICB.

The ICB has risk mitigation plans in place to reduce risks to the target level and these are documented within each risk and assured by Audit Committee.

The ICB has effectively managed its risks in 2022/23. Its systems have been in place for the year under review and up to the date of approval of the annual report and accounts. At the establishment of the ICB on 01 July 2022 there were eight high (amber) risks and at March 2023 this had changed to four extreme (red) risks and 22 high (amber) risks.

The ICB will continue to manage risks associated with patient safety and the quality of services and achievement of performance targets with rigor.

ICB's risk profile

The ICB's risk register was initially created following a review of its predecessor organisations, the clinical commissioning groups (CCGs) in the region. The risks were assessed to build an initial picture of risks faced by the ICB at its establishment.
Each risk has been aligned to an appropriate director and lead director and individual risk owners identified to manage the risks.

As a statutory body it is essential that the ICB demonstrates compliance with regulation and statute. In recognition of these duties, risks have created to acknowledge that managing these risks is of critical importance to a well-run organisation:

Risk Focus	Controls
ICB public accountability duties	Risk management strategy Annual audit plan ICB policy review and approval framework ICB constitution and governance structure
Conflict of interest	Signed declarations of interest. Register of interests Gifts and Hospitality Register Minutes of meetings (showing declared interests, exclusions etc.) Conflicts of Interest training
Economy, efficiency, probity	Financial Plan QIPP in place Financial reporting and monitoring process Financial governance arrangements, policies and schemes of delegation
Delivery of NHS constitutional standards	Contract management processes Performance management processes

Risk Focus	Controls
Safeguarding duties	Quality and safety committee Designated and named professionals in place Partnership arrangements with Local Safeguarding Children Boards and Local Safeguarding Adults Boards
Effective patient and public involvement	People and communities strategy Protocols in place to work with Healthwatch on delivery of involvement activities
System resilience and escalation planning	System-wide surge and escalation plan ICB business continuity plan Emergency planning, resilience and response (EPRR) compliance Place-based delivery urgent and emergency care groups

Other risk management processes

Equality and quality impact assessment processes have been established. Authors of reports to formal committees must complete an assessment setting out any risks and issues and provide assurances on these; state any conflicts of interest and indicate whether an equality impact assessment has been undertaken where required.

Key stakeholders and the public are involved in the management of risks though board meetings held in public. The risk register is included on the public agenda with an opportunity for questions to be asked about the register as a whole or about individual risks.

The ICB's involvement and engagement strategies, patient feedback, complaints and staff feedback are all used as an integral part of the approach to risk management.

Risk appetite

Risk appetite is the organisation's unique attitude to risk as the amount of risk that the organisation is prepared to accept, tolerate or to be exposed to. Risks are considered in terms of both opportunities and threats and the consequent impact on the capability of the ICB, its performance, and its reputation.

The ICB tries to reduce risks to the lowest level reasonably practicable however where risks cannot reasonably be avoided, every effort is made to mitigate the remaining risk. A clear risk appetite statement is currently being developed.

Capacity to handle risk

Responsibility for risk management is identified at all levels across the ICB from board members, executive directors and to all managers and staff. The risk management strategy sets out the duties and responsibilities for risk management across the organisation.

Understanding, monitoring, and mitigating risks are fundamental tasks in a successful organisation, as well as basic aspect of good governance. As such, it is the responsibility of the board to determine the best place for risk management to be positioned ensuring effective management and assurance processes are in place. The overall risk management approach ensures that the strategy is coordinated across the whole organisation.

Resources available for managing risk are finite. The ICB will aim to achieve a prioritised and effective response to risk, whilst striking a balance between cost and benefit. The ICB will therefore take action to manage risk to a level which the ICB can justify as being tolerable. This will be achieved by the board agreeing and reviewing the ICB's 'risk appetite' on an annual basis

As a formal committee of the board, the Audit Committee provides the board with an independent and objective view of the ICB's financial systems, financial information, and compliance with laws, regulations and directions governing the ICB as far as they relate to finance. The committee also provides assurance to the board that systems are in place and operating effectively for the identification, assessment, and prioritisation of risks, potential and actual, and to report on any major strategic issues and any associated financial implications to the board and other external agencies as appropriate.

The committee's specific responsibilities relating to risk management are to:

- Oversee the risk management system and obtain assurances that there is an effective system operating across the ICB
- Report to the board any significant risk management issues

The Audit Committee also reviews the Board Assurance Framework (BAF) to ensure the board receives assurances that effective controls are in place to manage all strategic risks. The BAF provides assurance with regards to risks relating to services being commissioned as well as risks to the organisation's strategic and operational plans.

The Quality and Safety Committee reviews and manages any strategic or operational risks relating to the committee's area of focus.

The Executive Committee receives the full ICB risk register on a bi-monthly basis to provide the executive team with a regular updated position on risks facing the organisation. The committee also receives all risks identified at place that have been assessed as high or

extreme to determine whether these risks should be escalated for management at ICB corporate level.

All members of the executive team are responsible for:

- Maintaining awareness of the main risks facing the organisation.

- Taking or delegate ownership of relevant risks that pose a threat to the achievement of objectives or the business of the organisation and ensure appropriate action is taken to mitigate and manage risks, ensuring regular updates are added to the risk register.

- Ensuring the processes for managing risk within the ICB are clearly understood, appropriately delegated and effective.

All senior leads have a responsibility to incorporate risk management within all aspects of their work and are responsible for ensuring the implementation of this strategy.
The ICB has a service line agreement in place with the North of England Commissioning Support Unit (NECS) to provide specialist risk management support, including training in conjunction with the ICB's governance staff. The support includes the use of the electronic system used to record and analyse all identified risks.

Other sources of assurance

Internal control framework
A system of internal control is the set of processes and procedures in place in the ICB to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The ICB system of internal control includes:

- A board that ensures that the ICB has appropriate arrangements in place to exercise its functions effectively, efficiently, and economically and in accordance with the principles of good governance

- An approved ICB constitution, incorporating standing orders

- A governance handbook, including a scheme of reservation and delegation, and prime financial policies

- A committee structure, where each committee has a vital role in contributing to the establishment of an effective governance infrastructure

- An appointed Accountable Officer who is responsible (amongst other duties) for ensuring that the ICB fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money

- The Accountable Officer, working closely with the chair of the ICB, ensures that proper constitutional, governance and development arrangements are put in place to assure the board of the organisation's ongoing capability and capacity to meet its duties and responsibilities

- An appointed Executive Director of Finance who is responsible for (amongst other duties) overseeing robust audit and governance arrangements leading to propriety in the use of the ICB's resources; and

- Staff members who are responsible for reporting problems of operations, monitoring and improving their performance, and monitoring non-compliance with the corporate policies and various professional codes, or violations of policies, standards, practices, and procedures.

Internal audit service
One important feature of the system of internal control is the work of the internal audit service. Through a systematic programme of work, internal audit provide assurance on key systems of control.

The Head of Internal Audit reports to the Audit Committee and has direct access to the Audit Committee Chair as required.

Policies
Another key feature of the system of internal control is the application of a range of policies and procedures.

The ICB has a suite of policies in place, including corporate policies, HR policies, and Information Governance policies. Each policy has a named executive director lead and staff are advised and reminded of the ICB's polices. Polices are scheduled for review at their due date.

The terms of reference for the ICB Executive Committee ensures that the committee receives assurance reports relating to statutory and mandatory training, compliance with health and safety, fire safety and first aid at work, information governance, equalities and diversity, and business continuity planning. There is commitment to continuing professional development, with robust processes in place for staff supervision, training, objective setting, performance review and appraisal.

The ICB has a Freedom to Speak Up: Raising Concerns (Whistleblowing) policy and the Audit Committee is scheduled to review the arrangements annually.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest (published June 2016) requires commissioners to undertake an annual internal audit of conflicts of interest management. To support ICBs to undertake this task, NHS England has published a template audit framework. The ICB's internal auditors have carried out an annual internal audit of conflicts of interest during 2022/23 and provided 'good assurance'. No issues were identified with the design of or compliance with the control framework in the areas reviewed.

Data quality

The ICB is highly dependent on high quality, timely and accurate data, as a result, the ICB has a data quality policy. This policy defines data and explains data standards and the importance of data validation.

The North of England Commissioning Support Unit (NECS) Data Management service has processes and systems in place to assess the quality and completeness of commissioning data managed on behalf of the ICB. Data is checked at all stages of processing through NECS systems and finally on publication of reports/analysis.

Data is compared against historic and planned levels to provide assurance on completeness as well as with peer organisations in the form of benchmarking analysis.

Processes are in place to raise any data quality issues with providers on a monthly basis. Feedback from these challenges is utilised to continually improve any processing routines as required. The ICB utilises contract levers where necessary, to ensure high quality data is captured at source and to minimise any updating of data once received by commissioners. Reconciliation accounts for each contract highlight any discrepancies between provider and commissioner data that are then investigated and resolved.

Significant validation steps are place in all routine data processing tasks to ensure poor quality data is not made available for analysis and then subsequently used as the basis for commissioning decisions.

