NHS
North East and
North Cumbria

Board meeting

MEETING
29 November 2022 09:30 GMT

PUBLISHED
28 November 2022

Agenda

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Mayor's Parlour, City Hall, Sunderland	29 Nov 2022	09:30

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Item: 4

NHS
North East and North Cumbria

North East and North Cumbria Integrated Care Board (ICB)

Minutes of the meeting held on 27 September 2022 at 09.45am in the Council Chambers, Northumberland County Council.

Minutes

Present: Professor Sir Liam Donaldson, Chair

Samantha Allen, Chief Executive

Nicola Bailey, Interim Executive Director of Place Based Delivery (North and North Cumbria)

Hannah Bow, Independent Non-Executive Member

David Chandler, Interim Executive Director of Finance

Professor Graham Evans, Executive Chief Digital and Information Officer

David Gallagher, Executive Director of Place Based Delivery (Central and South)

Tom Hall, Local Authority Partner Member

Professor Eileen Kaner, Independent Non-Executive Member

Annie Laverty, Executive Chief People Officer

Dr Saira Malik, Primary Medical Services Partner Member

Jacqueline Myers, Executive Director of Strategy and System Oversight

Dr Rajesh Nadkarni, Foundation Trust Partner Member

Dr Neil O'Brien, Executive Medical Director

David Purdue, Executive Chief Nurse

Claire Riley, Executive Director of Corporate Governance, Communications and Involvement

John Rush, Independent Non-Executive Member

Dr Mike Smith, Primary Medical Services Partner Member

David Stout, Independent Non-Executive Member

Aejaz Zahid, Executive Director of Innovation

In Attendance:

Jane Hartley, NENC VONNE

David Thompson, NENC Healthwatch

Jan Thwaites (minutes)

PB/2022/21 Welcome and Introductions

The Chair welcomed everyone to the second meeting of the ICB board. Introductions were made to David Purdue, Executive Chief Nurse, Hannah Bows, Independent Non-Executive Member and David Stout who were not in post for the first meeting of this board.

PB/2022/22 Apologies for Absence

Apologies were received from Ken Bremner, Foundation Trust Partner Member, Ann Workman, Local Authority Partner Member and Cath McEvoy-Carr Local Authority Partner Member.

PB/2022/09/23 Declarations of Interest

The members had all submitted their declarations prior to the meeting, no additional items were raised.

PB/2022/09/24 Minutes of the previous meeting held on 1 July 2022

As a point of accuracy an amendment was to be made to the integrated performance report to state ICB performance not national performance.

PB/2022/09/25 Matters arising from the minutes of the previous meeting held on 1 July 2022

Health and Inequalities task and finish group

The group were looking at the governance of how to manage health and equalities and prevention. A paper would be prepared and presented firstly to the Executive Committee and then to the ICB board. The group were ensuring the work was well connected into the governance of the ICB and delivery of Core 20+5. An update on the recommendations for spending of the national health and equalities budget would be given.

Policy review schedule

All the policies were reviewed to ensure they reflected the ICB ways of working going forward. A prioritisation schedule had been

developed which would be taken to the Executive Committee in October. An update to the board would be given at a future meeting.

PB/2022/09/26 Notification of items of any other business

There were no additional items of business.

PB/2022/09/27 Chief Executive's Report

The report provided an overview of recent activity carried out by the ICB Chief Executive and Executive Directors.

Key points were noted, these included the changes in the government with a new Secretary of State for Health and Social Care. A new ministerial team had also been appointed. A government plan for patients had been published focussing on ambulances, backlogs, care, doctors and dentists. Making performance more transparent across the health service in terms of ambulance response times, waiting lists and the backlog of elective care due to the Covid pandemic.

In terms of local accountability, addressing performance and access to primary care with contact within 2 weeks and telephone contact being easily available, would be closely scrutinised by the government. It was noted that some of the North East and North Cumbria (NENC) ICBs greatest challenges were in relation to social care and were working closely with local authority partners in terms of market management and availability of local workforce to ensure it was available to the public.

Following the ICBs assumed responsibility for eight CCGs, significant work had been undertaken to ensure access to evidence based practice in particular the implementation of NICE guidelines and evidence based treatment.

The inaugural meeting of the Integrated Care Partnership had taken place which was available to view on the public facing website. The partnership consisted of health, local authority and the community and voluntary sector partners and set out an ambition through the Integrated Care Strategy to focus on health and inequalities.

A Learning and Improvement event had been held which was widely attended. It was accepted that to share and adopt practice was the ICBs ambition.

It was noted that in regard to winter pressures the largest cause were delays in handover from ambulances being held up in emergency departments as there were no available beds to discharge patients to. There were increasing numbers of calls to both the ambulance service and NHS111. More work was required in these areas to understand the drivers for this. The latest national and

local response times were highlighted. It was acknowledged that these pressures would be around for the future.

A protocol had been developed by the voluntary sector, clinical networks and local community foundations around supporting a democratic and effective way of distribution of NHS funding as it came in to be spent in the voluntary and community sector. There were positive examples around supporting mental health transformation funding and the NHS charities together community grants programme.

A comment was made in relation to the funding of dentistry possibly remaining at historical levels. The perceived underfunding of the service was highlighted and the significant inequalities in certain areas of the population. A question was raised in relation to the possible delay in the ICB accepting the responsibility of the dentistry service. In response it was explained that this may be in shadow form for a year with the responsibility for resources remaining with NHS England (NHSE). Assurance was given that a very detailed piece of work was being undertaken under the banner of due diligence, to be clear on what would be taken on and being clear with NHSE on what would be required to take on the responsibilities particularly in relation to dentistry.

RESOLVED

The Board received the report for information and assurance.

PB/2022/09/28 1 July board meeting – feedback from members

The feedback received highlighted the following areas:

- Excellent chairing, clear agenda and good participation from all members
- Good engagement
- Recognition of the large amount of papers
- Slides information too small to read
- Set up of room and microphones which was being worked upon
- Structuring the agenda to align to the ICB strategic aims
- Inviting suggestions at the end of the meeting for future agenda items
- Reflections of the board members at the end of the meeting to share.

PB/2022/09/29 Amendments to the Executive Committee Terms of Reference

The report sought approval from the Board to update the terms of reference for the Executive Committee.

There had been a matter in relation to quoracy which had been amended.

RESOLVED

The Board approved the updated terms of reference.

PB/2022/09/30 Highlight report and minutes from the Executive Committee meeting held on 12 July 2022

An overview of the discussions and decisions of the Executive Committee meeting were provided.

A subsequent meeting had been held since 12 July, the minutes of which would be circulated to board members so as not to delay the sharing of information.

RESOLVED

The Board received the minutes for information.

PB/2022/09/31 Highlight report from the Finance, Performance and Investment Committee held on 1 September 2022

An overview of the discussions and decisions of the inaugural committee meeting were provided.

It was explained that the previous two meetings had been condensed into one and involved Foundation Trust representatives. Following discussion the terms of reference would be amended to include the subsequent changes.

RESOLVED

The Board received the minutes for information and noted an amended version of the terms of reference would be submitted to the November meeting for consideration and formal approval.

PB/2022/09/32 Urgent and emergency care – Operational Resilience Plan

The ICB focus was on managing the surge and resilience to the system for the coming challenging winter period. The governance had been refreshed and the system was being managed from the bottom up. All places were involved in the local A&E delivery boards which were partnerships of health, foundation trusts, primary care, the voluntary sector and local authorities that focus on this agenda. Through the Urgent, Emergency Care Network Strategic Board the terms of reference for the groups had been refreshed and were all chaired by chief executives of the foundation trusts. Clinical involvement had been improved by developing a professional group which would be chaired by the ICB Executive Chief Nurse. Significant support was provided by North East Commissioning Support (NECS) and there were strong links with the Provider Collaborative which would feed into the ICB Executive Board and then up to the ICB Board.

Priorities were looked at from a system level. Surge was managed via an on-call rota which was in the process of being strengthened. There would be two tiers of directors on call, strategic and tactical which would be based on the four ICP areas. Directors would have local knowledge of local systems and on any particular issues within surge.

It was explained that both RAIDR and Optica were IT systems to monitor flow through hospitals and urgent and emergency pressures such as waiting times and ambulance hand over delays available via an app.

The following three priority areas were discussed;

- Enhanced clinical triage
- Primary care access
- Improving discharge and patient flow

The ICB must deliver an effective flu and Covid vaccination programme ensuring that patients understand how to access the urgent and emergency care system. A plan had been released in relation to primary care for winter with changes in relation to primary care network enhanced services.

In regard to measures of success, the ICB Board would have to report against the six national metrics. Additional metrics had been proposed locally which aligned to system priorities

- Delays of discharge
- Number of 999 and 111 calls being clinically triaged
- Number managing to put into different pathways and vaccination rates.

A request had been made for the six national metric trajectories to be progressed once target performance had been received.

There was a potential ask for a 24/7 clinically staffed ICB operational hub, these conversations would be responded to once confirmed.

Full detail was awaited around the request for GP appointments within a maximum of 14 days.

Clarification was requested in relation to the correlation between the diagram on decision making and reporting and how the winter surge activity would relate in due course to the quality and safety committee. There was a need to look preventatively and set things in place before winter set in. In response it was explained that these national targets were quality targets and overlapped with the finance and performance committee. Issues could be raised between the two committees. Some of the areas in relation to harm for the patients related to ambulance delays and were reported on differing levels

across the ICS, this would require some consistency of reporting. Outcome measures were being looked at with local authorities for both health and social care.

It was explained that in the north there were significant variations in the services that were in place with major workforce issues in either social or primary care. Issues in relation to mental health care required more focus in terms of recovery from Covid and increased issues around poverty.

In regard to the Central and Tees area there were good examples of GP triage and access to primary care including the colocation of the Emergency Department (ED) with North Tess and Hartlepool. Discharge issues were across the patch and work was continuing with the local authority with the limiting factor of workforce issues being at the forefront.

A comment was made as to how to make the best use of mental health services in manging the surge. In response it was noted that the model on what clinical discharge would look like was still being developed, mental health interactions with ED were under pressure and would be picked up.

The pressure on the workforce could not be underrated, the plan was to ensure the focus on the metrics and what mattered across the North East and North Cumbia. The challenge would be on the day to day operational aspects supporting the system and the communities over a challenging period.

A comment was made in regard to prevention and early intervention and how to manage issues before they came into the hospital system. In response it was noted that work was being undertaken to increase and support and emergency care planning and good chronic disease management. There would also be a large number of patients with issues that were not known about. Through the prevention health and equalities workstreams there will be focus on these issues.

The following responses were given in relation to the comments that had been raised:

Some of the work with the voluntary sector was to articulate best practice both place based and regionally with regard to sharing and learning.

Working on the children and young people strategy and separate core 20+5 on the wider determinates of heath to influence future health requirements by starting early.

In relation to community pharmacy this was being engaged, extending the minor ailments scheme running a pilot for treatment of urinary tract infections which had been very successful. This had diverted potential patients away from primary care.

The variations on the PCN DES would be picked up.

PB/2022/09/33 Ockenden Report – Immediate Actions Review

The report provided a thematic review following insight visits of all maternity services in North East and North Cumbria (NENC) to review good practice and areas for improvement in maternity services, to enable targeted support from the Integrated Care System (ICS), Local Maternity Neonatal System (LMNS) and the regional team.

All trusts with maternity services were required to submit responses. The final report identified another 16 immediate actions, response to this had been delayed whilst awaiting the East Kent report which was expected in October 2022.

A rapid improvement had been seen in terms of individual organisations, eight local providers were listed in the report. Three organisations were compliant in all seven areas.

Two key areas were informed consent and risk assessment throughout pregnancy. The North East and North Cumbria would be the first Integrated Care System (ICS) in the country to have the same digital platform for all maternity providers.

Workforce remained amber for all providers which was a national issue. Recruitment of international midwives was underway, there was a year's lag for those able to work independently due to having undertaken their training overseas.

A question was raised in relation to the differential patient experience for black and BME women. In response it was noted that there were strong partnerships looking at those groups to be as effective as possible in raising concerns.

A question was raised in relation to whether any lessons learnt had been taken forward. In terms of improvement all the experiences were taken through women and their families who had been affected by the service. The second report was more focussed around neonatal and maternity care. As Senior Responsible Officer for the midwifery and neonatal delivery network the Executive Chief Nurse noted the work undertaken would be shared across the system.

The Maternity Voices Partnership had welcomed 2 new partners one of which was from a BAME background. In terms of the work they

would be assessing where people were and agree some outcome measures.

The reason for adopting a common digital platform across the area would lend itself to the learning culture and using the data to inform research going forward.

RESOLVED

The Board noted the paper.

PB/2022/09/34 Safeguarding and Learning from Life and Death Reviews of People with Learning Disabilities and Autistic People Position Paper

The report provided the current status of the ICB safeguarding function and the priorities for completion of the strategy due in December 2022 and to receive the Learning from Lives and Deaths of People with Learning Disabilities and Autistic People annual report for 2021/22.

The ICB had taken a review of the current position against the national framework and rated itself as amber. The multi-agency safeguarding hub was rated as green.

There were 13 community safeguarding partnerships, 10 adults safeguarding boards, 11 children's safeguarding boards, 13 multi-agency safeguarding hubs and 1 violence reduction unit.

Of the two amber areas further work was required on the revised safeguarding accountability and assurance framework which was published in July 2022 by NHS England. The framework highlighted clear safeguarding roles and responsibilities for all working in funded care settings and in NHS commissioning organisations.

In terms of next steps a Safeguarding Executive Committee would be set up which would report into the ICB Quality and Safety Committee to ensure safeguarding expertise was available to ICB commissioners, the development of a joint forward plan which would be inclusive and not carry either safeguarding or quality risks. To design and coordinate the operational strategic plan for 2022 into 2023/2024 and to ensure the safeguarding strategy was aligned to all ICB and NHSE priorities for safeguarding. Work would be aligned with good practice and shared learning.

The final strategy would be available from December 2022.

A comment was made that local authority social care safeguarding should also be included. It was acknowledged that the three statutory partners were involved.

In relation to LeDer a national report noted that men died 22 years younger if having a learning disability and women 26 years younger.

The ICB would fulfil their LeDer responsibilities ensuring core principles and values were undertaken. There had been a considerable number of underreporting of deaths in the BAME community. The ICS would adopt a named individual to ensure the challenges were understood, considered and addressed.

The ICS had set up a LeDer Governance Board with the Executive Chief Nurse as its Chair; the terms of reference had been adopted. The ICP LeDer panels would be established and functioning by December 2022. Learning from the 13 places needed to be widely understood.

RESOLVED

The Board received the report.

PB/2022/09/35 Vaccination Plan

The report updated the Board on the current status and future delivery strategy for all vaccination activities.

In regard to flu vaccination delivery there was an aspiration to try to match the coverage from last year. It was noted that the focus on Covid had helped to ensure people came forward for their vaccinations. It was reported that last winter flu was virtually non existent thanks in part to social distancing. There was a potential to have both flu and Covid waves which would put further strain on NHS services.

It had been agreed to extend the coordinating function with Newcastle Hospitals until January 2023 when the vast majority of vaccinations should have been given out.

It was explained that in the North East and North Cumbria 7 million vaccinations been given along with 250,000 spring boosters. The capacity to vaccinate in the networks were:

- 71 Primary Care Networks (PCNs)
- 130 community pharmacies
- 19 hospital hubs
- 15 roving services including the mass vaccination sites, to offer the capacity.
- 40% of the most vulnerable care home residents had been vaccinated
- Where practical flu and Covid vaccinations would be co-administered

In regard to the monkeypox vaccination programme which was led by the UK Health Security Agency, they had been linked into the ICB vaccination infrastructure. The initial delay in vaccine delivery had been resolved and the number of vaccinations had been increasing. Future delivery responsibility for this would come to the ICB in 2024. Sufficient capacity to cover this would be looked into and assured.

RESOLVED

The Board received the report for assurance.

PB/2022/09/36 Integrated Delivery Update Report

The report provided a high-level overview of quality, performance, outcomes and finance.

The ICB was in the process of developing an oversight framework in response to the national oversight framework. From this a range of reports, meetings and progress actions would be produced, these would address how the ICB worked with providers, place based boards, primary care and the oversight to key strategic programmes and clinical networks.

The ongoing work on the Integrated care strategy was highlighted.

Points of interest were highlighted, these included the following:

- The significant variation in regard to health inequalities
- A&E performance pressures remained although the North East and North Cumbria continue to exceed average performance in England,
- ambulance handovers an area of concern
- deterioration of cancer 62 day waits
- some interventions had been developed in relation to long waits, focus meetings with the three providers were ongoing.

Detail on the following slides were discussed

- variation and assurance icons
- friends and family test
- people promise taken from a staff survey
- referral to treatment and long waiters – a detailed deep dive was to be undertaken in this area
- urgent and emergency care – patients in A&E longer than 12 hours
- children and young people mental health – progress had been made in this area.

Data in relation to waiting times would be presented to the next ICB board meeting.

In regard to some recurring themes such as ambulance response times it was asked if there were any thoughts on a more forensic report and were there any plans to include social care. In response it was noted that concerns would be taken on board and that there would be an opportunity to discuss in detail in other committees areas such as ambulance delays. In relation to social care work it was noted that this was ongoing with local authorities.

A comment on the GP patient experience survey noted the work that needed to be undertaken over the next few months.

RESOLVED

The Board received the report for information and assurance.

PB/2022/09/37 Roadmap to place based working

The report set out a roadmap for the development and agreement of place based working with local partners.

One of the building blocks for the system was place – the report outlined a roadmap for the ICB clarifying with partners at place how the ICB would work with them ensuring the governance was robust.

The report highlighted the work undertaken previously and following a meeting on 21 June where conversations were held relating to ambitions with colleagues at place. Views would be collated by the end of October on how they considered working together going forward. A joint committee with partners would be formed, detail on this would be brought to the Board to agree how to take this forward in shadow form from 1 April 2023.

RESOLVED

The Board received the report noting the proposals.

PB/2022/09/38 Risk Management Strategy

The strategy set out the ICB's approach to risk and the management of risk.

The strategy had been approved by the Executive Committee and had been aligned to national policy.

A question was raised as to the timescale for implementation. In response it was noted this would be completed by November/December 2022. From a system point of view it had been agreed to align the system across the region.

RESOLVED

The Board formally ratified the risk management strategy.

PB/2022/09/39 Finance Update and Overview Report

The report provided the Board with an update on the financial performance for the period to 31 July 2022. The report had been approved at a recent Finance, Investment and Performance Committee meeting.

The ICB were working to four main financial duties and the report relayed where they stood against these targets.

The ICB should not spend more than its revenue allocation of around £6.5bn per annum.

The ICB's current forecast outturn of £2.6m planned surplus was on target to be achieved. Detail in the report covered variances in relation to overspends in prescribing, elective recovery funding and risks around packages of care.

The second duty was around a duty to breakeven as a collective with the Foundation Trusts (FTs), the current plan noted these providers were forecasting a deficit of £2.6m in line with plan. The providers were identifying risks in relation to recovery elective plans and agency costs.

The third duty was in regard to capital with a capital resource limit of £187m. It was currently forecast that this would be overspent by £32m, this was a planned breach.

The fourth duty was in relation to a running cost budget of £43m, this reduced every year. On track to deliver this year, next year would be more challenging and would require careful management.

A section of the report was dedicated to the Better Care Fund which was signed off at the Health and Wellbeing Board.

The risk of inflation was highlighted and when the full detail was expected. In response it was noted that NHS England had worked with the ICB to identify the inflationary pressures they may incur in year. NHSE had identified £90m of funding for the ICB of which approximately £80m of which went to FT providers who were identifying pressures on such areas as fuel costs. The biggest pressure was on staffing and filling vacancies.

In regard to BCF, resources were managed at place and any variances were identified and incorporated in the report. Further detail was required and it was identified that there is a need to work more collaboratively.

It was acknowledged that the workforce issue was not only across health and it was suggested that there may be appetite to do this more collaboratively. It was explained that these conversations were been undertaken. A workforce committee was being developed to look at this area with the inclusion of Health Education England.

RESOLVED

The Board noted the latest year to date and forecast financial position for 2022/23 and received assurance that overall performance was in line with plan.

It was noted there were a number of potential financial risks across the system to be managed and that BCF agreements were being agreed through Health and Wellbeing Boards in line with approved budgets.

PB/2022/09/40 Presentation of the 21/22 Annual Reports of the former clinical commissioning groups of Durham, North Cumbria and Northumberland.

The annual reports from the former clinical commissioning groups were presented to the Board.

RESOLVED

The Board received the reports for information.

PB/2022/09/41 Questions from the public on items on the agenda

There were no questions from the public.

PB/2022/09/42 Any other business from members

There were no items of any other business.

The meeting closed at 13:15.

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NHS
North East and North Cumbria

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

NENC ICB Board 29 November 2022	
Report Title:	**Learning Disabilities and Autism – Building the Right Support**

Purpose of report

To provide the ICB Board with an overview of the challenges and opportunities for the North Cumbria and North East Integrated Care System (NCNE ICS) to deliver together with our Councils' Transforming Care for Autistic people, people with Learning Disabilities and people with both.

Key points

- Autistic people and people with learning disabilities are more vulnerable to health inequalities than the general population.
- This includes not having the right accommodation, care, and support in the community.
- Without the right support unnecessary admissions to hospital are more likely and discharge from hospital becomes more challenging.
- People with the most complex needs are even more at risk of having long lengths of stay in hospital.
- The NENC still has too many autistic people and people with learning disabilities staying too long in hospital after their treatment is complete.

Risks and issues

- Transforming Care trajectories are not achieved as too many people are admitted unnecessarily to hospital and too few people are discharged when hospital treatment in no longer required.
- Without additional intensive support the independent care and housing sector is unable to support those people with the most complex needs.
- In the absence of a commissioning led market, the market conditions may produce provisions that do not fit with the principles of Building the Right Support resulting in a reduction of choice and control for people with a lived experience, their families, and advocates as to where and how people live.

• Significant amounts of funding are spent on off framework care and support packages which may not be safe, high quality and sustainable • The costs of delivering Transforming Care are significant: morally, financially and in relation to workforce capacity.
Assurances
• Mature and integrated ICB learning disabilities and autism workstream • Coproduction embedded in the delivery of Transforming Care • Co designed regional plan agreed by the ICB and NE ADASS.
Recommendation/Action Required
The Board is asked to: • Receive the report and the decisions made by the ICB committee to support the recommendations in this paper • Receive quarterly updates on the Transforming Care key performance indicators and the delivery of the ambitions of Building the Right Support.

Sponsor/approving director	Nicola Bailey, Interim Executive Director of Place Based Delivery (North and North Cumbria) Jacqueline Myers, Executive Director of Strategy and System Oversight
Report author	Kate O'Brien, Director of Transformation for Learning Disabilities, Mental Health and Autism

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

Relevant legal/statutory issues
Transforming Care, is a NHSE mandatory programme

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

Key implications	
Are additional resources required?	Yes, but not immediately. Further paper to be submitted on forecasted finances and a proposed ICB/S Autism statement

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Has there been/does there need to be appropriate clinical involvement?	Yes
Has there been/does there need to be any patient and public involvement?	Yes, via established coproduction programme
Has there been/does there need to be partner and/or other stakeholder engagement?	Yes, NENC Councils via NE ADASS

Item: 7.1

Learning Disabilities and Autism – Building the Right Support

1. Introduction

1.1 This paper is concerned with the NENC ICS systemwide approach to supporting those people who have the most complex needs, often our most vulnerable and at-risk individuals, many of whom have spent years in hospital living with deprivations of their liberty and human rights which we would find intolerable. This paper is not a blueprint for getting the system approach right first time. Indeed, this is not the first or sadly the second time we have tried to implement systemwide solutions, and whilst as partnerships of health and social care commissioners and providers we have got much right, we still have too many people living in hospital, or at high risk of admission, for whom without a radical change there is little chance of living as we all do, in the community with our own front door and the right to choose a life worth living.

1.2 The proposed solutions to supporting people with very complex needs in this paper require four things to happen simultaneously. These are:

Alliances between NHS providers of secondary mental health and disability services and social care and support providers.
NHS investment in complex care packages above the pricing of Local Authority framework rates.

The creation of Intensive Support Teams (ISTs) and respite resources able to wrap support into the places where people live rather than admitting people unnecessarily to hospital.
Market and workforce development and stimulation.

These proposals are covered in the paper and include both the current cost to the system and an estimated future cost. These costs to the system are both financial and moral, so intertwined as to be impossible to cite one without the other.

2. Complex Needs

2.1 The terminology of complex needs is not without critics. Another phrase used by the Local Government Association and NHS England is 'hefty reputations'. Both terms describe people who are burdened by the reputations they have been given because of behaviours, reactions, support requirements and large funding packages. These 'reputations' are often an index that the person's needs are not being met.

2.2 This paper is about these people, our citizens who have long-term care, behavioral, and social care needs. People who, if they are to have the opportunity to live in the community, need specialist accommodation, care, and support, overlain with long term intensive support from secondary mental health and learning disability services.

2.3 These are our people who incur high health and social care costs, increased rates of detention to hospital, poor physical health outcomes, and multiple breakdowns in

their care and support. Health services usage is significantly higher for these individuals yet, despite this high service use, they are the people who often experience the worse outcomes.

3. Current position

3.1 Across the NENC ICS there are:

- More than 8000 people with autism and/or a learning disability in receipt of long-term care and the combined annual budget across health and social care is around 450 million.
- The vast majority of people's care and support needs are commissioned via Local Authority frameworks which range from time and task domiciliary care provision to smaller numbers of high needs care providers. The rates of renumeration vary but average out between £15 and £19 per hour.
- 151 adults and 9 children are in mental health or learning disability hospitals of whom 39 have been identified as no longer needing to be in hospital.
- Delays to discharge are predominately due to a lack of suitable accommodation, care and support or absence of a legal framework to enable discharge (MM ruling).
- Approximately 50 people across the region at risk of admission to hospital because of placement breakdown, provider failure or lack of a suitable alternative.
- Growing numbers of autistic adolescents who are at risk or are placing others at risk who require access to regulated placements or secure care now, and for the future preventative and earlier intervention trauma informed pathways developing.
- Rising numbers of children and young people in extremely high-cost unregulated placements (30-45k per week).

3.2 Within the inpatient and community population there are approximately 30-35 people per year who require accommodation, care and support which is above what can reasonably be described as a social care / general housing provision. The housing requirements and support packages in these situations will include heavily modified environmental adjustments and ratios of 3:1/ 2:1 staffing.

3.3 Providers will be expected to support significant levels of aggression and emotionally deregulated behaviours through very specialist care plans requiring a consistent, highly trained workforce, who may also ideally require proactive support from specialist clinical teams. The risk of burn out in these care packages is extremely high particularly where staff have little training and external support and are paid the national minimum wage. These are the environments where without skilled leadership, supervision and system oversight, closed cultures can develop, with poor adult attachment between client and carer and abuse can more easily occur.

3.4 One key challenge is that the commissioned rate of renumeration via the Local Authority frameworks does not reflect the actual costs of retaining this highly skilled workforce in a stable way. This results in people with the most complex needs frequently having multiple placement breakdowns, interruption to relationships and

continuity of care and commissioners having to go 'off framework' to access providers who are not as robustly quality assured and who can charge up to £45 per hour. These multiple failed placements are often catastrophic for the individual and result in unplanned crisis driven moves to unprepared alternatives and / or lengthy unnecessary admission to hospital.

3.5 In the worst-case scenarios people have had to move to out of area residential facilities or independent hospitals of varying quality all of which fall short of the homes not hospitals principles of Transforming Care.

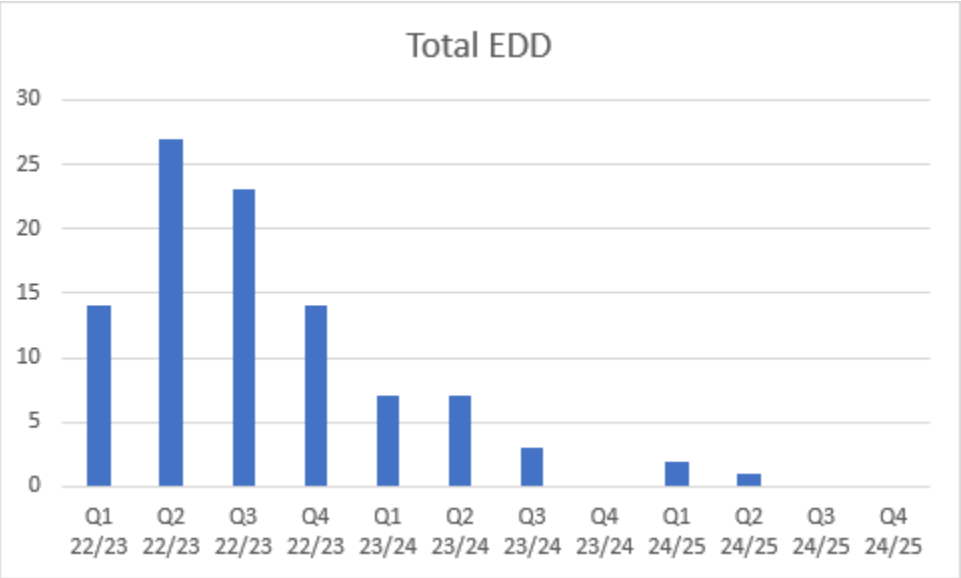
3.6 To redress the market conditions, the NENC ICS learning disabilities and autism team have been tasked, both by the ICB and North East Association of Directors of Adult Social Services (NE ADASS), to make the best use of regional / sub regional opportunities to develop accommodation, care, and support to facilitate people with the most complex needs moving from hospital to home or remaining in the community during times of crisis.

3.7 The scale of this challenge can be seen in the trajectories below.

4. Discharge Trajectories 2022-2024

4.1 The table below demonstrate the numbers of people in hospital by placed based area and the expected discharges by quarter by estimated discharge date (EDD).

Place	Number of people in hospital by place	Inpatient pathway - Learning Disability ATU	Inpatient pathway Mental Health ATU	Inpatient pathway Mitford ASD	Inpatient Hospital Based Rehab	Inpatient pathway Secure	No planned discharge at this time (n)	Total n patients overall discharge trajectory over the next 3 years by quarter from the EDDs
Cumbria	15	2	6			7	5	10
Northumberland	9		1			8	5	5
North Tyneside	13		1	1	1	10	8	5
Newcastle	20		10		1	9	6	14
Gateshead	5	2	2			1	2	3
South Tyneside	12	1	5			6	4	8
Sunderland	15		9			6	4	11
Durham	25	1	8	1	1	14	6	19
Darlington	6		6				5	1
Redcar Cleveland	9		4			5	4	5
Middlesbrough	23		16		1	6	8	15
Stockton	10		4			6	4	6
Hartlepool	7		2			5	6	1



4.2 Therefore, in order to secure timely, safe, and high-quality provision to enable discharge from hospital and prevent unnecessary admission to hospital across 2022- 2024 there will need to be an additional 90-100 provisions developed with around 50- 75% being for people with the most complex needs. These numbers do not include provisions for children coming through transitions or people who will require a step up in accommodation, care, and support. Modelling suggests that this additional requirement will be closer to 150 complex care developments across the next three years.

5. Workforce

5.1 The national Building the Right Support plan recognises that having the right workforce with the right skills and training to support people with a learning disability and autistic people is crucial in ensuring a person receives the best quality care and support, reducing the likelihood of an unnecessary admission to hospital.

5.2 Like other regions there is a significant migration of staff from the care industry to the retail and service sector compounded by the aftermath of the pandemic and Brexit. All providers on NENC complex care frameworks cite the lack of suitable applicants and the difficulties in retaining staff on competitive salaries as the major reason for placement failure, inability to retain consistent core teams vital to people with complex needs and reluctance to expand commercially. However, the second biggest factor alongside suitable housing is the limited support available from the NHS outside of Monday to Friday 9-5 to preventatively scaffold or provide intensive support during a crisis. This factor is reflected in the number of unplanned admissions which occur out of hours and is a legacy of how community learning disabilities were commissioned to provide support without a crisis or step-up function. Some places have addressed this to an extent, but none have a 24/7 integrated service able to flex into care and support packages to prevent admission or accelerate discharge. Reshaping and investing in community learning disability services to have intensive support teams shared across several places is vital to provide the stability and expertise to manage crisis and coordinate specialist support when needed. Without this support unnecessary admissions will continue and even the most robust community placements will falter in the face of extremely

challenging behaviours.

5.3 Alongside having access to specialised support there are several other key factors which enable and support social care providers to recruit and retain staff with the right expertise and right knowledge and skills to provide personalised and compassionate care. These are:

- Strategic needs assessments and commissioning intentions where commissioners (Health and Local Authority) are proactive, clear about the market requirements for people with the most complex needs at a regional and sub regional footprint
- Good housing plans and access to housing capital, including NHS housing capital
- Collaborative working between commissioners, providers, people, families, and advocates to develop the market together giving people choice and control about where they live and with whom
- Rates of pay that recognise the complexity of the people that care and support providers work with, and recognition that staffing levels may flex as support needs change over time, for example being higher as someone transitions from hospital, but reducing over time
- A proactively supported Dynamic Support Register
- Integrated commissioning teams from health and social care with strong leadership and delegated authority to commit resource.

5.4 The examples above are not exhaustive but are the building blocks enable people with complex needs the opportunity to live full lives in their community, in their home, with access to the care that is right for them, when and where they need it.

6. Cost

6.1 The cost of delivering Transforming Care is considerable and is borne financially in different parts of the system at different times. The cost of not delivering Transforming Care in the way envisioned, is arguable much higher than it would be if we did. The cost of providing inpatient services outstrips the investments by the ICS in assessment and treatment units and the devolved budgets of the Provider Collaborative. The costs of complex care packages in the community can range between 250-750k PA per individual and as reflected in the table above some areas are disproportionally affected due to historic issues such as having large hospitals in the locality.

6.2 As most people needing to be discharged are detained under the Mental Health Act and eligible for S117 aftercare, council's contributions range for 50% of the costs in the CNTW footprint to a much-reduced ratio in parts of TEWVs footprint. Councils, whilst absolutely recognising the need to enable people to live well in the community, have via NE ADASS expressed a view that people with the most complex needs have care and support requirements more akin to those normally funded by continuing health care. Councils also struggle to attract providers, particularly the smaller scheme providers who offer highly individualised care and support on the current frameworks designed for less complex needs. Most care packages for people with the most complex needs are commissioned off

framework after procurement fails leaving commissioners with little choice and the individual in receipt of care and support with practically, if not entirely, none.

6.3 Some of these risks could be mitigated with alliance models between NHS and social care providers to create hybrid commissioning options to flex expertise and clinical support to care packages or where the NHS provider becomes the lead provider initially with a tapering off to a social care provider over a period of time. These models already exist in CNTW and TEWV and have proven successful in creating strong discharge pathways for people with forensic needs and those with very challenging behaviours. The opportunity to extend and rethink how we use Personal Health Budgets offers a personalised approach to delivering are and support which is currently under utilised

7. Governance

7.1 The Learning Disabilities and Autism Programme is governed by the ICS Executive Strategy Group which is made up of senior representatives from the ICB, NE ADASS, VCSE, NHS England and places. People with a lived experience, experts by experience, advocates and inclusion groups are also represented as equal members. Funding decisions are recommended to the ICB Board usually following explicit instruction from NHS England around the purpose of use for Transforming Care central ICB allocations. Decisions around supporting recommendations e made jointly by ESG and NE ADASS and funding and / or resources are frequently pooled to achieve maximin impact

8. Working with people who have a lived experience, families and supporters

8.1 The NENC Learning Disability and Autism Programme implemented the coproduced Working Together Strategy in 2020, the Strategy states that children, young people and adults with a learning disability and autistic people and families should be involved in planning the support and services they need to live a good life.

8.2 This coproduced model is built on the Seven Keys of Citizenship and is illustrated through paid roles in the Citizenship Team, the establishment of the Involvement Leaders group and through the Family Workforce Manager role as a key member of the Workforce Team. There are also a number of funded project-based roles across Parent Carer Forums, self-advocacy groups and the voluntary sector including being part of Care, (Education) and Treatment Review panels and decision-making roles within Key Working and Autism in Schools.

8.3 We know that people with a learning disability die earlier than those without and the Stop People Dying Too Young Groups are instrumental in providing confirm and challenge to the LeDeR Steering Group and are an essential part of the governance of LeDeR across NENC. The two groups are made up of people with lived experience and their supporters.

8.4 The variety of funded roles undertaken by people with lived experience can be mapped to the priority areas in the Learning Disability and Autism Programme and contribute to the delivery of the LTP deliverables.

9. Core20PLUS5 framework

9.1 In NENC there are stark inequalities in the social determinants of health, risk factors, health care provision and clinical outcomes across socio-economic, disadvantaged and inclusion health groups.

9.2 Health inequalities are not caused by one single issue, but a complex mix of environmental and social factors which play out in a local area, or place. Autistic people and people with learning disabilities are more vulnerable to health inequalities than the general population with higher rates of unemployment, are more likely to live in deprived areas, experience poorer education and have higher rates of mortality and multimorbidity.

9.3 People with a learning disability die on average 15-20 years sooner than people without a learning disability and often from causes that are commonly preventable. To ensure a local strategy is fit for purpose an in-depth understanding of this population's health is underway to inform our deliver through the Core20PLUS5 framework and will target specific action identifying interventions to increase access to general health care for people with multiple and complex needs.

10. Executive action

10.1 Unless the NENC together as a system does something radically different to support people with the most complex needs, we will continue to have:

- Too many people in hospital unnecessarily for too long
- Over reliance on inpatient services
- Neurodiverse children at risk of being placed in residential, unregulated placements, or hospital
- People in unsuitable community placements
- People, particularly adolescences at risk of entering the criminal justice system
- An underdeveloped Housing and Care and Support market
- Serious lack of choice and control for people their families and advocates
- A stark lack of health and social equity for some of our most vulnerable individuals.

10.2 To make step changes over the next two years to improve the outcomes for people, address the market conditions and secure a workforce to deliver highly complex care packages, the Executive Committee agreed to:

- The development of a regional registry of complex care providers.
- Work in partnership with NENC Council's the development of a regional commissioning framework which renumerates at a rate which reflects the complexity of care and support required. A further paper outlining the financial cost to the ICB will be produced.
- Support the development of alliances between NHS providers of secondary mental health and disability services and social care and support providers.
- Consider investing in intensive support teams over a 5-year period.
- Continue to coproduce, co-create, and learn from people who have a lived experience and from the experience and knowledge of their families and supporters.

- Add learning disabilities and autism to the core20plus5 framework

11. Conclusion

People with Learning Disabilities and Autistic people who have complex needs are a small but very vulnerable population. They face some of the greatest health and welfare inequities and poorest wellbeing outcomes. Improving the integrated commissioning approach to people in hospital and those vulnerable to admission so that they have opportunity to live well in their own homes, with the right care and support will require a systems approach across health, social care, housing and the VCSE.

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Name of Sponsoring Directors: Nicola Bailey, NENC ICB Interim Executive Director of Place Based Delivery (North and North Cumbria)

Jacqueline Myers, NENC ICB Executive Director of Strategy and System Oversight

Date: **21/11/22**

Item: 7.2

NHS
North East and North Cumbria

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

NORTH EAST AND NORTH CUMBRIA ICB BOARD MEETING 29 November 2022	
Report Title:	**Chief Executive's Report**

Purpose of report

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

Key points

The report includes items on:

- The three reports published this month by Tees, Esk and Wear NHS Foundation Trust following the sad deaths of Christie, Emily and Nadia
- The National Audit Office report on Integrated Care Systems
- East Kent Report
- The new NHS England Operating Framework
- Our work on our Winter Plan, our Integrated Care Partnerships and Draft Integrated Care Strategy
- Progress with our vaccination programme for Covid-19 and influenza
- Progress on developing the learning and improvement network.

Risks and issues

There are no risks to raise.

Assurances

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

Recommendation/Action Required

The Board is asked to receive the report for information and assurance.

Sponsor/approving director	Samantha Allen, Chief Executive

Item: 7.2

Report author	Samantha Allen, Chief Executive

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

Relevant legal/statutory issues						
Note any relevant Acts, regulations, national guidelines etc.						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓

Key implications	
Are additional resources required?	None noted.
Has there been/does there need to be appropriate clinical involvement?	Not applicable – for information and assurance only.
Has there been/does there need to be any patient and public involvement?	Not applicable – for information and assurance only.
Has there been/does there need to be partner and/or other stakeholder engagement?	Not applicable – for information and assurance only.

NHS
North East and North Cumbria

Chief Executive Report

1. Introduction

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

2. National

2.1 National Audit Office Report

The National Audit Office (NAO) have published a report[1] examining the formation and set up of Integrated Care Systems (ICSs) and the risks they must manage. The report is an assessment of where ICSs are starting from and the challenges and opportunities ahead. The NAO makes recommendations intended to help manage the risks and realise those opportunities.

In the report the NAO identified the 'inherent tension between meeting national targets and addressing local needs, the challenging financial savings targets, the longstanding workforce issues and wider pressures on the system, particularly social care, mean that there is a high risk that ICSs will find it challenging to fulfil the high hopes many stakeholders have for them.'

2.2 East Kent Report

The investigation examined East Kent Hospitals University NHS Foundation Trust's maternity service in two hospitals, The Queen Mother Hospital in Margate and the William Harvey Hospital in Ashford, between 2009 and 2020. The report[2] details that, over that period the Trust providing clinical care was "suboptimal" and led to significant harm. The report shows that, during this period, there were multiple missed opportunities that should have led to problems being acknowledged and tackled effectively. Had care been given to the nationally recognised standards, the outcome could have been different in nearly half of the 202 cases assess by the Investigation's panel. The outcome could have been different in 45 of the 65 baby deaths, more than two-thirds of cases.

The themes identified are:

- Failures in teamwork: The report refers to "grossly flawed team working among and between midwifery and medical staff."

[1]Introducing Integrated Care Systems: joining up local services to improve health outcomes (Summary) (nao.org.uk)

[2]Reading The Signals: Maternity And Neonatal Services In East Kent - The Report Of The Independent Investigation

- Failures in professionalism: “Staff were disrespectful to women and disparaging about the capabilities of colleagues in front of women and families.”

- Failure of compassion: “Caring for patients in any setting requires not only technical skills but also kindness and compassion.”

- Failure to listen: Which, “directly affects patient safety, as we found repeatedly in the Trust’s maternity services, because vital information is ignored,” says the report.

- Failures around investigations:”…there appears to have been a collective unwillingness to engage with families and a reluctance to invite them to contribute to investigations; some families were not even made aware that an investigation was taking place” explains the report.

- Failures when responding to investigations: For example, one midwife recalled how, when new guidelines were introduced in response to incidents but no one explaining why: “Staff weren’t involved in improvement plans and yet they knew what went wrong. They knew how it could be fixed but they weren’t invited to comment”.

The recommendations of the East Kent report are summarised below:

- Recommendation 1: The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals amongst noise to display significant trends and outliers, for mandatory national use.

- Recommendation 2: Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained lifelong learning.

- Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance.

- Recommendation 3: Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how team working in

maternity and neonatal care can be improved, with particular reference to establishing a common purpose, objectives and training from the outset. Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, team working and development.

- Recommendation 4: The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies. Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.

  NHS England (NHSE) reconsider its approach to poorly performing trusts, with particular reference to leadership.

- Recommendation 5: East Kent Hospitals University NHS Foundation Trust to accept the reality of these findings; acknowledge in full the unnecessary harm that has been caused; and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input.

Nationally, a single delivery plan for maternity and neonatal services is in development. Guidance is expected to be released in February 2023. This single delivery plan will set out clear priorities to continue to deliver our maternity and neonatal safety ambitions and provide more personalised care. The delivery plan will bring together actions from the final Ockenden report, the East Kent report, the NHS Long Term Plan and Maternity Transformation Deliverables and will have input from service users, frontline colleagues, system leaders and national stakeholders including a new working group led by the Royal Colleges. The ICB will discuss this report and the impact and relevance to the services across North East and North Cumbria in more detail at our meeting in January.

3. North East and North Cumbria

3.1 NHS 2022 / 23 Operating Framework

On 17 October 2022, NHS England (NHSE) published its new operating framework[3], which sets out the ways of working that will enable it to deliver its purpose as the ‘new NHS England,’ which from April 2023 will include Health Education England and NHS Digital. The Framework styles itself as setting out 'the way we do things around here' for NHSE and as 'part of a cultural reset in the NHS to reflect the change to system-based approaches to improvement and stronger partnership working'. It does this by setting out the four core foundations: Purpose, Areas of value, leadership behaviours and accountabilities and, medium-term priorities and long-term aims.

The NHSE purpose is stated to be 'to lead the NHS in England to deliver high quality services for all'.

In terms of the key functions of NHSE, seven are highlighted:

1. Set direction
2. Allocated resources
3. Ensure accountability
4. Support and develop people
5. Mobilise expert networks
6. Deliver Services (e.g.: digital, procurement support)
7. Drive transformation

[3]https://www.england.nhs.uk/publication/operating-framework/

The section on accountabilities and responsibilities makes it very clear that whilst NHSE remains the statutory regulator for NHS providers, in practice direct oversight of providers by NHS England will be 'by exception and generally in agreement with Integrated Care Board (ICB)'.

ICBs are described as taking the lead in:

- Setting system level strategy and plans, including the joint 5 year forward and capital plans.
- Working with partners to ensure effective arrangements in place and across system to deliver performance, transformation and outcomes.
- Commissioning and managing contracts, delegation and partnership agreements with providers and primary care.
- First line oversight of health providers across the ICS – co-ordinating any support for providers and providing assurance input to regulator assessments.

The ICB operating model and oversight framework for providers has been reviewed in light of the new NHSE operating framework.

3.2 Winter Plan

The Executive Committee has approved the ICB arrangements for winter and to enhance operational resilience capacity. Since the last ICB Board meeting, NHSE has issued additional guidance in relation to these matters in its, 'going further our winter resilience plans letter', which was published on 18 October 2022. A full assessment of the asks in the letter has been undertaken. There is a high degree of congruence between the areas of focus in the letter and the plans already agreed by the ICB. The letter includes the requirement for each ICB to establish a System Command Centre by 1 December 2022. The ICB has a surge team supported by good access to real

time data and as such are well placed to meet the national ask in this regard. A further update on the Winter Plan and Operational Resilience arrangements is included in the Board paper pack. This includes reference to the Board Assurance Framework for the plan.

3.3 EPRR Annual Assurance Process

NHS England leads and maintains a set of standards for Category 1 responders as defined within the Civil Contingencies Act and each autumn it undertakes an assurance gathering round, which takes the form of a self-assessment of compliance with the standards by the relevant organisations, a check and challenge process and a Board approved submission of the self-assessment. This year, ICBs have been asked to lead the check and challenge of the category 1 providers in their patch. This exercise has recently been completed and the results were presented to the ICB Executive committee.

The initial self-assessment of the ICB itself against the relevant standards has been completed and the check and challenge process is due to take place at the end of November. Submission will then need to be made in December and will be brought to the ICB Board in January for post submission sign off.

3.4 Integrated Care Partnership and Strategy Development

At the first meeting of our Integrated Care Partnership (PCP) in September we agreed an operating model of one Strategic ICP supported by four Area ICPs. Terms of reference and recommended membership were then developed for these ICPs and we have been engaging with partners on these throughout October and November. We will present the final proposals on ICP terms of reference and membership to the next meeting of the Strategic ICP on 15 December.

Also, under consideration at that meeting will be our draft Integrated Care Strategy which has been developed by a multi-agency steering group co-chaired by Jacqueline Myers, our ICB Executive Director of Strategy and System Oversight, and Jane Robinson, Corporate Director of Adults and Health at Durham County Council. This strategy will set out our priorities as a partnership and will be a key document for the ICB as we develop our own five-year joint forward plan. The draft strategy has been widely circulated to stakeholders and over 150 responses have been received at the time of writing this report.

3.5 Provider Collaboratives

The 2022 Health and Care Act included a new 'duty to collaborate' for NHS providers. Each NHS provider is required to be a member of (at least one) provider collaborative.

ICBs are expected to reach an agreement with their provider collaborative(s) in relation to the responsibilities they will pick up on behalf on the ICB. In NENC, we have a provider collaborative that includes the 11 foundation trusts. It is chaired by our ICB Board member Ken Bremner. The provider collaborative is already taking the lead on a number of key ICB priorities, including Elective Recovery, the development of shared clinical support services and capital planning. This month we have a meeting to start the process to formalise the working relationship between the provider collaborative into a responsibility agreement. The agreement will cover key objectives, ways of working , governance, and resources. We are planning to complete this work by the end of December 2022. .

There is also an emerging primary care collaborative which is in the early stages of development and an established Independent Hospice Collaborative in our ICS.

3.6 Tees Esk and Wear Valley NHS Foundation Trust

Following external reviews three reports were published on the 02 November 2022, following the tragic deaths of Christie, Emily and Nadia whilst in the care of Tees Esk and Wear Valley NHS Foundation Trust (TEWV).

Recommendations for improvements have been identified with significant areas for improvement addressed.

We continue to work with TEWV to ensure the improvements are sustained. In addition, we are working closely with NHS England and the TEWV to support further improvements within the organisation and across the health and care system.

3.7 Care for People with a Learning Disability and/or a Mental Health Problem

There have been three separate television programmes in recent weeks focusing on the care of people with a mental health problem and/or a learning disability.

Each of these programmes provided difficult viewing and highlighted issues in the care provided and culture and attitudes of staff to people with a learning disability and or a mental health problem in specific providers across England.

One of the case studies included a person under the care of Newcastle University Hospitals NHS Foundation Trust. Working closely with our providers the ICB undertook a number of robust actions to seek assurance that the standards of care in both its mental health Trusts and independent providers is safe, effective and well led. This work continues and we have engaged experts by experience to assist us with this work that is being undertaken in partnership with our NHS providers.

Our Quality and Safety Committee will oversee the work. As part of this Acute NHS providers have been requested to undertake audits of the use of best interest meetings, to ensure that patients who lack capacity, are having the most appropriate care.

Improving the outcomes and experience for people with a learning disability and people with autism, is a key priority for the ICB.

3.8 Covid and Flu Vaccine Campaign

The Covid vaccination autumn campaign progresses. This is the fifth phase of the vaccination programme and locally we continue to utilise primary care, community pharmacy, community services (for some care homes and housebound), hospitals (healthcare staff and opportunistic eligible patients) and a range of mobile/roving and pop-up services.

Our official uptake for Covid vaccination data, as compared to the national position and the target (by cohort) as of 07 November 2022 is:

	Cohort 1: Care Homes	**Cohorts 2&3: H&SC Workers**	**Cohorts 4&5: 75+**	**Cohorts 6&7: 65-74**	**Cohorts 8-11: At Risk**	**Cohorts 12-14: 50-64**
NENC	78.1%	35.9%	77.0%	70.1%	27.7%	28%
National Actual	78.3%	33.4%	75.0%	68.3%	27.7%	30.4%
National Target	81%	61%	87%	87%	59%	75%

Despite excellent top-level progress, there is room for improvement when exploring areas of lower uptake, but this is to be expected at this midpoint in the autumn campaign. A data driven approach is by the vaccination team to identify specific wards requiring support our ICB place-based teams to identify local actions to address these.

A number of interventions are being deployed to engage those in the at-risk cohorts, this includes searches at GP practice level for those in the at risk and immunosuppressed groups, and a targeted personalised mailing inviting them for vaccination. In addition, our communication campaign (double your defences) has been launched recently with wide ranging advertising and media coverage.

The inequalities task and finish group, including public health leads, directors of public health and place-based leads are using the inequalities toolkit generated in earlier phases to support targeted activities to address these areas of lower uptake. This

includes some traditional underserved communities (for example areas of deprivation, rurality and minority communities).

Public perception of risk from Covid is that it is now low, so uptake particularly in younger cohorts may be challenging. Behavioural insight is being used to support particular actions to address this.

The flu vaccination had a slow start due to delayed deliveries of vaccine but has now caught up and in some areas exceeded Covid boosters. This is mainly down to the fact that the vast majority of general practices and community pharmacies are delivering flu vaccine, it is a much easier vaccine to deliver and the distribution of the vaccine is well established.

We are pleased to note that our data for North East and North Cumbria show that across most cohorts we are now ahead of where were at the same time last year. Particularly, the clinically at risk group which is 11% ahead. That said, we are aware that we are behind for some groups: pregnant women, 2/3 years olds and people with learning disabilities, which we will continue to focus on.

Flu coverage in care homes is 66.9% in North East and North Cumbria compared to 68.8% North East and Yorkshire regional aggregate rate. Overall flu coverage in care homes is about 10% lower for flu than it is for COVID. This is mostly explained by the fact that Covid vaccines were available earlier in September than flu vaccines and Covid was administered early on the principle of 'don't delay'. We continue to advise GPs, PCNs and ICB Place Locality leads to ensure that flu vaccine visits to care homes are caught up as soon as possible.

Pregnant women coverage is currently 8.3% which is higher than the rest of North East and Yorkshire region which ranges from 4.2% to 4.7%. However, we recognise that the coverage is behind where it was at the same time last year.

We are pleased to note that we have introduced a new scheme for vaccinating pregnant women, which is to offer them the vaccination while they are at their scan appointments. This is in addition to the primary offer by GP Practice and pharmacy. This is an innovative scheme and we are looking forward to the evaluation at the end of the season.

School based vaccinations (primary schools), the regional data show North East and North Cumbria to be low (12.4% compared to 15.6% North East and Yorkshire aggregate rate). We think this is a scheduling issue as the visits to the schools for children with learning disabilities were made first. These schools have fewer children but take a similar time to visit.

Our data show that over 50% of schools have been visited so far and the providers are on schedule to complete before the target date of 15 December 2022. Overall, the rate of uptake seen so far for the schools visited is 57%.

Social Care Workers, the feedback we are receiving from the field is that, while the offer is being made by and often in their workplaces, a large proportion are unwilling to take up the offer. We are now providing further comms to Social Care workers and their providers to make the case for vaccinations again and in different ways.

For Trust based front line health care workers, the uptake is lower this year than the same time last year. We have asked Trust and social care leaders be aware of this and seek further improvement.

3.9 North East and North Cumbria Learning and Improvement Network

Supporting the development of a thriving learning community across the North East and North Cumbria is an ambition that lies at the heart of our culture as a new ICS. To be the best at getting better through embedding learning at every layer of our system, so that challenges can be identified early, staff are empowered to explore solutions and system improvement is continuous and accelerated at all levels.

One of the firsts steps towards developing this community was a pivotal event held at St James' Park in Newcastle on 21 September 2022 which brought together a diverse group of leaders from across North East & North Cumbria region, with more than half (57%) of the over 180 participants from outside of the Newcastle / Gateshead / Northumberland area. The core purposes of this engagement were:

- Mobilise people from across North East and North Cumbria who can contribute to achieving our system goals for health improvement
- Create the founding membership of our NENC learning and improvement network
- Enable “boundaryless” learning across the NENC; making connections and sharing data and learning - across geographical, system, organisational and sector boundaries
- Acknowledge and celebrate the existing strengths and assets of our system for learning and improvement
- Create energy, build insight and work together as a system
- Agree actions to co-create the future

Participants were highly engaged throughout the full day event, which included a number of facilitated sessions. The full report[4] for the event can found on the ICB website.

The event also provided participants the opportunity to learn about a number of innovative improvement initiatives across the system, through a World Café session highlighting 19 such programmes, where participants could directly ask questions of colleagues leading or representing these initiatives in their respective areas. Enabling new connections to form across places and for participants to take learnings back to their own organisations.

[4]https://northeastnorthcumbria.nhs.uk/media/123je1bf/nenc-learning-system-output-report-final-version-al.pdf

Through a series of facilitated sessions, the participants collectively highlighted a number of priority challenges for the system which the group wished to discuss in greater detail and were encouraged to co-develop some 'big ideas' to address each area of need.

These resulted in the following seven areas of priority for the ICS to initially focus its learning and improvement efforts around over the next year:

1. Waiting times and crisis support for child & adolescent mental health services
   - Big Idea: Organise a Mental Health Summit for Children & Young People

2. Collaborative Leadership Across the System
   - Big Idea: Define a set of behaviours and system promise, or leadership charter

3. Shifting from Treatment to Prevention
   - Big Idea: Give the power and resource to communities to design/implement solutions

4. Sharing learning and joining up the system
   - Big Idea: ICB as a convenor to facilitate a learning network and create infrastructures/resources for learning

5. Social Care Workforce – Influencing the market and impacting patient flow
   - Big Idea: ICS to be accountable for a Joint Health & Care taskforce on funding, procurement and innovation in workforce development

6. Workforce Retention and Wellbeing
   - Big Idea: Framework for workforce sharing across the system and across sectors

7. Safe transfer and discharge out of hospital
   - Big Idea: Develop 7-day multi-agency collaborative working for patient pathways out of hospital

The initial face to face event was oversubscribed, leaving many people on the waitlist. Therefore, the event was followed up with a webinar on 2 November 2022

where a further 150 people from across the system were given an opportunity to input into discussion around the seven priority areas above.

It is clear from the feedback we have received from participants at both events that there is growing interest in the learning & improvement community, significant enthusiasm to continue and a willingness to follow through on the priority areas identified.

3.10 Annual Report Certification April – June 2022

The former clinical commissioning group's (CCG) across the ICB footprint prepared their tenth and final annual report covering April 2022 to June 2022. This report provided an insight into their hard work and achievements during their last three months as CCGs ahead of the transition to the ICB on 1 July 2022.

All former CCGs followed standardised annual report guidance and used a national template to ensure they meet relevant requirements including those set out in legislation the DHSC Group Accounting Manual 2021/2022[5] and relevant directions from NHS England.

[5]DHSC Group Accounting Manual (GAM) 2021/22

All CCG annual reports were reviewed and signed off by the former Clinical Commissioning Group Accountable Officers and Place Based Directors Group prior to submission to NHS England on 5 October 2022.

The final ICB annual report, which will include the CCG annual reports, will be presented to the Board prior to final submission to NHS England by the required deadline (as yet to be confirmed). The ICB is to submit final audited and signed CCG annual reports including final Head of Internal Audit Opinions and National Audit Office disclosure checklists for months April – June 2022.

The Regional Team will submit final certification of CCG months April – June 2022 and the ICB annual report. The ICB will publish the annual reports on their website, as part of the 2022/23 ICB annual report and accounts by September 2023.

4. Recommendations

The Board is asked to note the report for assurance and information.

Name of Author: Samantha Allen, Chief Executive

Date: 11 November 2022

Item: 7.3

NHS
North East and North Cumbria

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

NORTH EAST AND NORTH CUMBRIA ICB BOARD MEETING 29 November 2022	
Report Title:	**Integrated Delivery Report**

Purpose of report

The NENC Integrated Delivery Report provides an ICS overview of Quality, Performance and Finance. The performance and finance elements of the report will be discussed in detail at the Finance Performance and Investment Committee, and the Quality elements will be discussed in more detail at the Quality and Safety Committee.

Key points

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

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

Key changes from previous report

Quality

- Following a recent CQC inspection (published September 2022), North Tees and Hartlepool NHS FT were given an **overall** rating of 'requires improvement', compared to the previous rating of "good". Safe, Effective and Well-led domains were all rated '**requires improvement**' and the caring and responsive domains were rated as 'good'

- The CQC recently inspected the **Learning Disability and Autism wards** of Cumbria, Northumberland and Tyne and Wear (CNTW NHS FT) and Tees, Esk and Wear Valleys (TEWV) NHS FTs. In both Trusts the ratings for the Learning Disabilities wards deteriorated to "requires improvement" for CNTW and for TEWV "inadequate". This does not impact their overall Trust ratings

- STSFT Maternity Services have been removed from the enhanced surveillance process and quality assurance will now resume through the place based QRG meetings.

Performance

Tier 1 and Tier 2 escalation meetings – NHSE escalation for cancer and elective:

- South Tees NHS FT has moved out of tier 2 escalation for cancer due to improved performance
- Tees & Hartlepool NHS FT has moved into Tier 2 escalation for Cancer
- North Cumbria IC NHS FT - Notable progress has been made in reducing the cancer 62 day backlog - unpublished weekly PTL shows a decrease over 5 consecutive weeks.

Key Performance measures: The following standards have shown a significant deterioration this month:

- NEAS **Ambulance response times** Cat 2 mean response has deteriorated from 40:45 to 57:34 (although compares favourably to the national at 1:01:19)
- **average hours lost per day** have deteriorated significantly across NENC (106) compared to a target of 61.4
- **12 hour A&E breaches**: Patients waiting in A&E more than 12 hours following decision to treat has increased to significantly from 909 in September in NENC, to 1106 in October.

Key themes of the report and areas of focus:

Quality

Healthcare Acquired Infections

- Two cases of MRSA (1 hospital onset and 1 community onset) were reported in August 2022, which brings the year to date (YTD) total across region to 4
- Four Trusts are exceeding their YTD national thresholds for the number of Clostridium Difficile infections reported
- Five Trusts are exceeding their YTD national thresholds for the number of E. Coli cases reported
- Five Trusts are exceeding their YTD national thresholds for the number of Klebsiella cases
- Two Trusts are exceeding their YTD national thresholds for the number of P. Aeruginosa cases.

All providers are signed up to a set of principles for the management of COVID-19 IPC and there is a system wide approach to antimicrobial resistance.

Serious Incident (SI) Reporting

- 14 never events have been reported across the region YTD (31 October 2022) and these will be continued to be monitored via SI processes
- Two Trusts have improvement programmes in place as a result of SI theme where patients were lost to follow up.

Sickness absence Rates

All Trusts across NENC were above the England average (4.9%) in May 2022. Workforce pressures continue due to sickness absence and vacancies, although some improvement has been seen. Measures are in place to ensure operational challenges are managed, safe staffing levels are in place and support is offered to staff to maintain their health and wellbeing.

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Staff Turnover Rates
One Trust is above the national average and comprehensive plans are in place to reduce vacancy rates and improve retention and staff experience.

Patient Safety Alerts
Two Trusts are showing with alerts open past their deadlines. Confirmation has now been received from both Trusts that these have now been closed.

Mortality
One Trust is reporting more deaths than expected and continues to be a negative outlier for the Summary Hospital-level Mortality Indicator (SHMI).

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

CQC Inspections
Five Trusts have had recent CQC inspections:

- STSFT: Outcome will be published in due course
- NEAS Emergency Operations Centre: Three areas of concern were identified relating to incident reporting/feedback processes, safeguarding reporting/feedback processes and medicines management. Report has not yet been published
- CNTWFT Learning Disability and Autism Wards: Rated overall as 'requires improvement'
- TEWVFT Learning Disability and Autism Wards: Rated overall as 'inadequate'
- NTHFT: Rated overall as 'requires improvement'.

Regulation 28 Prevention of Future Deaths Report

- Two Trusts have recently been issued with Regulations 28 notices from the Coroner. Responses to the Coroners are being prepared and will be shared and discussed via the QRG meetings.

NEAS Independent Enquiry Update
An independent chair has been appointed and interviews are well underway, however there is some uncertainty about the process of interviewing staff who have left the organisation. The planned timescale for completion is the end of the year. Support continues to be offered to NEAS from the ICB and system.

Maternity Safety
All Trusts continue to provide regular progress updates in relation to their compliance against the Ockenden Reports via the QRG meetings. Good progress is being made against the seven immediate and essential actions and additional support is needed for three Trusts. The Maternity and neonatal services in East Kent: 'Reading the signals' report was published in October 2022 and Trusts will need to assess their compliance with this, alongside Ockenden. STSFT Maternity Services have been removed from the enhanced surveillance process and quality assurance will now resume through the place based QRG meetings. The Midwifery Led Birthing Centre was on track to re-open on 1 November 2022 at STSFT.

Independent Providers
Three independent providers (Butterwick Hospices, BPAS Middlesborough and Impact Medical) remain under scrutiny as a result of their CQC inspections.

Performance

Primary care

- GP appointment levels at pre-pandemic levels continue to increase, with a total of 1.5 m during September 22 which is within planned trajectory for September and a marked increase on August (1.4m)
- DNAs as a proportion of all appointments remain high at 5% in September, an increase on August but below the national rate (5.2%)
- Practices routinely offering face to face appointments where clinically necessary and they continue to increase, up to 72.6% of total appointments delivered in September. This exceeds the level nationally at 67.1%

Urgent and emergency care (UEC):

- Pressures due to high level of attendances, high bed occupancy and delays with social care discharges continue resulting in sustained pressure on UEC pathways. High levels of medically optimised patients is an ongoing feature across the system. NENC system is working hard to increase capacity and operational resilience ahead of winter with a continued focus on ambulance performance and response and discharge
- Ambulance response times continue to be a pressure although NEAS is meeting C1 mean and 90th Centile for October. Cat 2 means and 90th percentile standards continue to not be met with October NEAS performance deteriorating from 40:45 mins compared to the 18 min standard in September to 57:34 in October. This compares favourably to the national of 1:01:19
- Handover delays continue, resulting in 106 average hours lost per day across NENC as at November 2022 compared to a target of 61.4. Only 47.9% handovers took place under 30 minutes compared to a 95% standard, and 40% of handovers were over 60 minutes in October 2022 (expected standard of zero)
- Although not meeting the A&E 4 hour 95% standard, NENC performance is performing favourably compared to the national for October (all types) at 72.5%, compared to 61.8% nationally
- Patients waiting in A&E more than 12 hours following decision to treat has increased significantly from 909 in September in NENC, to 1106 in October. The % of patients waiting longer than 12 hours from arrival to discharge is above the 2% standard for August at 2.5% in NENC
- Patients who no longer meet the criteria to reside and whose discharge is delayed is at 7.6% compared to the target level of 9.2% in NENC in October. Although this has remained relatively stable since April, the pressures with social care discharges is creating considerable pressure
- Type 1 General and Acute bed occupancy remains high and has increased significantly to 92.4% in October. This is above the 85% national expectation, and above the operational plan level in NENC.

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

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

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In NENC the following Trusts are in Tiers 1 and Tier 2:

Tier 1

North Cumbria – Cancer

- Tier 1 cancer escalation; meeting chaired by NEY NHS E Director of Performance and Improvement with national cancer team, ICB and Trust representation
- the trust has a range of actions in place linked to validation, pathways and diagnostics
- notable progress has been made in reducing the cancer 62 day backlog - unpublished weekly PTL shows a decrease over 5 consecutive weeks
- NHS England has allocated funds to the Northern Cancer Alliance to support NCIC in implementing rapid improvement plans for diagnostics and histopathology.

Tier 2

Newcastle – Cancer & Elective

- Tier 2 cancer and elective escalation; meeting chaired by ICB Executive Director of Place with NHS E, ICB and trust representation
- The trust has implemented and sustained a range of improvements linked to validation, pathways and diagnostics
- The trust has a number of initiatives to increase capacity including the opening of the day treatment centre in September and maximising use of the independent sector in particular for dermatology
- Some progress has been made in reducing the cancer 62 day backlog
- there has been a sustained and significant reduction in the number of people waiting beyond 104 weeks for elective procedures, unvalidated data indicates well within October plan; complex spinal procedures being the remaining area of pressure
- There is a growing pressure of over 78 week waits Dermatology, Orthopaedics and Spinal are key areas of risk.

North Tees & Hartlepool – Cancer

- North Tees and Hartlepool FT are now in Tier 2 due to increasing backlog over recent weeks and the proportion of PTL waiting in excess of 62 days is now above 9.6%
- Both North and South Tees Trusts are committed to a collaborative approach, with pressures across Urology and Lung.

Non-tiered – South Tees has been stepped down from Tier 2 for Cancer

- Trust has implemented and sustained a range of improvements linked to validation, pathways and diagnostics
- Significant progress has been made in reducing the cancer 62 day backlog
- Following review at the last meeting a recommendation was made to the national cancer team that South Tees is removed from Tier 2 on the basis that they meet the three criteria for de-escalation:
  i) the proportion of the PTL waiting over 62 days is less than the national average
  ii) the trust has not been in the top 20 group of trusts of most concern for the last 4 weeks
  iii) the trust plan has resulted in improvement and there is confidence in the plan going forward to sustain improvement.

Elective care:

- The total number of patients on the waiting list continues to grow, exceeding the operational plan trajectory for September 22 and is at an all-time high for NENC at 320,841. More recent weekly unvalidated data shows a further increase in waiting list size across NENC from 341,263 (w/e 2 Oct) to 344,489 (w/e 30 Oct)
- There were 24 104+ week waiters as at end of September 2022, the key pressure being spinal patients at Newcastle upon Tyne Hospitals NHS FT. This is within the planned level for NENC (52 plan). The Trust continues to manage patients and seek additional capacity including through the independent sector (IS) providers, and current unvalidated weekly data shows this to continue to reduce. It is anticipated that this level will be at 22 by the end of March 2022. It should be noted that more recent unvalidated indicates 104+ week waiters at both NCIC (1) and at South Tees (2) in October, in addition to those spinal patients at NUTH
- 78+ waiters are increasing in NENC after a continual reduction over recent months and are now above planned levels in September (842 compared to 472 plan). The majority of 78+ waiters are at NUTH, with a proportion at South Tees, and CDDFT in addition. More recent unvalidated weekly data shows a continued increase across NENC to 956 (w/e 30 Oct)
- 52+ week waiters continue to increase and are above planned levels, this is the sixth consecutive monthly increase observed. Of the 8549 in total as at the end of September, the majority were at NUTH, followed by South Tees, and CDDFT. Pressures exist across high volume specialties at NUTH including T&O, Dermatology, Ophthalmology and Plastic Surgery. The plan is expected to maintain this level through to March 2022 with a significant focus at NUTH on 78+ waiters. More recent unvalidated weekly data shows a further increase in NENC through October to 9219 (w/e 30 Oct)
- Diagnostics >6 week performance for the 15 key diagnostic tests is relatively stable across NENC and continues below the requirement for 1% of patients to wait longer than 6 weeks, with 17.7% patients waiting over 6 weeks for a diagnostic test in September 2022 compared to 19.1% in August. Key pressure areas include Echo-cardiography, Endoscopy and Audiology

Cancer

- NENC are not currently achieving the faster diagnosis standard for September 22 which stands at 72.8% v the 75% target, a deterioration since August. This compares favourably to the national performance (67.2%). Variation between Trusts exists with highest performance at CDD FT (87.95%) and lowest at NCIC (57.99%)
- 31 day treatment standard and the 62 days referral to treatment standards are not currently being met. Currently 62.6% patients waiting longer than 62 days compared to the 85% standard in NENC, this is a deteriorating position and is slightly above the national at 60.5% for September. Variation between Trust 62 day performance ranges from 75.26% at Northumbria HC to 44.1% at NUTH
- South Tees, North Tees, NUTH, and North Cumbria have recently submitted revised trajectories for monitoring against the proportion of patients on cancer PTLs waiting longer than 62 days. There is current focus for Trusts on cancer performance through tier 1 & 2 cancer meetings at NUTH, North Tees and Hartlepool and NCIC.

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

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

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

Learning Disabilities and Autism

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

Finance

- The ICS is on track to deliver the planned breakeven position reporting a small surplus of £0.04 at Month 6
- The ICB is reporting a year to date variance of £0.16m and an outturn variance of £5.79m, prior to expected retrospective funding adjustments of £11.46m – deficit /(Surplus)
- The ICB is reporting an outturn variance of £5.68m, after expected retrospective funding adjustments of £11.46m, and improved position of £3.05m against the planned surplus of £2.63m – deficit/ (surplus)
- The ICB is reporting a YTD overspend of £0.9m and a forecast outturn overspend of £9.5m compared with the submitted financial plan and prior to expected retrospective funding of £11.46m
- The ICB is reporting a YTD and forecast outturn underspend of £0.77m and £1.07m respectively compared with the submitted financial plan
- ICB is reporting YTD QIPP savings of £23.771m and forecast savings of £48.433m in line with the submitted QIPP/Efficiency plan
- The ICB is on track to achieve the MHIS target for 2022/23 (growth in spend of 5.26%).

Risks and issues

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

Assurances

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

Recommendation/Action Required

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

Sponsor/approving director	Jacqueline Myers, Executive Director of Strategy and System Oversight
Report author	Claire Dovell, Planning and Performance Manager

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

Relevant legal/statutory issues						
Note any relevant Acts, regulations, national guidelines etc						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**		**N/A**	✓
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓

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

NHS
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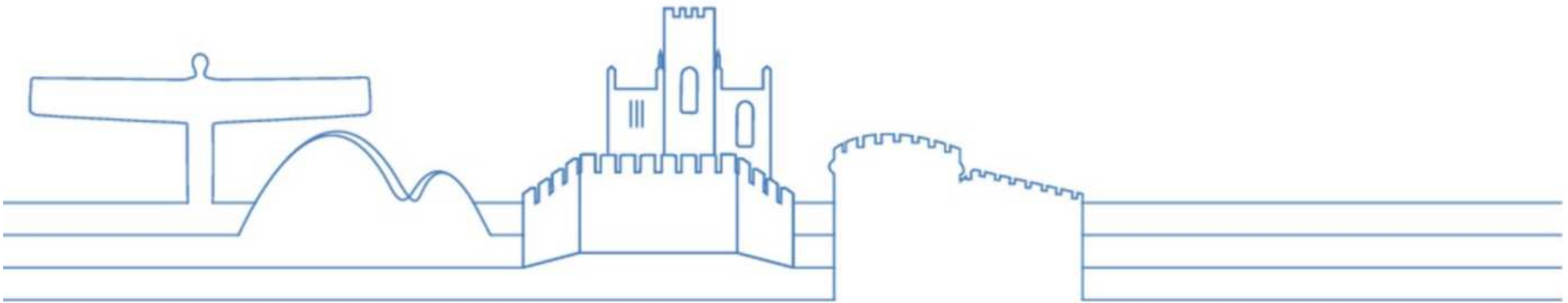
North East & North Cumbria ICB:

Board Meeting
29th November 2022

Integrated Delivery Report



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Executive Summary

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This report reviews Quality and Safety alongside Performance and Finance to ensure a parallel view of Quality, Performance and Finance, as recommended by the Francis Review (2013) and considered good practice. Published data is at September and October 2022 where possible, unless otherwise specified.

NHS Oversight Framework (NHS OF)

• The NHS OF delivers oversight to ensure delivery of the planning priorities and monitoring of the Long Term plan (LTP) commitments and encompasses quality, access and outcomes. This report provides the North East and North Cumbria (NENC) position in relation to the NHS planning priorities and is aligned to the NHS OF.

Outcomes and Health Inequalities

• A key focus in NENC is to address the health inequalities gap and improve outcomes for our populations through prevention, engagement with our communities and population health management. This section draws out some key points in relation to current system outcome measures, and work is currently underway to develop strategic outcomes and priorities of the NENC ICB.

Quality

•This section presents the quality dashboard for NHS Trusts set out by Area with Quality Exceptions narrative for the NENC ICB. Workforce and patient experience is included within this section.

Performance

• This report highlights key performance priority areas linked to the delivery of the Long Term Plan and any associated risks, achievements and mitigations.

NENC Oversight report: Executive Summary November 2022

NHS North East and North Cumbria

STRATEGIC UPDATE PLANNING PRIORITIES

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

PROGRESS UPDATE:

This report gives assurance of local progress against the 2022/23 priority areas within NHS Long Term plan (LTP) as detailed in the 2022/23 Operational Planning Guidance.

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

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

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

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

PREVENTION, HEALTH INEQUALITIES AND OUTCOMES

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

NB: North Cumbria data unavailable – Cumbria data used as a proxy

SYSTEM OVERSIGHT AND SEGMENTATION

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

PEOPLE LEADERSHIP AND WORKFORCE

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

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

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

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

FINANCE

Month 6 Position	Plan (Surplus) / Deficit £m	Actual/FOT (Surplus) / Deficit £m
NENC Commissioner		
YTD	0.01	0.16
FOT	(2.63)	(5.68)*
NENC Provider		
YTD	10.6	18.9
FOT	2.63	5.64

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

PATIENT EXPERIENCE

GP Patient experience Survey 2022

NENC Quality, Access & Outcomes

OPERATIONAL PERFORMANCE

= Standard met
= Standard partially met
= Standard not met

Indicator (and target)		Actual
A&E 4hr wait (95%) October		72.5%
12 hour breaches (2%) Aug		2.5%
Ambulance handovers		
Average Hours lost per day (Nov) (61.4)		106
30+ mins delays (5%) Oct		52.1%
111 call abandonment (<3%) Nov		9.6%
999 Mean Response (20 secs) Oct		39.2 s
% Patients not meeting criteria to reside (Oct)(9.2%)		7.6%
Ambulance response	NEAS	NWAS
C1 Mean (7 mins) Oct/Sept	8:09	8:43
C2 Mean (18 mins) Oct/Sept	57:34	38:14
Bed occupancy (85%) 86.8% (Oct)		92.4%
104+ waiters (0 March 23; 48 end Oct plan)		24 (Oct)
78+ waiters (0 by April 2023; 419 Oct plan)		956 (/Oct)
52+ waiters (0 by 2025; 4996 Oct)		9219 (9/Oct)
Diagnostics 6 week wait (1%) Sept		17.7%
Cancer FDS (75%) Sept		72.8%
Cancer 62 Days (85%) Sept		62.6%

PRIMARY CARE ACTIVITY

- Increased and continued patient demand for all primary care services
- GP appointment levels at pre-pandemic levels continue to increase, with a total of 1.5m during September 22 which is above planned trajectory for August and a slight increase on July.
- DNAs as a proportion of all appointments remain high at 5% in September. This is slightly lower than England rate at 5.25%
- Practices routinely offering face to face appointments where clinically necessary and they continue to increase, up to 71.21% of total appointments delivered in August, compared to 70.4% in July 2022. This exceeds the level nationally at 65.36%

MENTAL HEALTH

= Standard met
= Standard partially met
= Standard not met

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

LEARNING DISABILITY & AUTISM

= Standard met
= Standard partially met
= Standard not met

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

QUALITY

Indicator (and target)		Actual
Never events (zero tolerance)		14 to date
MRSA (zero tolerance)		4
Serious incidents 2 day reporting (95% target)	2 trusts outside the target in month	
C Difficile Infection	6 Trusts over trajectory Aug	

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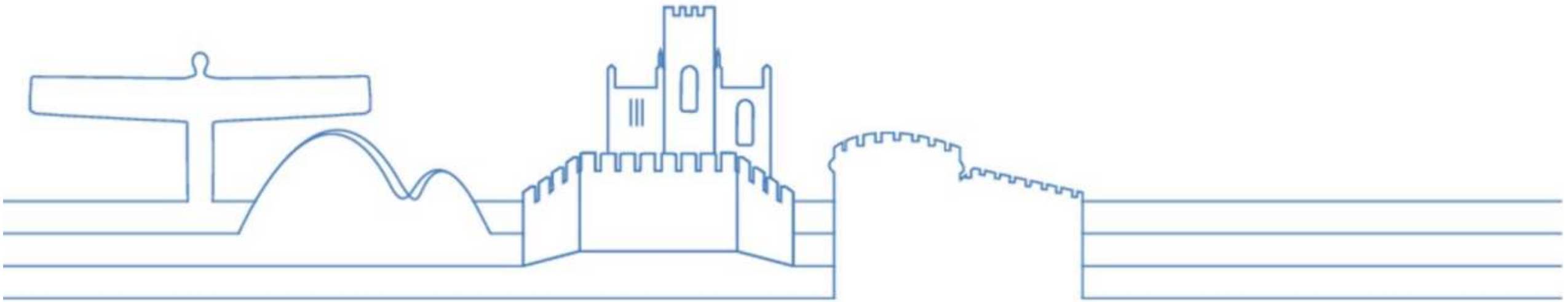
NENC System Oversight



NHS Oversight Framework (NHS OF)

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

Following publication of the NHS OF for 2022/23 in July 2022, the published framework of metrics which measures our progress against the LTP through assessment against quality, access and outcomes, people, health inequalities and prevention has now been published. This publication is currently being reviewed and expected to be updated in this report for the January Board.

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

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

System overview – CQC and Oversight framework

NHS
North East and North Cumbria

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

System Outcome Measures

Domain	Indicator	Metric Period	Northumberland	Newcastle upon Tyne	Gateshead	North Tyneside	Cumbria	South Tyneside	Sunderland	County Durham	Darlington	Stockton-on-Tees	Hartlepool	Middlesbrough	Redcar and Cleveland	NE&C	England
A reduction in health inequalities and an increase in healthy life years	Inequality in life expectancy at birth (Female) (PHOF A02a)	3 Years - 2017-19	▲ 9.9	▼ 8.4	▲ 9.6	▼ 10.6	▲ 8	▼ 6.9	▲ 8.7	▲ 7.9	▲ 9.7	▼ 13.3	– 10.4	▼ 11	▲ 8.6	N/A	▲ 7.6
	Inequality in life expectancy at birth (Male) (PHOF A02a)	3 Years - 2017-19	▲ 11.2	▼ 12.6	▲ 10.7	▲ 11.7	▼ 8.5	▲ 10.3	▼ 11	▲ 9.8	▼ 11.9	▼ 14.3	▲ 13.1	▲ 12.9	▲ 13.6	N/A	▼ 9.4
Every child has the best start in life	6-8 week breast feeding rate (PHOF 2.02ii)	Annual - 2019/20	▲ 38.8%	▲ 50.9%	38.7%	42.2 %	N/A	N/A	▼ 25.7%	▼ 27.8%	▼ 33.5%	N/A	N/A	▲ 32.6%	▲ 27.6%	▲ 34.6%	▲ 48%
	Inequality in attainment between children eligible and not eligible for free school meals	Annual - 2019	▼ 26%	▲ 19%	▲ 22%	▲ 24%	▲ 25%	▼ 21%	▲ 20%	– 22%	▼ 17%	N/A	▲ 29%	▲ 22%	▼ 19%	N/A	▼ 21%
	Inequality in attainment between children eligible and not eligible for free school meals (Achievement of KS2 (RWM) pupils eligible for free school meals (Expected Level))	Annual - 2019	▲ 45%	▼ 53%	▼ 51%	▼ 47%	▼ 44%	▲ 50%	▼ 52%	▼ 48%	▲ 53%	N/A	▼ 48%	▼ 49%	▲ 56%	N/A	▲ 47%
	Inequality in attainment between children eligible and not eligible for free school meals (Achievement of KS2 (RWM) pupils not eligible for free school meals (Expected Level))	Annual - 2019	▲ 71%	▼ 72%	▼ 73%	– 71%	▲ 69%	▼ 71%	▼ 72%	▼ 70%	▲ 70%	N/A	▲ 77%	▲ 71%	– 75%	N/A	– 68%
	Number of children living in poverty (PHOF B05)	Annual - 2021	▲ 25.6%	▲ 32.2%	▲ 28.9%	▲ 23.9 %	▼ 15.6%	▲ 31.1 %	▲ 30.8%	▲ 28.8%	▲ 28.5%	N/A	▲ 30.1%	▲ 42.4%	▲ 30.7%	N/A	▼ 18.5%
	School readiness % children with free school meals achieving a good level of development at the end of reception (PHOF B02a - free school meals)	Annual - 2019	▲ 61%	– 61%	– 53%	▼ 54%	▼ 50%	▼ 60%	▲ 63%	▼ 55%	▲ 61%	N/A	▲ 62%	▲ 55%	▼ 53%	N/A	– 57%
	Smoking at time of delivery (PHOF C06)	Annual - 2019/20	▲ 13.8%	▼ 12.8%	▼ 12.8%	▲ 11.7 %	▲ 13.6%	▼ 13.9 %	▲ 18.3%	▼ 16.8%	▲ 16.4%	▼ 16.5%	▼ 16.5%	▼ 16.5%	▼ 16.5%	▼ 15%	▼ 10.4%
Health and care offer built around people families and communities	Unemployment rate	Annual - 2022	▲ 5.2%	▲ 7.6%	– 5.9%	▲ 5.6%	▲ 3.1%	▼ 6.3%	▼ 5.9%	▲ 5.3%	– 5.3%	– 5.6%	– 6.8%	▼ 7.3%	▲ 5.9%	N/A	N/A
Increased focus across the system on prevention and early help	Deaths from drug misuse (PHOF C19d)	Annual - 2017-19	▲ 6.1	▲ 10.3	▼ 9.8	▼ 7.4	▲ 6.8	▲ 8.2	▲ 9.5	▼ 7.4	▲ 8.8	▲ 10.1	▲ 15.5	▲ 16.3	▲ 11	▲ 8.1	▲ 4.7
	Prevalence of children in year 6 of excess weight (PHOF C09a)	Annual - 2020	▲ 33%	▼ 40.2%	▲ 38.7%	▲ 35.7 %	▲ 34.3%	▲ 40%	▼ 36.7%	▼ 37.6%	▼ 37.6%	N/A	▼ 40.3%	▲ 40.2%	▲ 39.3%	N/A	▲ 35.2%
People and families are supported to live in their communities and to be as independent as possible	People with a learning disability supported into paid employment (ASCOF 1E)	Annual - 2020/21	▼ 4%	▲ 4.5%	▲ 10%	▲ 5.1%	▼ 2.5%	▼ 4.7%	▼ 3.2%	▼ 0.4%	▼ 4.4%	▼ 3.8%	▼ 21.8%	▼ 1.5%	▼ 6.4%	▲ 4.1%	▼ 4.8%
	Percentage of adult social care users who have as much social contact as they would like (ASCOF 1I)	Annual - 2019/20	▲ 100%	▲ 100%	▲ 100%	▲ 100 %	▲ 100%	▲ 100%	▲ 100%	▲ 100%	▲ 100%	▲ 100%	▲ 100%	▲ 100%	▲ 100%	▲ 100%	▲ 100%
	The proportion of adults with a learning disability who li ve in their own home or with their family (ASCOF 1G)	Annual - 2020/21	▼ 86.1%	▲ 88.6%	▲ 84.2%	▲ 94%	▼ 71.4%	▲ 86.4 %	▲ 93.7%	▼ 81.3%	▼ 95.3%	▲ 75.7%	▲ 91.5%	▲ 83.5%	▲ 85.9%	▲ 84.5%	▲ 78.8%
People experience excellent co-ordinated care with dignity and respect	Self-reported user experience (ADSC users survey)	Annual - 2019/20	▲ 64.7	▼ 62.7	▲ 64.2	▲ 66.4	▲ 74.4	▲ 65.9	▲ 72.2	▲ 69.6	N/A	▲ 70.2	▲ 69.3	▼ 70.2	▼ 68	N/A	▼ 64.2
Reduce avoidable disease/death	Under 75 mortality rate for cancers (persons) (PHOF E05a)	3 Years - 2017-19	▼ 125	▼ 157.9	▼ 157.2	▼ 147. 3	▼ 122.8	▼ 155.5	▲ 165.1	▼ 145.5	▲ 137.4	▼ 146.8	▼ 160.1	▼ 175.1	▼ 150.8	▼ 152.5	▼ 129.2
	Under 75 mortality rate for circulatory disease (persons) (PHOF E04a)	3 Years - 2017-19	▼ 69.9	▲ 87.9	▼ 86	▼ 77.7	▲ 75.5	▲ 90.3	▲ 89	▲ 78.9	▼ 74.3	▼ 73.1	▲ 99.1	▼ 100.8	▼ 88	▲ 85	▼ 70.4
	Under 75 mortality rate for respiratory disease (persons) (PHOF E07a)	3 Years - 2017-19	▲ 31.3	▼ 46.3	▲ 48.2	▲ 40	▼ 27.8	▼ 54.3	▲ 45.3	▲ 43	▲ 47.3	▼ 42	▲ 49.4	▲ 69.3	▲ 49	▲ 44	▼ 34.2

System Outcome Measures

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North East & North Cumbria

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

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

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

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

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

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

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

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

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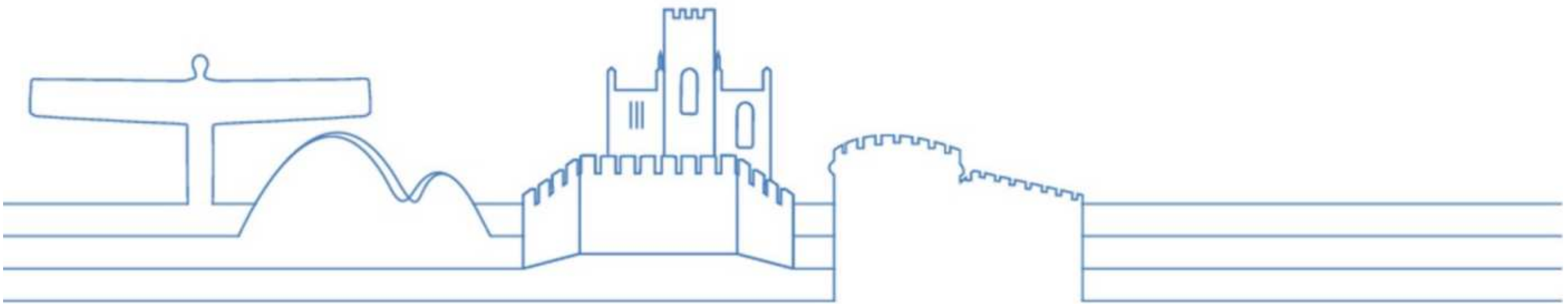
Quality



Quality - Executive Summary

NHS
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	Performance
Healthcare Acquired Infections	• Two cases of MRSA (1 hospital onset and 1 community onset) were reported in August 2022, which brings the year to date (YTD) total across region to 4. • Four Trusts are exceeding their YTD national thresholds for the number of Clostridium Difficile infections reported. • Five Trusts are exceeding their YTD national thresholds for the number of E. Coli cases reported. • Five Trusts are exceeding their YTD national thresholds for the number of Klebsiella spp cases. • Two Trusts are exceeding their YTD national thresholds for the number of P. Aeruginosa cases. All providers are signed up to a set of principles for the management of COVID-19 IPC and there is a system wide approach to antimicrobial resistance.
Serious Incident (SI) Reporting	• 14 never events have been reported across the region YTD (31 October 2022) and these will be continued to be monitored via SI processes. • Two Trusts have improvement programmes in place as a result of SI theme where patients were lost to follow up.
Sickness absence Rates	All Trusts across NENC were above the England average (4.9%) in May 2022. Workforce pressures continue due to sickness absence and vacancies, although some improvement has been seen. Measure are in place to ensure operational challenges are managed, safe staffing levels are in place and support is offered to staff to maintain their health and wellbeing.
Staff Turnover Rates	One Trust is above the national average and comprehensive plans are in place to reduce vacancy rates and improve retention and staff experience.
Patient Safety Alerts	Two Trusts are showing with alerts open past their deadlines. Confirmation has now been received from both Trusts that these have now been closed.
Mortality	One Trust is reporting more deaths than expected and continues to be a negative outlier for the Summary Hospital-level Mortality Indicator (SHMI).
Friends and Family Test	Two Trusts had recommendation scores below the England average.
CQC Inspections	Five Trusts have had recent CQC inspections: • STSFT: Outcome will be published in due course • NEAS Emergency Operations Centre: Three areas of concern were identified relating to incident reporting/feedback processes, safeguarding reporting/feedback processes and medicines management. Report has not yet been published. • CNTWFT Learning Disability and Autism Wards: Rated overall as 'requires improvement'. • TEWVFT Learning Disability and Autism Wards: Rated overall as 'inadequate'. • NTHFT: Rated overall as 'requires improvement'.
Regulation 28 Prevention of Future Deaths Report	Two Trusts have recently been issued with Regulations 28 notices from the Coroner. Responses to the Coroners are being prepared and will be shared and discussed via the QRG meetings.
NEAS Independent Enquiry Update	An independent chair has been appointed and interviews are well underway, however there is some uncertainty about the process of interviewing staff who have left the organisation. The planned timescale for completion is the end of the year. Support continues to be offered to NEAS from the ICB and system.
Maternity Safety	• All Trusts continue to provide regular progress updates in relation to their compliance against the Ockenden Reports via the QRG meetings. Good progress is being made against the seven immediate and essential actions and additional support is needed for three Trusts. The Maternity and neonatal services in East Kent: 'Reading the signals' report was published in October 2022 and Trusts will need to assess their compliance with this, alongside Ockenden. • STSFT Maternity Services have been removed from the enhanced surveillance process and quality assurance will now resume through the place based QRG meetings. The Midwifery Led Birthing Centre was on track to re-open on 1 November 2022.
Independent Providers	Three independent providers remain under close scrutiny as a result of their CQC inspections.