Robust data is provided to the board, and other committees of the ICB.

Information governance
The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

This is the ICB's inaugural year and the ICB will submit its Data Security and Protection toolkit for 2022/23 by 30 June 2023.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks.

Business critical models

Modelling is essential e.g. to forecast population growth, and models underpin decisions which affect people's lives. It is vital, therefore, that these models are fit-for-purpose. The ICB does not have any business-critical models as defined by Macpherson (2013) but is aware that for any future models used, that it must ensure that an appropriate framework and environment is in place to provide quality assurance of any business-critical models.

Third party assurances

The ICB currently contracts with several external organisations for the provision of back-office services and functions, and as such has established an internal control system to gain assurance from these.

These external services and systems include:

- The provision of Oracle financial system and financial accounting support from NHS Shared Business Services. The use of NHS Shared Business Services is mandated by NHS England for all ICBs and is fundamental in producing NHS England group financial accounts through the use of an integrated financial ledger system

- The provision of a wide range of commissioning support services from the North of England Commissioning Support Unit

- The provision of payroll services from Northumbria Healthcare NHS Foundation Trust

- The provision of the ESR payroll systems from NHS Business Services Authority (BSA)

- The provision of the Prescription Pricing Service operated by the NHS BSA

- The provision of Primary Care Support Services from Capita Business Services Limited

- The GP extraction and processing of GP data services operated by NHS England (formerly NHS Digital)

Assurance over the relevant control environments in place for these systems has been gained from independent service auditor reports for the year ended 31 March 2023, in accordance with ISAE 3000 or 3402 (International Standard on Assurance Engagements), together with additional testing of controls by the ICB's internal auditors. The outcome from these audits is reported to the Audit Committee.

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

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

The ICB's external auditors have reviewed all the type 2 service auditor reports of the outsourced bodies and have not identified any further risks to the ICB.

Control issues

Significant control issues are those issues could put delivery of the standards expected of the Accounting Officer at risk; that might prejudice the achievement of priorities; undermine the integrity or reputation of the ICB and/or wider NHS; make it harder to resist fraud or other misuse of resources or divert resources from another significant aspect of the business; have a material impact on the accounts; or put data integrity at risk.

The ICB has in place a robust system of internal control. The ICB has assurances from the Head of Internal Audit and from other sources to support this assessment.
The system continues to face recruitment challenges in the clinical and social care workforce, and a workforce working group has been set up to focus action.
The ICB continues to monitor delayed ambulance handovers. Mitigations include ICB winter plan and surge plan in place; monitoring through the local delivery boards at place; system situation reports (SitReps) are used during surge periods and a system wide surge exercise has been undertaken. Monitoring continues through quality and safety committee and audit committee (via the corporate risk register).

Review of economy, efficiency and effectiveness of the use of resources

The board receives reports from its relevant committees (Finance Performance & Investment Committee, Executive Committee, Quality & Safety Committee and Audit Committee) providing assurance that the ICB uses its resources economically, efficiently and effectively.

The ICB budget comprises the commissioning budget and the operating budget. The board received regular budget reports throughout the period 1 July 2022 to 31 March 2023.

The ICB commissioning budget is deployed to commission healthcare for the population of the North East and North Cumbria, in line with national guidance.

During the period 1 July 2022 to 31 March 2023 the ICB worked in close partnership with healthcare providers across the ICS to ensure that resources were utilised in the most effective way possible.

The ICB external auditors have concluded that ‘in all significant respects, the ICB had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.’

During the financial year the ICB received ' good assurance' for 6 out of 9 audits undertaken by internal audit, and the Head of Internal Audit Opinion also gave an overall assessment of ' good assurance '

In respect of the ICB operating budget, there is an agreed staffing structure, and ICB staff are organised into 10 directorates, each led by an executive director.

During the period 1 July 2022 to 31 March 2023, the ICB delivered a Quality, Innovation Productivity & Prevention (QIPP) programme.

A summary of our financial planning (including central management costs) and in-year performance monitoring is shown in the Performance Analysis – Financial Performance report.

The Remuneration Committee confirms the ICB pay policy including adoption of any pay frameworks for all employees including senior managers/directors (including board members) but excluding non-executive board member directors and excluding the Chair.

Delegation of functions

Delegation arrangements exist through the ICB's governance process and committee structures, as set out in the role and remit of each committee. The systems and processes to ensure resources are used economically, efficiently and effectively, together with the related assurance mechanisms highlighted above, apply throughout the organisation, covering all relevant committees and delegations.

This includes the Board which oversees the work of all committees, with formal reporting arrangements, together with the other assurance processes summarised above.

As noted in the third party assurances section above, the ICB has a number of outsourced services and systems which are managed by external providers. A summary of these services and the assurances obtained over them is included above.

Counter fraud arrangements

Our counter fraud activity plays a key part in deterring risks to the ICB's financial viability and probity.

An accredited counter fraud specialist, Audit One, is contracted to undertake counter fraud work proportionate to identified risks.

A counter fraud plan was agreed by the Executive Director of Finance and approved by the Audit Committee for the period 1 July 2022 to 31 March 2023, which focuses on the deterrence, prevention, detection, and investigation of fraud. Progress against this plan was regularly monitored by the Audit Committee within the counter fraud report.

Through our contract with Audit One, we have counter fraud arrangements in place that comply with the NHS Counter Fraud Authority’s (NHSCFA) standards. Audit One has provided the Audit Committee with a report against the Government Functional Standard GovS 013: Counter Fraud - NHS requirements and considers the relevant actions being implemented to address any identified deficiencies. There was executive support and direction for a proportionate work plan to address identified risks.

Between 1 July 2022 and 31 March 2023 was not subject to an NHSCFA engagement or assurance inspections therefore no recommendations have been made to the ICB where action was required and reported to audit committee.

A member of the board is proactively and demonstrably responsible for tackling fraud, bribery, and corruption. Counter-fraud requirements and regulations are discussed with both the Audit Committee and Executive Committee.

Head of internal audit opinion

Following completion of the planned audit work for the period 1/7/2022 to 31/3/2023 for the ICB the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

"From my review of your systems of internal control, I am providing good assurance that there is a sound system of internal control, governance and risk management designed to meet the organisation's objectives and that the controls are generally being applied consistently"

Summary of internal audit assurance work undertaken during this period is outlined below:

Audit area	Assurance			
	Substantial	Good	Reasonable	Limited
Assurance Areas				
Governance, Risk and Performance				
Governance Framework (Final Report)		√		
Risk Management and Board Assurance Framework (BAF) (Final Report)		√		
Conflicts of Interest *(Draft report)*		√		
Business Continuity Planning and Emergency Preparedness, Resilience and Response (EPRR) *(Final report)*			√	
Digital Programme Management *(Final Report)*	√			
Finance, Contracting and Capital				
HFMA: Improving NHS Financial Sustainability *(Final Report)*	In line with NHSE guidance this report included no assurance level and recommendations were not assigned any priority for action			
Procurement Arrangements *(Final Report)*			√	
Key Financial Controls	√			

Audit area	Assurance			
	Substantial	Good	Reasonable	Limited
Final Report				
Human Resources and Workforce				
Staff Experience and Engagement *(Final Report)*		√		
Digital Systems, Processes, and Information Governance				
Data Security & Protection Toolkit – Interim Assessment *(Final Report)*	The interim assessment provides a position statement against 13 assertions mandated by NHS Digital but does not include an overall risk assessment or assurance level.			
Data Security & Protection Toolkit - Final Assessment *(Final Report)*	*Assurance levels as below (in accordance with NHS Digital's 2022 guidance for internal auditors)			
• Overall risk assessment across all 10 National Data Guardian standards	**Moderate** - There are no standards rated as 'Unsatisfactory', and 1 or none rated as 'Limited'. However, not all standards are rated as 'Substantial'			
• Assurance level based on the confidence level of the independent assessor in the veracity of the ICB's self-assessment	**Substantial** - **Low level of deviation** - the organisation's self-assessment against the Toolkit does not differ / deviates only minimally from the Independent Assessment			
Totals	2	5	2	0

Key

ASSURANCE LEVELS	
Substantial	Governance, risk management and control arrangements provide substantial assurance that the risks identified are managed effectively. Compliance with the control framework was found to be taking place.
Good	Governance, risk management and control arrangements provide a good level of assurance that the risks identified are managed effectively. A high level of compliance with the control framework was found to be taking place. Minor remedial action is required
Reasonable	Governance, risk management and control arrangements provide reasonable assurance that the risks identified are managed effectively. Compliance with the control framework was not found to be taking place in a consistent manner. Some moderate remedial action is required.
Limited	Governance, risk management and control arrangements provide limited assurance that the risks identified are managed effectively. Compliance with the control framework was not found to be taking place. Immediate and fundamental remedial action is required.

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- The Board
- The Audit Committee
- The Executive Committee; Finance, Performance & Investment Committee; and Quality & Safety Committee
- Internal audit

The Board develops, implements, and delivers the ICB strategic priorities and receives assurances from the Audit Committee, the Quality and Safety Committee, the Executive Committee and the Finance, Performance & Investment Committee. Good assurance has also been received from the Head of Internal Audit.