Variation and Assurance Icons

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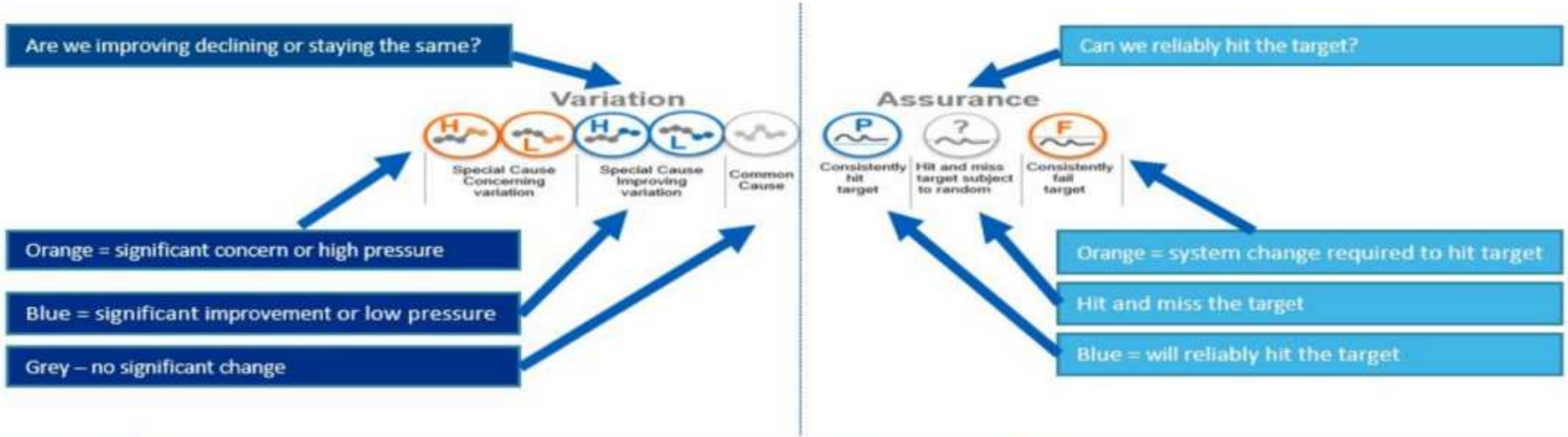
North East & North Cumbria



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

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

Quality - North and North Cumbria

		NCIC				Northumbria				NuTH				Gateshead FT			
	Indicator	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.
Quality - Serious Incidents	Proportion of incidents submitted within 60 days - October 2022	0%				88.9%				57.1%				0%			
	Proportion of incidents reported within 2 days - October 2022	100%				100%				100%				100%			
	Number of Serious Incidents reported - October 2022	4				6				10				4			
	Number of Serious Incident Never Events reported - October 2022	0				0				0				0			
Quality - Mortality	Summary Hospital-level Mortality Indicator (SHMI) value - June 2022	1.1259				0.9622				0.9148				0.955			
Quality - HCAI	Incidence of P. aeruginosa - September 2022	0	1			0	1			4	3			2	1		
	Incidence of MSSA - September 2022	2				5				9				3			
	Incidence of MRSA - September 2022	0	0			0	0			0	0			0	0		
	Incidence of Klebsiella spp - September 2022	4	2			7	4			18	13			5	2		
	Incidence of E Coli - September 2022	8	8			10	11			17	17			5	6		
	Incidence of C Difficile - September 2022	8	4			2	4			11	14			1	3		

		NCIC				Northumbria				NuTH				Gateshead FT			
	Indicator	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.
Quality - Staff	Staff Absence Rate - June 2022	5.2%				6.2%				6.1%				5.7%			
	Staff Turnover Rate - July 2022	1.3%				1.6%				1.7%				1.6%			
Quality - Friends and Family	Proportion of service users that would recommend Community Health Services - September 2022	98.2%				94.1%				98.1%				58.3%			
	Proportion of service users that would recommend Emergency Department - September 2022	81.8%				86.4%				0%				81.9%			
	Proportion of service users that would recommend Inpatient Services - September 2022	98.6%				94.4%				98.4%				93%			
	Proportion of service users that would recommend Maternity Services - September 2022	100%				85.4%				87%				0%			
	Proportion of service users that would recommend Mental Health Services - September 2022					88.2%											
	Proportion of service users that would recommend Outpatient Services - September 2022	99.4%				94.2%				97.1%				92.2%			

Quality - Central and South

		STSFT				CDDFT				NTHFT				STHFT			
	Indicator	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.
Quality - Serious Incidents	Proportion of incidents submitted within 60 days - October 2022	66.7%				0%				100%				50%			
	Proportion of incidents reported within 2 days - October 2022	100%				100%				50%				100%			
	Number of Serious Incidents reported - October 2022	6				6				4				9			
	Number of Serious Incident Never Events reported - October 2022	0				0				0				1			
Quality - Mortality	Summary Hospital-level Mortality Indicator (SHMI) value - June 2022	1.1105				1.1079				0.9887				1.0752			
Quality - HCAI	Incidence of P. aeruginosa - September 2022	2	2			0	1			1	1			1	1		
	Incidence of MSSA - September 2022	6				6				3				7			
	Incidence of MRSA - September 2022	0	0			0	0			0	0			0	0		
	Incidence of Klebsiella spp - September 2022	4	4			3	3			3	2			7	4		
	Incidence of E Coli - September 2022	13	10			8	9			6	6			18	12		
	Incidence of C Difficile - September 2022	13	5			6	5			3	5			10	9		

		STSFT				CDDFT				NTHFT				STHFT			
	Indicator	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.
Quality - Staff	Staff Absence Rate - June 2022	5.7%				6.1%				6%				6.2%			
	Staff Turnover Rate - July 2022	1.2%				1.5%				1%				0.9%			
Quality - Friends and Family	Proportion of service users that would recommend Community Health Services - September 2022	100%				100%				99.1%				97.5%			
	Proportion of service users that would recommend Emergency Department - September 2022	94.4%				96%				0%				82.3%			
	Proportion of service users that would recommend Inpatient Services - September 2022	97.1%				95.9%				88.6%				97.2%			
	Proportion of service users that would recommend Maternity Services - September 2022	29.2%				98.3%				94.4%				91.3%			
	Proportion of service users that would recommend Mental Health Services - September 2022	90.1%															
	Proportion of service users that would recommend Outpatient Services - September 2022	98.6%				99.3%				93%				94.9%			

Quality - Mental Health and Ambulance

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		NEAS				TEWV				CNTW			
-	Indicator	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.
Quality - Serious Incidents	Proportion of incidents submitted within 60 days - October 2022	60%				0%		L		87.5%			
	Proportion of incidents reported within 2 days - October 2022	0%				100%				100%		H	
	Number of Serious Incidents reported - October 2022	1				2				2			
	Number of Serious Incident Never Events reported - October 2022	0				0				0			

		NEAS				TEWV				CNTW			
-	Indicator	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.
Quality - Staff	Staff Absence Rate - June 2022	8.3%		H		6.1%		H		7.1%		H	
	Staff Turnover Rate - July 2022	1.3%				1.3%				1.3%			
Quality - Friends and Family	Proportion of service users that would recommend Mental Health Services - September 2022					92.6%				89.4%		H	

Quality - Exceptions - Safe

	Performance	Risks and Mitigations
Healthcare Acquired Infections (HCAI) (published data – August)	• MRSA: Two cases were reported in August 2022 (STSFT – hospital-onset and STHFT – community-onset). This brings the year to date (YTD) total across the region to n=4. 3 hospital onset (NHCFT, NuTHFT, STSFT) and 1 community-onset (STHFT). • C Difficile Infection: YTD 278 cases have been reported across the region, with four Trusts (NHCFT, CDDFT, STSFT, STHFT) exceeding their YTD national thresholds. • E. Coli: YTD 422 cases have been reported across the region, with five Trusts (NuTHFT, NCICFT, STSFT, CDDFT NTHFT) exceeding their YTD national thresholds. • MSSA: YTD 166 cases have been reported across region. NuTHFT is highest reporter (43 cases). • Klebsiella spp: YTD 181 cases reported across the region. Five Trusts (NHCFT, NCICFT, STSFT, STHFT, NTHFT) are exceeding their YTD national thresholds. • P. Aeruginosa: YTD 51 cases reported across the region. Two Trusts (NuTHFT, NTHFT) are exceeding their YTD national thresholds.	All providers are signed up to a set of principles for management of Covid IPC and there is a systemwide approach to antimicrobial resistance. • NuTHFT - the Gram-Negative Bacteraemia Blood Stream Infections (GNBSI) Steering Group continues to monitor and review ongoing Quality Improvement (QI) projects. A number of IPC initiatives continue to be rolled out of note there has been a 54% increase in compliance with Octenisan use and correct application within the cardiothoracic directorate following completion of a project. This is now being extended to other areas. The 'Gloves off' campaign demonstrated a 29% reduction in glove use, promoting correct PPE use and supporting the hand hygiene initiative and the sustainability project. • CDDFT - as part of their overall HCAI reduction plans for C-Difficile and Carbapenamase-Producing Enterobacteriaceae a full mattress and pillow audit was to be completed in September/October 2022 due to concerns of potential contamination. • STSFT - Combined South Tyneside/Sunderland place based HCAI/AMR action plan is in place and the Trust is operating a business-as-usual process for management of E. Coli, C. Difficile and MRSA. NENC AMR/HCAI Board are aware of increasing activity of C. Difficile and consideration being given to support an approach. The place-based Director of Nursing has escalated, to the Chief Nurse, the need for a NENC system wide approach to address increasing GNBSI and C. Difficile activity and suggested a revisit of current systems and processes that support the management of this to establish if there are any gaps. In the meantime, central areas IPC teams are promoting and offering educational work in the community around C. Difficile and E. Coli and are also raising awareness about other seasonal infections.
Never Events	• NENC ICS year to date (YTD) total n=14 as at 31.10.22 • NTHFT reported 2 never events in September 2022, wrong site surgery (incorrect seed placement during breast biopsy) and wrong site nerve block (administered to incorrect finger during surgical procedure). YTD the Trust has reported 2 never events. • STHFT reported a further never event in October 2022 involving a retained object (percutaneous lead). YTD the Trust has reported 5 never events.	Never events continued to be monitored via the serious incident management processes. STSFT remains in quality escalation in relation to never events and have undertaken a thematic review of incidents to identify wider organisational learning. The overarching action plan is to be presented at the next QRG.
Serious Incident (SI) reporting (September 2022)	• 2-day reporting: Two Trusts (CDDFT, NTHFT) were outside the 95% threshold for reporting serious incidents within two days of identification. • 60-day reporting: The 60-day timeframe is no longer a requirement under SI framework/Patient Safety Incident Response Framework (PSIRF). The timeframe was suspended at the start of the pandemic and has since been permanently removed. However, timescale remains in place as a measure for monitoring submission of reports.	• Regular discussion on SI performance takes place at all Trust QRG meetings and commissioner SI panels to gain assurance there are processes in place to manage the backlog of any cases. Please note that North Tees QRG is currently stood down as there are discussions being held in respect of combining both North and South Tees CQRGs. • NuTHFT Ophthalmology Lost to Follow-Up (LTFU) Theme: Transformation workstream and a comprehensive improvement plan is in place following a number of serious incidents reported. As part of the identified LTFU theme, approximately 2000 patients have been audited. Patients were brought in for assessment with follow up appointments, investigations and treatments arranged. On conclusion of this process, a further six patients were identified as having irreversible harm as a result of being LTFU. This was reported as a further SI in October 2022. • STHFT LTFU Theme: A programme of improvement work has commenced to address themes including staffing pressures, diagnostic reporting processes, incident identification and reporting. This has been included in the Trust Recovery Program and the Director of Nursing/Quality team receive regular updates on how the work is progressing. • CDDFT Screening Processes: NHSE/I screening team highlighted recently that they have concerns about the Trust's screening processes following a number of reported incidents. One SI involved a positive syphilis result failing to be followed up and a false positive syphilis result (child) and hepatitis. Initial enquiries by NHSE/I highlighted staffing concerns within the Trust's screening team, which may not be acting on the failsafe processes.

Quality Exceptions - Safe and Caring

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	Performance	Risks and Mitigations
NHS Sickness Absence Rates	All Trusts were above the England average for May 2022 (4.9%). Workforce pressures continue due to sickness absence and vacancies, although some improvement has been seen.	A range of measures are in place to ensure operational challenges are managed, safe staffing levels are in place and support is being offered to staff to maintain their health and wellbeing. Regular safe staffing updates are provided at QRG meetings.
Staff Turnover Rate	One Trust (GHFT) was showing above the national average for staff turnover.	As part of their People Strategy GHFT has comprehensive plans in place to reduce vacancy rates, staff turnover and improve staff retention and experience.
Outstanding Patient Safety Alerts Open on Central Alerting System (CAS) – August 2022	Two Trusts (GHFT and NEAS) have outstanding patient safety alerts open on the national CAS system	GHFT was showing with one outstanding alert 'NatPSA/2021/009/NHSPS - Infection risk when using FFP3 respirators with valves or Powered Air Purifying Respirators during surgical and invasive procedures' (deadline 25/11/21). The Trust has confirmed that this alert was closed in August 2022. NEAS is showing with one outstanding alert 'NatPSA/2022/005/UKHSA - Contamination of hygiene products with Pseudomonas aeruginosa' (deadline 15/07/22). This was raised with the Trust who confirmed that this alert is not relevant as they do not use the listed products.
Mortality – Summary Hospital-level Mortality Indicator (SHMI)	One Trust (STSFT) continues to be showing as a negative outlier, reporting more deaths than expected.	Site ratios show the number of deaths at St Benedict's Hospice is impacting on overall organisational SHMI value/banding position and the site level ratios for both Sunderland Royal Hospital and South Tyneside District Hospital are in the 'as expected' range. STSFT are assured that their use of palliative care coding is correct but are aware that there may be variation in the use of end-of-life supportive care specialist codes with some Trusts which impacts on the mortality metric. Alternative assurance is gained through other sources of mortality data and the mortality review process. The roll-out of the Community Medical Examiner (ME) programme is progressing with the pilot practices and additional sites being signed up on an incremental basis. Nationally, it has been agreed that hospice data will be removed from the SHMI. NHS Digital will be writing to all Trusts in due course.
Family and Friends Test	NHCFT: A drop in FFT recommendation score for mental health has been noted. NTHFT: A drop in FFT recommendation score for inpatients and A&E has been noted this month.	Both Trusts continue to monitor positive and negative comments received via FFT on a regular basis to ensure that issues or concerns are acted upon to reduce the reoccurrence of similar issues in the future. NHCFT also gathers patient experience via Patient Perspective and is in the process of implementing their new real time survey.

Quality exceptions and concerns including CQC visits

	Performance	Risks and Mitigations
STSFT	Unannounced CQC Inspection: The CQC undertook an unannounced inspection visit to the Trust in June 2022 and a well-led assessment in August 2022.	Report will be published in due course.
NTHFT	CQC inspection (published September 2022): An overall rating of 'requires improvement'. Safe, Effective and Well-led domains were all rated 'requires improvement' and the caring and responsive domains were rated as 'good'. Gynaecology two week wait referrals: these have seen an increase of thirty percent in numbers. Overdue clinic letters: There are ongoing issues with delayed (over six months) clinic letters especially for rheumatology services. • Cauda Equina Pathway: The Trust is reviewing this pathway and has invited NECS to work in collaboration with further involvement extended to primary care	CQC inspection (published September 2022): Currently CQRGs have been stood down (due to discussions about joint CQRGs with South Tees) however the ICB will be sighted on the improvement action plans. Gynaecology two week wait referrals: The contracting team are working alongside the Trust to support a recovery plan to meet these demands. Overdue clinic letters: An external provider has been sourced to support the backlog. Communication has been sent to primary care colleagues.
STHFT	The CQC conducted a focused inspection on a small number of wards at James Cook University Hospital and Friarage Hospital in February 2022. The CQC issued a Section 29A warning notice identifying improvements required in relation to ward-based documentation, nutrition, and hydration, MCA/DOLS and discharge.	The Trust was already acting on these areas as part of its clinically led recovery from the winter Omicron surge. The CQC undertook a follow-up visit in September 2022 and the verbal feedback provided at the time was positive, however, the full report will be published in due course.
NEAS	National Independent Enquiry: The Secretary of State for Health and Social Care has confirmed that the NHS will hold a full independent review into the allegations made against NEAS. NHSE UEC winter letter: Trust has submitted their trajectories regarding Category 2, 999 call answer rates and 111 call abandonment rates to the ICB, which are based on a realistic view of performance for the remainder of the year. Regulation 28 Prevention of Future Deaths Report: was issued by North Tyneside Coroner in September 2022. The matters of concern identified that a more detailed assessment should have been undertaken and clinical input sought leading to an ambulance dispatch. The coroner identified that the serious events of this nature should be subject of Trust wide learning and training to prevent further deaths, comprehensive retraining is required for those directly involved. An urgent review of Trust policy/protocol for handling/management of mental health related incidents should be undertaken. Unannounced CQC visit: The Trust had an unannounced CQC visit in July and an inspection in September. As previously reported, concerns raised included issues relating to the medicines management processes, incident reporting/feedback and safeguarding reporting/feedback processes.	National Independent Enquiry: Following adverse media coverage in May 2022 an enhanced surveillance programme was put in place led by the ICB Director of Nursing. A report has been prepared which will feed into the national independent enquiry. The chair of the independent enquiry has been appointed and the interviews associated with this are well underway. The majority of NEAS staff involved have been interviewed however there is uncertainty about the process for interviewing staff who no longer work for the Trust. The Trust report that the member of staff who raised the initial concerns which led to the media interest is not engaging with the process and has raised issues about the enquiry's draft terms of reference. This received recent media coverage in the Health Service Journal. The planned timescale for completion of the enquiry is the end of the year. Support continues to be offered to the Trust via the QRG, ICB and wider system. NHSE UEC winter letter: The difficulties of predicting demand going into winter have been acknowledged, particularly regarding unknown winter flu and COVID pressures. The two-hour urgent community response plans are seen as a good opportunity to improve performance. Regulation 28 Prevention of Future Deaths Report: NEAS is to review the events leading to the patient's death and identify any additional safeguards to be put in place to prevent future deaths. NEAS is required to respond to the Coroner by 10 November 2022, currently awaiting their response. Unannounced CQC visit: An improvement plan is being developed and NEAS is having regular calls with the CQC. This has been discussed at October's System Quality Group.

Quality exceptions and concerns including CQC visits

	Performance	Risks and Mitigations
CNTWFT	Regulation 28 Prevention of Future Deaths Report: was issued by North/South Northumberland Coroner in October 2022. The matters of concern were around the increased number of children/young people who are now being seen with regards to their emotional wellbeing, psychological distress and mental health difficulties which have impacted on them requiring support and assessment since the pandemic; and the delays that now exist before they receive treatment and support. CQC Inspection to wards for people with a learning disability and autism (published August 2022): Report was published in August 2022 and was rated overall as 'requires improvement'. All domains were rated as 'requires improvement' with the exception of the care domain which was rated as 'good'.	Regulation 28 Prevention of Future Deaths Report: The Trust has been requested to provide a response to the Coroner by 9 December 2022. This will be monitor discussed with the Trust at the next QRG meeting in November 2022. CQC Inspection to wards for people with a learning disability and autism (published August 2022): A copy of the Trust's improvement plan will be shared and discussed at the QRG meeting in November 2022.
TEWVFT	CQC Inspection to wards for people with a learning disability and autism (published October 2022): The CQC carried out a responsive inspection in response to information received and then extended this to a full comprehensive inspection due to the concerns identified. The inspection took place across both Lanchester Road Hospital and Bankfields Court sites. The full report is now published, and the overall rating received is inadequate.	CQC Inspection to wards for people with a learning disability and autism (published October 2022): The NHSE/I Quality Board will be sighted on the Trust's improvement action plan.
North Cumbria Update	Children Looked after Service: Is in 'business continuity' a contract term to notify of any interruption to the provider's ability to provide the service. The Children Looked After service has gone into business continuity as it is struggling with significantly increased demand. Pre-covid, the number of children looked after was around 600 (across the whole of Cumbria) but this has increased to around 1,100. Part of the issue relates to a number of private providers moving to North Cumbria because of the relatively cheap estate in the north of the county and consequently a lot of looked after children have moved into the area.	NCIC is developing an internal business case to seek short term funding to get the team out of business continuity and ensure this vulnerable cohort of patients are seen regularly and in a timely fashion. Commissioners and safeguarding leads are in favour of this approach. It is acknowledged that a longer term plan is needed and a new service specification is being developed incorporating the latest professional standards and requirements.
Maternity Safety and Ockenden Update	All Trusts continue to offer progress updates in relation to the recommendations of the Immediate Essential Actions (IEAs) following publication of the two Ockenden reports at the QRG meetings and report progress within their board meetings. Good progress is being made against the seven immediate and essential actions. Additional support is needed for three Trusts. The Maternity and neonatal services in East Kent: 'Reading the signals' report was published on 19 October 2022 and Trusts will need to assess their compliance alongside Ockenden. STSFT Maternity Services: Following October's enhanced surveillance meeting the Trust's maternity services have been removed from the enhanced surveillance process.	STSFT Maternity Services: Quality assurance will instead resume through the place-based QRG meetings. The Midwifery Led Birthing Centre remains on track to reopen on 1 November 2022 and the ICB has recommended that the Trust conducts a number of simulation exercises prior to reopening. The Trust has invited AuditOne to review their CNST (year 2) and Ockenden 1 positions and a schedule of dates are to be confirmed. The Trust is still awaiting the first draft of their CQC report.
Independent Providers	Butterwick Hospices: Both sites remain under CQC review. BPAS Middlesborough: the additional conditions imposed on the providers registration in respect of regulated activities remain in place at this time by CQC. Impact Medical: has been rated as 'inadequate' by CQC.	Butterwick Hospices: Work continues on an agreed action plan as of October 2022. A new interim Chief Executive has been appointed. Next contract meeting is planned for the end of October, update expected. BPAS Middlesborough: BPAS has undertaken extensive improvement work to date and continues to work towards the agreed action plan. Regular contract and quality meetings continue. Impact Medical: The provider is currently the subject of an NHSEI led Rapid Quality Review process following the inadequate CQC rating, one of the sites they operate from is NCICFT's West Cumberland Hospital.

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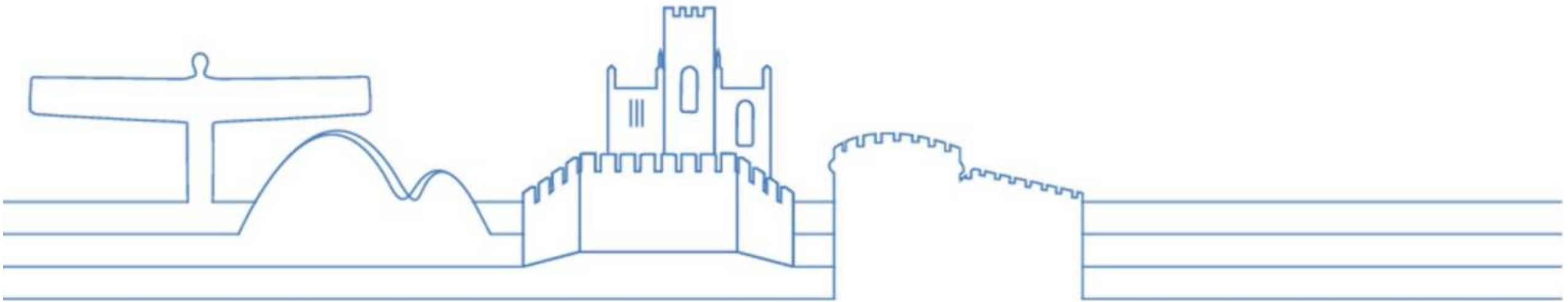
Performance



Performance - Executive Summary

	Performance
Primary Care	• GP appointment levels at pre-pandemic levels continue to increase, with a total of 1.5 m during September 22 which is within planned trajectory for September and a marked increase on August (1.4m). • DNAs as a proportion of all appointments remain high at 5% in September, an increase on August but below the national rate (5.2%). • Practices routinely offering face to face appointments where clinically necessary and they continue to increase, up to 72.6% of total appointments delivered in September. This exceeds the level nationally at 67.1%
Urgent and Emergency Care (UEC)	• Pressures due to high level of attendances, high bed occupancy and delays with social care discharges continue resulting in sustained pressure on UEC pathways. High levels of medically optimised patients is an ongoing feature across the system. NENC system is working hard to increase capacity and operational resilience ahead of winter with a continued focus on ambulance performance and response and discharge. • Ambulance response times NWAS: Category 2 performance is at 38m:14s for September compared to the 18 minute standard which is an improvement on August, and compares favourably to the national position for September at 47:59. • Response times continue to be a pressure although NEAS is meeting C1 mean and 90th Centile for October. Cat 2 mean and 90th percentile standards continue to not be met with October performance deteriorating from 40:45 mins compared to the 18 min standard in September to 57:34 in October. This compares favourably to the national at 1:01:19. • Handover delays continue, resulting in 106 average hours lost per day across NENC as at November 2022 compared to a target of 61.4. Only 47.9% handovers took place under 30 minutes compared to a 95% standard, and 40% of handovers were over 60 minutes in October 2022 (expected standard of zero) •October 22 A&E 4 hour wait performance continues to be a pressure due to volatile activity levels in the urgent care system with Type 1 performance still under significant pressure (55.7% NENC compared to 47.9% nationally). •Although not meeting the 95% standard, NENC performance is performing favourably compared to the national for October (all types) at 72.5%, compared to 61.8% nationally. • Patients waiting in A&E more than 12 hours following decision to treat has increased significantly from 909 in September in NENC, to 1106 in October. The % of patients waiting longer than 12 hours from arrival to discharge is above the 2% standard for August at 2.5% in NENC. Patients who no longer meet the criteria to reside and whose discharge is delayed is at 7.6% compared to the target level of 9.2% in NENC in October. Although this has remained relatively stable since April, the pressures with social care discharges is creating considerable pressure. • Type 1 General and Acute bed occupancy remains high and has increased significantly to 92.4% in October. This is above the 85% national expectation, and above the operational plan level in NENC.
Elective Care	• The total number of patients on the waiting list continues to grow, exceeding the operational plan trajectory for September 22 and is at an all-time high for NENC at 320,841. More recent weekly unvalidated data shows a further increase in waiting list size across NENC from 341,263 (w/e 2 Oct) to 344,489 (w/e 30 Oct). There were 24 104+ week waiters as at end of September 2022, the key pressure are being spinal patients at Newcastle upon Tyne Hospitals NHS FT . This is within the planned level for NENC (52 plan). The Trust continues to manage patients and seek additional capacity including through the independent sector (IS) providers, and current unvalidated weekly data shows this to continue to reduce. It is anticipated that this level will be at 22 by the end of March 2022. It should be noted that more recent unvalidated indicates 104+ week waiters at both NCIC (1) and at South Tees (2) in October, in addition to those spinal patients at NUTH. • 78+ waiters are increasing in NENC after a continual reduction over recent months and are now above planned levels in September (842 compared to 472 plan). The majority of 78+ waiters are at NUTH, with a proportion at South Tees, and CDDFT in addition. More recent unvalidated weekly data shows a continued increase across NENC to 956 (w/e 30 Oct). • 52+ week waiters continue to increase and are above planned levels, this is the sixth consecutive monthly increase observed. Of the 8549 in total as at the end of September, the majority were at NUTH, followed by South Tees, and CDDFT. Pressures exist across high volume specialties at NUTH including T&O, Dermatology, Ophthalmology and Plastic Surgery. The plan is expected to maintain this level through to March 2022 with a significant focus at NUTH on 78+ waiters. More recent unvalidated weekly data shows a further increase in NENC through October to 9219 (w/e 30 Oct). There is current focus for NUTH on Elective performance through Tier 2 meetings, see slide for detail. • Diagnostics >6 week performance for the 15 key diagnostic tests is relatively stable across NENC and continues below the requirement for 1% of patients to wait longer than 6 weeks, with 17.7% patients waiting over 6 weeks for a diagnostic test in September 2022 compared to 19.1% in August. Key pressure areas include Echo-cardiography, Endoscopy and Audiology

Performance - Executive Summary

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	Performance
Cancer	• NENC are not currently achieving the faster diagnosis standard for September 22 which stands at 72.8% v the 75% target, a deterioration since August. This compares favourably to the national performance (67.2%). Variation between Trusts exists with highest performance at CDD FT,(87.95%) and lowest at NCIC (57.99%). • 31 day treatment standard and the 62 days referral to treatment standards are not currently being met. Currently 62.6% patients waiting longer than 62 days compared to the 85% standard in NENC, this is a deteriorating position and is slightly above the national at 60.5% for September. Variation between Trust 62 day performance ranges from 75.26% at Northumbria HC to 44.1% at NUTH. • South Tees, North Tees, NUTH, and North Cumbria have recently submitted revised trajectories for monitoring against the proportion of patients on cancer PTLs waiting longer than 62 days. There is current focus for Trusts on cancer performance through tier 1 & 2 cancer meetings at NUTH, North Tees and Hartlepool and NCIC.
Mental Health	Please note Mental Health data has not been updated this month due to changes with the NHSE Publication. • IAPT % waits greater than 90 days is above the 10% standard in NENC and continues to increase to 37.89% • Patients accessing IAPT services is below plan • Dementia Diagnosis rate is at 65.3% as at August, below the trajectory of 66.1% • Proportion of people on SMI register receiving a full Health check continues to increase towards the end of year standard and is currently on plan.
Learning Disabilities and Autism:	• Reducing Reliance on IP care trajectories are on track overall for September, with a total of 146 patients in IP care, working towards no more than 71 adults in NENC by 2023/24. • Learning Disability Health checks is a cumulative target and as at August YTD NENC has completed 24% of the register which is a 20% increase on this time last year.

Tier 1 and Tier 2 Meetings

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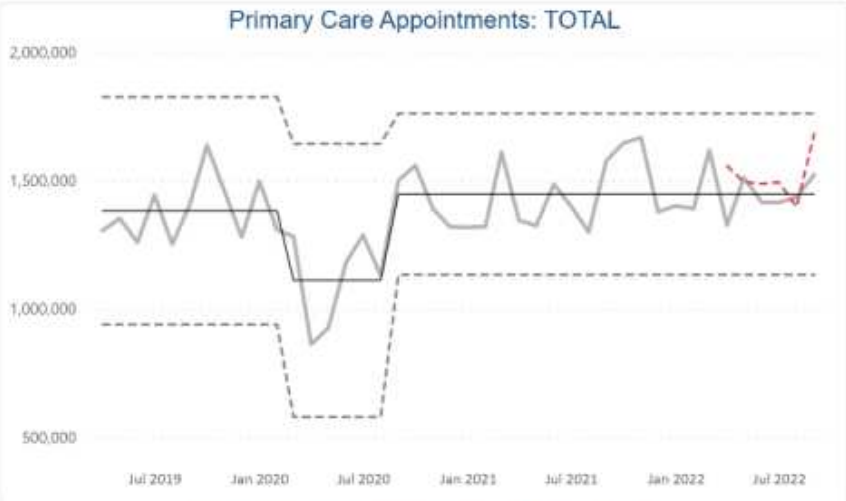
	Performance
Overview	The allocation of providers to tiers in relation to their elective and cancer backlog positions is a relatively new process initiated by NHS England. Trusts who are placed in Tier 1 will have regular (usually fortnightly) escalation meetings initiated by the NHS NEY Regional Team. For trusts placed in Tier 2 similar meetings will be initiated by the ICB. The ICB will work with colleagues from the Regional Team to ensure these meetings are arranged to include all the relevant parties and focussed on identifying and deploying high-quality support to aid rapid performance improvement. In NENC the following Trusts are in Tiers 1 and Tier 2:
Tier 1	North Cumbria – Cancer • Tier 1 cancer escalation; meeting chaired by NEY NHS E Director of Performance and Improvement with national cancer team, ICB and Trust representation • the trust has a range of actions in place linked to validation, pathways and diagnostics • notable progress has been made in reducing the cancer 62 day backlog - unpublished weekly PTL shows a decrease over 5 consecutive weeks. • NHS England has allocated funds to the Northern Cancer Alliance to support NCIC in implementing rapid improvement plans for diagnostics and histopathology
Tier 2	Newcastle – Cancer & Elective • Tier 2 cancer and elective escalation; meeting chaired by ICB Executive Director of Place with NHS E, ICB and trust representation • the trust has implemented and sustained a range of improvements linked to validation, pathways and diagnostics • the trust has a number of initiatives to increase capacity including the opening of the day treatment centre in September and maximising use of the independent sector in particular for dermatology • some progress has been made in reducing the cancer 62 day backlog • there has been a sustained and significant reduction in the number of people waiting beyond 104 weeks for elective procedures, complex spinal procedures being the remaining area of pressure • there is a growing pressure of over 78 week waits demonstrated by more currently weekly unvalidated data. Dermatology, Orthopaedics and Spinal are key areas of risk North Tees & Hartlepool – Cancer • North Tees and Hartlepool FTare now in Tier 2 due to increasing backlog over recent weeks and the proportion of their waiting list with patients waiting in excess of 62 days is now above 9.6% • Both North and South Tees Trusts are committed to a collaborative approach, with pressures across Urology and Lung.
Non-Tiered	South Tees has been stepped down from Tier 2 for Cancer • the trust has implemented and sustained a range of improvements linked to validation, pathways and diagnostics • significant progress has been made in reducing the cancer 62 day backlog shown by unpublished weekly PTL data. • following review at the last meeting a recommendation was made to the national cancer team that South Tees is removed from Tier 2 on the basis that they meet the three criteria for de-escalation: o the proportion of the PTL waiting over 62 days is less than the national average o the trust has not been in the top 20 group of trusts of most concern for the last 4 weeks o the trust plan has resulted in improvement and there is confidence in the plan going forward to sustain improvement

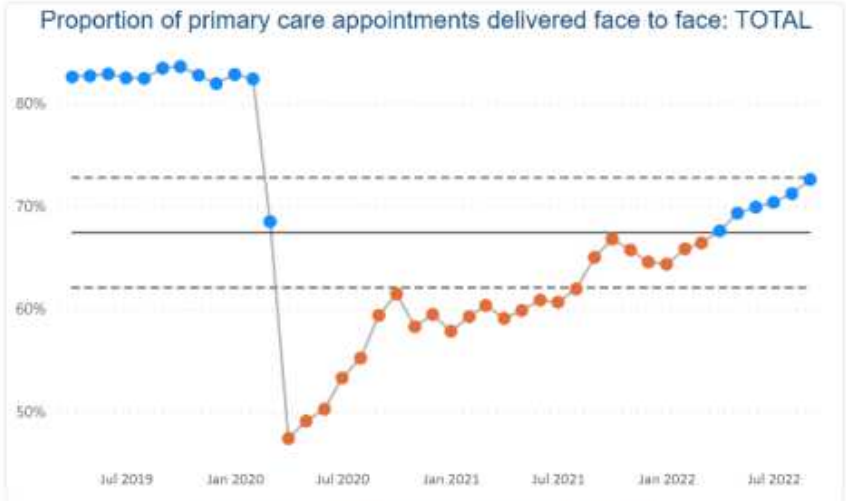
Primary care

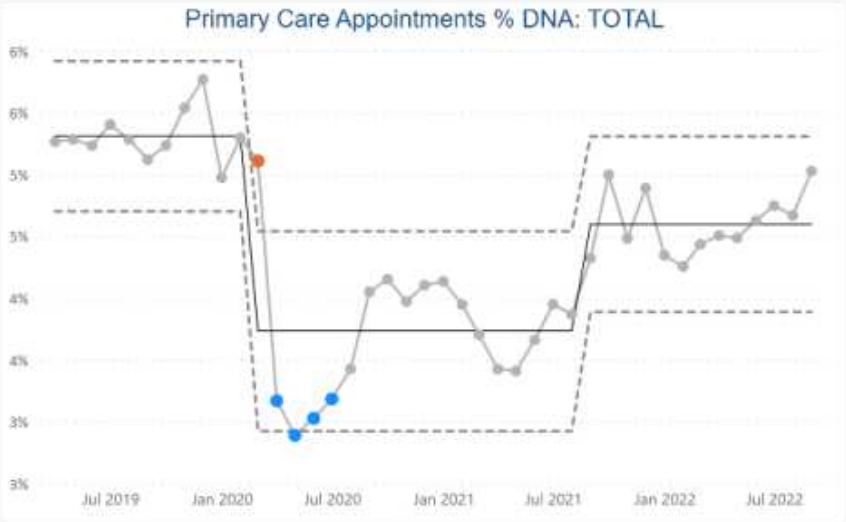
NHS
North East & North Cumbria

Metric	Latest date	Value	National	Target	Variation	Assurance
Primary Care Attends	Sep-22	1445981				
Primary Care Appointments	Sep-22	1522547		1681346		
Primary Care Appointments % DNA	Sep-22	5%	5.2%			
Proportion of primary care appointments delivered face to face	Sep-22	72.6%	67.1%			
Percentage of 111 calls abandoned	Nov-22	9.6%		3%		

Target







Performance

Increased and continued patient demand for all primary care services.

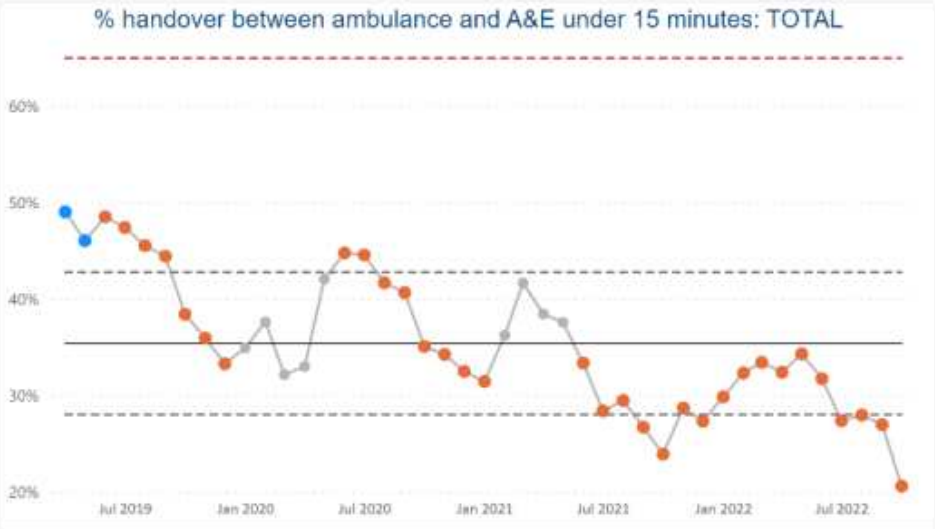
- GP appointment levels at pre-pandemic levels continue to increase, with a total of 1.5 m during September 22 which is within planned trajectory for September and a marked increase on August (1.4m).
- DNAs as a proportion of all appointments remain high at 5% in September, an increase on August but below the national rate (5.2%).
- Practices routinely offering face to face appointments where clinically necessary and they continue to increase, up to 72.6% of total appointments delivered in September. This exceeds the level nationally at 67.1%
- Practices and PCNs supported to review their Health Inequalities
- The percentage of 111 calls abandoned (NEAS only) is at 9.6% in November, compared to the national threshold of 3%. Work is underway to establish a position for NWAS covering North Cumbria.

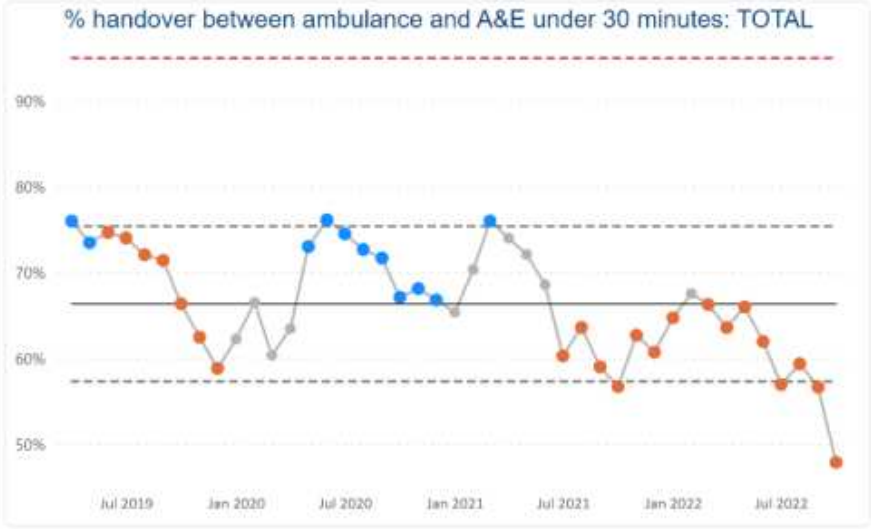
Ambulance Handover

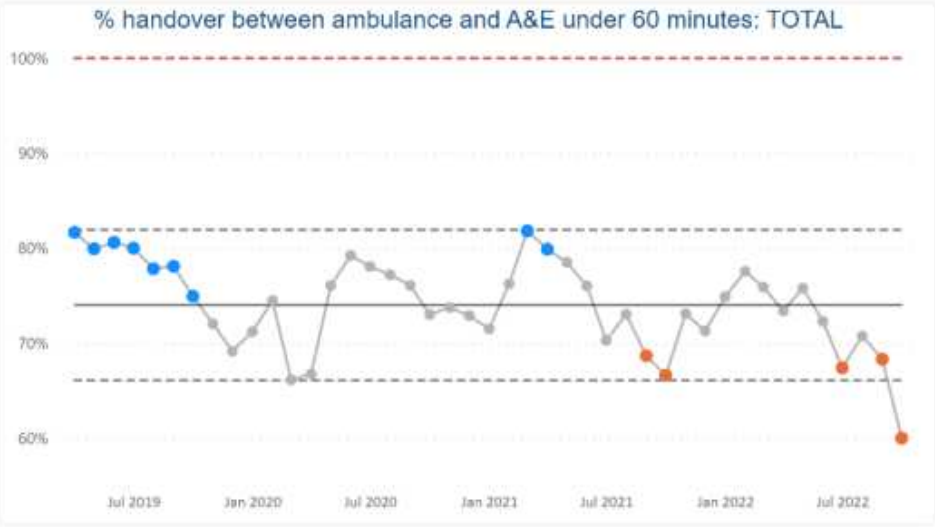
NHS
North East & North Cumbria

Metric	Latest date	Value	National	Target	Variation	Assurance
Average hours lost to handover delays per day vs local trajectory	Nov-22	106		61.4		
% handover between ambulance and A&E under 30 minutes	Oct-22	47.9%		95%		
% handover between ambulance and A&E under 15 minutes	Oct-22	20.6%		65%		
% handover between ambulance and A&E under 60 minutes	Oct-22	60%		100%		

Target







Performance

- NENC are working towards the following standards for ambulance handovers at our FTs: eliminating handover delays of over 60 minutes; ensuring 95% of handovers take place within 30 minutes; ensuring 65% of handovers take place within 15 minutes.
- Delays however do continue- resulting in 106 average hours lost per day across NENC as at November 2022 compared to a target of 61.4. Only 47.9% handovers took place under 30 minutes compared to a 95% standard, and 40% of handovers were over 60 minutes in October 2022 (expected standard of zero).

Risks and Mitigations

NWAS:

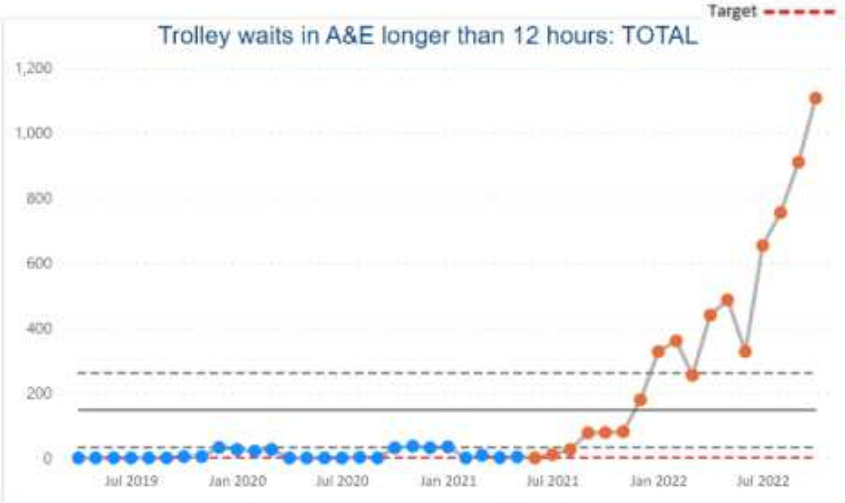
- Performance remains extremely variable and there are still issues at times of surge and when access to beds in the wider hospital is an issue. NCIC continues to work collaboratively with NWAS to implement fit to sit, conveyance direct to SDEC and cohorting to reduce ambulance delays to get crews back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

NEAS:

- Regional Acute trust visits have taken place. The visits have informed a set of recommendations to be implemented. Local improvement plans will now be developed reflective of the recommendations and other local issues. Delivery of these plans will be governed by the Urgent Emergency Care Network Board. Recommendations include developing Consistent data flows to UEC RAIDR app. An engagement exercise has commenced to seek patient public views on the implementation of an integrated Urgent Care model at the James Cook site, a QI lead into the Trusts 2 days per week and an IMPACT nurse to clinically manage up to 3 patients in the handover area. STFT are a regional outlier and delays impact both NWAS and YAS providers. An RPIW is planned for November 2022.

Accident and Emergency

Metric	Latest date	Value	National	Target	Variation	Assurance
Mean 999 Call Answering Time (seconds)	Oct-22	39.2	47.7	20		
% Patients spending 4 Hours or less in A&E	Oct-22	72.5%	61.8%	95%		
A&E 4 Hours (T1 only)	Oct-22	55.7%	47.9%	95%		
Trolley waits (from DTA) in A&E longer than 12 hours	Oct-22	1106		0		
% A&E waits from arrival to discharge, admission or transfer longer than 12 hours	Aug-22	2.5%		2%		



Performance

• October 22 A&E 4 hour wait performance continues to be a pressure due to volatile activity levels in the urgent care system with Type 1 performance still under significant pressure (55.7% NENC compared to 47.9% nationally). Ongoing pressures result from increased attendance and admission rates together with persistently high levels of medically optimised patients persists across the system. Although not meeting the 95% standard, NENC performance is performing favourably compared to the national for October (all types) at 72.5%, compared to 61.8% nationally.
• Patients waiting in A&E more than 12 hours following decision to treat has increased to significantly from 909 in September in NENC, to 1106 in October. The % of patients waiting longer than 12 hours from arrival to discharge is above the 2% standard for August at 2.5% in NENC.

Risks and Mitigations

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

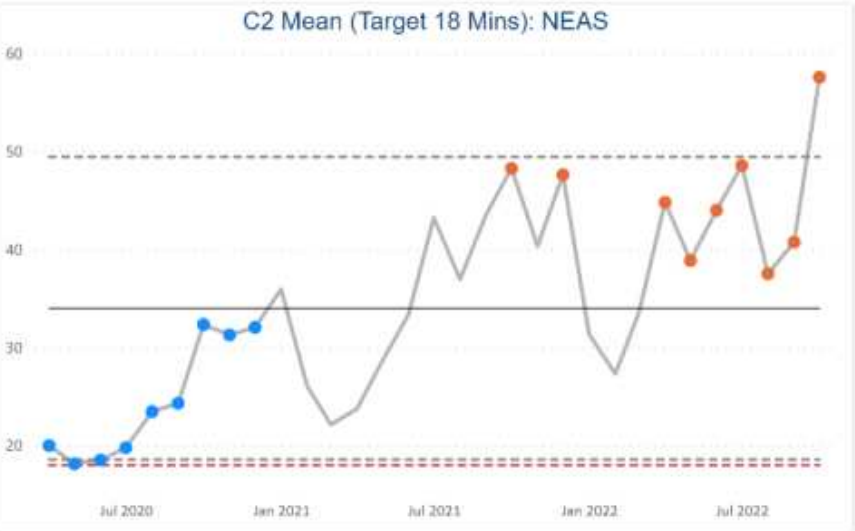
Tees Valley:
• STHFT 4-hour standard performance remains below average. The impact of COVID-19 on staffing levels in this staff group and patient flow (segregation of pathways) continues to be observed. Actions include the ECIST improvement project, and estate expansion and reconfiguration. NTHFT continue to receive a high number of ambulance diverts and is reviewing the operational model.

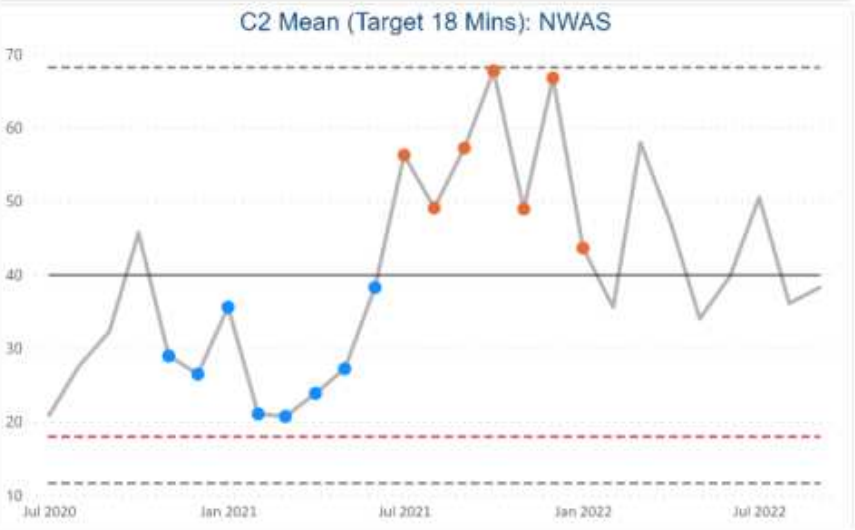
North Cumbria:
• NCIC is working with the national Emergency Care Improvement Support Team (ECIST) to expand the use of SDEC and implement the 'perfect day' improvement tools. Rapid Access and Treatment at West Cumberland Hospital went live in June and site co-ordination and internal escalation policies are being reviewed.

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

Ambulance Response Times

Metric		Latest date	Value	National	Target	Variation	Assurance
C2 Mean (Target 18 Mins):	NWAS	Sep-22	00:38:14		00:18:00		
C2 Mean (Target 18 Mins):	NEAS	Oct-22	00:57:34	01:01:19	00:18:00		





Target

		NEAS			NWAS		
Metric	Target	Value	Variation	Assur.	Value	Variation	Assur.
C1 Mean (Target 7 Mins)	00:07:00	00:08:09			00:08:43		
C1 90th Centile	00:15:00	00:14:15			01:24:21		
C2 Mean (Target 18 Mins)	00:18:00	00:57:34			00:38:14		
C2 90th centile	00:40:00	01:59:19			01:24:21		
C3 90th centile	02:00:00	08:14:23			07:15:27		
C4 90th centile	03:00:00	05:39:37			07:51:16		

NHS
North East & North Cumbria

Performance

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

NWAS:
• Response times for North Cumbria CCG remain challenged in September and below standard. C1 mean has been flagged a high concern and consistently failing the target. However, NWAS performance in North Cumbria continues to be notably better than other areas of the North West. C2 performance is at 38:14 for September compared to the 18 minute standard which is an improvement on August , and compares favourably to the national position for September at 47:59.

NEAS:
• Response times continue to be a pressure although NEAS is meeting C1 mean and 90th Centile for October. Cat 2 mean and 90th percentile standards continue to not be met with October performance deteriorating from 40:45 mins compared to the 18 min standard in September to 57:34 in October. This compares favourably to the national at 1:01:19.

Risks and Mitigations

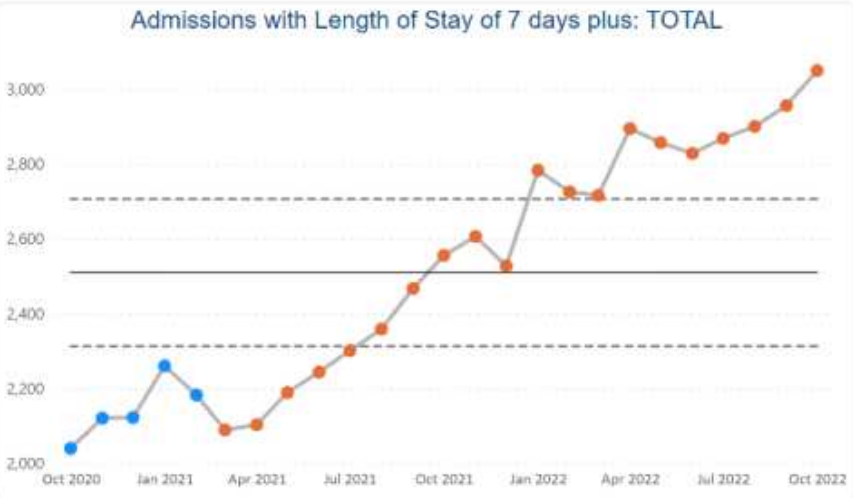
• National work to review Category 2 calls with a focus on improving safety for patients waiting for an ambulance to ensure all patients receive the right response for their clinical presentation.
• A three-year programme to increase capacity has been identified to enable patients to be responded to in a timely manner and minimise risk to life and outcomes.
• Recruitment of additional paramedics, Clinical Care Assistants, and health advisors
• Implementation of sickness absence plan focused on mental health and wellbeing
• RPIW focussing on increasing Clinical Assessment Service across the system and increasing alternative dispositions via 2UCR.