Sub-committees

Sub-committees are established by the Board and the link to the relevant parent committee is shown on the ICB's governance structure, and their terms of reference are shown in the scheme of reservation and delegation available here.

Conclusion

The system of control described in this report has been in place in the ICB for the period 1 July 2022 to 31 March 2023 and up to the date of the approval of the annual report and accounts. I have concluded that the ICB did have a generally sound system of internal control in place continuously throughout the period, designed to meet the organisation’s objectives and that the controls are being applied consistently. No significant internal control issues have been identified.

Remuneration and staff report

Remuneration report

Remuneration Committee
The Remuneration Committee is a committee of NENC ICB. It was in operation throughout the nine-month period from 1 July 2022 to 31 March 2023.

The Committee was established on 1 July 2022 and remains in place. The membership, purpose, roles and responsibilities of the Committee are set out in its terms of reference available at this link.

Pay ratio information [subject to audit]
Reporting bodies are required to disclose the relationship between the total remuneration of the highest paid director in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce.

Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director in the ICB in the period to 31 March 2023 was £255-260k. The relationship to the remuneration of the organisation's workforce is disclosed in the table below:

2022/23	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	35,571	48,788	82,508
Salary component of total remuneration (£)	35,571	48,526	81,599
Pay ratio information	7.2:1	5.3:1	3.1:1

During the reporting period 2022/23, no employees received remuneration in excess of that of the highest paid director. Excluding the highest paid director, banded remuneration ranged from £5-10k up to £175-180k.

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. Accordingly, the total remuneration figures reflected here exclude the pension related benefits shown in the salaries and allowances table on pages 131-132.

Policy on the remuneration of senior managers

The remuneration for senior managers for current and future financial years is determined in accordance with relevant guidance, best practice and national policy.

Continuation of employment for all senior managers is subject to satisfactory performance. Performance in post and progress in achieving set objectives is reviewed annually. There were no individual performance review payments made to any senior managers during the period and there are no plans to make such payments in future years. This is in accordance with standard NHS terms and conditions of service and guidance issued by the Department of Health and Social Care.

Contracts of employment in relation to the majority of senior managers employed by the ICB are permanent in nature and subject to between three and six months' notice of termination by either party.

Termination payments are limited to those laid down in statute and those provided for within NHS terms and conditions of service and under the *NHS Pension Scheme Regulations* for those who are members of the scheme.

Remuneration of Very Senior Managers

Reporting bodies are required to disclose where the salary of senior managers is in excess of the prime minister's salary of £150,000 on a pro rata basis. The pro rata basis represents the full-time salary for individuals who work part time. The agreement of reasonable pay and conditions for very senior managers is considered by the ICB's Remuneration Committee, which reports directly to the ICB Board. All posts which are not agenda for change, have their pay determined by the remuneration committee.

Senior manager remuneration

For the purpose of this remuneration report, the ICB has considered the definition of 'senior managers' within the 2022/23 Group Accounting Manual published by the Department of Health and Social Care Group Accounting Manual and considers that the Board members represent the senior managers of the ICB.

Details of the relevant salaries and allowances for all of the senior managers of the ICB can be found in the table below. There are no prior year comparative figures for the ICB.

Important note regarding 'all pension related benefits' stated in table below:

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension

rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

NENC ICB senior officers' salaries and allowances - 2022/23 [subject to audit]:

Name	Position	1 July 2022 to 31 March 2023						
		(a) Salary (bands of £5,000)	(b) Expense payments (taxable) (to nearest £100)	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (to the nearest £2,500)	(f) TOTAL (a to e) (bands of £5,000)	*Full time equivalent salary (bands of £5,000)*
		£000	£	£000	£000	£000	£000	*£000*
Professor Sir Liam Donaldson	Chair	55 - 60	-	-	-	-	55 - 60	*70 - 75*
Sam Allen	Chief Executive	185 - 190	6,400	-	-	165 - 167.5	355 - 360	*245 - 250*
Jacqueline Myers	Executive Chief of Strategy and Operations	65 - 70	600	-	-	120 - 122.5	185 - 190	*160 - 165*
Annie Laverty	Executive Chief People Officer	120 - 125	700	-	-	47.5 - 50	170 - 175	*160 - 165*
Mark Adams	Executive Area Director (North & North Cumbria) *From 01/07/2022 to 24/11/2022*	65 - 70	-	-	-	-	65 - 70	*155 - 160*
Nicola Bailey	Executive Area Director (North & North Cumbria) *From 05/09/2022*	85 - 90	4,300	-	-	30 - 32.5	120 - 125	*155 - 160*
Dave Gallagher	Executive Area Director (Central & South)	120 - 125	-	-	-	-	120 - 125	*160 - 165*
Professor Graham Evans	Executive Chief Digital and Information Officer	120 - 125	-	-	-	-	120 - 125	*160 - 165*
David Purdue	Executive Chief Nurse	120 - 125	700	-	-	272.5 - 275	395 - 400	*175 - 180*
Claire Riley	Executive Director of Corporate Governance, Communications & Involvement	120 - 125	4,700	-	-	75 - 77.5	200 - 205	*160 - 165*
Jon Connolly	Executive Director of Finance *From 01/07/2022 to 24/11/2022*	70 - 75	1,100	-	-	-	75 - 80	*160 - 165*
David Chandler	Executive Director of Finance	90 - 95	7,300	-	-	-	95 - 100	*160 - 165*

Name	Position	1 July 2022 to 31 March 2023						
		(a) Salary (bands of £5,000)	(b) Expense payments (taxable) (to nearest £100)	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (to the nearest £2,500)	(f) TOTAL (a to e) (bands of £5,000)	*Full time equivalent salary (bands of £5,000)*
		£000	£	£000	£000	£000	£000	*£000*
	From 05/09/2022							
Aejaz Zahid	Executive Director of Innovation	90 - 95	300	-	-	20 - 22.5	110 - 115	*120 - 125*
Dr Neil O'Brien	Executive Medical Director	130 - 135	-	-	-	50 - 52.5	180 - 185	*175 - 180*
Dr Hannah Bows	Independent Non-Executive Member	5 - 10	-	-	-	-	5 - 10	*10 - 15*
Professor Eileen Kaner	Independent Non-Executive Member	10 - 15	-	-	-	-	10 - 15	*10 - 15*
Jon Rush	Independent Non-Executive Member	10 - 15	-	-	-	-	10 - 15	*10 - 15*
David Stout	Independent Non-Executive Member	10 - 15	-	-	-	-	10 - 15	*10 - 15*
Dr Saira Malik	Primary Medical Services Partner Member	15 - 20	-	-	-	-	15 - 20	*20 - 25*
Dr Mike Smith	Primary Medical Services Partner Member	15 - 20	-	-	-	-	15 - 20	*20 - 25*

Note – Jacqueline Myers, Executive Chief of Strategy and Operations, was on secondment to the ICB from 1 July 2022 until commencing employment at the ICB from 1 November 2022. The costs shown above in columns (a) to (e) reflect the costs to the ICB from 1 November 2022.

Notes:

The taxable benefits included in the table above all relate to the estimated benefit in kind on lease cars (calculated based on the value of the vehicle and relevant CO2 emissions), car allowance (where relevant) and a VAT refund relating to a lease car.

No performance related benefits have been agreed for any senior officers.

All pension related benefits disclosed in this report relate to 'officer employment' only, i.e. for any general practitioners, the figures exclude any benefits derived from practitioner employment.

All senior officer remuneration is processed through the ICB's payroll.

The following senior officers are not employed by the ICB and receive no remuneration from the ICB for their role as Board members:

Name	Position
Ken Bremner	Foundation Trust Partner Member
Dr Rajesh Nadkarni	Foundation Trust Partner Member
Catherine McEvoy-Carr	Local Authority Partner Member
Tom Hall	Local Authority Partner Member
Cllr. Shane Moore	Local Authority Partner Member
Ann Workman	Local Authority Partner Member

The following two senior officers were employed in multiple roles during the period. The remuneration shown above for these individuals represents only that relating to their role as Board members. The total remuneration earned by each individual for all work across the ICB in 2022/23 is shown below:

Name	Position	2022/23 (9 months)		
		Salary (bands of £5,000) £000	Expense payments (taxable) (to nearest £100) £	Total (bands of £5,000) £000
Dr Saira Malik	Primary Medical Services Partner Member	65 - 70	-	65 - 70
Dr Mike Smith	Primary Medical Services Partner Member	35 - 40	-	35 - 40

NENC ICB senior officers' pension benefits - 2022/23 [subject to audit]:

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2023 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 July 2022	(f) Real increase in Cash Equivalent Transfer value	(g) Cash Equivalent Transfer Value at 31 March 2023	(h) Employer's contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Sam Allen Chief Executive	5 - 7.5	12.5 - 15	65 - 70	130 - 135	964	105	1,138	-
Jacqueline Myers Executive Chief of Strategy and Operations	2.5 - 5	2.5 - 5	45 - 50	90 - 95	728	44	856	-
Annie Laverty Executive Chief People Officer	2.5 - 5	-	20 - 25	-	290	25	345	-
Mark Adams Executive Area Director (North & North Cumbria). *From 01/07/2022 to 24/11/2022*	-	-	-	-	1,275	-	-	-
Nicola Bailey Executive Area Director (North & North Cumbria). *From 05/09/2022*	0 - 2.5	-	105 - 110	-	1,626	30	1,700	-
Dave Gallagher Executive Area Director (Central & South)	-	-	55 - 60	130 - 135	1,604	-	1,292	-
Professor Graham Evans Executive Chief Digital and Information Officer	-	-	-	-	-	-	-	1
David Purdue Executive Chief Nurse	7.5 - 10	20 - 22.5	70 - 75	155 - 160	1,142	194	1,438	-

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2023 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 July 2022	(f) Real increase in Cash Equivalent Transfer value	(g) Cash Equivalent Transfer Value at 31 March 2023	(h) Employer's contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Claire Riley Executive Director of Corporate Governance, Communications & Involvement	2.5 - 5	2.5 - 5	25 - 30	40 - 45	395	46	477	-
Jon Connolly Executive Director of Finance *From 01/07/2022 to 24/11/2022*	-	-	40 - 45	105 - 110	937	-	-	-
David Chandler Executive Director of Finance *From 05/09/2022*	-	-	40 - 45	80 - 85	825	-	798	-
Aejaz Zahid Executive Director of Innovation	0 - 2.5	-	5 -10	15 - 20	148	8	176	-
Dr Neil O'Brien Executive Medical Director	2.5 - 5	0 - 2.5	25 - 30	20 - 25	368	19	417	-
Dr Saira Malik Primary Medical Services Partner Member	-	-	-	-	266	-	-	-
Dr Mike Smith Primary Medical Services Partner Member	0 - 2.5	-	10 - 15	-	132	-	136	-

The tables above include only those senior managers who are members of the NHS pension scheme where the ICB made contributions to the scheme as an employer during the period.

The Consumer Prices Index up to September 2021 was 3.1%, therefore, an increase of 3.1% has been applied to pensions and CETV in accordance with NHS Business Services Authority instructions.

The pension figures shown relate to the benefits that individuals have accrued as a consequence of their total membership of the scheme. Benefits and related Cash Equivalent Transfer Values do not allow for a potential future adjustment arising from the McCloud judgment.

The figures included above reflect total pension benefits accrued within the NHS Pension Scheme, not just those accrued from employment within the ICB. No lump sum is shown for employees who only have membership in the 2008 section of the NHS Pension Scheme.

The real increase figures shown above relate only to the period each individual was in post as a senior officer.

Cash Equivalent Transfer Values
A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023 to 24 CETV figures.

Real increase in Cash Equivalent Transfer Values
This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement or for loss of office

No compensation has been paid by the ICB during the period for early retirement or for loss of office.

Payments to past directors

No payments have been made by the ICB to past directors.

Staff report

Number of senior managers

The ICB's has 26 senior officers (board members) which are listed in the remuneration report.

Staff numbers and costs

Details of staffing costs for the year and the average number of employees can be found in notes 3.1 and 3.2 of the financial statements, respectively.

Staff composition

The ICB staff gender profile is given in the table below. This reflects our gender representation of all ICB staff.

	Female	Male
Board members	11	15
Total employees	587	188

Sickness absence data

The ICB has an agreed policy on the management of staff absence which ensures all staff are treated fairly and equitably, with the relevant support from line managers and HR advisors. The ICB also has access to occupational health services.

The ICB sickness absence rate was 2.68%

Staff turnover percentages

The staff turnover for the ICB was 4.87%

Staff engagement percentages

No ICB staff surveys have been undertaken during this reporting period

Staff policies

The ICB has a suite of staff policies in place. The ICB has took positive steps throughout the reporting period to maintain and develop the provision of information to, and consultation with employees, including:

- Providing employees systematically with information on matters of concern to them as employees
- Consulting employees and their representatives on a regular basis so that the views of employees can be considered in making decisions which are likely to affect their interests
- Encouraging the involvement of employees in the ICB's performance
- Taking actions throughout the year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of the ICB
- Membership of the North East Partnership Forum, where staff representatives and ICB managers from across the region meet together
- The promotion of equality and diversity is actively pursued through these policies and ensures that employees receive fair, equitable and consistent treatment and ensure that employees, and potential employees, are not subject to direct or indirect discrimination.

Trade Union Facility Time Reporting Requirements

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

No TU facility time was recorded for ICB employed staff for the reporting period .

Other employee matters

The ICB is committed to equality of opportunity for all employees and is committed to employment practices, policies and procedures which ensure that no employee, or potential employee, receives less favourable treatment on the grounds of gender, race, colour, ethnic or national origin, sexual orientation, marital status, religion or belief, age, trade union membership, disability, offending background, domestic circumstances, social and employment status, HIV status, gender reassignment, political affiliation or any other personal characteristic.

Diversity is viewed positively and, in recognising that everyone is different, the unique contribution that everyone's experience, knowledge and skills can make is valued equally.

Expenditure on consultancy

Details of expenditure on consultancy services can be found in note 4 of the financial statements. For 2022/23, the value of consultancy services expenditure is £352k.

Off-payroll engagements

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

For all off-payroll engagements as at 31 March 2023 for more than £245* per day:

	Number
Number of existing engagements as of 31 March 2023	5
Of which, the number that have existed:	
for less than one year at the time of reporting	-
for between one and two years at the time of reporting	-
for between 2 and 3 years at the time of reporting	-
for between 3 and 4 years at the time of reporting	-
for 4 or more years at the time of reporting	5

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

All existing off-payroll engagements have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 2: Off-payroll workers engaged at any point during the financial period

For all off-payroll engagements between 1 July 2022 and 31 March 2023, for more than £245[1] per day:

	Number
No. of temporary off-payroll workers engaged between 1 July 2022 and 31 March 2023	5
Of which:	
No. not subject to off-payroll legislation[2]	-
No. subject to off-payroll legislation and determined as in-scope of IR35[2]	-
No. subject to off-payroll legislation and determined as out of scope of IR35[2]	4
the number of engagements reassessed for compliance or assurance purposes during the year	1
Of which: no. of engagements that saw a change to IR35 status following review	-

[1] The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

[2] A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: Off-payroll engagements of Board members / senior officials

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 July 2022 and 31 March 2023:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the 9 months to 31 March 2023	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the 9 months to 31 March 2023. This figure should include both on payroll and off-payroll engagements.	26

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

Table 1: Exit Packages

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	28	102,586	-	-	28	102,586	-	-
£10,000 - £25,000	-	-	-	-	-	-	-	-
£25,001 - £50,000	1	46,667	-	-	1	46,667	-	-
£50,001 - £100,000	1	71,068	-	-	1	71,068	-	-
£100,001 - £150,000	-	-	-	-	-	-	-	-
£150,001 –£200,000	1	160,000	-	-	1	160,000	-	-
>£200,000	-	-	-	-	-	-	-	-
TOTALS	**31**	**380,321**	**-**	**-**	**31**	**380,321**	**-**	**-**

This table reports the number and value of exit packages agreed in the financial period. All exit packages agreed relate to the transition of eight predecessor organisations into the ICB.

All redundancy costs have been paid in accordance with Agenda for Change requirements, contractual requirements or statutory provisions as appropriate. Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Parliamentary accountability and audit report

NHS North East and North Cumbria Integrated Care Board (the ICB) is not required to produce a Parliamentary Accountability and Audit Report.

The ICB has no disclosures on remote contingent liabilities, gifts and fees and charges. Disclosures on losses and special payments are shown in note 18 of the annual accounts.

An audit report is also included in this annual report from page 168

ANNUAL ACCOUNTS

NHS North East and North Cumbria ICB Financial Statements for the period ended 31 March 2023

CONTENTS **Page Number**

The Primary Statements:

Statement of Comprehensive Net Expenditure for the nine months ended 31 March 2023

	Note	9 months to 31 March 2023 £000
Income from sale of goods and services	2	(712)
Other operating income	2	(245)
Total operating income		**(957)**
Employee benefits	3.1	33,677
Purchase of goods and services	4	5,136,558
Depreciation and impairment charges	4	527
Other operating costs	4	1,252
Total operating expenditure		**5,172,014**
Finance costs	6	33
Net operating costs for the financial period		**5,171,090**
Net loss on transfer by absorption	8	465
Total net expenditure for the period		**5,171,555**

Statement of Financial Position as at 31 March 2023

	Note	31 March 2023 £000	1 July 2022 £000
Non-current assets:			
Right of use assets	7	4,441	4,968
Total non-current assets		**4,441**	**4,968**
Current assets			
Contract and other receivables	9	14,701	17,089
Cash and cash equivalents	10	1,624	564
Total current assets		**16,325**	**17,653**
Total assets		**20,766**	**22,621**
Current liabilities			
Trade and other payables	11	(471,564)	(335,566)
Lease liabilities	7	(667)	(621)
Cash overdrawn	10	-	(6,901)
Total current liabilities		**(472,231)**	**(343,088)**
Total assets less current liabilities		**(451,465)**	**(320,467)**
Non-current liabilities			
Lease liabilities	7	(3,813)	(4,353)
Total non-current liabilities		**(3,813)**	**(4,353)**
Assets less Liabilities		**(455,278)**	**(324,820)**
Financed by taxpayers' equity			
General fund		(455,278)	(324,820)
Total taxpayers' equity		**(455,278)**	**(324,820)**

The notes on pages 147 to 167 of the Annual Report form part of this statement.