Patient Flow & Discharge

NHS
North East & North Cumbria

Metric	Latest date	Value	National Target	Variation	Assurance
Admissions with Length of Stay of 21 days plus	Oct-22	1190.7	892		
Admissions with Length of Stay of 7 days plus	Oct-22	3050.5			
Adult general and acute type 1 bed occupancy (adjusted for void beds)	Oct-22	92.4%	86.8%		
Proportion of patients not meeting criteria to reside (acute hospitals) vs local trajectory	Oct-22	7.6%	9.2%		

Target



Performance

- Pressures due to high level of attendances, high bed occupancy and delays with social care discharges continue.
- Length of stay for patients residing in hospital over 7 and 21 days has continued to increase and is above trajectory.
- Patients who no longer meet the criteria to reside and whose discharge is delayed is at 7.6% compared to the target level of 9.2% in NENC in October. Although this has remained relatively stable since April, the pressures with social care discharges is creating considerable pressure.
- Type 1 General and Acute bed occupancy remains high and has increased significantly to 92.4% in October. This is above the 85% national expectation, and above the operational plan level in NENC.
- Trusts have recently been asked to submit updated trajectories which will be monitored locally. For the purposes of this report we will continue to monitor against the operational planning trajectories.

Risks and Mitigations

- Plans are underway to transform and build community services capacity to deliver more care at home and improve hospital discharge across NENC ICS.

- The ICS is committed to implementing new and enhancement of current virtual wards to support plans for elective recovery and improvement of UEC pathways.

- Local systems with their partners are making sure that their Urgent Crisis Response (UCR) models are part of the wider local health and care integration redesign. UCR data is being standardised across the ICS and will be included in future reports to ensure delivery of the 2 hour standard across the ICS.

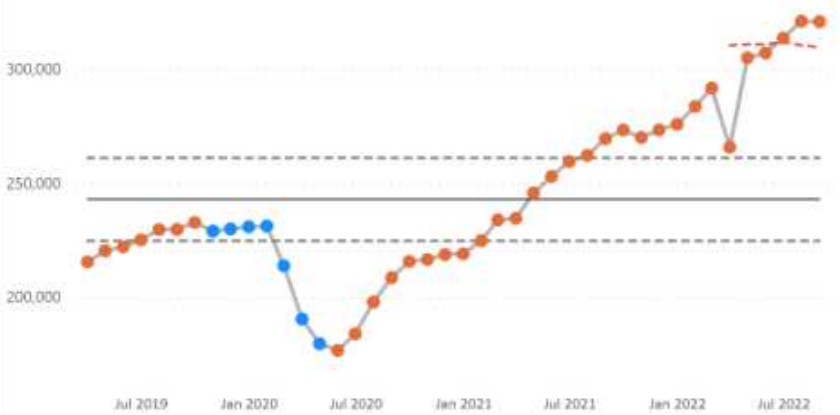
- Both Virtual wards and Urgent crisis response wok plan has been established together with ICS wide working groups to explore and share pathway models to standardise across the ICS.

Referral to Treatment and Long Waiters

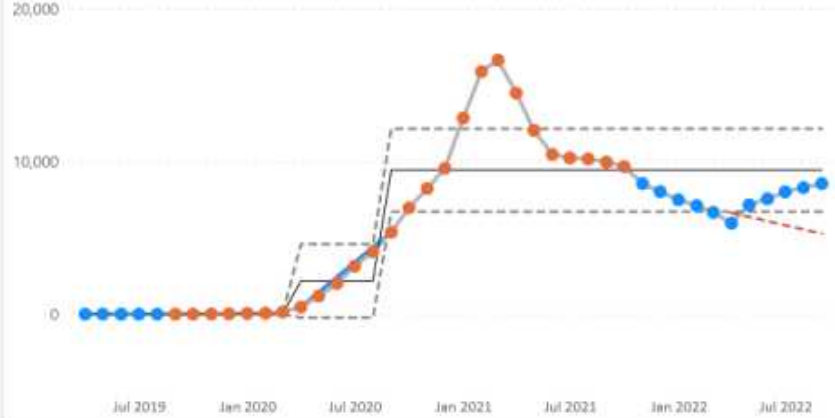
Metric	Latest date	Value	National	Target	Variation	Assurance
Number patients waiting more than 52 weeks for treatment (Incomplete pathways only)	Sep-22	8549		5270		
Number patients waiting more than 78 weeks for treatment (Incomplete pathways only)	Sep-22	842		472		
Number patients waiting more than 104 weeks for treatment (Incomplete pathways only)	Sep-22	24		52		
Number of patients on waiting list (RTT incomplete)	Sep-22	320841		309637		

Target

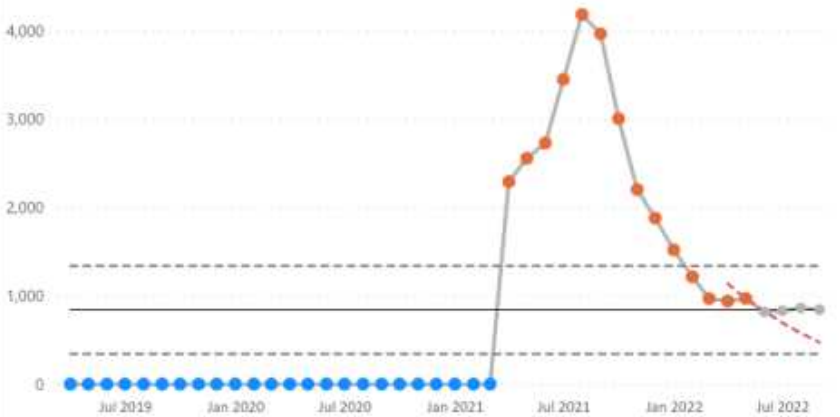
Number of patients on waiting list (RTT incomplete): TOTAL



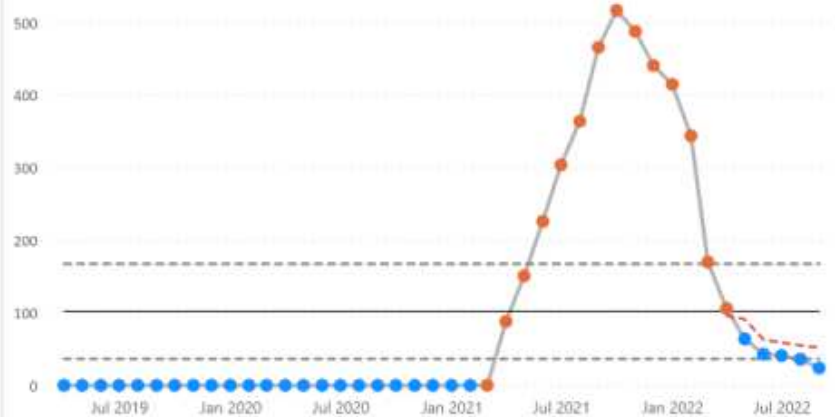
Number patients waiting more than 52 weeks for treatment (Incomplete pathways only): TOTAL



Number patients waiting more than 78 weeks for treatment (Incomplete pathways only): TOTAL



Number patients waiting more than 104 weeks for treatment (Incomplete pathways only): TOTAL



Performance

• The total number of patients on the waiting list continues to grow, exceeding the operational plan trajectory for September 22 and is at an all-time high for NENC at 320,841. More recent weekly unvalidated data shows a further increase in waiting list size across NENC from 341,263 (w/e 2 Oct) to 344,489 (w/e 30 Oct).

There were 24 104+ week waiters as at end of September 2022, the key pressure are being spinal patients at Newcastle upon Tyne Hospitals NHS FT . This is within the planned level for NENC (52 plan). The Trust continues to manage patients and seek additional capacity including through the independent sector (IS) providers, and current unvalidated weekly data shows this to continue to reduce. It is anticipated that this level will be at 22 by the end of March 2022. It should be noted that more recent unvalidated indicates 104+ week waiters at both NCIC (1) and at South Tees (2) in October, in addition to those spinal patients at NUTH.

• 78+ waiters are increasing in NENC after a continual reduction over recent months and are now above planned levels in September (842 compared to 472 plan). The majority of 78+ waiters are at NUTH, with a proportion at South Tees, and CDDFT in addition. More recent unvalidated weekly data shows a continued increase across NENC to 956 (w/e 30 Oct).

• 52+ week waiters continue to increase and are above planned levels, this is the sixth consecutive monthly increase observed. Of the 8549 in total as at the end of September, the majority were at NUTH, followed by South Tees, and CDDFT. Pressures exist across high volume specialties at NUTH including T&O, Dermatology, Ophthalmology and Plastic Surgery. The plan is expected to maintain this level through to March 2022 with a significant focus at NUTH on 78+ waiters. More recent unvalidated weekly data shows a further increase in NENC through October to 9219 (w/e 30 Oct).

Risks and Mitigations

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

Tees Valley:
• 52 and 78 week waits at STHFT continue to trend down, however the Trust did have a patient breach 104ww in July (who received treatment in August). The Trust have a renewed focus on outpatient and elective activity and completing patient pathways and continues to validate waiting lists and prioritise longest waiters, monitor forward planning, reallocate theatre capacity and allocate patients to consultants with capacity. NTHFT had 73 patients waiting 52 weeks in July, against a target of 10. As of the end of July, NTHFT maintains its trajectory position in line with NHSE phase 1 and 2 elective recovery and reports no patients waiting more than 78 and 104 weeks. The Trust continues to see an increase in referrals, with a quarterly increase of 6% compared to 2019/20 levels and whilst the overall waiting list size continues to grow this has plateaued over recent months .

Central:
• RTT performance continues to be strong in the Central patch with low levels of over 52 week waiters and a continued decrease in 104 week waiters. Pressures in the urgent care system however is beginning to impact on performance and elective care recovery. Additional resources have been committed via the ERF to increase elective capacity at Trusts and the Area continues to focus on maximising elective capacity through use of the I.S. Work has commenced across Durham and Sunderland to improve pathways in Dermatology to help manage pressures being seen in Secondary Care, standardising advice and guidance requests and access to community services.

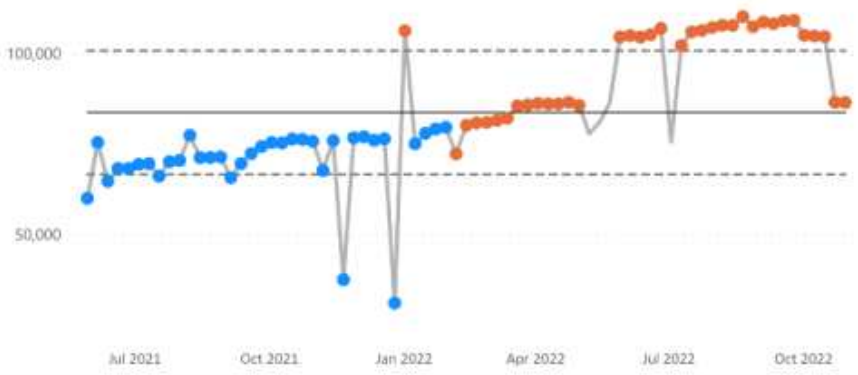
North Cumbria:
• NCIC successfully eliminated 104 week waits in 2021/22 although work is ongoing with validation process checks to eliminate instances where validation errors may occur and result in currently 1 pathway identified as a breach. Focus continues with the elimination of 78 week waits by the end of the current financial year and Trust within plan. Waiting list continues to grow. The theatre improvement programme remains a key priority and the NECS review of selected outpatient specialties has been used in the development of a transformation and improvement plan. In addition, the modular endoscopy unit is still on site, additional elective capacity has been secured from BMI and Nuffield and a sub-contract is in place for Ophthalmology

Elective Waiting List - Health Inequalities

NHS
North East & North Cumbria

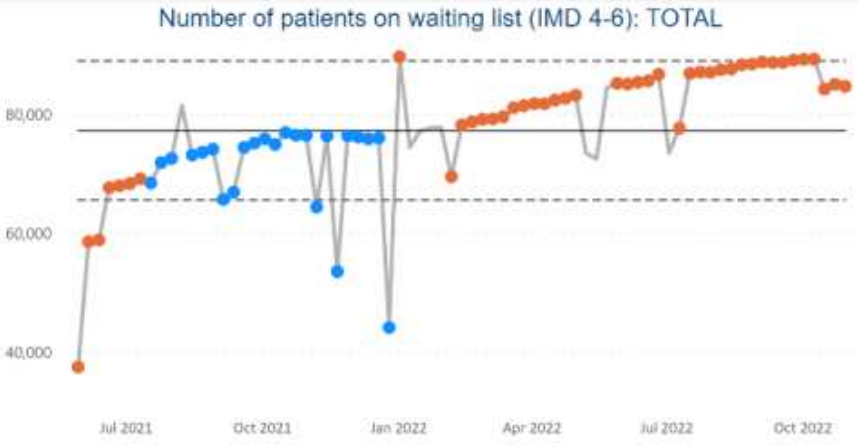
Provider	TOTAL		CDDFT		Gateshead FT		NCIC		Northumbria		NTHFT		NuTH		STHFT		STSFT	
	Val.	Var.	Val.	Var.	Val.	Var.	Val.	Var.	Val.	Var.	Val.	Var.	Val.	Var.	Val.	Var.	Val.	Var.
Number of patients on waiting list (Ethnicity White)	246108		31995		9096		28000		27581		14996		50229		36896		47315	
Number of patients on waiting list (Ethnicity BAME)	11246		577		287		425		377		1296		4337		2119		1828	
Number of patients on waiting list (Ethnicity Unknown)	86441		4544		2737		9102		5552		3683		43888		8947		7988	
Number of patients on waiting list (IMD 1-3)	134913		15482		5525		9955		9736		9404		38225		17433		29153	
Number of patients on waiting list (IMD 4-6)	84691		10172		2924		13091		9276		2952		23296		10045		12935	
Number of patients on waiting list (IMD 7-10)	96390		8911		2769		11439		11606		5308		29177		16332		10848	

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



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

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



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

Performance

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

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

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

Diagnostic Waiting List

Metric	Latest date	Value	National	Target	Variation	Assurance
Number of patients waiting more than 6 weeks from referral for a diagnostic test	Sep-22	13325				
% Patients waiting more than 6 weeks from referral for a diagnostic test	Sep-22	17.7%	29.9%	1%		

Target

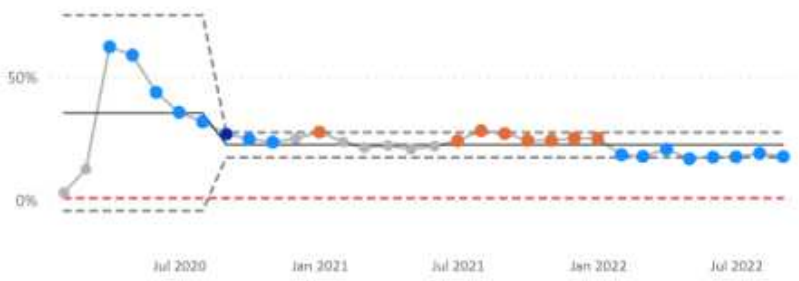
% Patients Waiting more than 6 weeks for a diagnostic test - by Modality

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

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

Metric	% Patients waiting more than 6 weeks from referral for a diagnostic test			Number of patients waiting more than 6 weeks from referral for a diagnostic test		
	Value	Variation	Assur.	Value	Variation	Assur.
TOTAL	17.7%			13325		
CDDFT	10.7%			1270		
Gateshead FT	18.9%			1074		
NCIC	14%			1098		
Northumbria	4.8%			467		
NTHFT	27.4%			2504		
NuTH	17.1%			2125		
STHFT	29.7%			2931		
STSFT	22.3%			1547		

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



Performance

• Diagnostics >6 week performance for the 15 key diagnostic tests is relatively stable across NENC and continues below the requirement for 1% of patients to wait longer than 6 weeks, with 17.7% patients waiting over 6 weeks for a diagnostic test in September 2022 compared to 19.1% in August. Key pressure areas include Echo-cardiography, Endoscopy and Audiology. ICSs have been asked to develop a local diagnostic performance improvement plan that delivers 95% achievement of the 6ww diagnostic target by March 25. The NENC Diagnostics workstream has recently set trajectories with FTs with a focus on a subset of 8 of the key diagnostic tests.

Risks and Mitigations

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

Central:
• The diagnostic position continues to improve overall, however echocardiography remains the main performance risk in South Tyneside and Sunderland due to the Central impact of COVID and workforce pressures. Performance continues to improve month on month due to additional capacity secured throughout 21/22 and 22/23. Community Diagnostic Hubs are now up and running across the ICP which is providing additional radiology capacity. Additional endoscopy is being mobilised across South Tyneside and Sunderland to help reduce the backlog which will help cancer diagnosis.

North:
• Significant echo backlogs have been cleared at NUTH through additional capacity, Gateshead continue with insourcing to clear echo backlog and central area has secured additional capacity through 22/23.

North Cumbria:
• An additional cardio-echo machine at West Cumberland Hospital, provides a further 30% capacity in Cumbria.
Community diagnostics funded schemes are increasing capacity in Radiology and endoscopy across NENC as well as additional capacity sought through the Independent sector. Audiology workforce pressures remain a risk across NENC

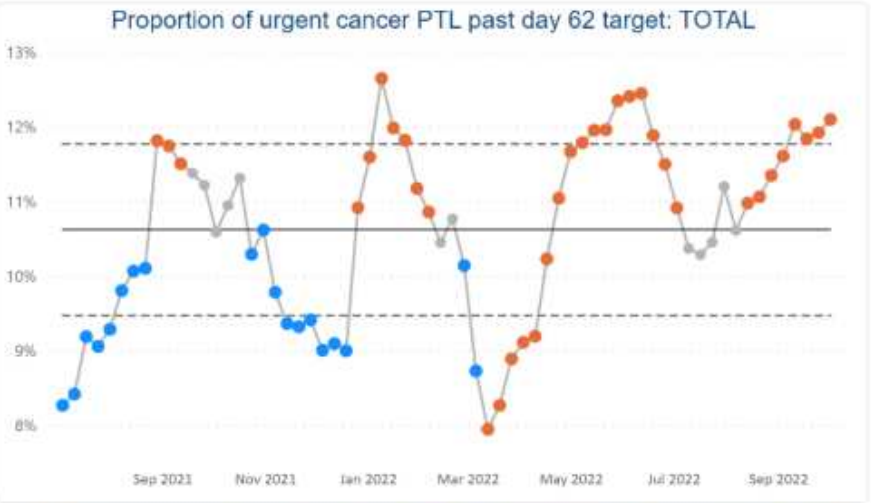
Tees Valley:
• STHFT diagnostic compliance remains below average but is improving against the 6 week standard, as backlogs and waiting list validations are addressed. All modalities have demand and capacity plans in place with actions and trajectories to work towards compliance, including the use of the future Community Diagnostic Hub capacity. Non urgent operations cancelled on day of surgery is more than in 20/21 due to the increase in cases booked alongside ongoing COVID19 incidence. Pressures have continued in Ultrasound at NTHFT, mainly due to staffing issues. A locum sonographer has been recruited (in August) to support recovery and some additional insourcing has also been arranged. Additional lists in Endoscopy appear to be making a positive impact, with an improved position been reported in July.

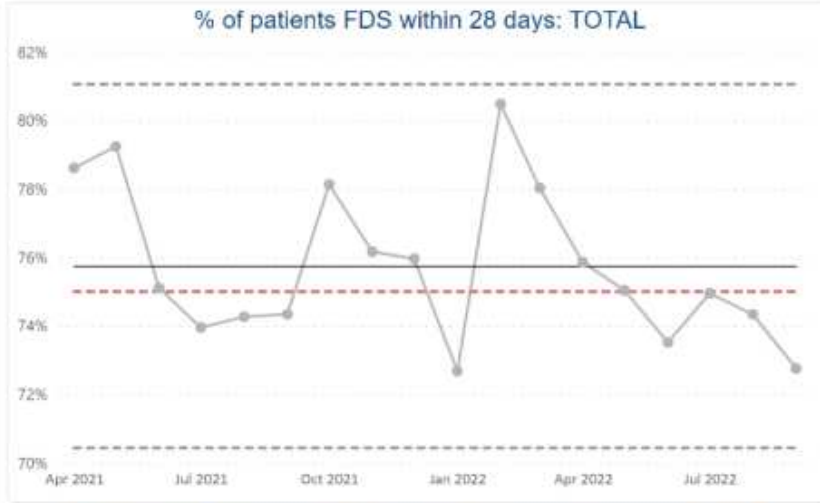
Cancer

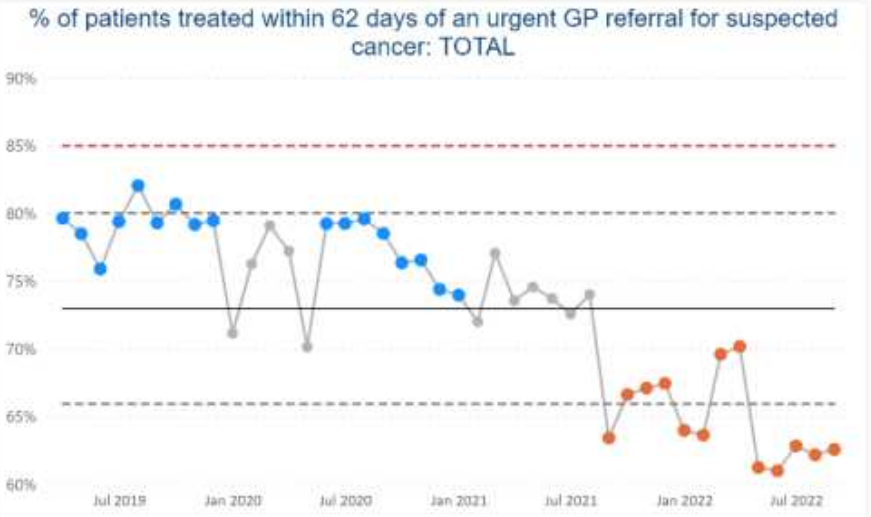
NHS
North East & North Cumbria

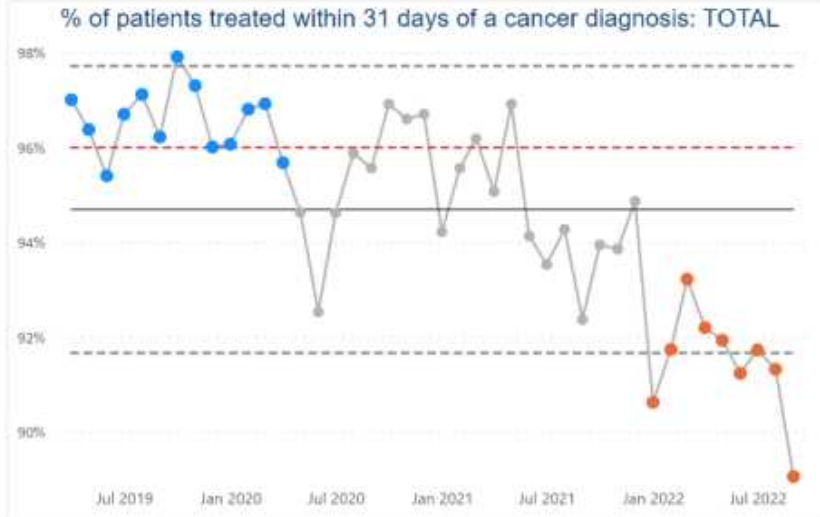
Metric	Latest date	Value	National	Target	Variation	Assurance
Proportion of urgent cancer PTL past day 62 target	Oct-22	12.1%				
% of patients FDS within 28 days	Sep-22	72.8%	67.2%	75%		
% of patients treated within 62 days of an urgent GP referral for suspected cancer	Sep-22	62.6%	60.5%	85%		
% of patients treated within 31 days of a cancer diagnosis	Sep-22	89.1%	91.1%	96%		

Target









Performance

• NENC are not currently achieving the faster diagnosis standard for September 22 which stands at 72.8% v the 75% target, a deterioration since August. This compares favourably to the national performance (67.2%). Variation between Trusts exists with highest performance at CDD FT,(87.95%) and lowest at NCIC (57.99%).

• 31 day treatment standard and the 62 days referral to treatment standards are not currently being met. Currently 62.6% patients waiting longer than 62 days compared to the 85% standard in NENC, this is a deteriorating position and is slightly above the national at 60.5% for September. Variation between Trust 62 day performance ranges from 75.26% at Northumbria HC to 44.1% at NUTH.

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

Risks and Mitigations

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

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

• Skin - Successful roll out of tele-dermatology pathway at NUTH has eased pressures in skin although seasonal referrals are creating additional pressure. Demand on services at Northumbria is also increasing.

• NCA non surgical oncology should improve the equitable and timely delivery of chemotherapy and radiotherapy across the ICS.

Improving Access to Psychological Therapies (IAPT)

NHS North East & North Cumbria

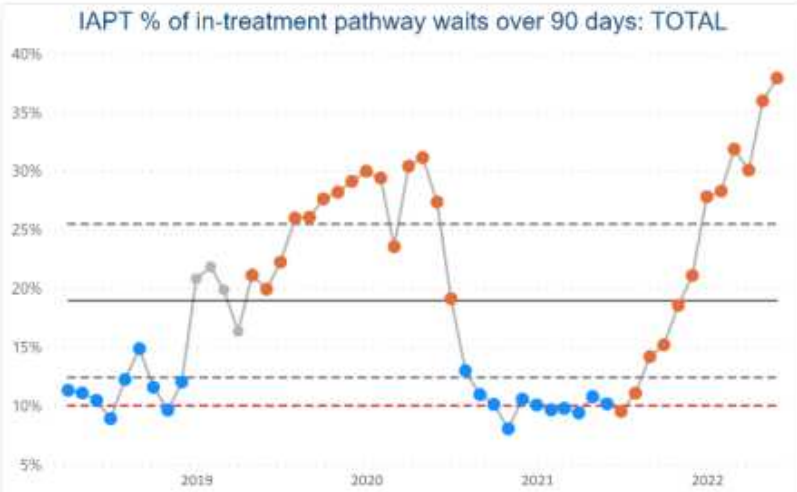
Metric	Latest date	Value	National	Target	Variation	Assurance
IAPT access: number of people entering NHS funded treatment during reporting period	Jun-22	4815		6286		
IAPT recovery rate for Black, Asian or Minority Ethnic groups	Jun-22	42.6%		50%		
IAPT % of in-treatment pathway waits over 90 days	Jun-22	37.9%		10%		
IAPT recovery rate: % of people that attended at least 2 treatment contacts and are m...	Jun-22	53.2%		50%		
IAPT % of people receiving first treatment appointment within 6 weeks of referral	Jun-22	97.8%		75%		
IAPT % of people receiving first treatment appointment within 18 weeks of referral	Jun-22	99.1%		95%		

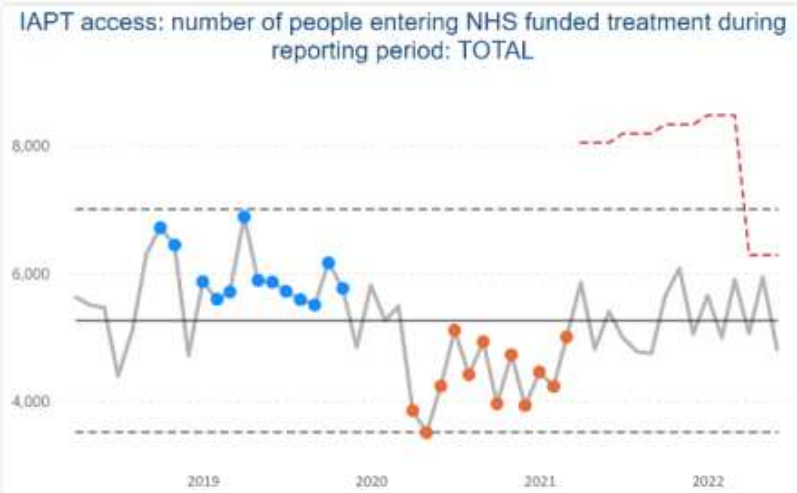
Please note, IAPT data has not been updated due to changes within the NHSE Publication

Target - - - - -

IAPT Recovery by Sub ICB location

Metric	IAPT recovery rate for Black, Asian or Minority Ethnic groups			IAPT recovery rate: % of people that attended at least 2 treatment contacts and are moving to recovery		
	Value	Variation	Assur.	Value	Variation	Assur.
TOTAL	42.6%			53.2%		
Co Durham	45.5%			52.2%	H	
N Cumbria	37.5%			53.8%	H	
N Tyneside	50%			55.9%	H	
Ncl-Gateshead	38.3%			52.3%		
Northumberland	40%			53.7%	L	
S Tyneside	60%			51.2%		
Sunderland	40%			55%		
Tees Valley	42.1%			53.8%		





Performance

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

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

Risks and Mitigations

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

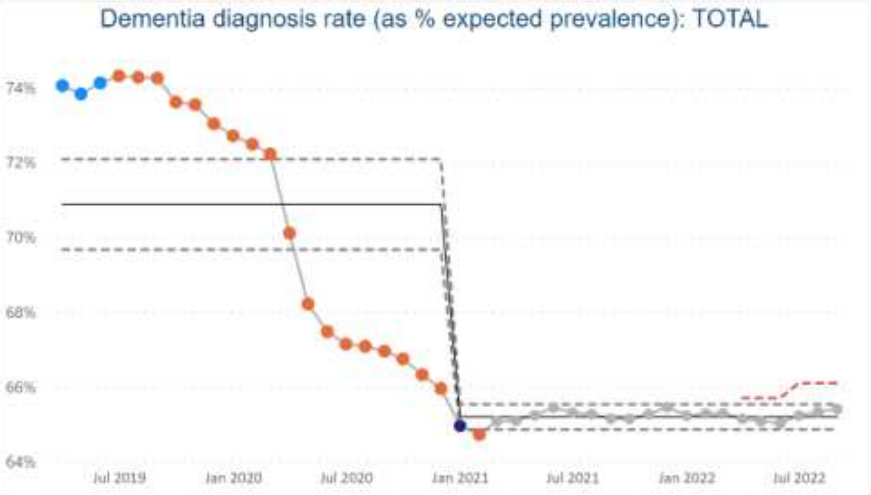
Mental Health (Adult)

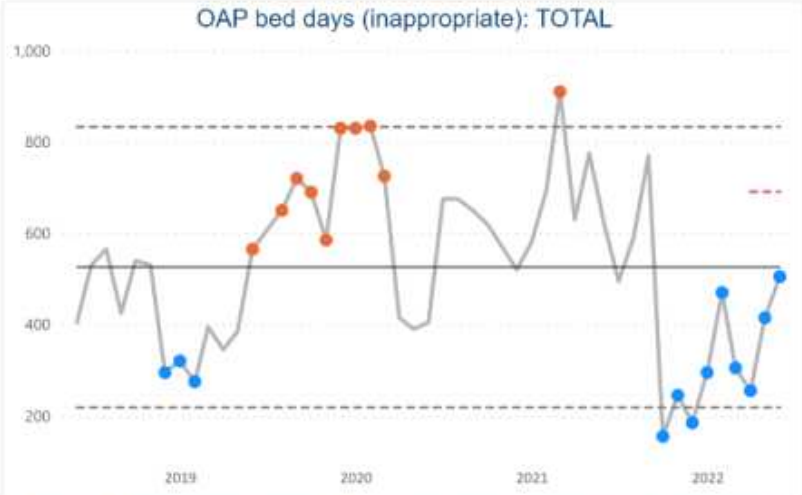
NHS
North East & North Cumbria

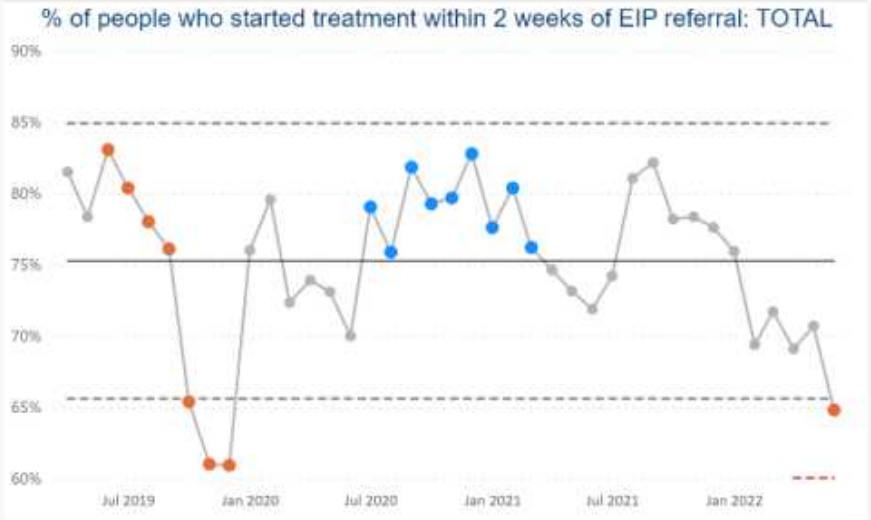
Metric	Latest date	Value	National	Target	Variation	Assurance
Total number of inappropriate Out of Area bed days	Jun-22	505		691		
EIP % of people who started treatment within 2 weeks of referral - All ages	Jun-22	64.8%		60.1%		
Number of people on GP SMI register receiving full physical health check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

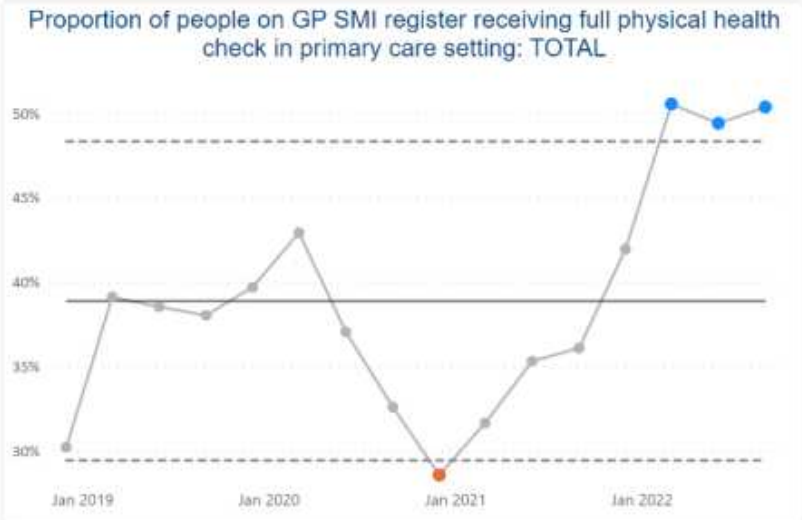
Please note, MHSDS data has not been updated due to changes within the NHSE Publication

Target









Performance

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

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

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

Risks and Mitigations

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

Children and Young People Mental Health

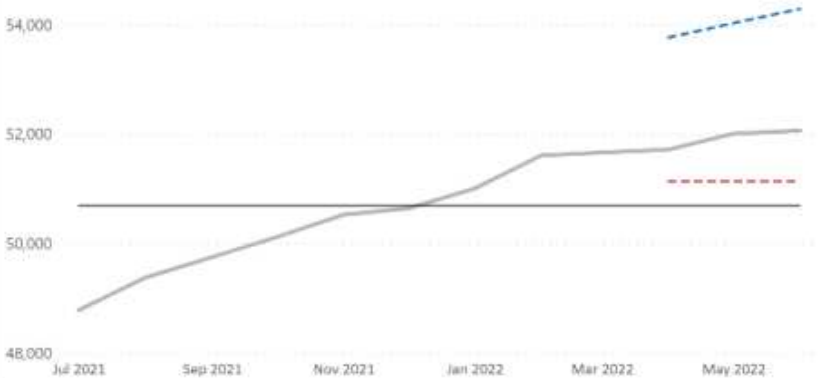
NHS
North East & North Cumbria

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

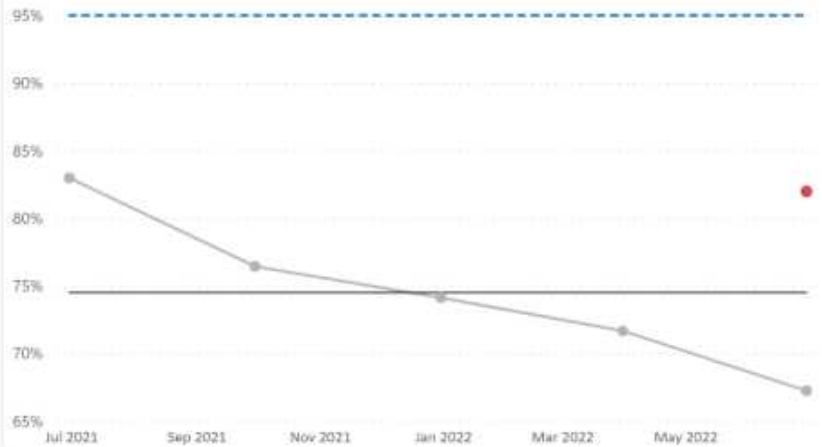
Please note, MHSDS data has not been updated due to changes within the NHSE Publication

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

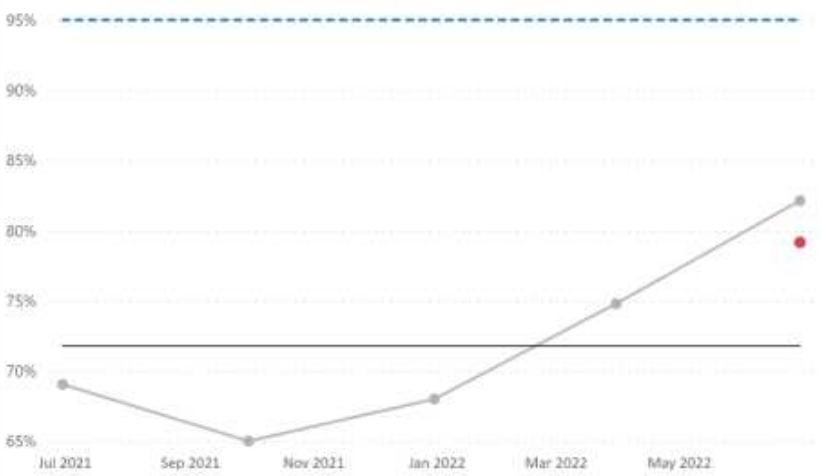
No of CYP accessing support by NHS funded community services (at least one contact) (rolling 12 months): TOTAL



% CYP with EDs (routine cases) seen within 4 weeks: TOTAL



% CYP with EDs (urgent cases) seen within 1 week: TOTAL



Performance

CYP Access

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

Children and Young People Eating Disorders

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

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

Risks and Mitigations

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

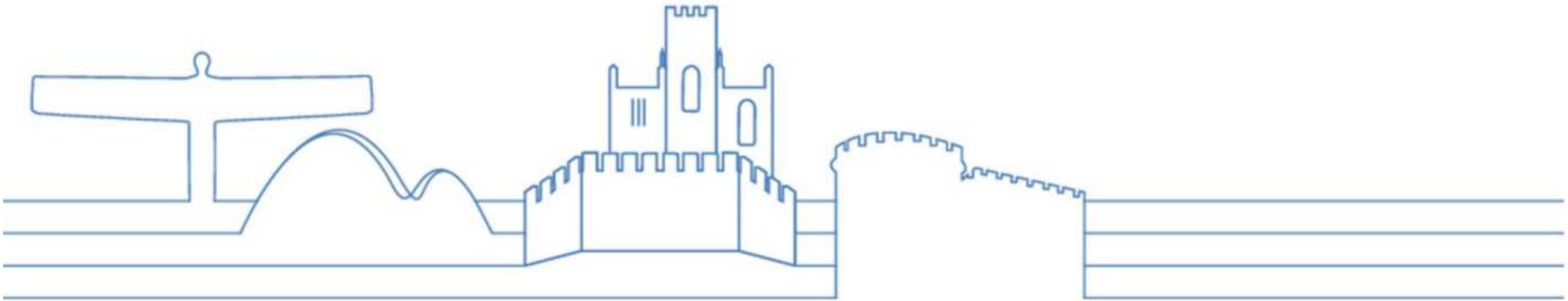
Learning Disability and Autism LTP Deliverables RAG Rating

NHS
North East & North Cumbria

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

NHS
North East &
North Cumbria

Finance



Executive Summary

NHS North East & North Cumbria

	M06 - September 2022		YTD	Forecast
Income & Expenditure	**Overall ICS 2022/23 Financial Position - (Surplus) / Deficit** For the financial year 2022/23 the ICS, including the Q1 position of the NENC CCGs, is on track to deliver the planned breakeven position reporting a small surplus of £0.04m at Month 6	Plan Actual	£10.62 m £19.08 m	£0.00 m (£0.04) m
	Overall ICB 2022/23 Financial Position - (Surplus) / Deficit The ICB is reporting a year to date variance of £0.16m and an outturn variance of £5.79m, prior to expected retrospective funding adjustments of £11.46m - Deficit / (Surplus)	Plan Actual	£0.01 m £0.16 m	(£2.63) m £5.79 m
	Expected ICB 2022/23 Financial Position after retrospective funding - (Surplus) / Deficit The ICB is reporting an outturn variance of £5.68m, after expected retrospective funding adjustments of £11.46m, an improved position of £3.05m against the planned surplus of £2.63m - Deficit / (Surplus)	Plan Actual	£0.01 m £0.16 m	(£2.63) m (£5.68) m
	July 2022 - March 2023 Programme Spend The ICB is reporting a year to date overspend of £0.9m and a forecast outturn overspend of £9.5m compared with the submitted financial plan and prior to expected retrospective funding of £11.46m	Plan Actual	£1,654.54 m £1,655.46 m	£4,981.97 m £4,991.46 m
	July 2022 - March 2023 Running cost The ICB is reporting a year to date and forecast outturn underspend of £0.77m and £1.07m respectively, compared with the submitted financial plan	Plan Actual	£14.35 m £13.58 m	£44.76 m £43.69 m
	Overall 2022/23 QIPP/Efficiency ICB is reporting year to date QIPP savings of £23.771m and forecast savings of £48.433m in line with the submitted QIPP/Efficiency plan	Plan Actual	£23.77 m £23.77 m	£48.43 m £48.43 m
	Overall 2022/23 Mental Health Investment Standard (MHIS) The ICB is on track to achieve the MHIS target for 2022/23 (growth in spend of 5.26%)		5.26%	5.26%

ICB Financial Position - Overview

NHS North East & North Cumbria

Month 6 - September 2022	YTD Plan	YTD Actual	YTD Variance	2022/23 Annual Plan	2022/23 Forecast Outturn	2022/23 Forecast Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Revenue Resource Limit	(1,668,880)			(5,029,363)		
Programme						
Acute Services	827,526	833,499	5,973	2,466,789	2,480,376	13,587
Mental Health Services	198,295	201,543	3,247	595,295	603,277	7,982
Community Health Services	156,887	156,336	(551)	472,576	470,179	(2,397)
Continuing Care	99,613	99,785	172	301,026	303,759	2,733
Prescribing	143,717	141,409	(2,307)	427,478	422,893	(4,585)
Primary Care	32,234	27,781	(4,453)	93,081	86,407	(6,674)
Primary Care Co-Commissioning	137,006	136,595	(410)	409,154	420,824	11,670
Other Programme Services	15,332	16,193	861	44,241	43,291	(950)
Other Commissioned Services	6,474	6,264	(210)	19,256	18,936	(320)
Programme Reserves	35,631	36,055	424	148,349	141,521	(6,828)
Contingency	1,828	0	(1,828)	4,725	0	(4,725)
Total ICB Programme Costs	**1,654,543**	**1,655,460**	**917**	**4,981,970**	**4,991,463**	**9,493**
Admin						
Running Costs	14,352	13,580	(772)	44,761	43,685	(1,076)
Total ICB Admin Costs	**14,352**	**13,580**	**(772)**	**44,761**	**43,685**	**(1,076)**
(Surplus) / Deficit	(15)	0	15	2,632	0	(2,632)
Total ICB Financial Position (Surplus)/Deficit	**1,668,880**	**1,669,039**	**159**	**5,029,363**	**5,035,148**	**5,785**
Central Funding expected for ARRS	0	0	0	11,464	0	(11,464)
Total ICB Financial Position after expected retrospective funding (Surplus)/Deficit	**1,668,880**	**1,669,039**	**159**	**5,040,827**	**5,035,148**	**(5,679)**

The ICB is currently reporting a forecast outturn deficit of £5.8m, prior to expected retrospective central funding of £11.46m relating to the Primary Care Additional Roles Reimbursement Scheme (ARRS).

The main factors driving this performance are:

- Acute overspend mainly relating to Independent Sector provider activity where Elective Recovery Fund income has not been assumed
- Mental Health overspend in particular pressures on s117 packages and specialist packages of care
- Continuing Healthcare pressures, in particular backdated high cost packages of care for children
- Prescribing underspend based on latest Prescription Pricing Data, although relatively early in the year
- Primary Care Delegated overspend of £11.67m relating to ARRS, £11.46m of central funding is expected for those costs identified above baseline allocations
- Management of reserves to balance overall ICB position

Whilst the ICB has reported an improved forecast to plan, a number of potential financial risks have been identified, totalling £18m. This includes in particular potential risks around prescribing, continuing healthcare, winter pressures and independent sector acute activity, linked to the elective recovery programme.

ICB Financial Position – 'Place/Area' level

NHS North East & North Cumbria

Month 6 - September 2022	YTD Plan	YTD Actual	YTD Variance	2022/23 Annual Plan	2022/23 Forecast Outturn	2022/23 Forecast Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Financial Position at 'Place/Area' level						
North Cumbria	167,215	175,001	7,786	507,486	518,484	10,998
North Cumbria Area	**167,215**	**175,001**	**7,786**	**507,486**	**518,484**	**10,998**
Newcastle	183,487	181,444	(2,043)	537,322	536,005	(1,316)
Gateshead	148,779	147,739	(1,041)	436,823	436,262	(562)
North Tyneside	103,293	103,004	(288)	308,146	307,260	(886)
Northumberland	155,794	156,916	1,122	467,382	470,417	3,035
North Area	**591,353**	**589,104**	**(2,249)**	**1,749,673**	**1,749,944**	**271**
County Durham	280,564	278,649	(1,915)	850,992	849,070	(1,922)
South Tyneside	83,636	82,694	(941)	250,590	248,746	(1,844)
Sunderland	150,213	149,428	(786)	447,868	446,228	(1,639)
Central Area	**514,413**	**510,771**	**(3,642)**	**1,549,449**	**1,544,044**	**(5,405)**
Tees Valley	346,017	344,985	(1,031)	1,036,565	1,039,410	2,845
Tees Valley (South) Area	**346,017**	**344,985**	**(1,031)**	**1,036,565**	**1,039,410**	**2,845**
System (Surplus)/Deficit	**0**	**0**	**0**	**0**	**0**	**0**
Total ICB Financial Position excl. Allocations	**1,618,998**	**1,619,861**	**864**	**4,843,173**	**4,851,882**	**8,709**

ICS Overall Financial Position

NHS North East & North Cumbria

Month 6 - September 2022	YTD Plan (Surplus) / Deficit	YTD Actual (Surplus) / Deficit	YTD Variance (Surplus) / Deficit	Annual Plan (Surplus) / Deficit	Forecast (Surplus) / Deficit	Forecast Variance (Surplus) / Deficit
	£000s	£000s	£000s	£000s	£000s	£000s
NENC Commissioner (ICB)						
Q1 CCG	22,903	0	(22,903)	22,903	0	(22,903)
Q2-Q4 ICB	(22,888)	159	23,048	(25,536)	5,785	31,321
Total ICB Position	**15**	**159**	**145**	**(2,633)**	**5,785**	**8,418**
Central Funding expected for ARRS costs	0	0	0		(11,464)	(11,464)
Total ICB Position after central funding	**15**	**159**	**145**	**(2,633)**	**(5,679)**	**(3,046)**
NENC Providers	10,603	18,922	8,319	2,633	5,640	3,007
Total Provider Position	**10,603**	**18,922**	**8,319**	**2,633**	**5,640**	**3,007**
Total ICS Financial Position 2022/23	**10,618**	**19,081**	**8,464**	**0**	**(39)**	**(39)**

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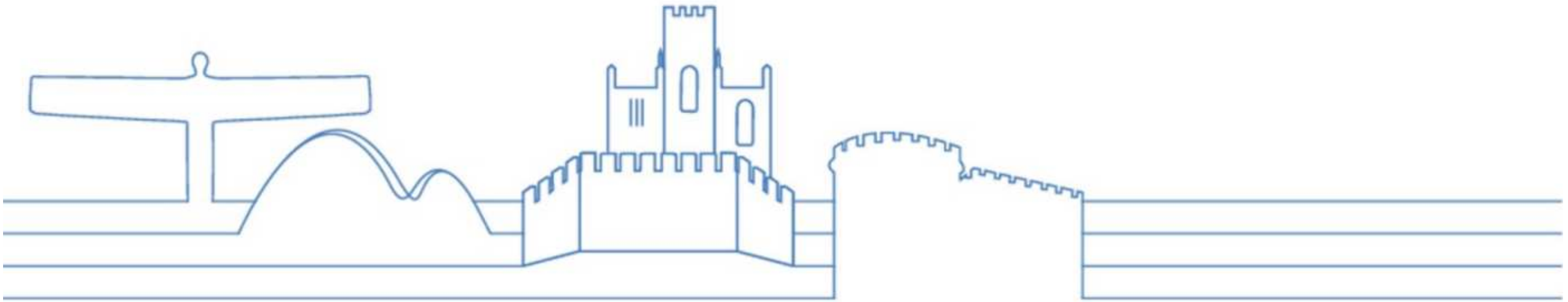
Appendices



Mental Health Core Data Monitoring Summary

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

NHS
North East & North Cumbria

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

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

Constitutional Standards - Provider

NHS
North East & North Cumbria

Cancer Indicators

Indicators	Target	Period	CDDFT	Gateshead FT	NCIC	Northumbria	NTHFT	NuTH	STHFT	STSFT	England
% of patients seen within 2 weeks of an urgent GP referral for suspected cancer	93%	Sep 2022	70.3%	79.8%	73.9%	94.2%	83.4%	56.4%	65.6%	92.9%	72.6%
		YTD	75.9%	86.4%	81%	94.4%	83.5%	74.1%	59.1%	91.7%	72.6%
% of patients treated within 31 days of a cancer diagnosis	96%	Sep 2022	90.8%	100%	76%	97.4%	97.1%	78.4%	91.9%	96.2%	91.1%
		YTD	94.4%	98.6%	88.6%	97.2%	95.5%	82.1%	93.4%	98.3%	91.1%
% of patients treated within 62 days of an urgent GP referral for suspected cancer	85%	Sep 2022	73.1%	72%	56.3%	75.3%	62.7%	44.1%	60.1%	72.7%	60.5%
		YTD	74.8%	59%	47.9%	75.1%	62%	52.3%	61.9%	73.2%	60.5%
% of patients treated within 62 days of an urgent referral from an NHS Cancer Screening Service	90%	Sep 2022	33.3%	92.1%	65%	100%	88.5%	58.8%	50%	100%	67.6%
		YTD	66.7%	90.8%	46.8%	66.7%	85.8%	50.9%	60.9%	86.4%	67.6%
% of patients treated for cancer within 62 days of consultant decision to upgrade status	N/A	Sep 2022	78.1%	100%	50%	69.2%	86.4%	48.6%	59.2%	79.5%	73.8%
		YTD	72.4%	85.7%	76.8%	74.1%	90.5%	53.8%	77.9%	87.5%	73.8%

RTT

Indicators	Target	Period	CDDFT	Gateshead FT	NCIC	Northumbria	NTHFT	NuTH	STHFT	STSFT
% patients waiting for initial treatment on incomplete pathways within 18 weeks	92%	Sep 2022	66.7%	74.3%	59.9%	82.5%	78.4%	69.2%	65.9%	76.8%
		YTD	70.2%	75.2%	62%	84.2%	80.3%	70.1%	65.7%	80.5%
Number patients waiting more than 52 weeks for treatment (Incomplete pathways only)	0	Sep 2022	1666	91	817	11	32	4733	1394	131
Number of unjustified mixed sex accommodation breaches	0	Sep 2022	3	0	17	0	0	77	34	0
		YTD	20	0	82	0	0	155	130	0

Diagnostics

Indicators	Target	Period	CDDFT	Gateshead FT	NCIC	Northumbria	NTHFT	NuTH	STHFT	STSFT	England
% patients waiting < 6 weeks for any the 15 Diagnostic Tests	99%	Jul 2022	91.3%	76.6%	78.9%	94.3%	78.8%	85.9%	68.6%	80.5%	72.1%
		YTD	93.2%	76.4%	74.7%	90.1%	84.8%	84.6%	69.6%	76.5%	71.6%

Dementia

Unavailable at Provider Level

A&E (Excl. North Tees)

Indicators	Target	Period	CDDFT	Gateshead FT	NCIC	Northumbria	NuTH	STHFT	STSFT
% Patients spending 4 Hours or less in A&E	95%	Oct 2022	64.5%	69.3%	63.8%	90.2%	76.7%	65.5%	70.1%
		YTD	69.6%	74.9%	69.5%	91.3%	80%	68.2%	74.2%

Constitutional Standards - Sub-ICB

NHS
North East & North Cumbria

Cancer Indicators

Indicators	Target	Period	Co Durham	N Cumbria	N Tyneside	Newcastle Gateshead	Northumberland	S Tyneside	Sunderland	Tees Valley	England
% of patients seen within 2 weeks of an urgent GP referral for suspected cancer	93%	YTD	81.8%	81.1%	88.6%	81.4%	89.8%	86.4%	87.7%	70.6%	72.6%
% of patients treated within 31 days of a cancer diagnosis	96%	YTD	94%	89%	87.8%	87.7%	86.8%	97%	96.7%	95.2%	91.1%
% of patients receiving subsequent treatment for cancer within 31 days - drugs	98%	YTD	98.8%	93.4%	97.8%	98.1%	98.4%	100%	99.5%	97.5%	98%
% of patients receiving subsequent treatment for cancer within 31 days - surgery	94%	YTD	80.6%	66.7%	77.8%	67.2%	77.5%	71.4%	81.8%	86.5%	80.7%
% of patients receiving subsequent treatment for cancer within 31 days - radiotherapy	94%	YTD	94.8%	98.4%	100%	95.8%	96.5%	97.5%	96.5%	94.6%	87.9%
% of patients treated within 62 days of an urgent GP referral for suspected cancer	85%	YTD	65.5%	48.5%	71.9%	55.9%	67.9%	76.1%	73.2%	63.2%	60.5%
% of patients treated within 62 days of an urgent referral from an NHS Cancer Screening Service	90%	YTD	82.9%	46.7%	57.9%	66.7%	58.1%	100%	92%	77.6%	67.6%
% of patients treated for cancer within 62 days of consultant decision to upgrade status	N/A	YTD	83.3%	76.3%	51.7%	51.2%	60%	88%	88.6%	82.4%	73.8%

RTT

Indicators	Target	Period	Co Durham	N Cumbria	N Tyneside	Newcastle Gateshead	Northumberland	S Tyneside	Sunderland	Tees Valley
Number patients waiting more than 52 weeks for treatment (Incomplete pathways only)	0	Sep 2022	1582	972	782	2497	907		291	1307
Number of unjustified mixed sex accommodation breaches	0	Sep 2022	14	25		36	11	6	10	28
		YTD	54	102	7	66	24	10	15	95

Diagnostics

Indicators	Target	Period	Co Durham	N Cumbria	N Tyneside	Newcastle Gateshead	Northumberland	S Tyneside	Sunderland	Tees Valley	England
% patients waiting < 6 weeks for any the 15 Diagnostic Tests	99%	Jul 2022	85.7%	79.1%	90.9%	82.3%	90.3%	88.8%	75.5%	75.6%	72.1%
		YTD	88.3%	75.1%	86.8%	82.3%	86.9%	83.8%	73.9%	77.5%	71.6%

Dementia

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

A&E

Unavailable at Sub-ICB Level

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NHS
North East and North Cumbria

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

NORTH EAST AND NORTH CUMBRIA ICB BOARD MEETING 29 November 2022	
Report Title:	**ICB Finance Report**

Purpose of report

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

Key points

The full financial report for the period was reviewed in detail by the Finance, Performance and Investment Committee at its meeting on 3rd November 2022. The report presented here provides a high level summary of the position.

ICB Revenue Position:

This year following the transition from Clinical Commissioning Groups (CCGs) to the ICB, the financial position shown here is effectively the month 3 position for the ICB as the ICB commenced on July 1st 2022.

As at 30th September 2022 the ICB is reporting a forecast deficit of £5.8m, prior to expected receipt of additional funding from NHS England of £11.46m to cover costs associated with the Primary Care Additional Roles Reimbursement Scheme (ARRS).

Once this funding is received, the ICB will report a forecast surplus of £5.6m against a planning surplus of £2.6m. The additional £3m surplus will offset a forecast deficit across relevant NHS providers, allowing a balanced financial position to be maintained across the ICS.

Financial pressures are being reported on acute services commissioning budgets, this relates to independent sector activity linked to elective recovery, as well as on continuing healthcare and section 117 packages of care. These are currently being offset through underspends on prescribing budgets and use of programme reserves.

The forecast overspend on primary care delegated budgets largely relates to the additional costs associated with the ARRS. As part of national funding arrangements in this area only a portion of this funding is included within ICB baseline budgets, with the remainder to be drawn down

from NHS England only once baseline budgets are exceeded. Total additional funding of £11.46m is expected based on current forecast ARRS costs.

ICS Revenue Position:

The ICS position is the combined total of the ICB and NENC NHS Foundation Trust (FT) Providers position. The forecast out-turn for the ICS as whole is a surplus against plan of £39k, as shown in Table 2. Since the last report one of the FT providers has reported a deterioration in forecast out-turn of £5.6m (from surplus to break-even). This forecast deficit against plan has been offset by a combination of additional surplus in the ICB as reported above of £3m and another local FT provider improving its forecast out-turn position by £2.6m.

ICB Running Costs:

A forecast underspend is expected on ICB running costs, largely due to the impact of vacancies in the current year. There remains a potential risk of overspend on a recurrent basis if all vacancies were filled and pay-awards continue to be unfunded in this area.

ICS Capital Position:

There is a potential forecast pressure of almost £26m on capital spending plans across the ICS in comparison to the confirmed ICS Capital Departmental Expenditure Limit (CDEL) allocation. Work continues to review relevant capital plans with individual provider trusts to reduce spending in this area and discussions continue with NHS England in respect of the capital funding allocation for the year. The expectation is that the forecast overspend will reduce over the coming months.

2023/24 Planning:

Work is underway across the ICS to understand underlying expenditure run rates across both the ICB and NHS Provider Foundation Trusts. The 2022/23 financial position across the ICS includes significant non-recurring benefits, both in respect of balance sheet movements and non-recurring delivery of efficiency programmes for example which will present a financial challenge in 2023/24. Further clarity is awaited from NHS England regarding funding allocations and requirements for 2023/24, however initial estimates indicate a significant recurring underlying financial deficit across the ICS.

Work continues in this area with system partners supported by NHSE and updates as further information becomes available will be reported to the Finance, Performance and Investment Committee.

Risks and issues

Whilst the ICB has reported a forecast in line with plan, a number of potential financial risks have been identified, totaling £18m for the ICB.

This includes risks in relation to both prescribing and continuing healthcare (CHC) expenditure as well as further growth in independent sector activity for Elective Services Recovery Funding not leading to additional ICB income due to ICS level performance being below target.

Mitigations have been identified to manage the majority of potential ICB risks, leaving an unmitigated potential risk of £4m linked to elective recovery fund activity. The unmitigated risk amounts to less than 0.1% of total ICB funding and will continue to be reviewed and managed as far as possible.

In addition to ICB specific financial risks there are a number of potential risks to the wider ICS financial position within Foundation Trusts. Unmitigated financial risk was assessed at £35m at

month 6. This includes potential financial pressures associated with pay award funding alongside risks relating to general cost pressures and delivery of cost savings in a number of providers.

Work is continuing across the system to conduct a deeper dive exercise to review potential pressures, risks and identify appropriate mitigations where possible but the Board should note there are significant unmitigated financial risks currently estimated at £39m that ICS partners are actively seeking to mitigate.

In respect of the national pay award offer risk, a funding allocation of £86.6m has been received to fund the additional costs of the Agenda for Change pay award offer for organisations in the ICS, based on a national average pay impact of 1.66%. Each provider trust has calculated the impact for their organisation based on their skill mix of staff which has identified a potential net shortfall in funding to support the full pay award of up to £20m. In the main, this is due to the NENC providers having a higher proportion of staff on lower pay bands than the national average. Discussions are ongoing within the ICS and with regional and national NHSE teams, who have recognised the issue, to seek a solution to close the funding gap for 2022/23 and recurrently. At present this represents a risk to be managed to ensure the delivery of a balanced financial position for the ICS.

Please see Table 4 for more information.

Assurances

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

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

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

Recommendation/Action Required

The Board is asked to:

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

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

Link to ICB corporate aims (please tick all that apply)

CA1: Improve outcomes in population health and healthcare	
CA2: tackle inequalities in outcomes, experience, and access	
CA3: Enhance productivity and value for money	✓
CA4: Help the NHS support broader social and economic development	

Relevant legal/statutory issues

Health and Care Act 2022

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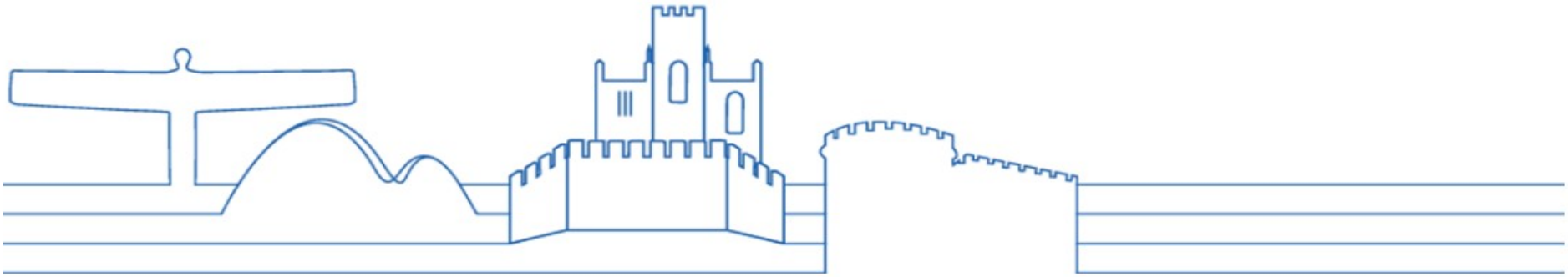
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment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

Key implications	
Are additional resources required?	n/a
Has there been/does there need to be appropriate clinical involvement?	n/a
Has there been/does there need to be any patient and public involvement?	n/a
Has there been/does there need to be partner and/or other stakeholder engagement?	Yes, engagement within the ICB and the wider ICS.

NHS
North East and North Cumbria

NENC ICB

Finance Report for the period ending 30th September 2022



Executive Summary

	M06 - September 2022		YTD	Forecast
Income & Expenditure	**Overall ICS 2022/23 Financial Position - (Surplus) / Deficit** For the financial year 2022/23 the ICS, including the Q1 position of the NENC CCGs, is on track to deliver the planned breakeven position reporting a small surplus of £0.04m at Month 6	Plan Actual	£10.62 m £19.08 m	£0.00 m (£0.04) m
	Overall ICB 2022/23 Financial Position - (Surplus) / Deficit The ICB is reporting a year to date variance of £0.16m and an outturn variance of £5.79m, prior to expected retrospective funding adjustments of £11.46m - Deficit / (Surplus)	Plan Actual	£0.01 m £0.16 m	(£2.63) m £5.79 m
	Expected ICB 2022/23 Financial Position after retrospective funding - (Surplus) / Deficit The ICB is reporting an outturn variance of £5.68m, after expected retrospective funding adjustments of £11.46m, an improved position of £3.05m against the planned surplus of £2.63m - Deficit / (Surplus)	Plan Actual	£0.01 m £0.16 m	(£2.63) m (£5.68) m
	July 2022 - March 2023 Programme Spend The ICB is reporting a year to date overspend of £0.9m and a forecast outturn overspend of £9.5m compared with the submitted financial plan and prior to expected retrospective funding of £11.46m	Plan Actual	£1,654.54 m £1,655.46 m	£4,981.97 m £4,991.46 m
	July 2022 - March 2023 Running cost The ICB is reporting a year to date and forecast outturn underspend of £0.77m and £1.07m respectively, compared with the submitted financial plan	Plan Actual	£14.35 m £13.58 m	£44.76 m £43.69 m
	Overall 2022/23 QIPP/Efficiency ICB is reporting year to date QIPP savings of £23.771m and forecast savings of £48.433m in line with the submitted QIPP/Efficiency plan	Plan Actual	£23.77 m £23.77 m	£48.43 m £48.43 m
	Overall 2022/23 Mental Health Investment Standard (MHIS) The ICB is on track to achieve the MHIS target for 2022/23 (growth in spend of 5.26%)		5.26%	5.26%
Statement of Financial Position	**Cash** The ICB cash balance for September is 0.99% and within the target set by NHS England of <1.25% of the monthly cash drawdown.		0.99%	<1.25%
	BPPC The BBPC target is for 95% of NHS and Non NHS invoices to be paid within 30 days		by volume	by value
		NHS Non NHS	99.76% 99.24%	100.00% 99.09%

Overview of the Financial Position

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

The ICB is currently reporting a forecast outturn deficit of £5.8m, prior to expected retrospective central funding of £11.46m relating to the Primary Care Additional Roles Reimbursement Scheme (ARRS). Once this funding is received, the ICB will report a forecast surplus of £5.6m against a planned surplus of £2.6m. The additional £3.0m surplus will offset a forecast deficit across relevant NHS providers, resulting in a balanced financial position across the ICS.

The main factors driving this performance are:

- Acute overspend mainly relating to Independent Sector provider activity where Elective Recovery Fund income has not been assumed
- Mental Health overspend in particular pressures on s117 packages and specialist packages of care
- Continuing Healthcare pressures, in particular backdated high cost packages of care for children
- Prescribing underspend based on latest Prescription Pricing Data, although relatively early in the year
- Primary Care Delegated overspend of £11.67m relating to ARRS, £11.46m of central funding is expected for those costs identified above baseline allocations
- Management of reserves to balance overall ICB position

The financial plan of the ICB required an overall efficiency target of £48.4m and the ICB is on track to deliver this.

The ICB is on track to deliver the Mental Health Investment Standard.

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

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

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

Whilst the ICB has reported an improved forecast to plan, a number of potential financial risks have been identified, totalling £18m. This includes in particular potential risks around prescribing, continuing healthcare, winter pressures and independent sector acute activity, linked to the elective recovery programme.

Mitigations have been identified to manage the majority of potential risks, leaving an unmitigated potential risk of £4m linked to elective recovery fund activity. Additional elective recovery funding to cover these costs is subject to overall system performance which presents a significant risk. In addition, a number of potential risks to the wider ICS financial position have been identified for NHS provider trusts, with unmitigated financial risk assessed at £35m. This includes potential pressures associated with the impact of the pay award. Work is continuing across the system to review potential pressures and identify appropriate mitigations where possible.

Table 1: ICB Financial Position

Month 6 - September 2022	YTD Plan	YTD Actual	YTD Variance	2022/23 Annual Plan	2022/23 Forecast Outturn	2022/23 Forecast Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Revenue Resource Limit	(1,668,880)			(5,029,363)		
Programme						
Acute Services	827,526	833,499	5,973	2,466,789	2,480,376	13,587
Mental Health Services	198,295	201,543	3,247	595,295	603,277	7,982
Community Health Services	156,887	156,336	(551)	472,576	470,179	(2,397)
Continuing Care	99,613	99,785	172	301,026	303,759	2,733
Prescribing	143,717	141,409	(2,307)	427,478	422,893	(4,585)
Primary Care	32,234	27,781	(4,453)	93,081	86,407	(6,674)
Primary Care Co-Commissioning	137,006	136,595	(410)	409,154	420,824	11,670
Other Programme Services	15,332	16,193	861	44,241	43,291	(950)
Other Commissioned Services	6,474	6,264	(210)	19,256	18,936	(320)
Programme Reserves	35,631	36,055	424	148,349	141,521	(6,828)
Contingency	1,828	0	(1,828)	4,725	0	(4,725)
Total ICB Programme Costs	**1,654,543**	**1,655,460**	**917**	**4,981,970**	**4,991,463**	**9,493**
Admin						
Running Costs	14,352	13,580	(772)	44,761	43,685	(1,076)
Total ICB Admin Costs	**14,352**	**13,580**	**(772)**	**44,761**	**43,685**	**(1,076)**
(Surplus) / Deficit	(15)	0	15	2,632	0	(2,632)
Total ICB Financial Position	**1,668,880**	**1,669,039**	**159**	**5,029,363**	**5,035,148**	**5,785**
Central Funding expected for ARRS costs	0	0	0	11,464	0	(11,464)
Total ICB Financial Position after expected retrospective funding	**1,668,880**	**1,669,039**	**159**	**5,040,827**	**5,035,148**	**(5,679)**

Table 1.1: ICB Financial Position

Month 6 - September 2022	YTD Plan	YTD Actual	YTD Variance	2022/23 Annual Plan	2022/23 Forecast Outturn	2022/23 Forecast Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Financial Position at 'Place/Area' level						
North Cumbria	167,215	175,001	7,786	507,486	518,484	10,998
North Cumbria Area	**167,215**	**175,001**	**7,786**	**507,486**	**518,484**	**10,998**
Newcastle	183,487	181,444	(2,043)	537,322	536,005	(1,316)
Gateshead	148,779	147,739	(1,041)	436,823	436,262	(562)
North Tyneside	103,293	103,004	(288)	308,146	307,260	(886)
Northumberland	155,794	156,916	1,122	467,382	470,417	3,035
North Area	**591,353**	**589,104**	**(2,249)**	**1,749,673**	**1,749,944**	**271**
County Durham	280,564	278,649	(1,915)	850,992	849,070	(1,922)
South Tyneside	83,636	82,694	(941)	250,590	248,746	(1,844)
Sunderland	150,213	149,428	(786)	447,868	446,228	(1,639)
Central Area	**514,413**	**510,771**	**(3,642)**	**1,549,449**	**1,544,044**	**(5,405)**
Tees Valley	346,017	344,985	(1,031)	1,036,565	1,039,410	2,845
Tees Valley (South) Area	**346,017**	**344,985**	**(1,031)**	**1,036,565**	**1,039,410**	**2,845**
System	**49,882**	**49,178**	**(704)**	**186,190**	**183,266**	**(2,924)**
Total ICB Financial Position excl. Allocations	**1,668,880**	**1,669,039**	**159**	**5,029,363**	**5,035,148**	**5,785**

Table 2: Overall ICS (Surplus) / Deficit

Month 6 - September 2022	YTD Plan (Surplus) / Deficit	YTD Actual (Surplus) / Deficit	YTD Variance (Surplus) / Deficit	Annual Plan (Surplus) / Deficit	Forecast (Surplus) / Deficit	Forecast Variance (Surplus) / Deficit
	£000s	£000s	£000s	£000s	£000s	£000s
NENC Commissioner (ICB)						
Q1 CCG	22,903	0	(22,903)	22,903	0	(22,903)
Q2-Q4 ICB	(22,888)	159	23,048	(25,536)	5,785	31,321
Total ICB Position	**15**	**159**	**145**	**(2,633)**	**5,785**	**8,418**
Central Funding expected for ARRS costs	0	0	0		(11,464)	(11,464)
Total ICB Position after central funding	**15**	**159**	**145**	**(2,633)**	**(5,679)**	**(3,046)**
NENC Providers	10,603	18,922	8,319	2,633	5,640	3,007
Total Provider Position	**10,603**	**18,922**	**8,319**	**2,633**	**5,640**	**3,007**
Total ICS Financial Position 2022/23	**10,618**	**19,081**	**8,464**	**0**	**(39)**	**(39)**

Table 3: ICB Efficiencies

Month 6 - September 2022	YTD Plan	YTD Actual	YTD Variance	2022/23 Annual Plan	2022/23 Forecast Outturn	2022/23 Forecast Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Acute	882	850	(32)	2,650	2,620	(30)
Community Healthcare	4,070	4,070	0	8,144	8,144	0
Primary Care (inc. Primary Co-Commissioning)	8,300	8,300	0	16,592	16,592	0
Continuing Healthcare	10,113	10,175	62	20,229	20,291	62
Other Programme Services	406	376	(30)	818	786	(32)
Total ICB Efficiencies	**23,771**	**23,771**	**0**	**48,433**	**48,433**	**0**
Of Which:						
Recurrent	8,647	8,647	0	17,280	17,280	0
Non Recurrent	15,124	15,124	0	31,153	31,153	0
Total ICB Efficiencies	**23,771**	**23,771**	**32**	**48,433**	**48,433**	**0**

Efficiency Schemes	YTD Plan	YTD Actual	YTD Variance	2022/23 Annual Plan	2022/23 Forecast Outturn	2022/23 Forecast Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Demand Management (referrals)	248	216	(32)	500	470	(30)
Evidence based interventions	882	882	0	2,650	2,650	0
Pathway transformation	2,670	2,670	0	5,346	5,346	0
Continuing Healthcare - cost per case review	10,113	10,175	62	20,225	20,287	62
Primary Care Prescribing	6,744	6,744	0	13,480	13,480	0
Tranforming community-based primary care	1,398	1,398	0	2,796	2,796	0
Non-NHS Procurement	734	704	(30)	1,462	1,430	(32)
Estates / NHS property rationalisation	228	228	0	456	456	0
Other	754	754	0	1,518	1,518	0
Total ICB Efficiencies	**23,771**	**23,771**	**0**	**48,433**	**48,433**	**0**

ICB Efficiencies key points

The tables above shows the efficiency targets set out in the ICB plan by ISFE category and programme area. At Month 6 the ICB is forecasting that it will achieve the overall planned position and the efficiencies embedded within it.

Table 4: ICS Risks and Mitigations

Risks	Potential impact before mitigations	Mitigating actions	Potential impact after mitigations
	£000s		£000s
ICB Risks			
Continuing Healthcare - risk around activity increases and fee rates	(4,878)	NR measures / stretch efficiency	0
Prescribing	(5,087)	NR measures / stretch efficiency	0
Potential additional IS activity pressures (Elective Recovery Fund gap)	(4,000)	Anticipated ERF income	(4,000)
Winter pressures including Covid Medicines Delivery Unit (CMDU) Surge and PC Extended Access	(1,962)	NR measures / stretch efficiency	0
Other (including backdated FNC, dom care rates & s117s)	(2,010)	NR measures / stretch efficiency	0
System Risks			
Pay award risk	(20,000)	System actively working collaboratively to develop plans to mitigate this risk	(15,000)
ERF and other pay/non-pay provider risks	(57,000)	System actively working collaboratively to develop plans to mitigate this risk	(20,000)
Total ICS Risks	**(94,937)**		**(39,000)**

Item: 7.5

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

NORTH EAST AND NORTH CUMBRIA ICB BOARD MEETING 29 November 2022	
Report Title:	**ICB Oversight Framework**

Purpose of report

To present the ICB Approved Oversight Framework to the Board for information and assurance.

Key points

This framework has been developed by a task and finish group, chaired by the Executive Director of Strategy and System Oversight and including members from across the ICB representing Place, Quality, Workforce and Finance and partners the Regional Team and representing providers.

The framework was presented to the October ICB Executive Committee for consideration and as agreed at that meeting has since been socialised by Executive Directors with provider Chief Executives and Chief Operating Officers and had further refinement in discussion with the Executive Directors of Place, Finance and Chief Nurse. It was then approved by the November ICB Executive Committee.

The responsibility for maintaining effective oversight arrangements sits with the Executive Committee. Once the Oversight Framework is approved it will be reviewed after one year and thereafter every three years.

Risks and issues

- The new oversight arrangements are more comprehensive and far reaching than those currently in place and may take some time to bed in/be accepted by all partners within the system
- Extensive business intelligence infrastructure and administrative support is needed to maintain the arrangement; it has been assumed this resource can be made available from within existing ICB resources including within North East Commissioning Support.

Assurances

- Responsibility for delivery of the oversight arrangements sits with the Executive Director of Strategy and System Oversight.

Item: 7.5

Recommendation/Action Required	
The Board is asked to: • Note the oversight arrangements set out within the Oversight Framework.	
Sponsor/approving director	Jacqueline Myers, Executive Director of Strategy and System Oversight
Report author	Jacqueline Myers, Executive Director of Strategy and System Oversight Lisa How, NECS Programme Director

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

Relevant legal/statutory issues						
Note any relevant Acts, regulations, national guidelines etc						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓

Key implications	
Are additional resources required?	No additional financial or additional capacity is required at this stage.
Has there been/does there need to be appropriate clinical involvement?	Yes, within the specific areas of work included in the plan.
Has there been/does there need to be any patient and public involvement?	Yes, within specific areas of work included in the plan.
Has there been/does there need to be partner and/or other stakeholder engagement?	In some specific areas of work.

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North Cumbria

Integrated Care Board Oversight Framework 2022/23

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Appendices

1 Purpose

The purpose of this Framework is to provide a comprehensive set of arrangements for effective oversight of the NHS services within NHS North East and North Cumbria (NENC).

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

2 Background

From 1 July 2022 ICBs have the general statutory function of arranging health services for their population and will be responsible for the performance and oversight of NHS services within their integrated care systems (ICSs).

This framework is informed by the NHS Oversight Framework[1], which was published in July 2022 and the agreement of a related Memorandum of Understanding (MOU)[2] between NHS England (NHSE) North East and Yorkshire (NEY) Regional Team and the NENC ICB, which was made in September 2022.

The NHS Oversight Framework sets out its purpose as follows:

- Ensure the alignment of priorities across the NHS and with wider system partners
- Identify where ICBs and/or NHS providers may benefit from, or require support
- Provide an objective basis for decisions about when and how NHS England will intervene.

The overarching **approach** to oversight is characterised by the following key principles:

- Working **with and through ICBs**, wherever possible, to tackle problems
- A greater emphasis on **system performance and quality of care outcomes**, alongside the contributions of individual healthcare providers and commissioners to system goals
- Matching **accountability for results** with improvement support, as appropriate
- **Autonomy** for ICBs and NHS providers as a default position
- **Compassionate leadership behaviours** that underpin all oversight interactions.

The MOU between NHSE NEY and the ICB outlines its purpose as setting out:

- The principles that underpin how the ICB and NHSE will work together to discharge their duties to ensure that people across the system have access to high-quality, equitable health, and care services
- The delivery and governance arrangements across the ICB and its partner organisations
- How NHSE, ICBs and NHS partner (foundation) trusts will work together to implement the requirements set out in the NHS Oversight Framework taking into consideration local delivery and governance arrangements, risks, and support needs

- How the ICB and NHSE will work together to address development-specific needs in the ICS and across the region.

3 Scope of this framework

This is a comprehensive framework and will include the arrangements for oversight of delivery of all elements of the ICB's statutory duties and strategic and operational priorities, which will incorporate all the measures of success included within the NHS Oversight Framework.

Oversight within the ICB will be examined through the following lens and accompanying processes:

- The overall ICB
- Provider trusts
- Places
- Primary Care providers
- Programmes and Clinical Networks

4 Approach and ways of working

4.1 The ICB values and behaviours

The ICB staff body has developed a set of values and behaviours and is using these to shape its approach to all areas of ICB endeavour. These are set out below in figure 1.

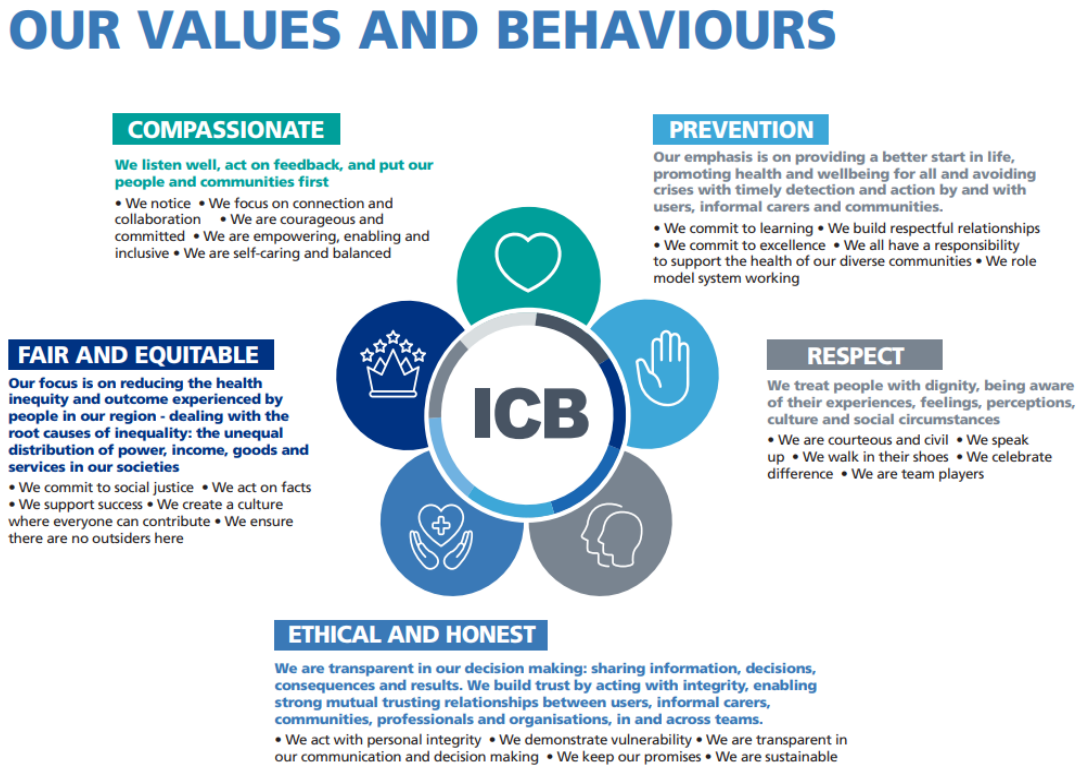

Fig 1: NHS NENC Values and Behaviours

4.2 The NENC Learning System and Community

The ICB has launched its Learning System and Community and is committed to threading a learning and continuous improvement approach through all its business processes including its Oversight Framework.

During 2022/23 as these arrangements are maturing, the ICB will work closely with local, system, regional and national partners to ensure the identification of opportunities to learn and improve are considered at every juncture. Within the Oversight Framework, this will specifically mean that the opportunity to draw in learning and support will always be built into each interaction.

The ICB Performance and Improvement Team will develop and maintain a support resource library and ensure appropriate offers of support are played into action and recovery plans.

4.3 Specific principles for the oversight arrangements

The ICB has developed a set of principles which will inform the way we work in the oversight arrangements. We have used these principles to shape this framework and we will also deploy them when we seek feedback from participants on the efficacy of the oversight arrangements. This will take place informally on a regular basis and formally via a questionnaire on an annual basis.

Transparency	Clarity of expectations and basis of any decision-making or action Early and regularly shared intelligence (soft and hard)
Respect	Recognition of achievement, reduction of oversight linked to improved performance Reasonable timeframes for actions and impact, an expectation of delivery and exception reporting on all parties
Coordination	One linked set of conversations, between the providers (or places etc), the ICB and Region Clear governance (flow of assurance, and links between quality, finance, and SOF meetings) Curation of support offers and inputs
Parity of priorities	Agreement via the Integrated Care Strategy and Place Plans of local priorities
Focus	Direction of ICB attention and support to where it is needed most Balance between upstream/prevention and current provision focus (80:20)
Learning	Supporting the build of a learning system and improvement culture: identifying and sharing good practice, and using improvement methods in support offers
Partnership	Prioritisation of action by partners to support partners to tackle wicked or systemic issues

Table 1: Oversight Framework Principles

4.4 Oversight as part of the ICB cycle of business

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) is developing its Integrated Care Strategy, in line with national guidance. This will be completed by the end of December 2022. During quarter 4 of 2022/23, the ICB will develop a 5-year forward plan.

Whilst the development of these key documents is awaited, the ICB will operate 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.

Figure 2 sets out the ICB's Cycle of Business.

In practice, this will mean that in setting the agenda for oversight meetings, the ICB will ensure that all the relevant topics are covered.

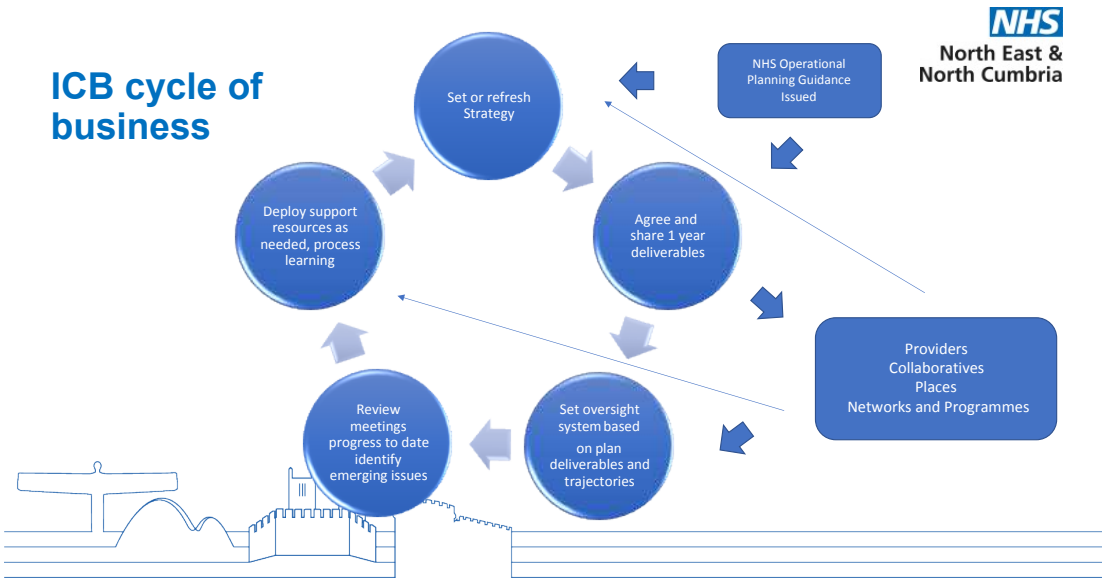

Fig 2: The ICB Cycle of Business

5 Roles and responsibilities

5.1 The role of the NHS England Regional Team

NHS England will:

- Work with ICBs to ensure that oversight arrangements at ICB, place and organisation level incorporate regular review meetings informed by a shared set of information
- Draw on regional, national and other expertise as necessary
- Establish focused engagement with the ICB and the relevant organisations where specific issues emerge
- Retain statutory accountability for oversight of both ICBs and NHS providers but in general discharge duties in collaboration with ICBs
- In exceptional circumstances, intervene directly with providers with full awareness of the ICB
- Lead the SOF segmentation of providers in accordance with the NHS Oversight Framework.

5.1 The role of the Integrated Care Board Team

NHS NENC will:

- Ensure delegations to place-based partnerships are discharged effectively
- Lead the oversight of individual providers within their ICS
- Ensure the oversight arrangements are delivered within a coordinated and intelligent manner, supported by reliable information and effective processes
- Oversee and seek to resolve local issues before escalation
- Share actual or prospective changes in performance with NHS England in a timely manner
- Manage and escalate quality risks in line with the National Quality Board quality risk response and escalation guidance
- Coordinate NHS support interventions within their system where appropriate in line with NHS Oversight Framework, working in partnership with NHS England (see Appendix 1).

6 Governance Arrangements

6.1 The Regional Oversight and Assurance Model

The NHSE NEY Regional Team have set out their oversight and governance model in Figure 3, below. The model shows that the central point of oversight between the Regional Team and ICBs is a quarterly ICS Focus Meeting. It also shows that there are parallel meetings that are quality and performance focussed (and it is understood there is also a regular dialogue between the respective finance teams). These regional-level conversations link into national teams and dialogues and in the case of the quality stream, are supported by the *National Guidance on Quality, Risk Response and Escalation in Integrated Care Systems*[3] published by the National Quality Board in June 2022.

2022- 23 Oversight & Assurance Model– Regional Governance

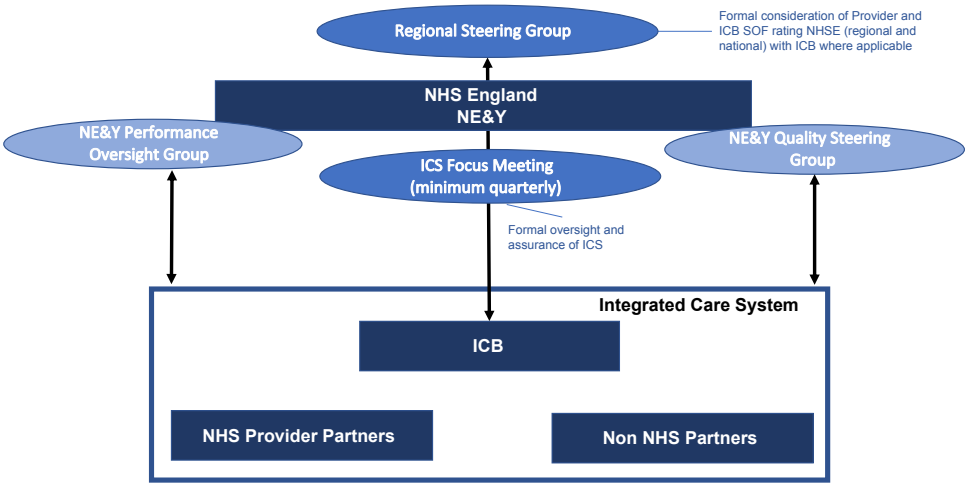

Fig 3: The NHS NEY Regional Oversight and Governance Model

6.2 The ICB Governance Model

The ICB's Scheme of Reservation and Delegation vests agreeing system oversight arrangements in its Executive Committee. The Executive Committee will, on behalf of the ICB Board, agree the ICB Oversight Framework. For 2022/23, the Executive

Committee will also approve the Memorandum of Understanding (MOU) with NHSE NEY in relation to oversight.

The Executive Committee will receive a monthly Integrated Performance Report and this report will include data and narrative on all the metrics within the national System Oversight Framework and summary reports on the key issues and actions identified within ICB oversight meetings. In addition, the ICB Quality and Safety Committee (QSC) will receive monthly reports on the quality indicators and the ICB Finance Performance and Investment Committee (FPIC) will receive monthly reports on the activity and finance indicators.

The Board Committees will consider whether they are sufficiently assured by the reports they receive and shall, by exception, identify additional actions to be undertaken and/or escalate matters to the ICB Board.

Figure 4 provides a schematic of the NHS NENC governance model.

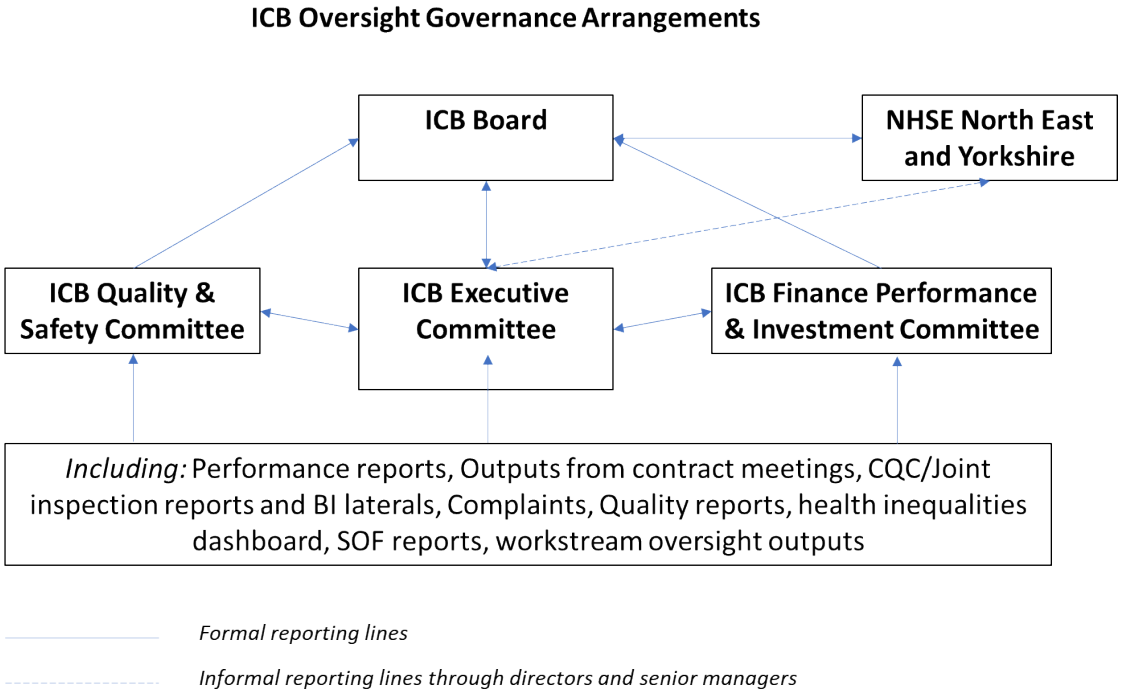

Fig 4: The NHS NENC ICB Governance Model

6.3 ICB Quality Oversight Arrangements

The ICB QSC will, on behalf of the Board, undertake oversight of all matters relating to the quality and safety of the services and the experience of patients and citizens within the ICB.

The QSC will be supported by a System Quality Group, which will maintain oversight of all matters relating to quality and safety and focus on learning and improvement, as well as feeding directly into the Regional Quality Board as set out in the guidance published by NHS England National Quality Board in June 2020: *National Guidance on Quality Risk Response and Escalation in Integrated Care Systems*

The ICB QSG will also have a link (dotted line) though to the Regional Quality Board, and it will share learning themes and brief up issues of concern and the progress of the ICB's response to them.

The QSC will be underpinned by 4 Local Integrated Care Partnership (ICP) footprint Quality Review Meetings (QRM), where the ICB will meet with the local providers and place teams (including local authority partners to undertake quality surveillance, learning and improvement.

Care Quality Commission (CQC) activity (for example a pending inspection, inspection report action plan with outstanding actions or where regulatory action is in train) will form part of the meeting agendas.

The QSC will be kept apprised of any additional actions that are agreed upon in relation to quality concerns in the provider oversight meetings to ensure there are no duplication or cross purposes within the quality focussed and integrated oversight arrangements. The involvement of the Executive Chief Nurse and the Executive Medical Director in both the QSC and FPIC oversight arrangements will further contribute to the coordination and focus of the ICB's overall response.

Where there is escalating concern in regard to a particular issue, the relevant Quality Review Meeting will trigger a Rapid Quality Review Meeting (RQRM) to understand the issues and agree an improvement plan and the deployment of any required support resource. Depending on the outcome of this RQRM, the resulting improvement plan may either be monitored via the relevant QRM and in the case of provider FTs, via the FT's oversight meeting, or for more complex issues, result in a local quality board being established to see the action plan through.

6.3.1 Safeguarding

The ICB will provide oversight of safeguarding via a Strategic Safeguarding Group which will report to the Board QSC. This group will link into the multi-agency Adult and Children's Safeguarding Boards which exist on each Local Authority footprint.

6.4 ICB Financial Oversight Arrangements

The ICB FPIC will, on behalf of the Board, undertake oversight of all matters relating to the finance and performance of the services commissioned by the ICB.

The FPIC will be supported by a Provider Finance Meeting, which will be chaired by the ICB Executive Director of Finance. This meeting will maintain an overview of the financial position and forecast against plans within the provider sector and work through recovery plans as necessary.

The ICB Board has approved financial governance arrangements and a financial framework for 2022/23, including budget delegation and an interim approach, outlined below in tables 2 and 3:

System Level Budgets
Running costs budgets and associated expenditure for the ICB
Nationally negotiated GP contract budgets and associated expenditure *
Acute in-hospital budgets and associated expenditure***
Ambulance service budgets and associated expenditure
Mental health, LD and autism in-hospital budgets and associated expenditure
Any Service Development Funding which is not already identified specifically for place based allocation or determination
Digital budgets and expenditure including but not limited to GPIT contracts
Contingency reserves

Place Level Budgets
All budgets and associated expenditure categorised as continuing healthcare in the financial ledger system (includes CHC, FNC, joint packages, children's CHC, CHC teams)
All budgets and associated expenditure included within the scope of Better Care Fund arrangements with Local Authorities or other integrated agreements in place prior to the establishment of the ICB
Primary care budgets and associated expenditure (with the exception of nationally negotiated GP contract budgets and associated expenditure) *
Prescribing budgets and associated expenditure including local contracts for medicines optimisation activities **
All budgets and associated expenditure for services commissioned and delivered in the community / out of hospital system
Mental health, LD and autism community-based budgets and associated expenditure (including section 117 packages of care)
Local safeguarding team budgets and associated expenditure
Service Development Funding which has already been identified and approved for place based allocation / determination on usage

In addition to note at Place:
*Note where local contracts for GP services have been commissioned from the Primary Care Delegated Allocation these will be delegated to place. NHS England primary care finance staff will continue to liaise with place-based colleagues to ensure all costs are reported appropriately.
**Prescribing budget delegated is under review at an ICB level and may be subject to amendment in the formal delegation exercise once undertaken.
***Acute budgets and expenditure are expected to be held at system level with individual contracts managed by Executive Directors of Place-Based Delivery and relevant teams.