The financial statements on pages 143 to 167 were approved and authorised for issue by the Board on 27 June 2023 and signed on its behalf by:

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

Accountable Officer
29 June 2023

Statement of Changes In Taxpayers' Equity for the nine months ended 31 March 2023

	General fund £000	Total reserves £000
Changes in taxpayers' equity for the nine months to 31 March 2023:		
Balance at 1 July 2022	-	-
Transfer by modified absorption from CCGs	(324,820)	(324,820)
Adjusted ICB balance at 1 July 2022	**(324,820)**	**(324,820)**
Changes in ICB taxpayers' equity for the nine months to 31 March 2023		
Net operating costs for the financial period	(5,171,090)	(5,171,090)
Transfers by absorption from other bodies	(465)	(465)
Net recognised ICB expenditure for the financial period	**(5,171,555)**	**(5,171,555)**
Net funding	5,041,097	5,041,097
Balance at 31 March 2023	**(455,278)**	**(455,278)**

Statement of Cash Flows for the nine months ended 31 March 2023

	Note	9 months to 31 March 2023 £000
Cash flows from operating activities		
Net operating costs for the financial period		(5,171,090)
Depreciation and amortisation	4	527
Movement due to transfer by modified absorption		(465)
Interest paid	6	33
Decrease in trade and other receivables	9	2,388
Increase in trade and other payables	11	135,998
Net cash outflow from operating activities		**(5,032,609)**
Net cash outflow before financing		**(5,032,609)**
Cash flows from financing activities		
Net funding received		5,041,097
Repayment of lease liabilities	7	(527)
Net cash inflow from financing activities		**5,040,570**
Net increase in cash and cash equivalents	10	**7,961**
Cash and cash equivalents (including bank overdrafts) at the beginning of the financial period		(6,337)
Cash and cash equivalents (including bank overdrafts) at the end of the financial period		**1,624**

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards (ICB) shall meet the accounting requirements of the Department of Health and Social Care's Group Accounting Manual, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2022/23. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to ICBs, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on the going concern basis.

The Health and Social Care Act was introduced into the House of Commons on 6 July 2021. The Act allowed for the establishment of Integrated Care Boards (ICB) across England and abolished Clinical Commissioning Groups (CCG). ICBs took on the commissioning functions of CCGs. The CCG functions, assets and liabilities were transferred to an ICB on 1 July 2022.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

When CCGs ceased to exist on 1 July 2022, the services continued to be provided by ICBs (using the same assets, by another public sector entity). The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Movement of Assets within the Department of Health and Social Care Group

As public sector bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 business combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care Group Accounting Manual requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

NHS North East and North Cumbria ICB (the ICB) was formed on 1st July 2022 by the absorption of 100% of eight former CCGs: NHS County Durham CCG, NHS Newcastle Gateshead CCG, NHS North Cumbria CCG, NHS North Tyneside CCG, NHS Northumberland CCG, NHS South Tyneside CCG, NHS Sunderland CCG and NHS Tees Valley CCG

For transfers of assets and liabilities from those bodies that closed on 30 June 2022 a modified absorption approach should be applied. This therefore applies to the assets and liabilities transferred from the former CCGs. For these transactions only gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries. Refer to note 8 for further details.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.4 Pooled Budgets

Where the ICB has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006, the ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. The ICB has assessed that joint control does not exist for any of these arrangements, refer to note 16 for further details.

1.5 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the ICB's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.5.1 *Critical Judgements in Applying Accounting Policies*

The following are the critical judgements, apart from those involving estimations (see below), that management has made in the process of applying the ICB's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

- determining whether a provision or contingent liability should be recognised in respect of certain potential future obligations, particularly in respect of continuing healthcare.

1.5.2 Key Sources of Estimation Uncertainty

The following are the key estimations that management has made in the process of applying the ICB's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

- the assumptions applied in the estimation of activity not yet invoiced as at the Statement of Financial Position date, estimated at £12,690k;
- the estimate of potential future liabilities in respect of continuing healthcare services, estimated at £107,875k; and
- the estimate of prescribing expenditure for the final two months of the period based on actual data from the Prescription Pricing Division, estimated at £100,051k.

1.6 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the ICB.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.7 Revenue

In the application of IFRS 15 a number of practical expedients offered in the standard have been employed. These are as follows:

• as per paragraph 121 of the standard the ICB will not disclose information regarding the performance obligations part of a contract that has an original expected duration of one year or less;

• the ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the standard where the right to consideration corresponds directly with the value of the performance completed to date.

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.8 Employee Benefits

1.8.1 *Short-term Employee Benefits*

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.8.2 *Retirement Benefit Costs*

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.9 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Expenses and liabilities in respect of grants are recognised when the ICB has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.10 Leases

Under IFRS16, the distinction between finance leases and operating leases is only applicable where the ICB is lessor. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.10.1 The ICB as Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The HM Treasury incremental borrowing rate of 3.51% is applied for leases commencing, transitioning or being remeasured in the 2023 calendar year under IFRS 16.

Lease payments included in the measurement of the lease liability comprise
- Fixed payments;
-Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
-The amount expected to be payable under residual value guarantees;
-The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
-Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.11 Cash & Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management. Cash, bank and overdraft balances are recorded at current values.

1.12 Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the ICB.

1.13 Non-clinical Risk Pooling

The ICB participates in the Properties Expenses Scheme and Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims, are charged to operating expenses as and when they become due.

1.14 Contingent liabilities and contingent assets

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.15 Financial Assets

Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income;
- Financial assets at fair value through profit and loss;

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

All ICB assets have been classified as financial assets at amortised cost.

1.15.1 *Financial Assets at Amortised cost*

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.15.2 *Impairment*

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.

The ICB adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the ICB does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.16 Financial Liabilities

Financial liabilities are recognised on the Statement of Financial Position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished, that is, the obligation has been discharged or cancelled or has expired.

1.16.1 *Other Financial Liabilities*

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from the Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.17 Value Added Tax

Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.18 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.19 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

- IFRS 14: Regulatory Deferral Accounts - not UK endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to Department of Health and Social Care group bodies.
- IFRS 17: Insurance Contracts (application from 1 January 2021) but not yet adopted by the FREM which is expected to be April 2025: early adoption is not therefore permitted.

The application of the Standards as revised would not have a material impact on the accounts for 2022/23, were they applied in that year.

Notes to the financial statements (continued)

2. Operating Income

	9 months to 31 March 2023 Total £'000
Income from sale of goods and services (contracts)	
Education, training and research	315
Other contract income	397
Total Income from sale of goods and services	**712**
Other operating income	
Other non contract revenue	245
Total other operating income	**245**
Total operating Income	**957**

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the ICB and credited to the General Fund.

Notes to the financial statements (continued)

3. Employee benefits and staff numbers

3.1 Employee benefits

	9 months to 31 March 2023		
	Total £000	Permanent Employees £000	Other £000
Employee benefits:			
Salaries and wages	26,071	25,683	388
Social security costs	2,884	2,884	-
Employer contributions to NHS Pension scheme	4,183	4,183	-
Other pension costs	67	67	
Apprenticeship levy	92	92	-
Termination benefits	380	380	-
Gross employee benefits expenditure	**33,677**	**33,289**	**388**

Included within salaries and wages is an estimate of the additional pay award offered to staff but not yet agreed of £1,406k.

No amounts were recovered in respect of employee benefits and no employee benefits were capitalised during the period.

3.2 Average number of people employed

	9 months to 31 March 2023		
	Total Number	Permanently employed Number	Other Number
Total	**556**	**548**	**8**

None of the above people were engaged on capital projects.

3.3 Exit packages agreed in the financial period

	2022/23 Compulsory redundancies	
	Number	£
Less than £10,000	28	102,586
£10,001 to £25,000	-	-
£25,001 to £50,000	1	46,667
£50,001 to £100,000	1	71,068
£100,001 to £150,000	-	-
£150,001 to £200,000	1	160,000
Over £200,001	-	-
Total	**31**	**380,321**

This table reports the number and value of exit packages agreed in the financial period. All exit packages agreed relate to the transition of eight predecessor organisations into the ICB.

All redundancy costs have been paid in accordance with Agenda for Change requirements, contractual requirements or statutory provisions as appropriate.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

The Remuneration Report includes the disclosure of any exit payments payable to individuals named in that Report.

Notes to the financial statements (continued)

3. Employee benefits and staff numbers (continued)

3.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/Pensions.