Tables 2&3: ICB 2022/23 scheme of financial delegation.

6.5 ICB Place Oversight Arrangements

Local partnership arrangements are established in each place that bring together the local authority, voluntary and community groups, and NHS commissioners and providers (increasingly including GPs and other primary care providers working together in Primary Care Networks), to take responsibility for the provision and quality of care for local communities. These place-based partnership arrangements will be the locus for the integration of health and social care. Where issues that require a multi-sectoral and local solution arise within sector-based oversight meetings; a link will be made with the relevant place based teams to take the lead on the system response.

During quarter 3 of 2022/23, each of the Places in NENC is developing its arrangements to deliver the ambitions set out in its own Place Plan, within a governance framework set out by the ICB.

Places will set/refresh their annual work programme during the annual planning round, and as part of this clarify measurable deliverables for the year ahead.

Oversight meetings will focus on progress against plan and any emerging risks and issues. They will be chaired by the relevant Executive Director of Place and will take place bi-annually. Within these meetings, the focus, in line with the ICS Values and

the learning approach set out within this framework, on supporting improvement, sharing learning and identifying and deploying support from within and without the Place to optimise the delivery of the Place Plan. A template agenda for Place Oversight Meetings is included in Appendix 2.

Place Directors will be expected to provide a monthly update report against their plan and on any additional actions agreed upon at previous oversight meetings. A template will be provided for this purpose.

7 Performance management support to Oversight Assurance

Each part of the oversight system will centre on regular oversight meetings, of variable frequency, depending on the assessed level of challenge in that part of the system.

The meetings will be supported by a regular flow of data to support and enable "business intelligence", setting out performance against the SOF metrics, including the locally determined priorities. Information packs will be updated monthly and shared with relevant stakeholders. The output of meetings will be captured in an action tracker and in the case of any specific areas of significant concern, a jointly agreed recovery plan. Action trackers and recovery plans will also be updated monthly.

The ICB Executive Committee and the ICB Executive Board will receive performance information through the NENC Integrated Quality, Performance and Finance report, which provides formal monthly system oversight, performance intelligence and data management. This report provides high-level oversight and assurance of local progress at ICS level against the key national planning priorities 2022/23 priorities and operational planning guidance. The report aims to deliver an ICS view of performance whilst being sighted on specific performance, highlighting key risks for escalation and associated mitigations. Full details of the reporting framework are included in Appendix 3.

The report is underpinned by a performance framework linked to the planning priorities which can be applied at place, local ICP and ICS level. Through the System Oversight framework (SOF) NHS Oversight Framework 2022/23 the report also delivers oversight across the key domains within the National Oversight Framework:

1. Quality, access, and outcomes
2. Health Inequalities and Prevention
3. People
4. Leadership
5. Finance
6. Local priorities

The report, which includes an executive summary, provides the NENC ICB Executive Team and Board with detail of oversight domains and associated performance to support performance review and identification of areas requiring further investigation. It encompasses the recommendations of the Francis review so that quality and safety are reviewed alongside performance and finance to ensure a

parallel view of quality performance, finance, and leadership. The report includes information to provide oversight and progress in delivery for:

- System Oversight Framework metrics (SOF)
- Population Health and Health Inequalities
- Finance
- Quality, including exception reporting
- People – workforce and leadership measures
- Patient experience

The quality and performance metrics within the report are largely displayed in Statistical Process Control (SPC) charts which are used to measure changes in data over time. SPC charts help to overcome the limitations of RAG ratings, by using statistics to identify patterns and anomalies, distinguishing between changes worth investigating (extreme values and normal variations). SPC within the report allows special areas of concern to be highlighted and escalated as appropriate and provide further insight into trends and variation and flag issues and risks on the horizon.

The report is held in Power BI, a secure cloud service and business intelligence solution which allows the NENC ICB user access to dashboards, reporting, and data analysis and takes advantage of how individual elements link together. Power BI allows a central platform for the sharing of information and data from a variety of sources in a secure manner to allow optimal information and intelligence for performance management and analysis. Data is input into Power BI and allows the user to note special cause variation which may be flagged on a particular metric. The tool allows for further drill down into the report by way of escalation to a particular place or provider, or a specific modality/specialty.

Feeding all metrics into the Power BI tool enables standardisation in reporting and "one version of the truth", and the tool can then be used to cut the same data sets to produce a standardised report for places. It also facilitates analysis of the same data sets at ICS, provider, and place level. Narrative, including risks, mitigations and action planning is recorded within the report.

8 Oversight arrangements for provider trusts

For provider trusts, the level of challenge will be codified using the System Oversight Framework (SOF) 1-4 ratings. The ICB will work closely with the NHSE NEY Regional Team and providers to ensure clarity and transparency in the application of the SOF categories so that the improvement requirements and support arrangements can be most effectively aligned.

For provider trusts, meeting frequency will be set according to the SOF rating and will be as follows:

- For SOF 1 Trusts - annually
- For SOF 2 Trusts – six monthly
- For SOF 3 Trusts - quarterly*
- For SOF 4 Trusts - monthly*

*In the case of SOF 3 and 4 Trusts the process is currently led by NHS England, and they will determine the frequency of meetings.

Oversight Meetings with SOF 1 and 2 Trusts will be chaired by the ICB CEO. Oversight Meetings for SOF 3 and 4 meetings will have a chair as agreed by NHS England. A full set of expected meeting participants and a template agenda for Provider Oversight Meetings are set out in Appendix 4.

Meetings will be supported by a standard information pack, which will be prepopulated by the ICB with performance data shown against the relevant national standards within the SOF and any related plans agreed via the annual planning round, with space for the Trust to add narrative updates. Any previously agreed action tracker or recovery plans will also be appended. These packs will be made available two weeks in advance of the meeting date and have a deadline for return one week before the meeting date.

All meetings will consider the efficacy of any support package options and agree where these will be deployed. The ICB will ensure these support options are followed up promptly and agree on the scope of the support with the Trust and the relevant support team(s). Normally the support will then be delivered directly to the Trust with the impact being reported back via the monthly updates, however, the ICB will where helpful, attend meetings relating to support offer work, for example where there may be actions for wider system partners.

Where Trusts are in SOF 3 or 4 the ICB will work in partnership with the NHSE NEY Regional and/or National Team and will work to bring clarity to the required improvements to achieve an improved SOF rating.

8.1 The role of finance and contract meetings and their link to the oversight arrangement

A key function of the ICB Oversight Framework is to set out the way in which the ICB will ensure it is making space for focussed attention with providers on quality assurance and improvement and financial management, whilst limiting duplication and ensuring it has a holistic view of the range of issues in play and their interaction.

To support these arrangements, each provider will be mapped to a lead team within the ICB. There will be 4 of these teams which will serve each of the 4 local ICP footprints and work to the Executive Directors of Place.

During the remainder of 2022/23, these teams will review with provider partners, the legacy bilateral meeting arrangements with each provider in relation to contracting, finance, data quality and performance. Following this and once the NHS operational planning guidance for 2023/24 has been issued, decisions will be made as to the ongoing requirement for and frequency of such meeting as part of the oversight arrangements.

8.2 Performance Meetings including Tier 1 and Tier 2 Cancer and Elective Meetings

The allocation of providers to tiers in relation to their elective and cancer backlog positions is a relatively new process initiated by NHS England. Trusts who are placed in Tier 1 will have regular (usually fortnightly) escalation meetings initiated by the NHS NEY Regional Team. For trusts placed in Tier 2 similar meetings will be initiated by the ICB.

Tier 2 meetings will be chaired by the relevant Executive Director of Place.

The ICB will work with colleagues from the Regional Team to ensure these meetings are arranged to include all the relevant parties and that focussed on identifying and deploying high-quality support to aid rapid performance improvement.

Meeting decisions and actions will be captured in an action log and as with the other topic-specific meetings with providers, the ICB will ensure that these are fed into the overarching oversight meetings and that as far as possible, duplication of effort and meetings is avoided.

For 2022/23, the ICB does not propose routine performance meetings with providers other than those within the Tier system. Performance will be a key part of SOF Oversight Meetings. In addition, the ICB will work with providers within the key strategic programmes to drive performance improvement via service improvement and the deployment of programme investment, via the following programmes:

- The Urgent and Emergency Care Programme
- The Cancer Alliance
- The Strategic Elective Board
- The Diagnostic Programme

In addition, by exception, the ICB, working closely NHSE Regional Team, will initiate a Rapid Performance Review Meeting to understand any issues of concern with the relevant provider and agree preventative and or improvement action with a view to heading off formal designation within the national Tiering System.

9 Oversight for primary care

For 2022/23, oversight of primary care remains a joint undertaking with NHS England. Plans are in development for the full delegation of primary care to the ICB with effect from 1 April 2023.

The arrangements for the oversight of the performance of primary care providers against their contracts and of any quality or sustainability issues that arise are in development between the Executive Directors of Place and the Executive Director of Strategy and System Oversight, to determine the respective responsibilities of the corporate and place-based teams.

Any CQC activity in relation to primary care provision will also be fed into the Quality System Board and the Board QSC.

10 Oversight arrangements for strategic programmes and clinical networks

ICS strategic programmes (formerly known as workstreams) and clinical networks are responsible for the delivery of ICS strategic priorities. Strong governance and programme management arrangements are built into each of the NENC programmes and networks. Each programme has a Senior Responsible Owner, either CE, AO, or senior leader, and has a structure that builds in clinical and other stakeholder input, representation from each of the ICPs and each relevant service sector. Some clinical networks function as a delivery arm of the ICS for instance the

Cancer Alliance. Programmes report by exception to the ICS Management Group or Provider Collaborative as appropriate.

The ICB has launched its Learning System and is developing a comprehensive approach to promulgating learning and improvement, including the provision of quality improvement and programme and project management tools and techniques, excellent provision of insight, a community of learning and sharing of best practice.

ICB strategic programmes and clinical networks will set/refresh their annual work programme during the annual planning round, and as part of this elucidate measurable deliverables for the year ahead.

Oversight meetings will focus on progress against plan and any emerging risks and issues. They will be chaired by the Executive Director who is the designated Senior Responsible Officer for the programme and will take place annually. A template agenda for Programme and Clinical Network Oversight Meetings is included in Appendix 6.

Programme Directors will have a regular monthly peer support meeting convened by the ICB which will also provide the conduit through which programmes and networks will be apprised of ICB policy, process, and support resources for programmes.

Programme and Network Directors will be expected to provide a monthly update report against their plan and on any additional actions agreed upon at previous oversight meetings. A template will be provided for this purpose.

Appendix 5 providers a template for the Strategic Programme and Network Oversight Meetings.

11 The role of provider collaboratives and oversight arrangements

The ICB is committed to developing provider collaboration as a powerful delivery mechanism for its strategic goals as well as a forum for mutual support amongst providers pursuant to their own strategic goals. The ICB will agree a memorandum of understanding (MOU) with each of the provider collaborative and within these MOUs, make clear the roles and responsibilities it is delegating to the relevant provider collaborative.

For 2022/23 it is not anticipated that the ICB will be delegating any oversight responsibilities to a provider collaborative.

The FT Provider Collaborative is however, delivering a number of strategic programmes on behalf of the ICB, including the Strategic Elective Programme and the Provider Capital and Estates Programme. During Q3 of 2022/23, a responsibility agreement will be agreed between the ICB and the FT provider collaborative to reflect these arrangements. This will be reviewed in 2023/24 as the range of responsibilities of the FT Provider Collaborative develops.

A similar responsibility agreement will follow for the other provider collaboratives as they mature.

Oversight of the provider collaboratives by the ICB will take place annually and be chaired by the ICB Chief Executive. Meetings will be supported by the responsibility agreement that has been reached and an information pack that covers the strategic programmes of work and other areas of responsibility delegated to the provider collaborative.

Formal oversight will be supported by regular informal contact with the provider collaborative chairs and members to co-produce priority pieces of work.

Version Control: ICB Executive Committee Approved 20221115

Review Date: November 2023

Owner: ICB Executive Director of Strategy and System Oversight

Appendix 1
NHS Oversight Framework 22/23 - Identification of supports needs

Identification of Support Needs

	Segment description		Scale and nature of support needs
	ICB	Trust	
1	Consistently high performing across the six oversight themes Capability and capacity required to deliver on the statutory and wider responsibilities of an ICB are well developed	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place based and overall ICB priorities	No specific support needs identified. Trusts encouraged to offer peer support Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations
2	On a development journey, but demonstrate many of the characteristics of an effective ICB Plans that have the support of system partners are in place to address areas of challenge	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Flexible support delivered through peer support, clinical networks, the NHS England universal support offer (e.g. GIRFT, Right Care, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the six oversight themes Significant gaps in the capability and capacity required to deliver on the statutory and wider responsibilities of an ICB	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts)	Bespoke mandated support, potentially through a regional improvement hub, drawing on system and national expertise as required (see Annex A)
4	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	In actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme (see Annex A)

- To provide an overview across systems, inform oversight and target support, NHSE NE&Y have allocated ICBs & trusts to one of four 'segments' for 2022/23.
- Segmentation decisions are determined by assessing the level of support required based on a combination of objective criteria and judgement.
- For individual trusts, NHS England and relevant ICB will together discuss segmentation and any support required.
- NHS England will be responsible for making the final segmentation decision and taking any necessary formal enforcement action.

Appendix 2
Template Agenda for Place Oversight Meetings

1	Welcome, apologies and introductions Meeting purpose Meeting approach: adherence to the 7 Oversight Framework Principles: ***Transparency*Respect*Co-ordination*Parity of local priorities *Focus*Learning*Partnership**
2	Progress in delivery of the Place-Based Plan • Key progress and achievements • Risks and issues • Preventing ill-health and reducing inequalities • Integration of services at neighbourhood and place
3	Quality and safety concerns
4	Finance and use of resources
5	People, including leadership and capability
6	Other Local strategic priorities / hotspots / issues • Specific provider or sector issues by exception
7	Examples of good practice to share with the wider system
8	Update of the action log
9	Summary and wrap up
10	Next meeting:
	Attendees: Executive Director of Place (Chair) Place Director Place Aligned Finance, Nursing and Medical Director Other members of the Place Based Board as defined by the Place leadership Team Other Exec Directors of the ICB are defined by the agenda

Appendix 3
NHS England System Oversight Framework, metrics for 2022/23

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ght-metrics-for-2022

Appendix 4
Template Agenda for Provider Oversight Meetings

1	Welcome, apologies and introductions Meeting purpose Meeting approach: adherence to the 7 Oversight Framework Principles: ***Transparency*Respect*Co-ordination*Parity of local priorities *Focus*Learning*Partnership**
2	Key strategic issues • E.g.:Large scale service change •
3	Quality of care, access, and outcomes Quality and safety overview in provider including: • High-risk issues (e.g., ambulance handovers, maternity services) • Issues of increasing risk Activity and performance overview: • High-risk issues (e.g., 104 ww, 78ww, TWL, Cancer etc) • Issues of increasing risk
4	People • High-risk issues (by exception including vacancy rate hotspots and agency spend plan)
5	Finance and use of resources 2022/23 • Revenue and capital forecasts and hotspots and proposed actions 2023/24 • Outlook and actions including making efficiency savings recurrent Operational planning • High-risk issues • Issues of increasing risk
6	Leadership and capability • Specific issues / risks
7	Local partnership issues • FT input into local place based plan development and delivery
8	Review of SOF rating and roadmap to maintain/improve
9	Summary and wrap up

10	Next meeting:
	Attendees: ICB CEO (Chair) ICB Executive Director of Strategy and System Oversight ICB Executive Chief Nurse ICB Chief Finance Officer Other ICB Execs as the agenda dictates Provider CEO Provider COO Provider Chief Nurse Provider Director of Finance Other Provider team members as the agenda dictates Aligned Place Director

Appendix 5
Template Agenda for Strategic Programme and Clinical Network Oversight Meetings

1	Welcome, apologies and introductions Meeting purpose Meeting approach: adherence to the 7 Oversight Framework Principles: ***Transparency*Respect*Co-ordination*Parity of local priorities *Focus*Learning*Partnership**
2	Progress in delivery of the Programme/Network • Key progress and achievements • Risks and issues •
3	Finance and use of resources
4	Leadership and capability
5	Other strategic priorities / hotspots / issues
6	Update of the action log
7	Summary and wrap up
9	Next meeting:

Item: 7.6

NHS
North East and North Cumbria

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

BOARD MEETING 29 November 2022	
Report Title:	**ICB Operational Resilience – Winter Plan Delivery**

Purpose of report

This report will inform the Board of the progress made against the key ICB priorities supporting operational resilience.

Key points

- Increased clinical triage and use of non-ED pathways
- Increasing access to urgent primary care
- Improving discharge and patient flow.

Risks and issues

- Compromised workforce across the ICS providers - exploring different ways of working whilst applying the principles from the workforce strategy
- Delays in accessing social care due to the gap between demand and capacity across the system
- Unprecedented surge – escalation frameworks in place with actions to support high levels of activity (divert policy, FCP, handover procedure and Repatriation policy)
- Fuel Poverty - identification of the most vulnerable within localities informing fuel companies. Taking the learning from COVID. Actions will be developed and delivered at Place
- Ability to staff the expansion of the clinical assessment service and related models
- Lack of clarity and ownership of the data flows relating to some of the new metrics; leading to inconsistency of measurement

Assurances

- Each risk and issue have associated mitigation identified which will be closely monitored and escalated should this be required.

Item: 7.6

Recommendation/Action Required	
The Board is asked to assess the progress of the Winter Plan, note the schemes that deliver the asks of the two winter letters and the risks associated with delivery.	
Sponsor/approving director	Jacqueline Myers, Executive Director of Strategy and System Oversight
Report author	Siobhan Brown, Director of Transformation System

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

Relevant legal/statutory issues						
None noted.						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	

Key implications	
Are additional resources required?	N/A
Has there been/does there need to be appropriate clinical involvement?	Yes through a wide range of clinical networks, task and finish groups and the UEC Strategic Board professional reference group.
Has there been/does there need to be any patient and public involvement?	N/A
Has there been/does there need to be partner and/or other stakeholder engagement?	Yes – system-wide workshops and involvement.

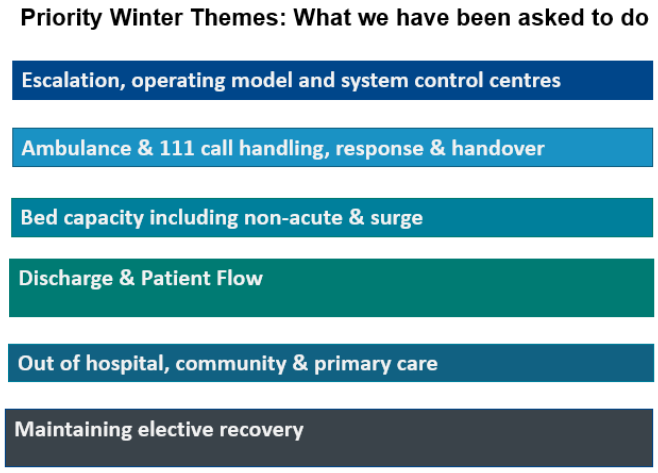
Item: 7.6

NHS
North East and
North Cumbria

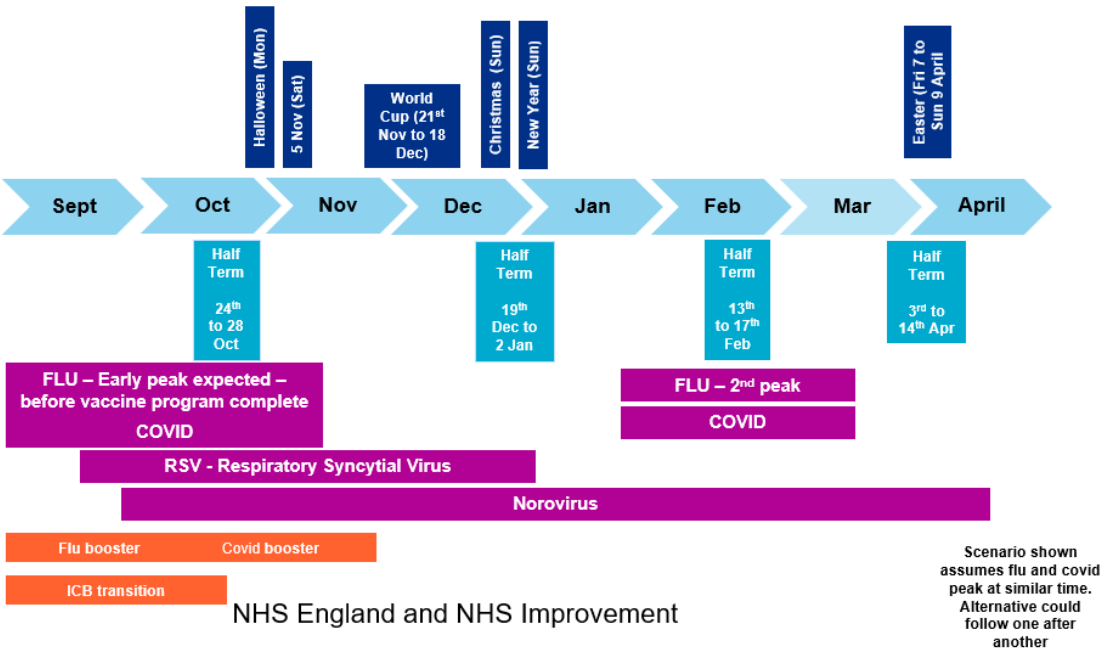
Operational Resilience

Background

NHS England publications PR1929 August 2022 'Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter' and PR2090 October 2022 'Going further on our winter resilience plans' set national priorities in relation to winter with key actions to improve operational resilience. The priority winter themes can be summarised as:



The operating context including current forecasting of Covid-19, Flu and Respiratory Syncytial Virus (RSV) peaks - which are subject to change based on public health modelling - is outlined below:



Governance and Assurance Processes to NHS England

The recently developed Board Assurance Framework (BAF) which is reported monthly to NHS England is the main route of Assurance for Urgent and Emergency Care and the delivery of the winter plan. A bilateral meeting between North East and North Cumbria Integrated Care Board (NENC ICB) and NHSE took place on 2 November 2022 which was also part of the Assurance process, which was a successful meeting noting progress and also actions underway but not complete.

NENC Urgent and Emergency Care and Winter Resilience Governance Arrangements

Dr Neil O'Brien the ICB Chief Medical Officer is the ICB Senior Responsible Officer for Urgent and Emergency Care. The Programme of work is developed and overseen by the ICB Urgent and Emergency Care Network, supported by 5 local area A&E Delivery Boards (LADBs) Each LADB is chaired by a Trust Chief Executive or Chief Operating Officer. The formal governance is supported by a weekly senior huddle and a professional reference group.

Assessment of NENC ICB Delivery against the Winter Asks

Next steps in increasing capacity and operational resilience in UEC ahead of Winter – Letter August 2022		RAG (Risk to System)
Action	**Commentary**	
Deliver an integrated COVID-19 booster and flu vaccination programme to minimise hospital admissions from both viruses.	Very well placed for delivery of this programme which is ongoing	
Implement UKHSA's IPC guidance in a proportionate way and	Also looks at interface to nursing homes and residential care and IPC	

develop strategies to minimise the impact of 'void' beds.	associated with Covid-19 positive patients; also designated bed options	
Open additional beds across England, to match the additional capacity identified by ICSs to be able to deliver against expected winter demand	Plans in place for opening 292 additional beds. Some programmes behind schedule but high priority for the system to deliver. NENC has more beds open than in 2019.	
Increase the number of NHS 111 call handlers and 999 call handlers	High achievement given investment and recruitment to these roles and ongoing	
Increase provision to high intensity users	Delivered through LADBs and Places and looking at system level approaches – wide range of data sources requiring cross check and consistent approaches	
Good working with the independent sector and facilitating patient choice		
Increase two-hour Urgent Community Response provision	All Places have this – key issue is creating single point of access and getting people into the services	
Increase the number of virtual wards Linked to ARI Hub work from October letter	Plans in place to deliver 353 by Dec 2022, 529 by April 2023, 687 by Dec 2023 and 770 by April 2024. Currently step down and respiratory focused but looking at step up and frailty too.	
Maximise recruitment of new staff in primary care across the winter	**One of top three priorities for the ICB – increased access to primary care** ARRS roles in place and in recruitment; also economies of scale in PCNs	
ICBs to actively support and engage with PCNs to work with each other and other providers		
Mental health – best practice, work with VCS and LA, community and crisis provision	Programme for increasing capacity and access to community and crisis provision underway	
Maintain and increase elective capacity and reduce cancer waits	Major programme of work led through Provider Collaborative underway with focus on system sharing of capacity	
Discharge - Implement the 10 best practice interventions through the 100-day challenge	**One of top three priorities for the ICB.** All places are delivering actions but impact on delayed discharges not yet showing. Medically optimised patients in acute beds biggest pressure across the system. Release of £500M funding and solutions urgently in devp.	
Encourage a shift towards home models of rehab for patients with less severe injuries or conditions.	Work to review community rehab pathways planned	
Wide range of asks related to 999 ambulance services including live	**One of three top priorities for the ICB.** Wide range of actions including	/

data, reduced handovers, transport and wider clinical advice and NHS 111 performance	greater capacity for 111 activity, widened MDT in CAS, zero tolerance to over 1 hour handover delays, alternative dispositions increased. NENC ambulance performance better than national averages.	
Preventing avoidable admissions - DOs profiling, SDEC devp. Patient transport, acute frailty services, out of hospital pathways and use of NHS@Home	Wide range of work going on in 13 Places across the ICB all in various stages of development and delivery. ICB is establishing Communities of Practice to fully understand and plan ahead where gaps and unwarranted variation found	
Workforce staff sharing, international recruitment, wellbeing and role of volunteers	Various models for workforce sharing in progress and crossover with local authorities and independent sector too.	
Data and performance management	Building on UEC RAIDR App development and live reporting and moving towards forecasting and prevention of crises	
Communications	Implementing communications at system and local levels for maximum impact	

Going Further on our winter resilience plans - Letter October 2022

Action	Commentary	
Putting in place a community-based falls response service in all systems for people who have fallen at home including care homes	All 13 LAs have 24/7 Falls Service offer. Places have a variety of response services including some provision by NEAS. Collation and next steps across the system underway through Communities of Practice	
Maximising the use of virtual wards, and actively considering establishing an Acute Respiratory Infection (ARI) hub to support same day assessment	This is being picked up as part of Virtual wards workstream. Plan is to maximise effectiveness of all services where such patients attend like SDEC, VWs, other Respiratory Services and consider a blended model	
Providing additional support for care homes through reducing unwarranted variation in ambulance conveyance rates	Enhanced support to care homes and sharing of the patient record and care plans integral to this and all Places have models for delivery but require review and next steps. Analysing top 20% of care homes' calls to NEAS and admissions to hospital and actions to deal with differently in future	
Supporting delivery of additional beds including previously mothballed beds	Audit underway of volume of these – some already turned into extra physical bed capacity	

All systems setting up a 24/7 System Control Centre to support system oversight and decision making based on demand and capacity across sites and settings	All on track for delivery 1 December 2022. Main outstanding issue is out of hours clinical cover.	
Ensuring all ambulance services deploy 24/7 mental health professionals in emergency operation centres and on-scene	Links to widened workforce in NEAS including extra MH expertise in CAS and access for paramedics on scene, MH training for paramedics and alternative 'warm' transfers to crisis services	
Ensure timely discharge and support people to leave hospital when clinically appropriate. Use of share of £500M funding (now announced) is pivotal.	Building provision in Pathways 1,2 and 3 alongside LA colleagues	
Range of further actions to support elective activity and cancer backlogs and condition specific pathways	All Trusts and Provider Collaborative working to maintain elective delivery with focus on pathways that make up largest volumes of long waiters	
IPC, Symptomatic testing and staff vaccination	Keeping up to date with IPC, testing of staff and focusing on areas of low uptake of vaccinations in staff groups	

Board Assurance Framework – a new approach to accountability

System working also means a new approach to accountability. NENC ICB is accountable for ensuring that its system providers and other partners deliver their agreed role in the local plans and work together effectively for the benefit of the populations they serve.

NHSE has identified the following six specific metrics, key to the provision of safe and effective urgent and emergency care, that NHS England and ICBs will use to monitor performance in each system through the Board Assurance Framework

- 111 call abandonment
- Mean 999 call answering times
- Category 2 ambulance response times
- Average hours lost to ambulance handover delays per day
- Adult general and acute type 1 bed occupancy (adjusted for void beds)
- Percentage of beds occupied by patients who no longer meet the criteria to reside.

From a local perspective, three metrics have been identified and they are:

- 111 and 999 calls clinical triage rates
- 111 and 999 call disposal by pathway
- Vaccination rates.

The BAF also included a template on plan delivery which is updated and submitted to NHS England each month. It consists of four sections that cover Demand and Capacity

Assurance, Delivery of the UEC Action Plan, Operational Self-assessments by Provider and a Good Practice Checklist for identifying areas for development where concerns are found. To date we have submitted for September and October 2022, but following the second Winter letter, the BAF will alter to reflect new asks of the ICB. The ICB's submissions have been well received but calibration of the ICB's responses in comparison to other ICBs suggest that our progress may be further ahead than currently reported. Bed capacity developments, medically optimised patients in acute beds, workforce to deliver the asks and data quality are four of the top risks currently in NENC ICB. This will be shared with the Board on completion of the end of November 2022 return.

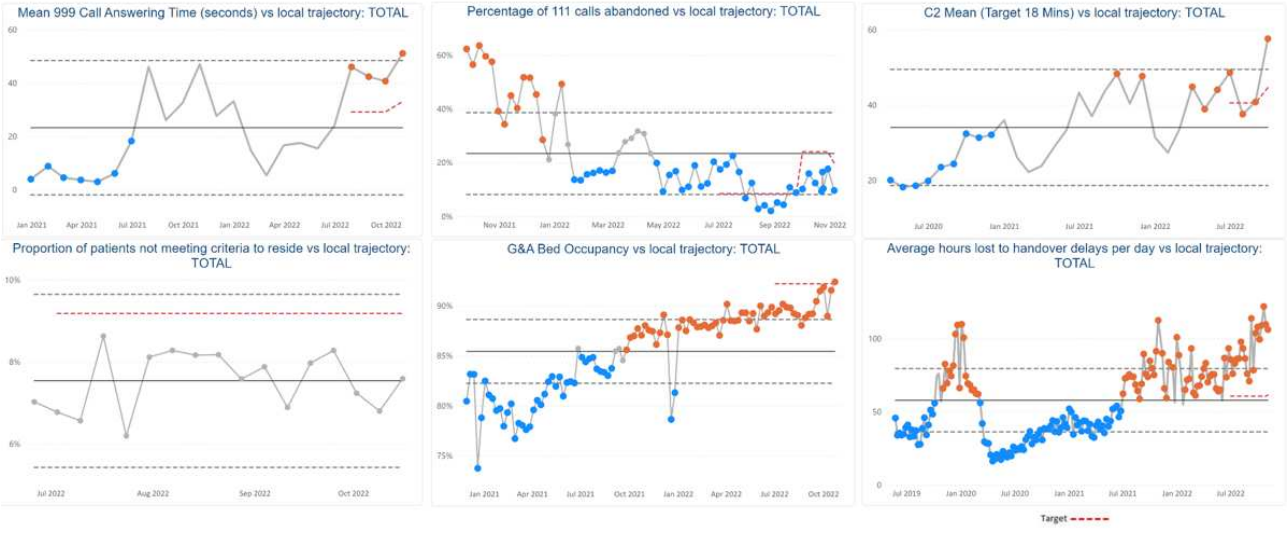
NENC ICB Performance against trajectories

Against the national metrics, the ICB is performing well on the number of 111 calls abandoned due to the increased recruitment and volume of call takers. The criteria to reside metric is currently within range of the trajectory but improving upon this remains a priority. The remaining four metrics are all underperforming against the set trajectories. This is indicative of the immense pressure the whole system is under and is reflected in the national picture too.

The actions described in the following sections of the report are the ICB's approach to have a relentless focus on improving patient access and quality of care and patient experience across the whole of UEC.

North East and North Cumbria Urgent and Emergency Care Operational Resilience Metrics

Metric	Latest Date	Value	Target	Variation
111 Calls Abandoned - Total	06/11/2022	9.6%	19.8%	Improvement (Low)
Mean 999 Call Answering Time (Seconds) - Total	Oct-22	51	33	Concern (High)
Category 2 ambulance response - Total	Oct-22	00:57:34	00:44:34	Concern (High)
Average Daily Hours lost to handover delays - Total	05/11/2022	106	61	Concern (High)
Adult general and acute type 1 bed occupancy -Total	23/10/2022	92.4%	92.2%	Concern (High)
Proportion of patients not meeting criteria to reside (acute hospitals) - Total	16/10/2022	7.6%	9.2%	Common Cause



Local Metrics

Metric 1: 111 and 999 calls clinical triage rates from the NEAS Emergency Treatment Centre – where all calls come in

This data demonstrates that the use of clinical triage when assessing 999 and 111 calls manages to find alternative dispositions for patients that do not require an ambulance and/ or do not need to go to Emergency Departments. The difference between this outcome and where patients actually go are separate analyses and a high priority for understanding to make sure patients have easy access to the right place for their care. The analysis of 111 Online clinical triage is outlined under ICB Priority 1 in the next section of the report.

ETC Initial Dispositions October 2022

	Total ETC Dispositions	Referred to CAS		Referred to ED		Referred to UTC/UCC		Referred to other	
NHS Northumberland CCG	592	208	35%	92	16%	248	42%	44	7%
NHS North Tyneside CCG	424	126	30%	56	13%	201	47%	41	10%
NHS Newcastle Gateshead CCG	1122	295	26%	226	20%	538	48%	63	6%
NHS South Tyneside CCG	332	121	36%	70	21%	125	38%	16	5%
NHS Sunderland CCG	901	216	24%	156	17%	482	53%	47	5%
NHS County Durham CCG	1989	401	20%	264	13%	1085	55%	239	12%
NHS Tees Valley CCG	1848	501	27%	306	17%	941	51%	100	5%
Out of Area	243	31	13%	59	24%	52	21%	101	42%
North East	7451	1899	25%	1229	16%	3672	49%	651	9%

CAS deflects **83%** (1567) of cases away from ED/Ambulance

Only 21% (1561) of all calls reaching an initial disposition of ETC are directed to ED

Metric 2: Outcomes from 111 dispositions by pathway

This analysis highlights the urgency of building greater capacity in primary care to deal with patient need resulting from 111 calls and is a priority for the ICB. Dental care also has a relatively high volume of patient need and offers patients access to urgent dental services.

111 outcomes:

111 Outcome	August	September
Emergency Treatment Centre	11.8%	11.7%
Ambulance	15.6%	16.1%
Dental	12.6%	11.9%
Pharmacy	0.3%	0.2%
Not recommended any other service	11.7%	12.3%
Other service	4.8%	5.1%
Primary Care	43.1%	42.6%

Metric 3: Covid-19 and Flu vaccination rates

The Covid-19 and Flu vaccinations programmes are now well underway across the population of the ICB delivered across a wide range of settings including vaccination centres, primary care, community pharmacy and community services. Uptake is monitored by priority group cohorts such as Care Homes, At Risk, Pregnancy, Health and Social Care Workers, School Age, Age 50-64, over 65 and over 75 age groups.

Comparisons with our neighbouring ICBs demonstrate good performance. For example, the snaphot (unvalidated data) of delivery ending Friday 18 November 2022 shows Care

Home uptake of the Covid Autumn boosters is already at 80% and for Flu at 73%. Age 65-74 uptake for Covid-19 is 75% and for Flu over 65 uptake is 76%. Cohorts such as health and care workers are also a priority and supported by sustained campaigns to encourage staff groups to be vaccinated.

NENC ICB Priority Actions for Winter

In response to the two winter letters, NENC ICB through highly attended winter events and workshops identified and agreed a set of key priorities to support system operational resilience. These are:

1. Increased clinical triage and use of non-Emergency Department (ED) pathways
2. Increased access to urgent primary care
3. Improved discharge and patient flow.

1. Increased clinical triage and use of non-ED pathways

Following the ICS Rapid Improvement Workshop (RPIW) held on 12 October the system agreed to implement these enhanced clinical assessment priorities.

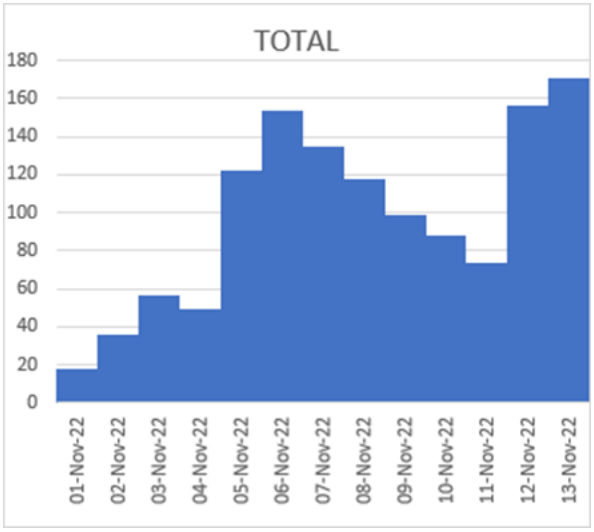
An alternative service to respond to the 111 activity which results in the need for a primary care clinician to speak to the patient.

Discussions are also underway with the ICB and North East Ambulance Service (NEAS) about alternative solutions to manage the workload generated from 111 activity that result in 'Primary Care Speak To' dispositions (meaning patients who call 111 and the outcome is that they need to speak to a primary care clinician), so the NEAS Call Assessment Service (CAS) can concentrate on the more clinically complex patients. This includes 111 online activity including the Primary Care Speak To activity online allowing NEAS CAS to focus on triaging those with greatest need.

The online 111 activity that requires a primary case 'speak to' was outsourced with effect from 1 November 2022 with evaluation embedded into the model. The additional capacity generated is being used by NEAS for clinician call backs and Emergency Treatment Centre resilience including validation as clinical demand increases in line with forecast call demand. October 2022 activity data suggests that Online work makes up around 10% of overall CAS demand.

Further discussions are taking place regarding the 'speak to' activity generated by 111 telephone activity.

Item: 7.6



Between 1st Nov -13th Nov **1277** cases from 111 Online activity have been referred to Vocare.

111 Online: NHS 111 Vocare Clinician Call back - Speak to Clinician dispositions 24/7 – **194**

111 Online: Vocare North East Out of Hours Service – Primary Care activity OOH - **544**

CCAS - Vocare Local Covid Clinical Assessment Service – Covid Activity 24/7 – **539**

Urgent Community Response Service Access to Category 3 and 4 (C3 & C4) NEAS Calls on the Stack

An experienced practitioner from Place will join the NEAS CAS Team actively pulling C3 and C4 patients off the stack directing them to the most appropriate community services including the two-hour urgent community response services with the ambition of at least 70% of 2-hour UCR demand to be seen within two hours in each ICB.

As part of the demand management and shared system risk discussions at the improvement workshop held on 12 October 2022, there was agreement that the model being developed between Tees Valley and NEAS should be progressed, piloted, and rolled out across the system. This is in addition to the 'push' model ready to be piloted in Tees whereby NEAS clinicians will refer suitable patients to the UCR community services electronically.

There are examples across the country that have already taken this work forward, one area being Warrington. Through collaborative working, the North West Ambulance Service and UCR Service have developed a pathway underpinned by a Memorandum of Understanding (MoU) which NENC ICB is testing with NEAS and UCR Services.

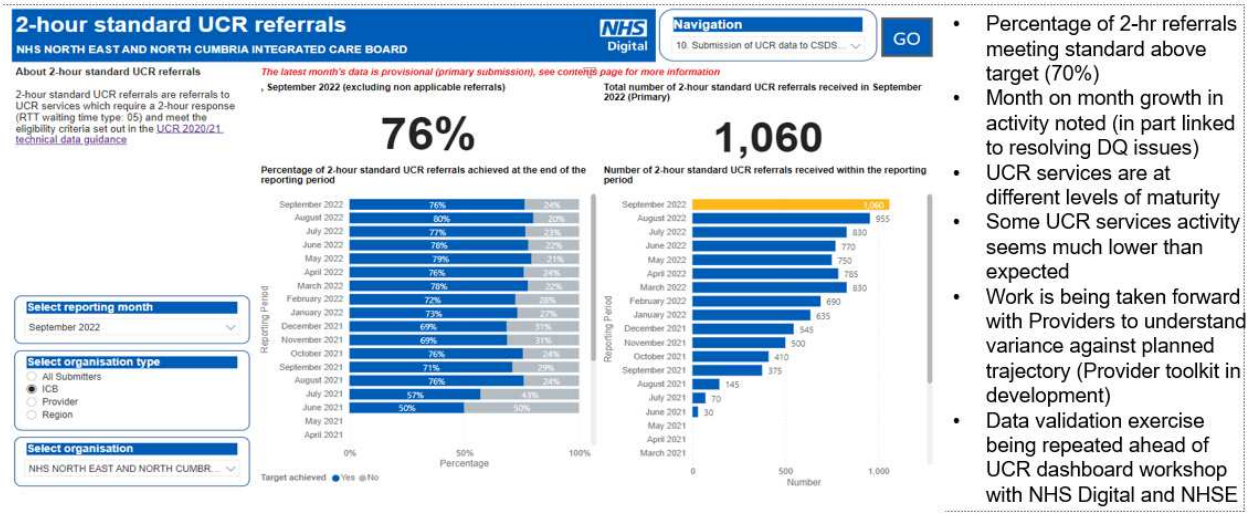
Baseline metrics and evaluation criteria have been developed and anticipated outcomes include:

- Improved patient experience and outcomes
- Increased integration between all providers delivering an improved collaborative style of demand management
- Reduced pressure on NEAS through prompt access to alternative pathways
- Reduced pressure on emergency departments through better utilisation of alternative pathways
- Reduced adverse/serious incidents/harm relating to delayed response to attend to patients in the community

- Improved staff experience for providers
- Clinical approach supporting shared system learning and improved management of patients
- Increased visibility of system wide demand and capacity and associated risk.

With regard to delivery across NENC of the 2 Hour UCR Referrals, the data for September 2022 is summarised below. Data quality is one of the key areas for development as only three codes capture the new model of care delivery so volumes will be under-reported.

2-Hour Standard UCR Referrals - NENC



- Percentage of 2-hr referrals meeting standard above target (70%)
- Month on month growth in activity noted (in part linked to resolving DQ issues)
- UCR services are at different levels of maturity
- Some UCR services activity seems much lower than expected
- Work is being taken forward with Providers to understand variance against planned trajectory (Provider toolkit in development)
- Data validation exercise being repeated ahead of UCR dashboard workshop with NHS Digital and NHSE

Note: September data is primary data therefore this figure will be expected to rise once this has been refreshed in December 2022

Northumbria Specialist Emergency Care Hospital (NSECH) and NEAS Pilot

There is a pilot currently underway between NSECH and NEAS where emergency care Consultants in NSECH access the NEAS stack and revalidate clinical dispositions with senior clinical advice with a view to navigating patients to the best disposition and avoiding unnecessary conveyances to ED. If successful, this will be explored for roll out more widely across the system. Another area of work for exploration would be with regard to other 'heralded' patients known to be coming to ED (for example from GPs) but who could be appropriately dealt with in other ways.

Development of wider Multidisciplinary Team (MDT) members in the CAS

Mental Health

From a mental health perspective, plans are already underway for recruitment of more mental health practitioners into the NEAS CAS which supports the delivery of the Mental Health 111 Roadmap for NEAS. The second NHSE winter letter outlines in particular the need for greater MH input to the CAS and on scene. Clinical conversations across the system are exploring mental health practitioner support potentially using an Alliance model and also training for paramedics handling mental health patients and greater access and

capacity for 'warm' transfers of patients to crisis services which could involve service delivery models using the Community Voluntary Services Sector.

From an ‘at scale’ working perspective across organisational and geographic boundaries. a business case has been developed for an expansion of the Crisis Support and Hospital Discharge / Admission Avoidance service provided by Home Group since April 2022. The service has enabled a significant reduction in hospital length of stay, admission avoidance and early discharge. Expansion would allow the rollout of this support potentially into Primary Care, Emergency Departments and NEAS MH Ambulance response / CAS.

Evaluation of performance to date demonstrates high levels of success in terms of admission avoidance, facilitating routes into housing, and the interface with alternatives to crisis services. The service is inclusive of people with learning disabilities and autism, as well as those with mental health and / or mental wellbeing concerns. Key outcomes it could deliver are:

- Clinical Triage: through potential expansion of service to integrate non-clinical Mental Health Practitioners into NHS 111 CAS and to provide mental health support at scene ambulances.
- UTCs and Primary Care Interface: reducing demand on primary care following hospital discharge.
- Discharge and Flow: enabling faster hospital discharge through transition support and housing; reducing re-admission rates through better community integration and support.

Regarding transport, there is also a capital funding avenue for ambulance services for mental health transport but needs to be backed up by a strong MH CAS operating model in the first instance which the actions above will help create.

End Of Life

Developing a more multi-disciplinary NEAS CAS with the inclusion of Palliative Care Specialist Advice through a Single Point Of Contact (SPOC) advice line for paramedics and OOH services to help follow care plans and reduce unwanted and un-needed hospital transfers. The benefits of this will:

- Improve the volume of 'flagged' EOL patients with NEAS to the target of 1% of our total population
- More targeted triaging of those 'flagged' on the stack to 'place' based teams rather than 'blue light response' if appropriate
- Following Advanced Care Plans (ACP) and facilitating document sharing with improved IT, using the regional IT platform of choice the Great North Care Record
- Linking in with 'place based' teams and working 2-hour community response teams where appropriate for better patient experience and avoid ED.

2. Increasing access to urgent primary care and its interfaces

Integrated Urgent Treatment Centres (UTCs)

Audits have taken place across NENC ICB of all UTCs' opening times, their provision and how this relates to the Directory of Services (DoS). UTC capacity reports are available however they need further development to understand the variation being seen in actual opening times and how demand is being managed across sites.
All NENC UTCs operate a minimum standard of the enhanced UTC national DoS profile however North Tees and Hartlepool have the strongest UTC profile across the region. All UTCs have GP supervision but not all have GPs on site, some operating a virtual model. North Cumbria UTCs are in a slightly different position due to their DoS responsibilities not being with the North East DoS Team.

Next steps

- UTC services need to use their capacity figures to flag system pressures and to have clear contingencies in place for when are no appointments are available to support the system. Maximising the capacity of the current UTCs is a priority
- Further development work is required to understand the final disposition of the patients seen in UTCs. This will require work with NECS to utilise data from other tool such as RAIDR and will support further strategic planning to understand the use of the UTC resource in the future
- Further evaluation is required to assess the redesign of the "front of house" of emergency departments with a UTC model for all walk-in patients. This would maximise the benefits which UTCs bring to supporting the emergency department model.

111

The inter-relationship between general practices and 111 is a complicated one and is impacted by protocols within 111, how GP practices manage capacity and demand and finally patient behaviour in the services access points they choose to use.

In October 2022, 111 dealt with 8000 cases, 48% had a primary care outcome, 31% were referred to a UTC, 6% a GP access hub and the remaining 15% were managed as self-care or referred to NEAS.

NENC can identify those practices whose patients are the highest users of 111 services. Practices already make some provision for directly bookable appointments by 111 into their GP clinical systems. Some areas such as within Tees provide an incentives scheme to increase this provision further whereas others do not. In addition, evaluation is required to understand the mismatch that is occurring between 111 requiring an urgent disposition within 4 hours to general practice versus the timings and actual availability of these appointments through the day.

Use of 111 services by patients to book an appointment with their GP may be a legitimate course of action however this provision is limited and high use of 111 by a practice may also indicate significant sustainability pressures within that practice.

Next steps

- Dialogue needs to be facilitated by the ICB between 111 and its high use practices to understand the pressures on capacity and review availability of booked provision, within the confines of the GP contract.

- Dental care is making up a large part of 111 work and further work is required to build up preventative dental provision across NENC in order the reduce this 111 burden.
- Sustainability of general practice is a priority as indicated by the Fuller report. This will be achieved by local support at place by the ICB and greater collaboration with wider system partners.

Working across place the system in Communities of Practice

Due to the complexity of the UEC system and the wider NHS a proposal is in development to create an ICB forum where place and system can meet to discuss the issues around UEC and develop solutions to address winter pressures and the longer term transformation agenda. All thirteen places across NENC ICB have local delivery mechanisms that span the UEC, Community, Primary Care and Prevention agendas and mapping all delivery, plans for the future and harnessing the power of systems working will be priorities for the Community of Practice.