Both Schemes are unfunded, defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care, in England and Wales. The Schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each Scheme is accounted for as if it were a defined contribution scheme: the cost to the ICB of participating in the Scheme is taken as equal to the contributions payable to that Scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FREM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

3.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

3.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

The employer contribution rate for NHS Pension Schemes increased from 14.3% to 20.6% from 1st April 2019. For 2022/23, the ICB continued to pay over contributions at the former rate with the additional amount being paid by NHS England on behalf of the ICB. The full cost and related funding has been recognised in these accounts.

Notes to the financial statements (continued)

4. Operating expenses

	9 months to 31 March 2023 £000
Purchase of goods and services	
Services from other ICBs and NHS England	27,631
Services from foundation trusts	3,359,410
Services from other NHS trusts	22,169
Services from other WGA bodies	2
Purchase of healthcare from non-NHS bodies	701,928
Purchase of social care	109,179
General dental services and personal dental services	-
Prescribing costs	455,114
Pharmaceutical services	616
General ophthalmic services	21
Primary Medical Services Costs (GPMS/APMS and PCTMS)	433,086
Supplies and services – clinical	3,037
Supplies and services – general	5,779
Consultancy services	352
Establishment	3,828
Transport	18
Premises	12,269
Audit fees	340
Other non statutory audit expenditure	
· Other services	65
Other professional fees	527
Legal fees	489
Education and training	698
Total Purchase of goods and services	**5,136,558**
Depreciation and impairment charges	
Depreciation	527
Total Depreciation and impairment charges	**527**
Other operating expenses	
Chair and Non Executive Members	112
Capital grants	980
Clinical negligence	25
Expected credit loss on receivables	122
Other expenditure	13
Total other operating expenses	**1,252**
Total operating expenses	**5,138,337**

Included within Other professional fees is £293,235 paid for Internal Audit Services for the 9 months to 31 March 2023.

The total of £340k under Audit Fees consists of:
- Mazars LLP's Audit Fee of £211.3k (+ £43k VAT at 20%) for the ICB's 22/23 External Audit (Q2-Q4).
- Residual Mazars LLP Audit Fees of £53.4k (+ £10.3k VAT at 20%) for the predecessor CCG 22/23 Q1 External Audits – Northumberland CCG, North Tyneside CCG, Newcastle & Gateshead CCG, South Tyneside CCG, and Sunderland CCG. Delivery of this work commenced during the ICB's Financial Year, therefore these costs have been incurred by the ICB.
- Residual Ernst & Young LLP Audit Fees of £18.6k (+ VAT of £3.7k at 20%) for the predecessor CCG 22/23 (Q1) External Audits - Tees Valley CCG and County Durham CCG. Delivery of this work commenced during the ICB's Financial Year, therefore these costs have been incurred by the ICB.

The total of £65k under Non-Statutory Audit Expenditure consists of:
- An estimated Mental Health Investment Standard (MHIS) fee of £72k (£60k base fee + £12k VAT at 20%) for work to be completed by Mazars LLP for both the predecessor CCGs covering Q1 22/23 and the ICB covering Q2-Q3 22/23. The accrual is for the amount directed by Mazars LLP but is subject to change in 23/24 when the work is anticipated to be completed and the actual fee is agreed.
- The reversal of accruals for MHIS fees within the predecessor CCG 22/23 Financial Statements totalling -£7k (£6k base fee + £1k VAT at 20%).

Notes to the financial statements (continued)

5. Better Payment Practice Code

Measure of compliance	9 months to 31 March 2023 Number	9 months to 31 March 2023 £000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the period	104,653	1,180,680
Total Non-NHS Trade invoices paid within target	103,788	1,171,898
Percentage of Non-NHS Trade invoices paid within target	**99.17%**	**99.26%**
NHS Payables		
Total NHS Trade invoices paid in the period	4,439	3,406,734
Total NHS Trade invoices paid within target	4,426	3,406,620
Percentage of NHS Trade invoices paid within target	**99.71%**	**100.00%**

The Better Payment Practice Code requires the ICB to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

6. Finance costs

	9 months to 31 March 2023 £000
Interest	
Interest on lease liabilities	33
Total interest	**33**

Notes to the financial statements (continued)

7. Leases

7.1 Right of use assets

	9 months to 31 March 2023 Buildings £000	9 months to 31 March 2023 Total £000	3 months to 1 July 2022 Total £000
Cost or valuation at 1 July 2022 / 1 April 2022	-	-	-
IFRS 16 Transition Adjustment	-	-	5,130
Transfer from other public sector body	5,130	5,130	-
Cost/Valuation at 31 March 2023 / 1 July 2022	**5,130**	**5,130**	**5,130**
Depreciation 1 July 2022 / 1 April 2022	-	-	-
Charged during the period	(527)	(527)	(162)
Transfer from other public sector body	(162)	(162)	-
Depreciation at 31 March 2023 / 1 July 2022	**(689)**	**(689)**	**(162)**
Net Book Value at 31 March 2023 / 1 July 2022	**4,441**	**4,441**	**4,968**
Net Book Value by Counterparty:			
Leased from other group bodies		**4,441**	**4,968**

7.2 Lease liabilities

	9 months to 31 March 2023 £000	3 months to 1 July 2022 £000
Lease liabilities at 1 July 2022 / 1 April 2022	-	-
IFRS 16 Transition Adjustment	-	(5,133)
Interest expense relating to lease liabilities	(33)	(14)
Repayment of lease liabilities (including interest)	527	173
Transfer from other public sector body	(4,974)	-
Lease liabilities at 31 March 2023 / 1 July 2022	**(4,480)**	**(4,974)**

7.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	31 March 2023 £000	1 July 2022 £000
Within one year	(667)	(684)
Between one and five years	(1,808)	(1,964)
After five years	(2,242)	(2,601)
Balance at 31 March 2023 / 1 July 2022	**(4,717)**	**(5,249)**
Effect of discounting	237	275
Included in:		
Current lease liabilities	(667)	(621)
Non-current lease liabilities	(3,813)	(4,353)
Balance at 31 March 2023 / 1 July 2022	**(4,480)**	**(4,974)**

7.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	9 months to 31 March 2023 £000	3 months to 1 July 2022 £000
Depreciation expense on right-of-use assets	527	162
Interest expense on lease liabilities	33	14
Expense relating to short-term leases	164	42

7.5 Amounts recognised in Statement of Cashflows

	9 months to 31 March 2023 £000	3 months to 1 July 2022 £000
Total cash outflow on leases under IFRS 16	(527)	(172)

IFRS16 applied from 1 April 2022.

Notes to the financial statements (continued)

8. Net gain/(loss) on transfer by absorption

As referenced within note 1.1, the ICB was established on 1 July 2022 and took on the commissioning functions of eight former CCGs across the North East and North Cumbria, which were abolished. All of the assets and liabilities of those former CCGs were transferred to the ICB on 1 July 2022.

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Balances from CCGs to ICBs were transferred under “Modified Absorption” and are shown below within NHS England Group Entities, for these transactions only gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure

The transfer from NHS England to the ICB for Previously unassessed period of care (PUPOC) liability has been recorded as Transfer by Absorption.

	2022/23			
	Total £'000	NHS England Parent Entities £'000	NHS England Group Entities (non parent) £'000	Non NHSE Group £'000
Transfer of right of use (ROU) assets	4,968	-	4,968	-
Transfer of cash and cash equivalents	564	-	564	-
Transfer of receivables	17,089	-	17,089	-
Transfer of payables	(335,566)	-	(335,566)	-
Transfer of right of use (ROU) liabilities	(621)	-	(621)	-
Transfer of borrowings	(6,901)	-	(6,901)	-
Transfer of previously unassessed period of care (PUPOC) liability	(465)	(465)	-	-
Transfer of lease liabilities (Non Current)	(4,353)	-	(4,353)	-
Net loss on transfers by absorption / modified absorption	**(325,285)**	**(465)**	**(324,820)**	**-**

9. Contract and other receivables

	Current 31 March 2023 £000	Non-current 31 March 2023 £000	Current 1 July 2022 £000	Non-current 1 July 2022 £000
NHS receivables: Revenue	4,437	-	1,773	-
NHS prepayments	-	-	213	-
NHS accrued income	1,650	-	39	-
Non-NHS and Other WGA receivables: Revenue	5,803	-	4,470	-
Non-NHS and Other WGA prepayments	3,029	-	9,462	-
Non-NHS and Other WGA accrued income	83	-	755	-
Expected credit loss allowance - receivables	(631)	-	(509)	-
VAT	304	-	874	-
Other receivables	26	-	11	-
Total contract and other receivables	**14,701**	**-**	**17,089**	**-**
Total current and non current	**14,701**		**17,089**	

The great majority of trade is with other NHS bodies, including other ICBs as commissioners for NHS patient care services. As ICBs are funded by Government to commission NHS patient care services, no credit scoring of them is considered necessary.

9.1 Receivables past their due date but not impaired

	31 March 2023 £000
By up to three months	1,194
By three to six months	134
By more than six months	346
Total	**1,674**

£1,261k of the amount above has subsequently been recovered post the Statement of Financial Position date.

The ICB did not hold any collateral against receivables outstanding at 31 March 2023 (1 July 2022: none).

9.2 Expected credit losses on financial assets

The ICB has expected credit losses on contract and other receivables of £631k for the nine months to 31 March 2023 (1 July 2022: £509k).