Primary Care Delivery in NENC ICB that supports UEC

The ICB across its Places has actively engaged and supported General Practices and Community Pharmacies with seasonal preparedness and operational delivery.
It has completed a system framework for supporting General Practice to rapidly prioritise practical interventions to improve patient experience of access and staff workload locally engaging in national process to secure potential funding for technology and estate solutions. Consideration has been given to supporting Primary Care Networks (PCN) working with each other and other providers to develop collaborative models to manage specific winter pressures for example, oximetry monitoring for COVID; winter hubs; community and CVSE led support for vulnerable groups.

The ICBs has offered intensive hands-on quality improvement support to practices working in the most challenging circumstances such as areas of high deprivation, areas with highest need or workforce challenges via the national ‘Accelerate’ support programme available to 400 practices for 2022/23 alongside addressing barriers outside the scope of the support.

Cloud based telephony in General Practice has expanded its numbers of practices on cloud-based telephony, supporting transition from analogue to cloud-based through expanded scope and pace of current pilots.

Business Intelligence tools have been rolled out to General Practice thus expanding availability of Business Intelligence tools to understand demand and capacity, providing support to build capability to use for improvement.

The use of a unified directory of services across the ICS to direct patients to the right services and communicate clearly on primary care pathways and processes e.g. promoting the use of community pharmacy services.

3. Discharge and Improved Patient Flow

Discharge

The ICB working with the system is implementing the 10 best practice interventions identified in the first phase of the Health and Social Care Discharge Taskforce via the '100-day challenge' to reduce variation. It continues to expand the use of small, one-off Personal Health Budgets (PHBs) to facilitate early discharges and will increase capacity of pathway one discharge teams to match demand and supply for this winter. Medically optimised patients in acute beds are the highest cause of pressure across the whole system.

The funding allocations for the £500 million Adult Social Care Discharge Fund have now been published and of the funding 40% (£200 million) will be distributed to local authorities and 60% (£300 million) to Integrated Care Boards. The NENC share of these funds is £12.297m directly to local authorities and £13.453 to the ICB. Local authorities and ICBs will work together to plan how to spend the money locally. With regard to the NENC ICB, the top three priorities are outlined below:

Top 3 Priorities
Review of 10 High Impact Interventions by Trust **Actions to share best practice** **Identifying areas to improve pathways 0 and 1**
Utilise Personalisation approach to implement PHBs for patients and families as part of discharge support alongside CVS organisations
Support social care to provide additional dom care packages/alternatives to admission but utilising £500m once it becomes available. **Agree shared metrics with Health and Social Care to monitor impact**

Ambulance Handover Event 24 November 2022

A second ICB RPIW has been scheduled on Ambulance Handover with representation from across the system. The session will state the challenges felt by patients and staff from both NEAS and Acute Hospital Provider perspectives. The session will have a myth busting session, stories of patient experience and will showcase learnings from top performing Acute Hospital Providers for Ambulance Handovers. Following presentations, group work will produce solutions that will be themed with agreed principles and actions that will be implemented across the ICS as part of the Ambulance Handover Process/Procedure. The work needs to dovetail with the National Winter Improvement Collaborative, aimed at rapidly improving ambulance handover times and its three workstreams:

- Risk based flow management models: such as standardised escalation models which optimise flow
- Streaming and direct access: such as direct access to the most appropriate care pathway

- Ways of working and standardisation: such as standardisation of pathways and capacity management.

This process will be overseen by a national steering group with NHS England executive officers and representatives from the Royal Colleges and regulators.

Virtual Wards

The ICB working with the system is implementing out of hospital home based pathways, including virtual wards (VWs), to improve patient flow by reducing hospital attendances e.g. reducing un-necessary attendances for patients with mild illness through revised NHS@home pathways that incorporate broader acute respiratory infections. The rollout plan is outlined below by Place. The early focus is on step down VWs for respiratory conditions and a standard operating model for respiratory infections has been approved by the VW Task and Finish Group for use across the system. The next stage is to expand the remit of VWs to look at frailty and falls as part of the wider frailty and falls work outlined above. Digital solutions are a huge part of this and require integration into the work on a larger scale.

	Actual / expected total virtual ward capacity in 'beds'							
Milestone date	North Cumbria	Newcastle	Gateshead	North Tyneside & Northumberland	County Durham	South Tyneside and Sunderland	Tees Valley	Total
Apr-22	0	0	20	0	0	0	10	30
Dec-22	20	25	35	25	38	30	180	353
Apr-23	40	50	48	65	50	56	220	529
Dec-23	60	50	50	150	70	62	245	687
Apr-24	80	50	50	150	70	110	260	770

Place	North Cumbria	Newcastle	Gateshead	North Tyneside & Northumberland	County Durham	South Tyneside and Sunderland	Tees Valley	Total
No. wards	1	2	2	3	3	2	3	16

Three short examples of VW models are outlined below:

- Durham: VW model for respiratory disease agreed in April 2022 and is being implemented. Review of intermediate care provision has been undertaken and procurement completed. Number of block beds has been increased as 'time to think' beds. Additional beds are being commissioned for winter. Funding bid for frailty virtual ward has been supported
- Sunderland: assistive technology scheme already in place via Luscii app managing respiratory infections through the urgent and rehabilitation 24/7 nursing team
- South Tyneside: implementing of virtual wards with system partners including assessment of cohort of patients currently in acute beds that would be suitable for Virtual Ward.

Acute Respiratory Infection Hubs

The second winter letter also asked systems to consider the establishment of hubs for adults and children for Acute Respiratory infections (ARIs). An examination of this hub model for NENC ICB concluded that the evidence for the effectiveness of such models was compelling but that due to the huge number of new initiatives already being developed in the system including VWs, that there is a need to map out current provision and gaps across SDEC/111/ED/Other delivery services as there is a risk of duplication and confusion. The proposal, due to be discussed at the UEC Strategic Board, would be to revisit this issue in the Spring 2023 and look at introducing a blended model.

Falls

The second winter letter outlines a wide range of community schemes including universal falls services, building on a wide range of service developments in places. This includes all thirteen local authorities 24/7 falls services. With regard to dispositions for patients who fall, a large number have been assessed as suitable for 2 Hour UCR and other options in the future will also be VWs.

Summary of Falls Data 2021/22

	Total	With fracture	With hip fracture			?Suitable for UCR*
Number of emergency admissions (65+)- due to falls (NENC data)	19,004	9,655	(3,619)			9,349
	Total number of calls	Calls only	Hear & Treat	See & Treat	See & Convey	
NEAS 999 calls – Falls or faints **without injury** (65+)	4,780	704	813	1,441	1,884	1,884
	Total	With fracture	With hip fracture			
Care home residents – emergency admissions due to falls (65+)**	3,467	1,725	(932)			1,742

* Estimated number of people aged 65+ who could potentially be diverted into UCR pathway; it is assumed that those sustaining fracture will need to attend hospital

** Work is being taken forward to ensure care homes ring UCR services, where appropriate, instead of Ambulance Services

Data provided by North England Commissioning Support (NECS)

Physical Bed Capacity Schemes

Following the commitment by NHSE to fund system demand and capacity plans enhancing bed capacity across the country the ICB identified and submitted 23 schemes across the ICS to increase bed capacity with a total cost of £9.5m. The number of beds planned to open by March 2023 is 292. The risk associated with delivering these bed numbers is workforce. Mothballed beds are also due to be opened and the ICB is assessing the volume of these due to come online currently. The beds by function are listed below:

- 10 schemes focused on ensuring timely discharge
- 8 schemes focused on increasing capacity outside of acute trusts
- 5 schemes focused on reducing hospital occupancy.

Some schemes will provide additional G&A beds (circa 66) for example an additional ward at Freeman Hospital and additional acute beds at County Durham and Darlington Foundation Trust.

Some schemes will provide additional community beds (circa 98) for example, spot purchasing of care home beds, block booking of intermediate care beds and creation of additional community beds at West Cumberland Hospital. Other schemes support admission avoidance or early discharge to equivalent create bed capacity (circa 111).

System Coordination Centre Development

In line with National guidance NENC ICB will have in place a System Coordination Centre from the 1 December 2022. The national operating environment will be much more about proactive system planning and forecasting and mitigating potential pressures before they occur and in which ICBs play a pivotal role. It is expected that a robust accountability and responsibility approach will underpin SCCs and the key national trigger will be around Ambulance Handover delays over one hour.

The SCC will cover a 7-day period, 365 days a year and will be responsible for the coordination of ICB, National and Regional sit- rep returns. The dedicated team will monitor and report activity and surge ensuring timely escalation is triggered to support the system. The staffing structure will offer subject matter expertise to systems and support the Regional Process and Policy i.e. Repatriation Policy, Full Capacity Process, Divert Policy. The SCC will centrally coordinate the one Strategic and four Tactical on call rotas providing end of day handover to Tactical on call Directors and taking a handover following the out of hour period. The SCC will ensure the inbox is monitored and that the web page is kept up to date. It will cascade communications in the event of a critical incident in hours and will support SMS proactive texting for alerts and actions for the ICS. The SCC will record and log events and associated actions. The SCC will also develop robust data flows and forecasting technology to support early warning systems and triggers for action before the event. The ICB's position against the SCC specification is outlined below and is a very strong position:

Requirement	NENC forecast position by 1 Dec
Staffed 7 days 8-8	Staffed 7 days 8:30-5:30 – weekend cover prioritised for Dec 1
24/7 access to senior clinical decision maker	In hours ICB senior clinicians can deliver; out of hours could deliver but would have to consult on change and disruptive to on-call arrangements
Director level on- call access to SCC	Yes
Named Exec Lead	Yes
Access data sets	In progress 90% there for 1 Dec
Real time ambulance h/o data and actions	Yes, via RAIDR – updated OPEL framework expected imminently and will need to implement
REAP & OPEL linked action cards	Yes, built into RAIDR
Supports pro-active planning for BHs etc	Yes, already in action
SCC staffed and EPRR aligned	Yes, both under new Director of System Resilience
SPOC mailbox for cascade comms	Yes
UEC sitrep and returns	Yes
System leadership of repats	Yes, but working on real time data flow

Winter Funding

There are a number of pots of funding that have been recently identified to support the delivery of enhanced resilience for the winter and beyond. The ICB has a £4m pot available for system wide interventions; the ICB has been awards £662k for mental health winter schemes and at time of writing, the ICB's share of the £500m for reducing discharge delays and supporting adult social care has just been announced.

Current winter schemes	
ICB non-recurrent winter fund	4,000
Primary Care scheme	(750)
111 online clinical assessment service scheme	(580)
Third sector schemes (various)	(335)
Remaining	2,335
MH fund	662
MH place based and at scale schemes prioritized	(662)
Potential to scale MH housing scheme	(300 – 1,000)
System control centre development and staffing scheme	(200)
Remaining funds*	1,135 – 1,835
*Work with LABDs to check sufficient funding in baselines for schemes	
ICB share of £500m (announced 17/11/22)	13,453
LA share of the £500m (announced 17/11/22)	12,297
Spend to be confirmed in ICB/LA workgroup w/b 21/11/22	

With all proposals further work is currently being undertaken to understand what is already provided for within existing budgets and testing how realistic quoted spend levels and implementation timescales are within the current financial year.

The UEC Strategic Board will assess all funding bids and make recommendations to the ICB for approval.

4. Recommendations

The Board/Committee is asked to assess the progress of the Winter Plan, note the schemes that deliver the asks of the two winter letters and the risks associated with delivery.

Name of Author: Siobhan Brown, Director of Transformation System

Name of Sponsoring Director: Jacqueline Myers, Executive Director of Strategy and System Oversight

Date: 17 November 2022

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North East and North Cumbria

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

NORTH EAST AND NORTH CUMBRIA ICB BOARD MEETING 29 November 2022	
Report Title:	**NHS England Commissioning Delegations - Primary Care and Specialised Commissioning.**

Purpose of report

To provide the Board with an update on:

- the status of delegation to Integrated Care Boards (ICBs) in respect of pharmacy, optometry and dental (POD) services, including the North East and North Cumbria approach, progress and next steps.
- an update on the status and plans for the delegation of a tranche of specialised services to the ICB from NHS England.

Key points

All ICBs assumed delegated responsibility from NHS England for the commissioning for primary medical services from July 2022 and a number of ICBs also took on responsibility for some, or all, of the pharmacy, optometry and dental services. The North East North Cumbria ICB (the ICB) made a decision to take on delegation for primary medical services only and will assume responsibility for community pharmacy, optometry and dentistry (POD) from 1 April 2023.

The Executive Director of Place Based Delivery (Central and South), the Director of Primary Care and Head of Primary Care at NHS England are overseeing the safe transition of POD commissioning responsibilities to the ICB.

From April 2023, ICBs can either accept the delegation of specialised service commissioning where they are assessed as ready or can put in place a joint commissioning arrangement to enable further capacity and capability development ready to take on full delegation from April 2024.

In Yorkshire and the North East and North Cumbria, discussions have now been held between specialised commissioners and the four ICB executive leads to explore the delegation timeframe and consider the risks, challenges and opportunities from this policy development. From this, a

collective view has formed that in order to better understand and manage the risks, the option to develop a joint commissioning arrangement discharged via a joint committee from April 2023 with full delegation from April 2024 should be taken.

The Executive Committee considered the joint commissioning approach in November and recommended that there are two joint committees established, one for Yorkshire and Humber and one for the North East and North Cumbria It is understood that this approach is being taken by the majority of the ICBs nationally.

The Deputy Director of Strategic Commissioning is working with a nominated Director of Finance and Medical Director to lead oversight of the joint commissioning arrangement from April 2023 and the required due diligence and transition to full delegation of specialised commissioning by April 2024.

Risks and issues

POD delegation risk and issues:

- There is lack of experience within the ICB in respect of pharmacy, optometry and dental contracting, commissioning and transformation
- NHS England is currently subject to organisational change, with potential 30/40% reduction in capacity, and as yet it is still unclear if the Primary Care Team and associated support function staffing will be affected by change.
- It is still unclear if the clinical support currently available to Primary Care Teams will continue to be provided in the current form post delegation.
- There are also a number of enabling functions that support the primary care teams, these include, finance, complaints management, media and Freedom of Information enquiries, nursing team support to the serious incident management and quality processes, community pharmacy fitness to practice, national performer lists and administration (including practitioner performance) and wider ICB programmes, for example digital and capital expenditure. Clarity is required on the resources available post delegation.

The proposal to delegate specialised commissioning responsibilities to the ICB identifies the following main risks:

- Financial risk to the ICB of being delegated services to commission that will be funded by a yet to be determined budget that will derive from a new population needs based allocation in subsequent years
- The inheritance of responsibility for potential service quality and sustainability risks
- Potential workforce capacity risks as staffing implications of the delegation are unknown at this time.

Assurances

POD delegation assurances:

- Completion of safe delegation checklist to ensure there is robust due diligence prior to transfer
- Oversight at regular POD Delegation Group
- Discussions ongoing with NHS England regarding staff supporting POD functions
- Discussions ongoing with NHS England regarding continuation of current clinical support
- Discussions ongoing with NHS England regarding continuation of current supporting functions.

Specialised commissioning delegation assurances:

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• Executive Committee approved the recommendation to opt for a joint commissioning arrangement with NHS England from April 2023 and aim for full delegation from April 2024. This will enable the ICB to better understand the specialised commissioning responsibilities and implications and carry out the required due diligence
Recommendation/Action Required
The ICB Board is asked to: • Note the update and current position in relation to the proposed delegation of specialised service commissioning; • Approve the Executive Committee recommendation to form a joint committee with NHS England from April 2023; • Delegate responsibility for approval of the PDAF submission to the Executive Director of System Oversight; • Note that further updates on progress to establishing a joint commissioning arrangement and full delegation in April 2024 will be provided.

Sponsor/approving directors	Dave Gallagher, Executive Director of Place Based Delivery, Central and South Jacqueline Myers, Executive Director of Strategy and System Oversight
Report author	Denise Dodgson, Head of Primary Care, NHS England Paul Turner, Deputy Director of Strategic Commissioning.

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

Relevant legal/statutory issues						
National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✔	**N/A**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**	✔	**N/A**	
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**	✔	**N/A**	

Key implications	
Are additional resources required?	N/A

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Has there been/does there need to be appropriate clinical involvement?	Yes, clinical support linked to the POD Design Group. A clinical lead/medical director has also been identified to work as part of the ICB multi-disciplinary team overseeing the specialised commissioning delegation joint commissioning and due diligence ahead of full delegation.
Has there been/does there need to be any patient and public involvement?	No
Has there been/does there need to be partner and/or other stakeholder engagement?	ICB/NHS England colleagues

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North East and North Cumbria

NHS England Commissioning Delegations: Primary Care and Specialised Commissioning

1. Purpose

This paper outlines:

- the status of delegation to ICBs in respect of Pharmacy, Optometry and Dental (POD) Services, including the North East North Cumbria approach, progress and next steps
- an update on the status and plans for the delegation of a tranche of specialised services to the North East and North Cumbria Integrated Care Board (the ICB) from NHS England.

2. Introduction

As part of the recent legislative changes and the introduction of Integrated Care Boards (ICBs), NHS England has plans to delegate elements of their commissioning responsibilities to ICBs. The main intention of the proposed delegations is to ensure a more joined up approach to commissioning and service development than perhaps was possible under previous clinical commissioning group and NHS England commissioning infrastructure.

3. Update

Appendix A provides an update on POD delegation and **Appendix B** details the report taken to the Executive Committee on 15 November 2022t, where outlined recommendations were approved, as a status update on the proposed delegation of specialised commissioning.

4. Recommendations

The Board is asked to:

- Note the update and current position in relation to the proposed delegation of specialised service commissioning;
- Formally approve the Executive Committee recommendations to form a joint committee with NHS England from April 2023;

- Delegate responsibility for approval of the PDAF submission to the Executive Director of System Oversight;
- Note that further updates on progress to establishing a joint commissioning arrangement and full delegation in April 2024 will be provided.

Report authors: **Denise Dodgson, Head of Primary Care (North East and North Cumbria), NHS England**

Paul Turner, Deputy Director of Strategic Commissioning

Sponsoring Directors: **Dave Gallagher, Executive Director of Place Based Delivery, Central and South**

Jacqueline Myers, Executive Director of Strategy and System Oversight

Date: **11 November 2022**

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Appendix A

Primary Care Commissioning and Contracting Functions for Delegation

1. Introduction

1.1 This paper sets out the position in respect of delegation to Integrated Care Boards (ICBs) in respect of primary care services, including the North East North Cumbria approach, progress and next steps.

1.2 All ICBs assumed delegated responsibility from NHS England for the commissioning for primary medical services from July 2022 and a number of ICBs also took on responsibility for some, or all, of the pharmacy, optometry and dental services. The North East North Cumbria Integrated Care Board (the ICB) decided to take on delegation for primary medical services only and will assume responsibility for community pharmacy, optometry and dentistry (POD) services from 1 April 2023.

1.3 This update will focus on the progress being undertaken for the safe transfer of the POD services from 1 April 2023.

2. Pharmacy, Optometry and Dental (POD) Design Group

2.1 The POD Design Group has been set up to oversee the safe transfer of services and decision making to the ICB. The Group has representatives from NHS England and the ICB and is chaired by Dave Gallagher, Executive Director of Place Based Delivery (Central and South) as Senior Responsible Officer for primary care commissioning.

2.2 The terms of reference for the Group were received at the meeting on 26 August 22 and approved following amendments on 16 September 2022. The Group meets on a fortnightly basis.

2.3 The POD Design Group also maintains an overview of the key documents that are required to be completed as part of the delegation process, these are detailed in the timeline below.

3. Timeline

3.1 The timeline for the delegation of POD services has been reviewed and key dates noted. Initially, work focussed in the completion of the pre-delegation assessment framework (PDAF) and the safe delegation Checklist (SDC).

3.2 **Pre-Delegation Assessment Framework (PDAF)**

The timeline for submission and national approval of the PDAF is set out below:

Action/date	Update
By 19 Sep 2022 - ICB approve the PDAF for submission to regional team	Completed on time
By 19 Sept 2022 - ICBs to submit their PDAF to the Regional Team	Completed
22 Sept 2022 - ICB meeting with region colleagues	Dave Gallagher and Denise Dodgson attended
29 Sept 2022 - Final PDAF submission to Regional Team	Complete and submitted on time
3 October 2022 - Regional NHSE submission to the National Team	Complete
12 October 2022 – PDAF reviewed by a National Moderation Panel	Complete and PDAF submitted to NHS England Board for formal approval
1 December 2022 - NHS England Board approval	Outcome awaited

3.3 **Safe Delegation Checklist (SDC)**

In order to ensure that there is due diligence for the safe delegation of the POD functions it is recommended, and has been supported the POD Design Group, to ensure that the NHS England SDC is completed. Whilst nationally, completion of the SDC is scheduled for February 2023, regional colleagues are requesting completion of the SDC by January 2023.

3.4 Completion of the SDC requires support from both NHS England teams and the ICB, key individuals from both have been identified and work is progressing to populate the checklist.

4. Governance

4.1 Work has recently taken place to understand the appropriate governance and decision-making process for primary medical care and discussions are currently taking place in parallel to understand if POD governance and decision making can be brought in line with this.

4.2 To support development of the operating model for POD functions, a piece of work has been undertaken to understand the scale and scope of the decision making, In order to support this work the we have mapped volume of decisions that have taken place from January 2022 to the end of June 2022. In addition, work has also been undertaken to map the functions to where decisions may need to be made.

4.3 In addition, the POD Design Group and the governance work is also exploring the merits of having an ICB wide Pharmaceutical Regulatory Services Committee (PSRC), as opposed to the current North East and Yorkshire wide PSRC. Under the Regulations, the ICB is required to have a PSRC and the NHS England Pharmacy Manual sets out the requirement for PSRC to make decisions on both market entry applications and decisions on any contractual action to be taken in line with the performance management of community pharmacies.

4.4 It is expected that outputs of this work will be presented to the ICB Executive Committee on 14 December 2022.

5. Regional assurance on Progress

5.1 Oversight of the transition of the POD functions to the ICB is being maintained by the Regional NHS England team through the Regional Commissioning and Planning Group. In addition, there are also Regional POD Delegation meetings held on a monthly basis, with representatives from NHS England and ICB colleagues.

6. Risks and Challenges

6.1 Having undertaken some early due diligence, the ICB has identified that the current skills and experience within the ICB in respect of pharmacy, optometry and dental contracting, commissioning and transformation is negligible. It is therefore imperative that the current staff supporting these functions within NHS England continue to support the ICB in delivering its delegated functions. However, NHS England is currently subject to organisational change and, as yet, it is still unclear if the Primary Care Team and associated support function staffing will be affected by change.

6.2 It is still unclear if the clinical support currently available to primary care teams will continue to be provided in the current form post delegation. Work is currently ongoing which the Regional NHS England Team is leading to provide clarity on the support available.

6.3 There are also a number of enabling functions that support the primary care teams, these include, finance, complaints management, media and Freedom of Information queries, nursing team support to the serious incident and quality processes, community pharmacy fitness to practise, national performer lists and administration (including practitioner performance), wider ICB programmes for example digital and capital expenditure.

7. Recommendations

The Board is asked to note the timeline for the actions required in respect of delegation of POD functions.

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Name of Author:	**Denise Dodgson, Head of Primary Care (North East and North Cumbria), NHS England**
Name of Sponsoring Director:	**Dave Gallagher, Executive Director of Place Based Delivery, Central and South**
Date:	**11 November 2022**

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Appendix B

Delegation of Specialised Service Commissioning to Integrated Care Boards

1. Introduction

1.1 This report provides an update on the status and plans for the delegation of a tranche of specialised services to the North East and North Cumrbia Integrated Care Board (the ICB) from NHS England.

1.2 The national road map for the delegation of specialised services to ICBs was published at the end of May 2022 setting out how the commissioning model for specialised services will evolve in the coming years. It charts a phased and managed approach to integrating specialised commissioning within the wider ICB commissioning responsibilities.

1.3 To support this process, discussions have now been held between specialised commissioners and the four ICB executive leads in Yorkshire and NENC to explore the delegation timeframe and consider the risks, challenges, opportunities from this policy development.

2. Background

2.1 NHS England is the accountable commissioner for 154 prescribed specialised services. This portfolio of services, which is set out in regulations, is hugely varied in nature, with some services that look after a handful of patients with rare conditions a year, to others, like radiotherapy or neurosurgery that treat tens of thousands each year as part of wider pathways of care that also span primary, community and other secondary care services currently commissioned by Integrated Care Boards (ICBs).

2.2 The establishment of specialised commissioning as part of NHS England following the Health and Social Care Act (2012) has brought many benefits in terms of how specialised services are commissioned with a commitment to national service specifications, universal access across the country and a robust policy development process. This led to a period of consolidation of services as compliance with new national standards was achieved. Although generally seen as a success, this has brought specific issues:

- A fragmentation of the commissioning pathway between the former clinical commissioning groups and now ICBs and NHS England
- Legislative barriers meaning that risk sharing between commissioners was possible but difficult to achieve in practice

- As NHS England has provider-based allocations, it was difficult to plan for population health across a geography.

2.3 The recent changes from the Health and Care Act 2022 brought in legislative changes to address some of these concerns, specifically allowing delegation of services where this is deemed appropriate. Although not mandated in legislation, the policy of NHS England is to support the devolution of commissioning to the most appropriate level and to delegate some specialised services to ICBs (or multi-ICBs footprints as appropriate). Health and justice, operational delivery networks and some specialised services will continue to be commissioned by NHS England, with around 65 services suitable for delegation to ICBs as part of the initial tranche.

3. Key Issues and Current Status

3.1 Services for delegation

Not all specialised services will be suitable for delegation and it is recognised that some services that are likely to benefit in the future will not yet be ready. To determine which services are appropriate for delegation, an analysis of the entire portfolio has been conducted by NHS England using a set of criteria to guide both the suitability and readiness of services for greater ICB leadership from April 2023.

Annex 1 provides a current list of the 65 services expected to be suitable for delegation. Further work will be conducted over the coming months to refine this list, with a final version to be confirmed later in the year.

Annex 2 provides an indication of the financial scale of the proposed delegated services, c£501m.

NHS England will retain accountability and will continue to set national standards, service specifications and develop clinical policies governing access to specialised treatments based on the advice of clinical leaders and the clinical reference groups (CRGs). They will also remain responsible for commissioning the retained list of specialised services.

3.2 Financial framework

NHS England's aims for the specialised commissioning financial framework, which will apply to ICBs following delegation, are to:

- Move to population-based budgets (from the current provider-based allocation) to support population health planning across the system to help

focus on health inequity. This will require an improvement in data quality nationally to allow accurate reporting to be produced

- Develop a needs-based allocation for specialised services following the recent formal consultation by Advisory Committee on Resource Allocation (ACRA). This will result in a dedicated needs-based methodology for specialised services being rolled out over the next 5-10 years.

Allocations will continue to be based on historical costs in the first instance. The needs-based formula that will determine the future shape of allocations, will be subject to an agreed pace of change policy over a number of years to maintain financial stability and avoid any cliff-edge changes. The transition to needs weighted population-based funding allocation for specialised services will begin in April 2024 at the earliest.

3.3 Risks and Issues

The proposal to delegate specialised commissioning responsibilities to the ICB identifies the following main risks:

- Financial risk to the ICB of being delegated services to commission that will be funded by a yet to be determined budget that will derive from a new population needs based allocation in subsequent years.
- The inheritance of responsibility for potential service quality and sustainability risks.

- Potential workforce capacity risks as at this time staffing implications of the delegation are not known.

As such, discussions between specialised commissioners and ICB executive leads in Yorkshire and North East and North Cumbria (NENC) have raised the following themes and concerns about accelerating too quickly to delegation:

- Lack of national information to consider; such as future contracting, financial architecture and the move to population-based models, data and information products, operating models etc. These are currently not fully developed and there is the potential for these products to be delayed
- The due diligence and associated risk underpinning delegation is unclear and would need to be fully described, including financial, service and quality risks.
- The move to a population-based allocation alongside a lack of data completeness was a specific risk identified
- Capacity and staffing resource - risks across all organisations to successfully deliver with ICBs just established as organisations, especially in light of the recent announcement of a 30-40% reduction in NHS England headcount
- How the residual commissioning functions of NHS England will be managed.

- Associated risks as ICBs emerge from the pandemic and address the significant recovery ambition and how this has impacted on specialised services already.

Understanding and mitigating these risks can be supported by opting for a less accelerated transition, as described later in this report.

3.4 Phased implementation

The delegation of specialised service commissioning to ICBs will be implemented in phases.

The national road map for specialised services indicated that during 2022/23 existing partnership forums should be used to support capability and readiness for delegation.

These partnership arrangements will not change formal statutory commissioning responsibilities during 2022/23. However, ICBs will be increasingly involved over the year for those services deemed appropriate by the service portfolio analysis. NHS England will continue to hold the commissioning budget and contracting function for specialised services and has made indicative allocations at ICS level available in 2022/23 so that ICSs can begin to plan how they would commission pathways of care when they take delegated responsibility.

From April 2023, ICBs can either accept delegation where they are assessed as ready or can put in place a joint commissioning arrangement to enable further capacity and capability development ready to take on full delegation from April 2024.

In Yorkshire and NENC, discussions have now been held between specialised commissioners and the four ICB executive leads to explore the delegation timeframe and consider the risks, challenges, opportunities from this policy development. From this a collective view has formed that in order to better understand and manage the risks the option to develop a joint commissioning arrangement discharged via a joint committee from April 2023 with full delegation from April 2024 should be taken.

If the approach is formally approved by respective ICBs, it is envisaged that there will be two joint committees, one for Yorkshire and Humber and one for NENC. It is understood that this approach is being taken by the majority of the ICBs nationally.

3.5 Joint commissioning arrangements from April 2023

For the reasons already described regarding the risks of full delegation a recommendation to enter into a joint commissioning arrangement with NHS England from April 2023 is being made rather than moving to full delegation.

Pursuant to section 65Z5 of the NHS Act, NHS England and ICBs are able to establish and maintain joint arrangements in respect of the discharge of their commissioning functions. As such they can discharge agreed joint functions through a joint committee.

ICB officers have had sight of an early draft of a joint commissioning agreement for use by NHS England and ICBs to set out their arrangements for a joint committee to oversee specialised commissioning in their area from April 2023, as per the proposed approach in Yorkshire and NENC.

The draft agreement identifies the following in terms of what establishing a joint arrangement and joint committee from April 2023 would practically involve:

- The arrangements are intended to give ICBs greater involvement in the commissioning of specialised services, in order to better align and transform pathways of care around the needs of local populations

- The joint committee will enable partners to collaboratively make decisions on the planning and delivery of the specialised services agreed as in scope. They are intended as a transition mechanism for ICBs that require additional support before they are ready to take on full delegated commissioning responsibility from April 2024

- The arrangements do not involve NHS England or the ICB delegating the exercise of any of their commissioning functions or any other functions to any other partner

- The joint arrangements enable the ICB to contribute to the development of service specifications and local services models in respect of specialised services. ICBs will also contribute to setting strategic priorities, joint strategic needs assessment, and population-based planning and commissioning. The ICB will be fully involved in the oversight and monitoring of the service quality, operational and financial performance and risk and issue management

- Whilst the ICB will contribute to financial planning via the joint committee, NHS England will continue to hold the population-based budget for specialised services in 2023/24, and related liability. Given NHS England is

not delegating its duties and retain liability, the final draft of the joint agreement is expected to state that it will hold the casting vote should there be any disagreement at the joint committee

- NHS England and the ICB may, for the purposes of exercising their joint commissioning under this agreement, establish and maintain a pooled fund in accordance with section 65Z6 of the NHS Act

- Exit and termination arrangements are still to be finalised but the draft agreement suggests that six months' notice will be required.

3.6 Pre-delegation assessment framework (PDAF)

ICBs will have their readiness assessed by NHS England prior to delegation being approved. All ICBs are expected to go through the PDAF process in quarter three of 2022/23 even if they have opted to form a joint commissioning arrangement from April 2023 and take on full delegation a year later in April 2024.

PDAF submissions can reflect the less accelerated timeline however and as such be proportionate to the status of readiness. ICB PDAF submissions are currently expected to be made by 23 November 2022.

Annex 3 sets out NHS England's current timeline for the PDAF process for April 2023.

The PDAF will assess system readiness against the following domains:

Domain	Principle
Transformation	There is a clear understanding of how receiving each new responsibility will benefit population health outcomes
	There is a shared understanding across all ICS partners of the benefits of delegation.
Governance and leadership	Clinical leadership combines the specialist expertise to lead and scrutinise individual functions, and the collaborative working necessary to identify, enable and oversee clinical improvements.
Finance	Major financial risk factors and issues are clearly understood and mitigated, and

	there is a track record of delivering a balanced budget.
Workforce capacity and capability	There is an understanding of the workforce, capability and capacity requirements, with any major risks understood and processed for mitigation.
Data, analytics and reporting infrastructure	There is a clear understanding of the level of digital maturity required, with any gaps identified and prioritised for improvement.
Health and care geography	There is a meaningful geographical footprint which takes into account key patient flows, with clear plans in place to manage and mitigate against any risks.

NHS England specialised commissioners and senior ICB officers have been meeting weekly since the end of September 2022 to ensure that the PDAF is completed and submitted in line with the required timelines.

3.5 Assurance and oversight for delegation

NHS England will remain accountable for the commissioning of all specialised services even after full delegation and will establish mechanisms to ensure responsibilities delegated to ICBs are being appropriately delivered. The assurance framework will align to and support what is set out in the delegation agreement and the system oversight framework.

NHS England will establish a delegated commissioning group for specialised services for those services deemed appropriate for ICB commissioning. This group will manage the approval of national standards, approve gateways for national transformation programmes, guide support to regions and ICBs, and provide oversight (as appropriate to the assurance frameworks) of these services.

3.6 Next steps

There is a significant amount of work to be undertaken to achieve the April 2024 delegation timeline. The key tasks can be broken down into three main areas:

1. Subject to Board approval, establish a joint committee from April 2023, and formalise agreement of its scope and role (awaiting full national guidance on this at time of writing).

2. Complete the PDAF submission jointly with NHS England and submit by 23 November 2022 deadline
3. Undertake due diligence and development tasks in preparation for safe transition to full delegation by:
    - Developing governance arrangements for the multi ICB working, for example lead ICB models and financial risk share arrangements
    - Conducting financial due diligence on services to be delegated including understanding the move to population allocations
    - Developing understanding patient flows and impact on services across ICBs
    - Conducting due diligence on services to be delegated including quality impact
    - Mapping data flow changes and the impact of identification rule changes to ensure ICBs and providers are aware and sighted on these
    - Developing future contracting arrangements underpinned by the proposed aligned incentive model and the likely changes to how lead contract/ associate arrangements will work.
    - Developing staffing models, roles and functions at a regional and ICB level to ensure accountability and governance arrangements are collectively agreed and implemented.

Name of Author:	**Paul Turner, Deputy Director of Strategic Commissioning**
Name of Sponsoring Director:	**Jacqueline Myers, Executive Director of Strategy and System Oversight**
Date:	**October 2022**

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Annex 1 - List of services suitable for joint commissioning from April 23 and delegation from April 24 *(Note: this is DRAFT and subject to change)*

PSS Manual Line	PSS Manual Line Description	Service Line Description	Programme of Care
2	Adult congenital heart disease services	Adult congenital heart disease services (non-surgical)	Women and Children
2	Adult congenital heart disease services	Adult congenital heart disease services (surgical)	Women and Children
3	Adult highly specialist pain management services	Adult highly specialist pain management services	Trauma
4	Adult highly specialist respiratory services	Severe asthma	Internal Medicine
4	Adult highly specialist respiratory services	Interstitial lung disease	Internal Medicine
4	Adult highly specialist respiratory services	Pulmonary vascular services	Internal Medicine
4	Adult highly specialist respiratory services	Management of central airway obstruction	Internal Medicine
5	Adult highly specialist rheumatology services	Adult highly specialist rheumatology services	Internal Medicine
7	Adult Specialist Cardiac Services	Inherited cardiac conditions	Internal Medicine
7	Adult Specialist Cardiac Services	Cardiac electrophysiology & ablation	Internal Medicine
7	Adult Specialist Cardiac Services	Cardiac magnetic resonance imaging	Internal Medicine
7	Adult Specialist Cardiac Services	Cardiac surgery (inpatient)	Internal Medicine
7	Adult Specialist Cardiac Services	Cardiac surgery (outpatient)	Internal Medicine
7	Adult Specialist Cardiac Services	Complex device therapy	Internal Medicine
7	Adult Specialist Cardiac Services	PPCI for ST- elevation myocardial infarction	Internal Medicine
7	Adult Specialist Cardiac Services	Transcatheter Aortic Valve Replacement (TAVI)	Internal Medicine
9	Adult specialist endocrinology services	Adult specialist endocrinology services	Internal Medicine
11	Adult specialist neurosciences services	Neurology	Trauma
11	Adult specialist neurosciences services	Neurophysiology	Trauma
11	Adult specialist neurosciences services	Neuroradiology	Trauma

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11	Adult specialist neurosciences services	Neurosurgery	Trauma
11	Adult specialist neurosciences services	Mechanical Thrombectomy	Trauma
12	Adult specialist ophthalmology services	Adult specialist ophthalmology services	Trauma
12	Adult specialist ophthalmology services	Artificial Eye Service	Trauma
13	Adult specialist orthopaedic services	Orthopaedic surgery	Trauma
13	Adult specialist orthopaedic services	Orthopaedic revision	Trauma
15	Adult specialist renal services	Access for renal dialysis	Internal Medicine
15	Adult specialist renal services	Renal dialysis	Internal Medicine
16	Adult specialist services for patients infected with HIV	Adult specialised services for people living with HIV	Blood and Infection
17	Adult specialist vascular services	Adult specialist vascular services	Internal Medicine
18	Adult thoracic surgery services	Complex thoracic surgery	Cancer
18	Adult thoracic surgery services	Adult thoracic surgery services: outpatients	Cancer
30	Bone conduction hearing implant services (adults and children)	Bone anchored hearing aids service	Trauma
30	Bone conduction hearing implant services (adults and children)	Middle ear implantable hearing aids service	Trauma
35	Cleft lip and palate services (adults and children)	Cleft lip and palate services	Women and Children
36	Cochlear implantation services (adults and children)	Cochlear implantation services	Trauma
40	Complex spinal surgery services (adults and children)	Complex spinal surgery services	Trauma
54	Fetal medicine services (adults and adolescents)	Fetal medicine services	Women and Children
58	Highly specialist adult gynaecological surgery and urinary surgery services for females	Severe Endometriosis	Women and children

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58	Highly specialist adult gynaecological surgery and urinary surgery services for females	Complex urinary incontinence and genital prolapse	Women and children
58A	Highly specialist adult urological surgery services for men	Penile implants	Cancer
58A	Highly specialist adult urological surgery services for men	Surgical sperm removal	Cancer
58A	Highly specialist adult urological surgery services for men	Urethral reconstruction	Cancer
59	Highly specialist allergy services (adults and children)	Highly specialist allergy services	Blood and Infection/ Women and Children
61	Highly specialist dermatology services (adults and children)	Highly specialist dermatology services	Internal medicine
62	Highly specialist metabolic disorder services (adults and children)	Highly specialist metabolic disorder services	Women and Children
63	Highly specialist pain management services for children	Highly specialist pain management services for children	Women and Children
64	Highly specialist palliative care services for children and young adults	Highly specialist palliative care services for children and young adults	Women and Children
65	Highly specialist services for adults with infectious diseases	Highly specialist services for adults with infectious diseases	Blood and Infection
65	Highly specialist services for adults with infectious diseases	Specialist Bone and Joint Infection	Blood and Infection
72	Major trauma services (adults and children)	Major trauma services	Trauma
78	Neuropsychiatry services (adults and children)	Neuropsychiatry services	Trauma
83	Paediatric cardiac services	Paediatric cardiac services	Women and Children
94	Radiotherapy services (adults and children)	Radiotherapy services (Adults)	Cancer
94	Radiotherapy services (adults and children)	Radiotherapy services (Children)	Cancer
94	Radiotherapy services (adults and children)	Stereotactic Radiosurgery / radiotherapy	Cancer

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105	Specialist cancer services (adults)	Anal cancer	Internal medicine
105	Specialist cancer services (adults)	Biliary tract cancer	Internal medicine
105	Specialist cancer services (adults)	Chemotherapy	Cancer
105	Specialist cancer services (adults)	Gynaecological cancer	Cancer
105	Specialist cancer services (adults)	Head and neck cancer	Cancer
105	Specialist cancer services (adults)	Kidney, bladder and prostate cancer	Cancer
105	Specialist cancer services (adults)	Liver cancer	Internal Medicine
105	Specialist cancer services (adults)	Malignant mesothelioma	Cancer
105	Specialist cancer services (adults)	Oesophageal and gastric cancer	Cancer
105	Specialist cancer services (adults)	Other rare cancers	Cancer
105	Specialist cancer services (adults)	Pancreatic cancer	Internal Medicine
105	Specialist cancer services (adults)	Rare brain and CNS cancer	Cancer
105	Specialist cancer services (adults)	Skin cancer	Internal Medicine
105	Specialist cancer services (adults)	Testicular cancer	Cancer
9	Adult specialist endocrinology services	Adrenal Cancer	Internal Medicine
106A	Specialist colorectal surgery services (adults)	Complex inflammatory bowel disease	Internal Medicine
106A	Specialist colorectal surgery services (adults)	Complex surgery for faecal incontinence	Internal Medicine
106A	Specialist colorectal surgery services (adults)	Transanal endoscopic microsurgery	Internal Medicine
106A	Specialist colorectal surgery services (adults)	Distal sacrectomy for advanced and recurrent rectal cancer	Internal Medicine
107	Specialist dentistry services for children	Specialist dentistry services for children	Women and Children
108	Specialist ear, nose and throat services for children	Specialist ear, nose and throat services for children	Women and Children

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109	Specialist endocrinology and diabetes services for children	Specialist endocrinology and diabetes services for children	Women and Children
110	Specialist gastroenterology, hepatology and nutritional support services for children	Specialist gastroenterology, hepatology and nutritional support services for children	Women and Children
112	Specialist gynaecology services for children	Specialist paediatric surgery services - Gynaecology	Women and Children
113	Specialist haematology services for children	Specialist haematology services for children	Women and Children
115B	Specialist maternity care for women diagnosed with abnormally invasive placenta	Specialist maternity care for women diagnosed with abnormally invasive placenta	Women and Children
118	Specialist neonatal care services	Specialist neonatal care services	Women and Children
119	Specialist neuroscience services for children	Specialist neuroscience services for children	Women and Children
119	Specialist neuroscience services for children	Paediatric neurorehabilitation	Women and Children
119	Specialist neuroscience services for children	Selective dorsal rhizotomy	Women and Children
120	Specialist ophthalmology services for children	Specialist ophthalmology services for children	Trauma
121	Specialist orthopaedic services for children	Specialist orthopaedic services for children	Women and Children
122	Specialist paediatric intensive care services	Specialist paediatric intensive care services	Women and Children
125	Specialist plastic surgery services for children	Specialist plastic surgery services for children	Women and Children
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	Specialist rehabilitation services for patients with highly complex needs	Trauma
127	Specialist renal services for children	Specialist renal services for children	Women and Children
128	Specialist respiratory services for children	Specialist respiratory services for children	Women and Children
129	Specialist rheumatology services for children	Specialist rheumatology services for children	Women and Children
130	Specialist services for children with infectious diseases	Specialist services for children with infectious diseases	Women and Children

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131	Specialist services for complex liver, biliary and pancreatic diseases in adults	Specialist services for complex liver, biliary and pancreatic diseases in adults	Internal Medicine
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	Specialist services for complex liver diseases In adults	Internal Medicine
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	Specialist services for complex pancreatic diseases In adults	Internal Medicine
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	Specialist services for haemophilia and other related bleeding disorders (Adults)	Blood and Infection
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	Specialist services for haemophilia and other related bleeding disorders (Children)	Blood and Infection
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	Prosthetics	Trauma
135	Specialist paediatric surgery services	Specialist paediatric surgery services - General Surgery	Women and Children
136	Specialist paediatric urology services	Specialist paediatric urology services	Women and Children
139A	Specialist morbid obesity services for children	Specialist morbid obesity services for children	Women and Children
139AA	Termination services for expectant mothers with significant comorbidities that require either or both critical care and medical support	Complex termination of pregnancy	Women and Children
ACC	Adult Critical Care	Adult critical care	Trauma
111	Clinical genomic services (adults and children)	Pre-Implantation genetic diagnosis and associated in-vitro fertilisation services	Women and Children
106	Specialist cancer services for children and young people	Children's cancer	Cancer
106	Specialist cancer services for children and young people	Teenage and young adult cancer	Cancer

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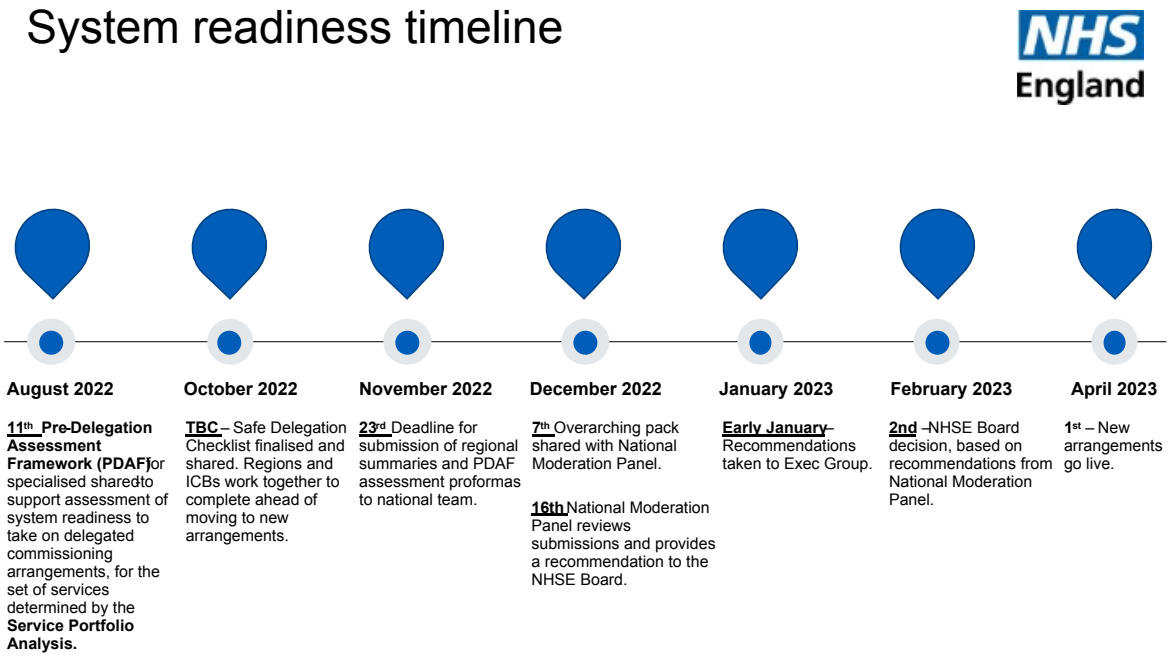
Annex 2 - Cost of proposed delegated services across ICBs in the north region

22/23 Baseline - Excludes High Cost Drugs and Devices*	Services suitable and ready for greater ICS leadership £m	Services suitable but not ready for greater ICS leadership £m	Remain commissioned on a whole provider/hosted basis £m	Services not suitable for more integrated commissioning £m	TBC** £m	Grand Total £m
NHS SOUTH YORKSHIRE ICB	244	30	24	9	21	328
NHS NORTH EAST AND NORTH CUMBRIA ICB	501	54	33	23	100	711
NHS HUMBER AND NORTH YORKSHIRE ICB	257	24	10	6	36	333
NHS WEST YORKSHIRE ICB	345	43	28	14	68	498
NE & YORKSHIRE Total	**1,348**	**151**	**94**	**52**	**226**	**1,870**

*2019/20 outurn plus the step 2 adjustments (non-recurrent removal, MH take and 20/21 & 21/22 growth apportioned on a straight line basis).
** Further analysis required - almost entirely relates to Mental Health.

Annex 3 - PDAF approval timeline.



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

NORTH EAST AND NORTH CUMBRIA ICB BOARD MEETING 29 November 2022	
Report Title:	**Establishing our Integrated Care Partnerships (ICP)**

Purpose of report

To update the ICB on the formation of the Strategic ICP and four Area ICPs, and to seek views on their terms of reference and membership.

Key points

Integrated Care Partnerships (ICPs) are statutory committees of ICBs and local authorities that bring together a broad set of system to develop a health and care strategy for their area. ICPs will facilitate joint action to improve health and care outcomes and work together to influence the wider determinants of health and broader social and economic development.