The ICB has reviewed all receivables to determine whether an impairment value is required. In determining the recoverability of a receivable, the ICB considers any change in credit quality of the receivable from the date credit was initially granted up to the reporting date. The overall level of credit risk is considered to be relatively low due to the proportion of the customer base which is comprised of NHS bodies.

Notes to the financial statements (continued)

10. Cash and cash equivalents

	9 months to 31 March 2023 £000	3 months to 1 July 2022 £000
Balance at 1 July 2022 / 1 April 2022	(6,337)	1,657
Net change in period	7,961	(7,994)
Balance at 31 March 2023 / 1 July 2022	**1,624**	**(6,337)**
Made up of:		
Cash with the Government Banking Service	1,624	564
Cash and cash equivalents as in Statement of Financial Position	**1,624**	**564**
Bank overdraft: Government Banking Service	-	(6,901)
Total bank overdrafts	**-**	**(6,901)**
Balance at 31 March 2023 / 1 July 2022	**1,624**	**(6,337)**

The ICB held £nil cash and cash equivalents at 31 March 2023 on behalf of patients (1 July 2022: none).

Some of the predecessor CCGs completed BACS payment runs on 30 June 2022 which were due to clear the bank account in early July 2022 to enable them to clear balances owed to suppliers prior to the merger. This resulted in the CCGs having a net credit ledger cash position of £6,901k. This is acceptable and only reflects a timing difference between the drawdown process and cash being available in th bank account on 1 July 2022. This is only a technical adjustment and the net amount that the CCGs had overdrawn their bank accounts is recorded as Borrowings within the Statement of Financial Position. This balance was cleared in early July 2022.

11. Trade and other payables

	Current 31 March 2023 £000	Non-current 31 March 2023 £000	Current 1 July 2022 £000	Non-current 1 July 2022 £000
NHS payables: revenue	3,022	-	1,499	-
NHS accruals	18,176	-	11,171	-
Non-NHS and Other WGA payables: Revenue	99,189	-	18,612	-
Non-NHS and Other WGA accruals	335,020	-	294,339	-
Social security costs	479	-	537	-
VAT	-	-	16	-
Tax	508	-	496	-
Other payables	15,170	-	8,895	-
Total trade and other payables	**471,564**	**-**	**335,566**	**-**
Total current and non-current	**471,564**		**335,566**	

At 31 March 2023, the ICB had no liabilities due in future years under arrangements to buy out the liability for early retirement over 5 years (1 July 2022: none).

Other payables include £4,776k in respect of outstanding pension contributions at 31 March 2023 (1 July 2022: £5,151k).

12. Commitments

There were no contracted or non-cancellable contracts entered into by the ICB at 31 March 2023 which are not otherwise included in these financial statements.

13. Financial instruments

13.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

As the ICB is financed through Parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The ICB has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the ICB in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the ICB's standing financial instructions and policies agreed by the Integrated Care Board. Any treasury activity would be subject to review by the ICB's internal auditors.

13.1.1 Currency risk

The ICB is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The ICB has no overseas operations. The ICB therefore has low exposure to currency rate fluctuations.

13.1.2 Interest rate risk

The ICB has no borrowings and has only limited powers to borrow funds from government for capital expenditure, subject to affordability as confirmed by NHS England. The ICB therefore has low exposure to interest rate fluctuations.

13.1.3 Credit risk

Because the majority of the ICB's revenue comes from Parliamentary funding, the ICB has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

13.1.4 Liquidity risk

The ICB is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The ICB draws down cash to cover expenditure, as the need arises. The ICB is not, therefore, exposed to significant liquidity risks.

13.1.5 Financial Instruments

As the cash requirements of the ICB are met through the estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with the ICB's expected purchase and usage requirements and the ICB is therefore exposed to little credit, liquidity or market risk.

Notes to the financial statements (continued)

13. Financial instruments (continued)

13.2 Financial assets

	Financial Assets measured at amortised cost 31 March 2023 £000	Total 31 March 2023 £000
Contract and other receivables:		
· NHSE bodies	5,752	5,752
· Other DHSC group bodies	515	515
· External bodies	5,101	5,101
Cash and cash equivalents	1,624	1,624
Total Financial assets	**12,992**	**12,992**

13.3 Financial liabilities

	Other 31 March 2023 £000	Total 31 March 2023 £000
Trade and other payables:		
· NHSE bodies	2,727	2,727
· Other DHSC group bodies	31,529	31,529
· External bodies	440,067	440,067
Total Financial liabilities	**474,323**	**474,323**

14. Operating segments

The ICB has considered the definition of an operating segment contained within IFRS 8 in determining its operating segments, in particular considering the internal reporting to the Integrated Care Board, considered to be the 'chief operating decision maker' of the ICB, which was used for the purpose of resource allocation and assessment of performance.

All activity performed by the ICB relates to its role as a commissioner of healthcare for its relevant population. As a result, the ICB considers that it has only one operating segment, being the commissioning of healthcare services.

An analysis of both the income and expenditure and net assets relating to the segment can be found in the Statement of Comprehensive Net Expenditure and Statement of Financial Position respectively.

Notes to the financial statements (continued)

15. Pooled budgets

Individual pooled budget arrangements exist between the ICB and each of the 13 Local Authorities across the North East and Cumbria in respect of the Better Care Fund, through a section 75 agreement. The ICB contribution to the pooled budget was used to commission a range of health and social care services in line with the agreed objectives of the Better Care Fund. During 2022/23, the BCF agreements also include an allocation from the £500 million Adult Social Care Discharge Fund published 18 November 2022. This contribution to the Better Care Fund is recognised within the financial statements as ICB expenditure.

A number of other pooled budget arrangements exist with Local Authorities across the North East and Cumbria as set out below.

Management have assessed that joint control does not exist for any of these arrangements. The ICB's share of expenditure handled by the pooled budget in the financial period are shown below.

			Amount recognised in entity's books only 2022/23	
			Income	Expenditure
Name of arrangement	Parties to the arrangement	Description of Prinicipal Activities	£000	£000
Better Care Fund	NENC ICB / Durham County Council	The Better Care Fund is a Section 75 Agreement designed to integrate health and social care services, reduce hospital based care and promote community based services.	-	40,151
Better Care Fund	NENC ICB - Northumberland County Council	The Better Care Fund is a Section 75 Agreement designed to integrate health and social care services, reduce hospital based care and promote community based services	-	22,496
Better Care Fund	NENC ICB / South Tyneside Council	The Better Care Fund is a Section 75 Agreement designed to integrate health and social care services, reduce hospital based care and promote community based services	-	17,907
Better Care Fund	NENC ICB / Sunderland City Council	The Better Care Fund is a Section 75 Agreement designed to integrate health and social care services, reduce hospital based care and promote community based services	-	125,746
Better Care Fund	NENC ICB / Lancashire & South Cumbria ICB / Cumbria County Council	The Better Care Fund is a Section 75 Agreement designed to integrate health and social care services, reduce hospital based care and promote community based services	-	22,714
Better Care Fund	NENC ICB / Newcastle Local Authority	The Better Care Fund is a Section 75 Agreement designed to integrate health and social care services, reduce hospital based care and promote community based services	-	21,466
Better Care Fund	NENC ICB / Gateshead Local Authority	The Better Care Fund is a Section 75 Agreement designed to integrate health and social care services, reduce hospital based care and promote community based services.	-	15,029
Better Care Fund	NENC ICB / Darlington Borough Council	The Better Care Fund is a Section 75 Agreement designed to integrate health and social care services, reduce hospital based care and promote community based services.	-	7,290
Better Care Fund	NENC ICB / Stockton Council	The Better Care Fund is a Section 75 Agreement designed to integrate health and social care services, reduce hospital based care and promote community based services.	-	13,218
Better Care Fund	NENC ICB / Hartlepool Council	The Better Care Fund is a Section 75 Agreement designed to integrate health and social care services, reduce hospital based care and promote community based services.	-	6,808
Better Care Fund	NENC ICB / Redcar & Cleveland Council	The Better Care Fund is a Section 75 Agreement designed to integrate health and social care services, reduce hospital based care and promote community based services.	-	10,365
Better Care Fund	NENC ICB / Middlesbrough Council	The Better Care Fund is a Section 75 Agreement designed to integrate health and social care services, reduce hospital based care and promote community based services.	-	10,749
Better Care Fund	NENC ICB / North Tyneside MBC	The Better Care Fund is a Section 75 Agreement designed to integrate health and social care services, reduce hospital based care and promote community based services.	-	15,397
Gateshead Carers	NENC ICB / Gateshead Local Authority	Carers Service	-	341
Section 75	NENC ICB / South Tyneside Council	Care of Learning Disability Clients	-	7,079
Section 75	NENC ICB / South Tyneside Council	Delivery of legal advice in respect to CHC, Joint packages and S117	-	19
Section 75	NENC ICB / South Tyneside Council	Equipment Store	-	520
Section 76	NENC ICB / South Tyneside Council	Joint Commissioning Unit	-	423
Children's Preventative Care	NENC ICB / Sunderland City Council	Children's Preventative Care and improving commissioning initiatives	-	2,256
Gateshead Equipment Service	NENC ICB / Gateshead Local Authority	Purchase of home loans equipment for Gateshead residents	-	1,210
Tees Community Equipment Service	NENC ICB / Middlesbrough Council / Hartlepool Council / Stockton Council / Redcar & Cleveland Council	Tees Community Equipment Service	-	842

Notes to the financial statements (continued)

16. Related party transactions

During the 9 month period to the 31 March 2023, the ICB has undertaken transactions with the following Integrated Care Board members or members of the key management staff, or

Integrated Care Board Members	Declaration	Related Party	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
S Allen Chief Executive	Board Member	Academic Health Science Network	1,388	(143)	1,217	(131)
D Chandler Executive Director of Finance	Chair of Northern Branch	HFMA	51	-	43	-
Dr N O'Brien Executive Medical Director	GP Partner	Cestria Health Centre	1,769	-	147	-
	Practice is a member	Chester-le-Street Primary Care Netwo	751	-	-	-
	Practice is a member	Chester-le-Street Health Ltd	1,123	-	68	-
	Practice is member of Central Durham GP Providers Ltd	Coxhoe Medical Practice	880	-	35	-
	Practice is a member	Central Durham GP Providers Ltd	1,369	-	93	-
C Riley Executive Director of Corporate Governance, Communications and Involvement	Non Executive Director	Explain Market Research	27	-	-	-
Professor G Evans Executive Chief Digital & Information Officer	Wife is a Trustee	Butterwick Hospice Trust	349	-	215	-
D Gallagher Executive Area Director (Central and South)	Non-Executive Director	Academic Health Science Network	1,388	(143)	1,217	(131)
Dr M Smith	GP Partner and PCN Clinical Director	Claypath & University Medical Group	3,174	-	231	-
Partner Member - PMS	Practice is member of Central Durham GP Providers Ltd	Central Durham GP Providers Ltd	1,369	-	93	-
M Adams Executive Director of Place Based Delivery - North Cumbria and North	Director	Goalseeker Ltd	-	(35)	-	-
A Workman Local Authority Partner Member	LA Partner Member	Stockton Borough Council	23,830	-	11,734	-
T Hall Local Authority Partner Member	LA Partner Member	South Tyneside Council	27,236	-	16,159	(99)
S Moore Local Authority Partner Member	LA Partner Member	Hartlepool Borough Council	13,311	-	3,933	-
C McEvoy-Carr Local Authority Partner Member	LA Partner Member	Newcastle City Council	43,668	-	19,744	(703)
K Bremner Foundation Trust Partner Member	Board member	Academic Health Science Network	1,388	(143)	1,217	(131)

All of these transactions were undertaken under standard terms and conditions in the normal course of business.

The Department of Health and Social Care (DHSC) is regarded as the parent department. During the period the ICB has had a significant number of material transactions with entities for which the DHSC is regarded as the parent Department. For example:

- NHS England;
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Resolution; and,
- NHS Business Services Authority.

In addition, the ICB has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Local Authorities across the North East and North Cumbria.

Notes to the financial statements (continued)

17. Events after the end of the reporting period

Agenda for change pay award:
In March 2023 the government announced an additional pay offer for 2022/23, in addition to the pay award earlier in the year. Additional funding was made available by NHS England for implementing this pay offer for 2022/23 and the income and expenditure has been included in these accounts as guided by the Department of Health and Social Care and NHS England. In May 2023 the government confirmed this offer will be implemented as a further pay award in respect of 2022/23 based on individuals in employment at 31 March 2023.

There are no other post balance sheet events which would have a material effect on the financial statements of the ICB.

18. Losses and special payments

There has been seventeen ex gratia payments made for the total value of £13k in relation to lease car VAT repayments, in line with NHS England approval. These amounts are reported on an accruals basis but excluding provisions for future losses.

19. Financial performance targets

ICBs have a number of financial duties under the NHS Act 2006 (as amended).

The ICB's performance against those duties was as follows:

	9 months to 31 March 2023 Target £000	9 months to 31 March 2023 Performance £000	Duty Achieved?
Capital resource use does not exceed the amount specified in Directions	-	-	**Yes**
Revenue resource use does not exceed the amount specified in Directions	5,173,834	5,171,090	**Yes**
Revenue administration resource use does not exceed the amount specified in Directions	47,427	41,850	**Yes**
Additional directions on resource use: funding for agenda for change pay offer	1,372	1,372	**Yes**

ICB financial performance is reported on an in-year basis. The figures within this note reflect only the in-year position, being the difference between the in-year allocation (plus any pre-approved surplus drawdown) and total expenditure.

The ICB received no capital resource during the nine months to 31 March 2023 and incurred no capital expenditure.

Performance against the revenue expenditure duties is further analysed below:

	9 months to 31 March 2023 Programme Resource £000	9 months to 31 March 2023 Administration Resource £000	9 months to 31 March 2023 Total £000
Revenue resource	5,126,407	47,427	**5,173,834**
Net operating cost for the financial period	5,129,240	41,850	**5,171,090**
(Over)/underspend against revenue resource	**(2,833)**	**5,577**	**2,744**

The ICB has delivered a in-year surplus of £2,744k for the nine months to 31 March 2023, this is against a planned surplus of £2,632k.

Independent auditor's report to the Board of NHS North East and North Cumbria Integrated Care Board

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of NHS North East and North Cumbria Integrated Care Board ('the ICB') for the nine-month period ended 31 March 2023, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2022/23 as contained in the Department of Health and Social Care Group Accounting Manual 2022/23, and the Accounts Direction issued by NHS England with the approval of the Secretary of State as relevant to Integrated Care Boards in England.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2023 and of its net expenditure for the nine-month period then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2022/23; and
- have been properly prepared in accordance with the requirements of the Health and Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

The Accountable Officer is responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on regularity

In our opinion, in all material respects the expenditure and income reflected in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Responsibilities of the Accountable Officer for the financial statements

As explained more fully in the Statement of Accountable Officer's Responsibilities the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is also responsible for ensuring the regularity of expenditure and income.

The Accountable Officer is required to comply with the Department of Health and Social Care Group Accounting Manual 2022/23 and prepare the financial statements on a going concern basis, unless the ICB is informed of the intention for dissolution without transfer of services or function to another public sector entity. The Accountable Officer is responsible for assessing each year whether or not it is appropriate for the ICB to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice and as required by the Local Audit and Accountability Act 2014.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Based on our understanding of the ICB, we identified that the principal risks of non-compliance with laws and regulations related to the National Health Service Act 2006 (as amended by the Health Care Act 2022), and we considered the extent to which non-compliance might have a material effect on the financial statements.

We evaluated the Accountable Officer's incentives and opportunities for fraudulent manipulation of the financial statements (including the risks of override of controls) and determined that the principal risks related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, significant one-off or unusual transactions and the risk of fraud in financial reporting relating to expenditure recognition due to the potential to inappropriately record expenditure in the wrong period.

Our audit procedures were designed to respond to those identified risks, including non-compliance with laws and regulations (irregularities) and fraud that are material to the financial statements. Our audit procedures included but were not limited to:

- discussing with management and the Board, the policies and procedures regarding compliance with laws and regulations;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the ICB which were contrary to applicable laws and regulations, including fraud.

Our audit procedures in relation to fraud included but were not limited to:

- making enquiries of management and the Board on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud;
- addressing the risks of fraud through management override of controls by performing journal entry testing;
- addressing the risk of fraud in expenditure recognition through testing payments in the pre and post year end period to ensure they were recognised in the right year, sample testing material period-end payables and provisions and reviewing intra-NHS reconciliations and data matches provided by the Department of Health and Social Care.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with management and the Board. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit

of financial statements and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in December 2021.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report

Report on the ICB's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the nine-month period ended 31 March 2023.

We have not completed our work on the ICB's arrangements. On the basis of our work to date, having regard to the guidance issued by the Comptroller and Auditor General in January 2023, we have not identified any significant weaknesses in arrangements for the period ended 31 March 2023.

We will report the outcome of our work on the ICB's arrangements in our commentary on those arrangements within the Auditor's Annual Report. Our audit completion certificate will set out any matters which we are required to report by exception.

Responsibilities of the Accountable Officer

As explained in the Statement of Accountable Officer's responsibilities, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the ICB's resources.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required under section 21 of the Local Audit and Accountability Act 2014 to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Health and Care Act 2022; and
- the other information published together with the audited financial statements in the Annual Report for the period for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS England; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014; or
- we issue a report in the public interest under section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the ICB under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects**.**

Use of the audit report

This report is made solely to the members of the Board of NHS North East and North Cumbria ICB, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to

the members of the Board of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the ICB, as a body, for our audit work, for this report, or for the opinions we have formed.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources and complete the work necessary to provide assurance to the NAO on the whole of government accounts return.

Cameron Waddell,
Partner
For and on behalf of Mazars LLP

The Corner
Bank Chambers
26 Mosley Street
Newcastle upon Tyne
NE1 1DF

4 July 2023