ICBs and local authorities are required to establish an effective and broad-based ICP, and these requirements have guided the establishment of inclusive ICP arrangements for the North East and North Cumbria set out in the attached Terms of Reference (TOR) and membership.

Our Strategic ICP met for the first time in September 2022 and agreed to consider detailed terms of reference (TOR) and membership at its next meeting in December. These TOR have therefore been drafted to build on existing partnership structures that will both galvanise the partnership behind common aims and set the culture of the system that health and care organisations across the North East and North Cumbria all work in.

Risks and issues

ICBs are required to work with local authorities in their area to establish an Integrated Care Partnership. As a core statutory member of, the ICB will need to consider the attached TOR prior to the next meeting of the ICP.

Item: 9.1

Assurances						
We have engaged on the attached draft through four multi-sectoral Area ICP meetings in the North, Central, Tees Valley and North Cumbria and the current draft reflects the feedback we received at those meetings. The proposed ICP model also builds on the steer we received from partners through the Joint Management Executive Group (JMEG) series of meetings chaired by Sir Liam Donaldson in 2021-2022.						
Recommendation/Action Required						
That the ICB gives its views on the attached Terms of Reference and membership for the Strategic ICP and Area ICPs.						
Sponsor/approving director	Claire Riley, Executive Director of Corporate Governance, Communications and Involvement.					
Report author	Dan Jackson, Director of Policy, Public Affairs and Stakeholder Affairs.					
Link to ICB corporate aims (please tick all that apply)						
CA1: Improve outcomes in population health and healthcare	✓					
CA2: tackle inequalities in outcomes, experience and access	✓					
CA3: Enhance productivity and value for money	✓					
CA4: Help the NHS support broader social and economic development	✓					
Relevant legal/statutory issues						
Every integrated care system area is required to have an Integrated Care Partnership comprised of the ICB, all of the local authorities in the area, and wider partners to be determined locally						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**	✓	**N/A**	
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**	✓	**No**		**N/A**	
Key implications						
Are additional resources required?	The ICB has agreed to provide administrative support to the ICP.					
Has there been/does there need to be appropriate clinical involvement?	Yes, through the process of developing an integrated care strategy for the ICP.					

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Has there been/does there need to be any patient and public involvement?	Yes, via the involvement of Healthwatch on the ICP.
Has there been/does there need to be partner and/or other stakeholder engagement?	Yes, this paper has been drafted following a multi-agency engagement exercise.

North East and North Cumbria Integrated Care Partnership (ICP)

Terms of Reference and Membership for the Strategic ICP and Area ICPs

Background

1. The North East and North Cumbria Integrated Care Partnership (herein referred to as the Strategic ICP) is a joint committee established by the North East and North Cumbria Integrated Care Board and the soon to be fourteen upper tier local authorities (County Durham, Cumberland, Darlington, Gateshead, Hartlepool, Middlesbrough, Newcastle upon Tyne, North Tyneside, Northumberland, Redcar and Cleveland, South Tyneside, Stockton-on-Tees, Sunderland and Westmorland & Furness) as equal partners, with a focus on aligning their ambitions to improve the health and care of the residents of the North East and North Cumbria. The Strategic ICP will facilitate joint action to improve health and care outcomes and work together to influence the wider determinants of health and broader social and economic development.

2. Together, the North East and North Cumbria Integrated Care Board (ICB) and the North East and North Cumbria Integrated Care Partnership (Strategic ICP) forms the new statutory North East and North Cumbria Integrated Care System (ICS).

3. While acknowledging the diversity of organisations and partners in our integrated care system there are a number of responsibilities placed on the ICB and local authorities as statutory co-owners and equal partners to formally engage with stakeholders and establish an effective and broad-based ICP. These requirements have guided the establishment of an inclusive ICP for the North East and North Cumbria, that builds on existing partnership structures to galvanise the partnership behind some common aims and set the culture of the system that we all work in.

Purpose

4. Our ICP will create the space for partners to develop joint strategies that better serve local populations, based on population health management approaches. They will enable partners to plan for the future and develop strategies for using available resources creatively to address the longer-term challenges which cannot be addressed by a single sector or organisation alone.

5. National guidance states that ICPs will highlight where coordination is needed on health and care issues and challenge partners to deliver the action required. These include, but are not limited to:
   - helping people live more independent, healthier lives for longer
   - taking a holistic view of people's interactions with services across the system and the different pathways within it
   - addressing inequalities in health and wellbeing outcomes, experiences and access to health services
   - improving the wider social determinants that drive these inequalities, including employment, housing, education, environment, and reducing offending
   - improving the life chances and health outcomes of babies, children and young people
   - improving people's overall wellbeing and preventing ill-health.

6. In meeting these challenges, the Strategic ICP has a specific responsibility for developing the **North East and North Cumbria Integrated Care Strategy** for the whole population. The strategy will build on the Joint Local Health and Wellbeing Strategies from all of the Health and Wellbeing Boards in our ICS area, use the best available evidence and data, covering health and social care (both children's and adult's social care), and seek to address the wider determinants of health and wellbeing. The strategy

will be built bottom-up from local assessments of needs and assets and the strategy will be focused on improving health and care outcomes, reducing inequalities, ensuring inclusion, and addressing the consequences of the pandemic for our communities.

7. While the Strategic ICP has no formal delegated powers from its constituent organisations, it will provide leadership, oversight, and support for system-wide activities, playing a key role in ensuring joint accountability to our population. The Strategic ICP will also continue to evolve in the way it works in response to the changing priorities of the partnership.

Responsibilities of the Strategic ICP

8. The Strategic ICP's responsibilities are to:
    - Develop and approve an Integrated Care Strategy for the population of North East and North Cumbria – which the ICB and local authorities will be required by law to have regard to the ICP's strategy when making decisions, and commissioning and delivering services.
    - Ensure the Integrated Care Strategy:
        - is focused on reducing health inequalities
        - uses the best available evidence and information
        - is built 'from the bottom up' taking account of challenges, assets and resources locally
        - expands the range of organisations and partners involved in strategy development and delivery
        - is underpinned by insights gained from our communities
        - benefits from strong clinical and professional input and advice
        - Focuses on those issues where ICP partners need to take joint action in relation to managing collective issues and challenges
    - Design and oversee a joint accountability framework to ensure the delivery of the Integrated Care Strategy.

9. In addition to these responsibilities, the Strategic ICP will:
    - Consider recommendations from partners and reach agreement on priority work programmes and workstreams that would benefit from a cross-partnership approach
    - Commission specific advice from established groups – including but not limited to the ICB's Clinical Leadership Group and the multi-agency Healthier and Fairer Advisory Group to obtain subject matter expertise, in setting the direction of the Strategic ICP
    - Provide active support to the development of four Area ICPs across the North East and North Cumbria, enabling local partnership arrangements, engagement and co-production, bringing together Local Authorities, voluntary and community groups, and other key partners
    - Facilitate and support cross-area working and sharing of best practice where this would benefit the population or provide efficiencies in our approach
    - Ensure that the ICP has a greater focus on population health improvement, integration of health and care services around the needs of residents, and a focus on care provided in primary and community settings.

10. For the avoidance of doubt, it is not a function of the Strategic ICP to duplicate the statutory functions of its constituent organisations. The Strategic ICP will not perform a health scrutiny function and will itself be subject to scrutiny by the Health Scrutiny Committees as appropriate of the fourteen local authorities in the ICS area.

Membership

11. The statutory membership of the Strategic ICP will comprise the Chair and Chief Executive of the Integrated Care Board and an elected member and senior officer from

each of the fourteen local authorities. Subject to the agreement of the Strategic ICP, an additional initial range of members will be as set out in Appendix 1.

12. In addition to the membership outlined in Appendix 1, the Strategic ICP may appoint such additional persons as it sees fit, either as co-opted voting members or as observers who shall be entitled to participate in discussion at its meetings but shall not be entitled to vote.

13. At the discretion of the Chair, additional ICB directors and other representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues.

Deputies

14. If a member is unable to attend a meeting of the Strategic ICP, they will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and understanding of the issues to be considered to represent their organisation effectively. Deputies will be eligible to vote if required. The Chair of the Strategic ICP must be informed in advance of the relevant meeting of the identity of a substitute.

Chairing

15. Until a substantive chair of the ICP is appointed in 2023, meetings will be convened and chaired by the chair of the ICB on an interim basis.

Frequency of Strategic ICP Meetings

16. The Strategic ICP will meet at least biannually to instigate and then sign off the Integrated Care Strategy development process. As a formal joint committee of the ICB and the local authorities the Strategic ICP will be required to meet in public, and its meetings will be livestreamed on the ICB website.

Operating Model and Area ICPs

17. Whilst there is a legislative basis for Integrated Care Partnerships, and extensive national guidance on the formation of Integrated Care Systems, there is, in addition, considerable flexibility for the Integrated Care Partnership's members to determine its operating model.

18. Therefore, the statutory members of the ICP have agreed a "one plus four" model, with one Strategic ICP (with a core membership of the ICB and all the local authorities in the ICS) which will be built up from the four existing and well-established partnership forums within North East and North Cumbria. These are based on geographical groupings that created valuable forums to think through how we better coordinate care and create new opportunities for wider access to services. NHS chairs and local authority leaders, as well as their chief executives and senior officers, have already been meeting together informally in this way for several years, building the relationships and trust that are helping to deliver increasing levels of integration and joint planning.

19. Therefore, our Area ICPs will be based on these existing geographies within our ICS:
    - **North**: Gateshead, Newcastle upon Tyne, North Tyneside, and Northumberland;
    - **Central**: County Durham, South Tyneside, and Sunderland;
    - **Tees Valley**: Darlington, Hartlepool, Middlesbrough, Redcar & Cleveland, and Stockton-on-Tees;
    - **North Cumbria**: Cumberland, and Westmorland & Furness (given part of the latter authority is within the North East and North Cumbria ICS area). It was agreed to establish this as a separate Area ICP given the unique challenges of geographical

isolation and service fragility within North Cumbria, and their need to collaborate on these challenges with the neighbouring ICP for Lancashire and South Cumbria, as well as its neighbours to the east.

Complimentary role of the Strategic ICP and Area ICPs

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

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

22. The membership of the Area ICPs will be diverse and drawn from a range of organisations as set out in Appendix 2 – including the Integrated Care Board, local authorities, foundation trusts, primary care networks, the voluntary sector and HealthWatch, and other partners.

Chairing of Area ICPs

23. Proposals for the chairing of Area ICPs will be considered at the Strategic ICP meeting on 15 December 2022.

Relationship of ICPs to place through Health and Wellbeing Boards

24. ICPs' central role is in the planning and improvement of health and care. They should support place-based partnerships and coalitions with community partners which are well-situated to act on the wider determinants of health in local areas. ICP should bring the statutory and non-statutory interests of places together.

25. The principle of subsidiarity has been a driving force in the creation of our ICS and will ensure that decisions are taken by communities at the most appropriate geography. The ICP should complement place-based working and partnerships, developing relationships and tackling issues that are better addressed on a bigger area.

26. In recognition of the importance of place, the 2022 Health and Care Act includes an important role for Health and Wellbeing Boards. They will remain legally distinct from Integrated Care Partnerships but the latter's strategic priorities should be informed by local population health data as expressed through Joint Strategic Needs Assessments,

and Joint Local Health and Wellbeing Strategies. Our Area ICPs should facilitate opportunities to share innovation and expertise in how to deliver integrated approaches in the context of local circumstances – but they should not seek to overrule or replace existing place-based plans.

Frequency of Area ICP Meetings

27. Meetings of the Area ICP will be held be held on a quarterly basis as a minimum. As these are not formal joint committees of public bodies their meetings are not required to be made public but Area ICPs can hold meetings in public if they wish, and their minutes will be published on the ICB website.

Reporting arrangements

28. Area ICPs will provide regular updates to the Strategic ICP via the minutes from each meeting. These minutes will be agreed by the Chair and circulated to representatives for approval and ratification (with the exception of any elements of any minutes need to be redacted due to conflicts of interest or withheld for reasons of commercial or personnel confidentiality).

Administrative Support

29. The ICB's Corporate Governance, Communications and Involvement team will provide a secretariat to the Strategic and Area ICPs to ensure the effective administration of the partnership, including the publication of meeting details on the ICB's website and the recording of meetings. The agenda and papers for meetings of the Strategic ICP and Area ICPs will be distributed no less than five working days in advance of the meeting unless agreed with the chair.

Conflicts of Interest

30. It is imperative that members ensure complete transparency in any discussions and/or subsequent recommendations by declaring any interests, both actual and/or perceived. The matter must always be resolved in favour of the public interest rather than the individual member or related organisation.

31. Members of the ICP are responsible for declaring any conflicts of interest in relation to the agenda items of the Partnership's meetings. Where any representative has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair shall use their discretion to decide, having regard to the nature of the potential or actual conflict of interest, whether or not that representative may participate in that part, or any other parts of the meeting, in which the relevant matter is discussed. Each representative must abide by all policies of the organisation he/she represents in relation to conflicts of interest.

Conduct of the ICPs

32. Each representative and those in attendance at ICP meetings will abide by the 'Principles of Public Life' and the NHS Code of Conduct, and the Standards for members of NHS boards and governing bodies, Principles of the Citizen's Charter and the Code of Practice on Access to Government Information together with all other applicable guidance, statutory guidance and/or requirements applying from time to time.

Date of review

33. The Partnership will review its own effectiveness, membership and terms of reference annually, however an initial review will take place after a period of six month following its establishment. Recommendations for amendment of the terms of reference will be submitted to the Board for approval.

Approved by the members of the Strategic ICP: December 2022

Appendix 1:

Strategic ICP Membership

Members from statutory partner organisations:

Integrated Care Board
- Chair: Professor Sir Liam Donaldson
- Chief Executive: Samantha Allen

County Durham
- Cllr Chris Hood, Lead Member for Adults Services
- Jane Robinson, Corporate Director, Adult and Health Services

Cumbria (interim position pending the council reorganisation in 2023)
- Cllr Martin Harrison, Lead Member for Adults (Cumberland)
- Cllr Patricia Bell, Lead Member (Westmorland & Furness)
- Colin Cox, Director of Public Health

Darlington
- Cllr Kevin Nicholson, Cabinet Member for Health & Housing
- James Stroyan, Group Director of People

Gateshead
- Cllr Lynne Caffrey, Chair of the Health and Wellbeing Board
- Alice Wiseman, Director of Public Health

Hartlepool
- Cllr Shane Moore, Leader of the Council
- Craig Blundred, Director of Public Health

Middlesbrough
- Cllr David Coupe, Chair of the Health and Wellbeing Board
- Erik Scollay, Director of Adults Services

Newcastle upon Tyne
- Cllr Karen Kilgour, Deputy Leader of the Council
- Matt Wilton, Assistant Chief Executive

North Tyneside
- Cllr Karen Clark, Chair of the Health and Wellbeing Board and the Cabinet Member for Public Health
- Wendy Burke, Director of Public Health

Northumberland
- Cllr Wendy Pattison, lead member for Adult Wellbeing
- Liz Morgan, Director of Public Health

Redcar & Cleveland
- Mary Lanigan, Leader of the Council
- Patrick Rice, Corporate Director Adults and Communities

South Tyneside
- Cllr Anne Hetherington, Lead Member for adults, health and independence
- Tom Hall, Director of Public Health

Stockton-on-Tees
- Cllr Bob Cook, Leader of the Council & Chair of the Health and Wellbeing Board
- Ann Workman, Director Adults & Health Services

Sunderland
- Cllr Kelly Chequer, Healthy City Portfolio Holder
- Gerry Taylor, Director of Public Health

Members from non-statutory partner organisations:

ICS VCSE Partnership
- Jane Hartley, Social Prescribing and Health Partnerships Strategic Manager (and ICB Participant)
- Lisa Taylor, Health and Wellbeing Programme Director

ICS HealthWatch Network
- David Thompson, Chair of Healthwatch Northumberland (and ICB Participant)

Housing Sector
- Tracy Harrison, Chief Executive of the Northern Housing Consortium
- Chris Smith, Chief Executive of Thirteen Housing Group

Social Care Provider Sector
- (Member TBC)

Regional Hospice Network
- (Member TBC)

University Sector
- (Member TBC)

Police and Fire & Rescue Services
- (Members TBC)

At the discretion of the Chair, additional representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues.

Appendix 2:

Area ICP Membership
This will be for local determination, but it is expected that each Area ICP will have members drawn from the following organisations and sectors:

- **NHS North East and North Cumbria Integrated Care Board**
- **Foundation Trusts (Acute, Mental Health and Ambulance)**
- **Local Authorities (e.g. Health and Wellbeing Board Chairs and Directors of Adult's Services, Children's Services & Public Health)**
- **Primary Care Networks**
- **Housing Sector**
- **Police and Fire & Rescue Services**
- **University and Education sector**
- **VCSE providers and local infrastructure organisations**

Item: 9.2

NHS
North East and North Cumbria

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

NORTH EAST AND NORTH CUMBRIA ICB BOARD MEETING 29 November 2022	
Report Title:	**Constitution of the NHS North East and North Cumbria Integrated Care Board**

Purpose of report

To present the Board with an updated Constitution for the North East and North Cumbria Integrated Care Board (the ICB).

Key points

The ICB Constitution was presented to the ICB Board's inaugural meeting held on the 1 July 2022.

Following commencement of the Health and Care Act (2022) NHS England's legal team conducted a review of the model Constitution that was published in May 2022 and identified several small amendments that needed to be made.

These are summarised below and are track-changed within the attached Constitution for ease of reference:

- Section 1.4.7 (f) – Health and Care Act reference 'section 14Z44' corrected to read 'section 14Z454'
- Section 3.2.4 – Reference to the 'Scottish Bankruptcy Act 1985' corrected to read 'Part 13 of the Bankruptcy (Scotland) Act 2016'.
- Section 3.2.7 – Definition of a Health Care Professional updated to remove reference to 'section 14N of the 2006 Act'.
- Appendix 1 – updated to include a definition of 'Health Care Professional' as 'an individual who is a member of a professional regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professional Act 2002.

The updated Constitution is attached at appendix 1.

Risks and issues

The Constitution is a key governance document and needs to be kept under review to reflect current legislation, guidance and the ICB's Operating Model.

Assurances

Item: 9.2

These required amendments have been issued to all ICBs following legal review of the Model Constitution.						
Recommendation/Action Required						
The Board is asked to approve the proposed amendments, following which the revised Constitution will be submitted to NHS England for formal approval.						
Sponsor/approving director	Claire Riley, Executive Director of Corporate Governance, Communications and Involvement					
Report author	Jacqui Keane, Head of Governance					
Link to ICB corporate aims (please tick all that apply)						
CA1: Improve outcomes in population health and healthcare	✓					
CA2: tackle inequalities in outcomes, experience and access	✓					
CA3: Enhance productivity and value for money	✓					
CA4: Help the NHS support broader social and economic development	✓					
Relevant legal/statutory issues						
The amendments ensure accurate reflection of the Health and Care Act 2022, Bankruptcy (Scotland) Act 2016 and the National Health Service Reform and Health Care Professional Act 2002.						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓
Key implications						
Are additional resources required?	None					
Has there been/does there need to be appropriate clinical involvement?	Not applicable					
Has there been/does there need to be any patient and public involvement?	Not applicable (original Constitution was subject to wide engagement)					
Has there been/does there need to be partner and/or other stakeholder engagement?	Not applicable (original Constitution was subject to wide engagement)					

North East and North Cumbria

NHS North East and North Cumbria Integrated Care Board

CONSTITUTION

Version	Changes	Date approved by the ICB	Effective date
V1.0	First version	N/A	July 1st 2022
V1.1	Incorporating technical amendments required by NHSE (all ICBs)		

CONTENTS		

Introduction

1.1 Background/ Foreword

NHSE has set out the following as the four core purposes of ICSs:

a) improve outcomes in population health and healthcare
b) tackle inequalities in outcomes, experience and access
c) enhance productivity and value for money
d) help the NHS support broader social and economic development.

The ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible

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

We are the largest ICS in the country, with a population of 3 million people spread across large conurbations and some of the most rural and isolated parts of England. Our ICS covers thirteen locality areas and all of these places are rightly proud of their history and are ambitious for their future so we are determined to play our part in improving the health of all our communities, ensuring the health and care services they receive are of the highest quality, and contributing to their development.

The North East and North Cumbria has much to be proud of with some of the most accessible primary care services and best performing emergency care in the country. We are known for innovation with a track record of ground-breaking surgery, pioneering new treatments and research programmes, world-class facilities and national centres of excellence. We have also made huge progress to improve the health of our communities in some key areas such as stroke, heart attacks, the prevalence of smoking in adults and teenage pregnancies.

However, overall public health in our region is still amongst the worst in the country and we face some of the starkest health inequalities. Our ambition is to change that. We want our ICB to be the leading system in England for people in terms of their experience of care and their outcomes of care. We don't just want to add years

to people's lives and life expectancy, we also want to improve our population's quality of life from birth through to living well and ageing well.

In consultation with local partners, the ICB will produce a five-year plan (updated annually) for how NHS services will be delivered to meet local needs. In developing this plan and carrying out our work, the ICB must have regard to the Integrated Care Strategy set by our Integrated Care Partnership (ICP) – a statutory committee of the ICB and the thirteen local authorities in the North East and North Cumbria – which in turn will be informed by the joint health and wellbeing strategies published by each of the twelve Health and Wellbeing Boards in our area.

As a system we recognise that there are significant benefits in working together at scale and that local plans need to be complemented with a common vision and shared strategy for the North East and North Cumbria as a whole, so that we strive to deliver the very best healthcare, accelerate innovation and ensure the NHS – as a network of 'anchor institutions' in each of our communities – plays its part in the wider economic development of our region.

However, this constitution and its supporting documents also creates the framework for the Integrated Care Board to delegate decision-making authority, functions and resources to our thirteen places to ensure that we meet the diverse needs of our citizens and communities. These place-based partnerships, overseen by Health and Wellbeing Boards, and including councils, health and care providers, the voluntary community and social enterprise sector and Healthwatch, are key to achieving the ambitious improvements we want to see.

The ICB is committed to meaningful conversations with the communities it serves and highly values the feedback that people share with us. We recognise too that effective approaches to equality, diversity and inclusion leads to improved health delivery and greater staff and patient experiences of the NHS. We want to ensure that everyone working and learning in our ICS can develop and thrive in an inclusive environment that embraces diversity helping us to tackle health inequalities through a whole systems approach.

Effective public involvement, particularly with those with lived experience and who are seldom heard, ensures that we make the right decisions together about our health and care services, and that is why we have included as participants on our Board both the ICS HealthWatch Network and the ICS Voluntary Sector Partnership to ensure that the voice of our citizens, service-users and communities of interest are at the heart of our health and care system. These conversations will be a key part of our journey over the months and years ahead.

This document – our constitution – sets out how we will organise ourselves to meet these ambitions to provide the best health and care, ensuring that our decisions are always taken in the interest of the patients and populations that we are proud to serve.

1.2 Name

1.2.1 The name of this Integrated Care Board is NHS North East and North Cumbria Integrated Care Board ("the ICB").

1.3 Area Covered by the Integrated Care Board

1.3.1 The area covered by the ICB[3] comprises Borough of Allerdale, City of Carlisle, County of Durham, Borough of Darlington, District of Eden, Borough of Gateshead, Borough of Hartlepool, Borough of Middlesbrough, City of Newcastle-upon-Tyne, Borough of North Tyneside, County of Northumberland, Borough of Redcar and Cleveland, Borough of South Tyneside, Borough of Stockton-on-Tees, City of Sunderland and partial inclusion of the Borough of Copeland (excluding LSOAs: E01019283, E01019289, E01019290, E01019293, E01019298, E01019299).

1.4 Statutory Framework

1.4.1 The ICB is established by order made by NHS England under powers in the 2006 Act.

1.4.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

1.4.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its constitution (section 14Z29). This Constitution is published at Home | North East and North Cumbria ICS

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act);
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
c) Duties in relation to children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014)
d) Adult safeguarding and carers (the Care Act 2014)
e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35);
f) Information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000), and
g) Provisions of the Civil Contingencies Act 2004

1.4.6 The ICB is subject to an annual assessment of its performance by NHS England which is also required to publish a report containing a summary of the results of its assessment.

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under:
a) section 14Z34 (improvement in quality of services),
b) section 14Z35 (reducing inequalities),
c) section 14Z38 (obtaining appropriate advice)
d) section 14Z40 (duty in respect of research),
e) section 14Z43 (duty to have regard to effect of decisions)
f) section 14Z454 (public involvement and consultation),
g) sections 223GB to 223N (financial duties), and
h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z61).

1.5 Status of this Constitution

1.5.1 The ICB was established on 1 July 2022 by *[name and reference of establishment order when received]*, which made provision for its Constitution by reference to this document.

1.5.2 This Constitution must be reviewed and maintained in line with any agreements with, and requirements of, NHS England set out in writing at establishment.

1.5.3 Changes to this Constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this Constitution

1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:

a) where the ICB applies to NHS England in accordance with NHS England's published procedure[6] and that application is approved; and

b) where NHS England varies the Constitution on its own initiative, (other than on application by the ICB).

1.6.2 The procedure for proposal and agreement of variations to the Constitution is as follows:

a) The Chair and/or Chief Executive may periodically propose amendments to the Constitution, which shall be submitted to the Board for approval. Agreed proposed changes will then be submitted to NHS England for approval.

b) Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related Documents

1.7.1 This Constitution is also supported by a number of documents which provide further details on how governance arrangements in the ICB will operate.

1.7.2 The following are appended to the constitution and form part of it for the purpose of clause 1.6 and the ICB's legal duty to have a Constitution:

a) **Standing orders–** which set out the arrangements and procedures to be used for meetings and the selection and the processes to appoint the ICB committees.

1.7.3 The following do not form part of the Constitution but are required to be published.

a) **The Scheme of Reservation and Delegation (SoRD)–** sets out those decisions that are reserved to the board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated to.

b) **Functions and Decision Map -** a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decision map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).

c) **Standing Financial Instructions –** which set out the arrangements for managing the ICB's financial affairs.

d) **The ICB Governance Handbook –** This brings together all the ICB's governance documents so it is easy for interested people to navigate. It includes:

- The above documents a) – c)
- Terms of reference for all committees and sub-committees of the Board that exercise ICB functions.
- Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.
- Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
- The up-to-date list of eligible providers of primary medical services under clause 3.6.2
- Committee structure
- Remuneration Guidance

e) **Key policy documents -** which should also be included in the Governance Handbook or linked to it including, but not limited to:

- Standards of Business Conduct and Declarations of Interest Policy
- Communities and People Involvement and Engagement Strategy for the North East and North Cumbria.

2 Composition of the Board of the ICB

2.1 Background

2.1.1 This part of the Constitution describes the membership of the Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in section 3.

2.1.2 Further information about the individuals who fulfil these roles can be found on our website at Home | North East and North Cumbria ICS

2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this Constitution as "the board" and members of the ICB are referred to as "board Members") consists of:

a) a Chair
b) a Chief Executive
c) at least three Ordinary members.

2.1.4 The membership of the ICB (the board) shall meet as a unitary board and shall be collectively accountable for the performance of the ICB's functions.

2.1.5 NHS England Policy, requires the ICB to appoint the following additional Ordinary Members:

a) three executive members, namely:
- Director of Finance
- Medical Director
- Director of Nursing

b) At least two independent non-executive members.

2.1.6 The Ordinary Members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as Partner Members) are nominated by the following and appointed in accordance with the procedures set out in Section 3**:**

- NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description
- the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description
- the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.

While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board, they are not to act as delegates of those sectors.

2.2 Board Membership

2.2.1 The ICB has eight Partner Members.

a) Two Partner members – NHS and Foundation Trusts

b) Two Partner members – Primary medical services

c) Four Partner members – Local Authorities

This is in order to take account of the geographical size and complexity of the ICS area.

2.2.2 The ICB has also appointed the following further Ordinary Members to the board

a) In addition to the statutory minimum of two Non Executive Members, a further two are added in order to take account of the geographical size and complexity of the ICS area and the need for independent leadership of key committees.

b) In addition to the statutory minimum executive roles (Medical Director, Director of Nursing, Director of Finance - which in our ICB will be called the Executive Medical Director, Executive Chief Nurse, and Executive Finance Director), a further seven member director roles will be created. The precise portfolios of these additional roles will be at the discretion of the Chair and Chief Executive. These will be:

- One Executive Chief People Officer
- One Executive Chief Digital & Information Officer
- One Executive Director of Innovation
- One Executive Director of Corporate Governance, Communications and Involvement
- One Executive Director of Strategy and System Oversight
- Two Executive Directors of Place Based Delivery – one covering the 'North' (North: Gateshead, Newcastle upon Tyne, North Tyneside and Northumberland) and North Cumbria; and one covering the 'Central' and 'South': (Central: County Durham, South Tyneside and Sunderland; South: Darlington, Hartlepool, Middlesbrough, Redcar & Cleveland, Stockton-on-Tees).

2.2.3 The board is therefore composed of the following members:

a) Chair
b) Chief Executive
c) Two Partner member(s) NHS and Foundation Trusts
d) Two Partner member(s) Primary medical services
e) Four Partner member(s) Local Authorities
f) Four Non Executive Members
g) One Executive Finance Director
h) One Executive Medical Director
i) One Executive Chief Nurse
j) One Executive Chief People Officer
k) One Executive Chief Digital & Information Officer
l) One Executive Director of Strategy and System Oversight
m) Two Executive Directors of Place Based Delivery – North and North Cumbria and Central and South
n) One Executive Director of Innovation
o) One Executive Director of Corporate Governance, Communications and Involvement

Other board-level Director roles of the ICB (attending as participants rather than voting members) will be at the discretion of the Chair and Chief Executive.

2.2.4 The Chair will exercise their function to approve the appointment of the ordinary members with a view to ensuring that at least one of the Ordinary or Partner board Members will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

2.2.5 The board will keep under review the skills, knowledge, and experience that it considers necessary for members of the board to possess (when taken together) in order for the board effectively to carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcoming.

2.3 Regular Participants and Observers at Board Meetings

2.3.1 The board may invite specified individuals to be Participants or Observers at some of its meetings (or parts of its meetings) in order to inform its decision-making and the discharge of its functions as it sees fit. Participants will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote.

2.3.2 Participants will include:

a) ICB Directors with specific portfolio areas
b) Representative from North East and North Cumbria ICS Healthwatch Network
c) Representative from the North East and North Cumbria Voluntary, Community and Social Enterprise Partnership
d) Any other person identified by the Chair

2.3.3 Observers will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the Board meetings, or part(s) of a meeting by the Chair. Any such person may not address the meeting and may not vote.

2.3.4 Participants and / or observers may be asked to leave the meeting by the Chair in the event that the board passes a resolution to exclude the public as per the Standing Orders.

3. Appointments Process for the Board

3.1 Eligibility Criteria for Board Membership

3.1.1 Each member of the ICB must:

a) Comply with the criteria of the "fit and proper person test"
b) Be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles)
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.2 Disqualification Criteria for Board Membership

3.2.1 A Member of Parliament

3.2.2 A person whose appointment as a Board member ("the candidate") is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

3.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted -

a) in the United Kingdom of any offence, or
b) outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, Part 13 of the Bankruptcy (Scotland) Act 2016~~sections 56A to 56K of the Bankruptcy (Scotland) Act 1985~~ or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

3.2.5 A person who has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.

3.2.6 A person whose term of appointment as the chair, a member, a director or a governor of a health service body, has been terminated on the grounds:

a) that it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office
b) that the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings,
c) that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest, or
d) of misbehaviour, misconduct or failure to carry out the person's duties.

3.2.7 A health care professional ~~(within the meaning of section 14N of the 2006 Act)~~ or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was:

a) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated
b) the person's erasure from such a register, where the person has not been restored to the register
c) a decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded, or
d) a decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to -

a) a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or
b) an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

3.2.9 A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which

the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

3.2.10 A person who has at any time been removed, or is suspended, from the management or control of any body under -

a) section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities), or
b) section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State.

3.3.2 In addition to criteria specified at 3.1, this member must fulfil the following additional eligibility criteria

a) The Chair will be independent.
b) Any other criteria as may be set out in any NHS England guidance

3.3.3 Individuals will not be eligible if:

a) They hold a role in another health and care organisation within the ICB area.
b) Any of the disqualification criteria set out in 3.2 apply

3.3.4 The term of office for the Chair will be three years and the total number of terms a Chair may serve is three.

3.4 Chief Executive

3.4.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.

3.4.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.

3.4.3 The Chief Executive must fulfil the following additional eligibility criteria

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Meets the Person Specification for the role
c) No further local criteria proposed
d) Any other criteria as may be set out in any NHS England guidance

3.4.4 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) Subject to clause 3.4.3(a), they hold any other employment or executive role.

3.5 Partner Member(s) – NHS Trusts and Foundation Trusts

3.5.1 These Partner Members are jointly nominated by the NHS trusts and/or foundation trusts which provide services for the purposes of the health service within the ICB's area and meet the forward plan condition or (if the forward plan condition is not met) the leve lof services provided condition.

a) County Durham and Darlington NHS Foundation Trust
b) Cumbria, Northumberland and Tyne & Wear NHS Foundation Trust
c) Gateshead Health NHS Foundation Trust
d) Newcastle upon Tyne Hospitals NHS Foundation Trust
e) North Cumbria Integrated Care NHS Foundation Trust
f) North East Ambulance Service NHS Foundation Trust
g) North Tees and Hartlepool NHS Foundation Trust
h) North West Ambulance Service
i) Northumbria Healthcare NHS Foundation Trust
j) South Tees Hospitals NHS Foundation Trust
k) South Tyneside and Sunderland NHS Foundation Trust
l) Tees, Esk and Wear Valleys NHS Foundation Trust

3.5.2 These members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be the Chief Executive or an Executive Director of one of the NHS Trusts or Foundation Trusts within the ICB’s area
b) Fulfil any other criteria as may be set out in NHS England guidance
c) Declare themselves willing to serve as a full member of a unitary board, *inter alia* responsible for stewardship of NHS funds and be

bound by individual and collective accountability for decisions even where these may be unpopular or attract criticism.

d) Agree that they will bring knowledge and perspective from their sector but not be delegates or carry agreed mandates from any part of that sector.

3.5.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) Any other exclusion criteria set out in NHS England guidance applies.
c) They cannot provide unequivocal assurances in relation to the criteria in 3.5.2 c) or d).

3.5.4 These members will be approved by the ICB Chair, supported by an Appointments Panel. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process. The appointment process will include both nomination and selection elements.

3.5.5 The appointment process will be as follows:

a) Joint Nomination:

- When a vacancy arises, each eligible organisation listed at 3.5.1.a will be invited to make nominations.
- Eligible organisations may nominate individuals from their own organisation or another organisation
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c)

- The full list of nominees will be considered by a panel convened by the Chief Executive or ICB Chair.
- The panel will assess the suitability of the nominees against the requirements of the role and will include ensuring that equality, diversity and inclusion is taken into account at each stage of the process. The role requirements will be published

before the nomination process is initiated and will confirm that nominees meet the requirements set out in clause 3.5.2 and 3.5.3

- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval

- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.5.6. The term of office for these Partner Members will be up to four years. Their service will be limited to two terms but at the end of each term of office, the sector will be asked if there are alternative nominations for this role. Should there be more eligible nominations than positions available, then the appointments process will be followed. If no additional nominations are received and the incumbent postholder remains eligible in line with the criteria outlined at 3.1 and 3.5.3, then they will be considered for reappointment to the role.

3.5.7 On first appointment to the role, the ICB may stagger the end date of the length of the term of office to avoid all terms of office expiring at the same time.

3.6 Partner Member(s) - Providers of Primary Medical Services.

3.6.1 These Partner Members are jointly nominated by providers of primary medical services for the purposes of the health service within the ICB's area and that are primary medical services contract holders responsible for the provision of essential services, within core hours to a list of registered persons for whom the ICB has core responsibility.

3.6.2 The list of relevant providers of primary medical services for this purpose is published as part of the Governance Handbook. The list will be kept up to date but does not form part of this Constitution.

3.6.3 This member must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be a provider of primary medical services within the ICB's area
b) Fulfil any other criteria as may be set out in NHS England guidance
c) Declare themselves willing to serve as a full member of a unitary board, *inter alia* responsible for stewardship of NHS

funds and be bound by individual and collective accountability for decisions even where these may be unpopular or attract criticism.

d) Agree that they will bring knowledge and perspective from their sector but not be delegates or carry agreed mandates from any part of that sector.

3.6.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) Any other exclusion criteria set out in NHSE guidance apply
c) They cannot provide unequivocal assurances in relation to the criteria in 3.6.3 c) or d).

3.6.5 This member will be approved by the ICB Chair, supported by an Appointments Panel.

3.6.6 The appointment process will be as follows:

a) Joint Nomination:

- When a vacancy arises, each eligible organisation described at 3.6.1 and listed in the Governance Handbook will be invited to make nominations.
- Eligible organisations may nominate individuals from their own organisation or another organisation
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c)

- The full list of nominees will be considered by a panel convened by the Chief Executive or Chair.
- The panel will assess the suitability of the nominees against the requirements of the role and will include ensuring that equality, diversity and inclusion is taken into account at each stage of the process. The role requirements will be published before the nomination process is initiated and will confirm

that nominees meet the requirements set out in clause 3.5.2 and 3.5.3

- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval

- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.6.7 The term of office for this Partner Member will be up to four years. Their service will be limited to two terms but at the end of each term of office, the sector will be asked if there are alternative nominations for this role. Should there be more eligible nominations than positions available, then the appointments process will be followed. If no additional nominations are received and the incumbent postholder remains eligible in line with 3.1 and 3.5.3 above, then they will be considered for reappointment to the role.

3.6.8 On first appointment to the role, the ICB may stagger the end date of the length of the term of office to avoid all terms of office expiring at the same time.

3.7 Partner Member(s) – eligible local authorities

3.7.1 These Partner Members are jointly nominated by the local authorities whose areas coincide with, or include the whole or any part of, the ICB's area. Those local authorities are:

a) Cumbria County Council
b) Darlington Borough Council
c) Durham County Council
d) Gateshead Council
e) Hartlepool Borough Council
f) Middlesbrough Council
g) Newcastle upon Tyne City Council
h) North Tyneside Council
i) Northumberland County Council
j) Redcar & Cleveland Borough Council
k) South Tyneside Council
l) Stockton-on-Tees Borough Council
m) Sunderland City Council

3.7.2 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Fulfil any other criteria as may be set out in NHS England guidance

a) Declare themselves willing to serve as a full member of a unitary board, *inter alia* responsible for stewardship of NHS funds and be bound by individual and collective accountability for decisions even where these may be unpopular or attract criticism.

b) Agree that they will bring knowledge and perspective from their sectors but not be delegates or carry agreed mandates from any part of that sector.

3.7.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) Any other exclusion criteria set out in NHSE guidance applies
c) They cannot provide unequivocal assurances in relation to the criteria in 3.7.2 b) or c).

3.7.4 This member will be approved by the ICB Chair, supported by an Appointments Panel.

3.7.5 The appointment process will be as follows:

a) Partner members will be nominated jointly by their respective sector in line with the requirements of the Act and related Guidance.

b) Nominated individuals who meet the criteria outlined at 3.1 and 3.5.3 will complete an application process against a published role specification.

c) Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process. We will look to ensure a breadth of perspectives from across our whole ICS geography, with members that bring expertise from key professional backgrounds including adults' services, children's services, and public health.

3.7.6 **a) Joint Nomination:**

- When a vacancy arises, each eligible organisation listed at 3.7.1.will be invited to make nominations.
- Eligible organisations may nominate individuals from their own organisation or another organisation
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c)

- The full list of nominees will be considered by a panel convened by the Chief Executive
- The panel will assess the suitability of the nominees against the requirements of the role and will include ensuring that equality, diversity and inclusion is taken into account at each stage of the process. The role requirements will be published before the nomination process is initiated and will confirm that nominees meet the requirements set out in clause 3.7.2 and 3.7.3
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval

- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.7.7 The term of office for this Partner Member will be up to four years. Their service will be limited to two terms but at the end of each term of office, the sector will be asked if there are alternative nominations for this role. Should there be more eligible nominations than positions available, then the appointments process will be followed. If no additional nominations are received and the incumbent postholder remains eligible in line with 3.1 and 3.5.3 above, then they will be considered for reappointment to the role.

3.7.8 On first appointment to the role, the ICB may stagger the end date of the length of the term of office to avoid all terms of office expiring at the same time.

3.8 Medical Director

3.8.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Be a registered Medical Practitioner

3.8.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) Any other exclusion criteria set out in NHS England guidance applies.

3.8.3 This member will be appointed by the Chief Executive supported by an Appointments Panel headed by the Chair or Non-Executive Member of the board and the recommended appointment will be subject to the approval of the Chair. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process.

3.9 Executive Chief Nurse

3.9.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Be a registered Nurse
c) Any other criteria set out by NHS England's guidance.

3.9.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) Any other exclusion criteria set out in NHS England guidance applies.

3.9.3 This member will be appointed by the Chief Executive supported by an Appointments Panel headed by the Chair or Non-Executive Member of the board and the recommended appointment will be subject to the approval of the Chair. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process.

3.10 **Executive Finance Director**

3.10.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Full membership of a recognised professional Chartered Accountancy Body.
c) Any other criteria set out by NHS England's guidance

3.10.2 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply
b) Any other exclusion criteria set out in NHS England guidance applies.

3.10.3 This member will be appointed by the Chief Executive supported by an Appointments Panel headed by the Chair or Non-Executive Member of the board and the recommended appointment will be subject to the approval of the Chair. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process.

3.11 Four Non-Executive Members

3.11.1 The ICB will appoint four Non-Executive Members

3.11.2 These members will be approved by the ICB chair, supported by an Appointments Panel.

3.11.3 The appointments will be made following an openly advertised application. A panel will be established and chaired by the ICB Chair to assess the applications and interview suitable applicants. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process.

3.11.4 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Not be employee of the ICB or a person seconded to the ICB
b) Not hold a role in another health and care organisation in the ICB area

c) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee

d) One should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee

e) One should have specific knowledge, skills and experience that makes them suitable to express an informed view about the ICB's duty in relation to patient and public involvement

f) One to undertake the role of Senior Independent Non-Executive Member

g) Will be living in, or have a connection to, the area covered by the ICB (as described at 1.3.1)

h) Any other criteria set out by NHS England.

3.11.5 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply

b) They hold a role in another health and care organisation within the ICB area

c) any additional criteria set out in NHS England guidance applies

d) any additional criteria proposed by the ICB applies.

3.11.6 The term of office for a non-executive member will be up to three years and the total number of terms an individual may serve is three terms after which they will no longer be eligible for re- appointment.

3.11.7 Initial appointments may be for a shorter period in order to avoid all non-executive members leaving office at once.

3.11.8 Subject to satisfactory appraisal and the support of the Chief Executive, the Chair may approve the re-appointment of a non-executive member up to the maximum number of terms permitted for their role.

3.12 Other Board Members

3.12.1 Additional Board members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act

b)Any other criteria set out by NHS England’s guidance

3.12.2 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply
b) Any other exclusion criteria set out in NHS England guidance applies.

3.12.3 Additional Executive board Members (listed at 2.2.2(b) will be appointed by the Chief Executive supported by an Appointments Panel headed by the Chair or Non-Executive Member of the board and the recommended appointment will be subject to the approval of the Chair. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process.

3.13 Board Members: Removal from Office.

3.13.1 Arrangements for the removal from office of Executive members of the board is subject to the terms of appointment, and application of the relevant ICB policies and procedures.

3.13.2 With the exception of the Chair, board members shall be removed from office if any of the following occurs:

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance
b) Fail to attend 50% of the ICB meetings (unless there are extenuating circumstances). This is at the Chair's discretion;
c) If they are deemed to not meet the expected standards of performance at their annual appraisal
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise: gross misconduct.
e) Are deemed to have failed to uphold the Nolan Principles of Public Life
f) Persistently fail to conform to the principles of a unitary board.
g) Are subject to disciplinary proceedings by a regulator or professional body that has resulted in a decision by the Regulatory Body which had the effect of preventing the person from practising the profession in question, where that decision hasnot been

superseded, or had the effect of imposing conditions on the person's practice, where those conditions have not been lifted.

3.13.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.13.2 apply.

3.13.4 Executive Directors (including the Chief Executive) will cease to be Board members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

3.13.5 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State.

3.13.6 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:

a) terminate the appointment of the ICB's chief executive; and

b) direct the chair of the ICB as to which individual to appoint as a replacement and on what terms.

3.14 Terms of Appointment of Board Members

3.14.1 With the exception of the Chair and Non-executive members, arrangements for remuneration and any allowances will be agreed by the Remuneration Committee in line with the ICB remuneration policy and any other relevant policies published in the Governance Handbook on the ICB's website and any guidance issued by NHS England or other relevant body.

3.14.2 Remuneration for the Chair will be set by NHS England.

3.14.3 Remuneration for Non-Executive Members will be set by a Panel, which will include the Chair, Chief Executive and Executive Chief People Officer.

3.14.4 Other terms of appointment will be determined by the Remuneration Committee.

3.14.5 Terms of appointment of the Chair will be determined by NHS England.

3.15 Specific arrangements for appointment of Ordinary Members made at establishment

3.15.1 Individuals may be identified as “designate ordinary members” prior to the ICB being established.

3.15.2 Relevant nomination procedures for partner members in advance of establishment are deemed to be valid so long as they are undertaken in full and in accordance with the provisions of 3.5 - 3.7.

3.15.3 Any appointment and assessment processes undertaken in advance of establishment to identify designate ordinary members should follow, as far as possible, the processes set out in section 3.5 - 3.12 of this Constitution. However, a modified process, agreed by the Chair, will be considered valid.

3.15.4 On the day of establishment, a committee consisting of the Chair, Chief Executive and Executive Chief People Officer will appoint the ordinary members who are expected to be all individuals who have been identified as designate appointees pre ICB establishment and the Chair will approve those appointments.

3.15.5 For the avoidance of doubt, this clause is valid only in relation to the appointments of the initial ordinary members and all appointments post-establishment will be made in accordance with clauses 3.5 to 3.12.

3.16 Review of Board Size and Composition

In view of the necessity to create additional board membership to address the size and complexity of the ICS jurisdiction, an annual review of the board size and composition will be carried out to ensure that it is fit for purpose in meeting good governance standards. Any necessary changes will be proposed thereafter.

4 Arrangements for the Exercise of our Functions.

4.1 Good Governance

4.1.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Nolan Principles of Public Life and any governance guidance issued by NHS England.

4.1.2 The ICB's Standards of Business Conduct and Declarations of Interest Policy sets out the expected behaviours that members of the board and its committees will uphold and guide decision making whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. This Policy is published in the Governance Handbook and is available on the Website at Home | North East and North Cumbria ICS

4.2 General

4.2.1 The ICB will:

a) comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations;
b) comply with directions issued by the Secretary of State for Health and Social Care
c) comply with directions issued by NHS England;
d) have regard to statutory guidance including that issued by NHS England;
e) take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England, and
f) respond to reports and recommendations made by local Healthwatch organisations within the ICB area.

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with (a)-(f) above, documenting them as necessary in this Constitution, its governance handbook and other relevant policies and procedures as appropriate.

4.3 Authority to Act

4.3.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

a) any of its members or employees

b) a committee or sub-committee of the ICB

4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

4.3.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act the board must authorise the arrangement, which must be described as appropriate in the SoRD.

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a scheme of reservation and delegation (SoRD) which is published in full as part of the Governance Handbook at Home | North East and North Cumbria ICS

4.4.2 Only the board may agree the SoRD and amendments to the SoRD may only be approved by the board

4.4.3 The SoRD sets out:

a) those functions that are reserved to the board;
b) those functions that have been delegated to an individual or to committees and sub committees;
c) those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act

4.4.4 The ICB remains accountable for all of its functions, including those that it has delegated. All those with delegated authority are accountable to the board for the exercise of their delegated functions.

4.5 Functions and Decision Map

4.5.1 The ICB has prepared a Functions and Decision Map which sets out at a high level its key functions and how it exercises them in accordance with the SoRD.

4.5.2 The Functions and Decision Map is published in the Governance Handbook at Home | North East and North Cumbria ICS

4.5.3 The map includes:

a) Key functions reserved to the board of the ICB
b) Commissioning functions delegated to committees and individuals.
c) Commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body;
d) functions delegated to the ICB (for example, from NHS England).

4.6 Committees and Sub-Committees

4.6.1 The ICB may appoint committees and arrange for its functions to be exercised by such committees. Each committee may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees.

4.6.2 All committees and sub-committees are listed in the Scheme of Reservatoin and Delegation.

4.6.3 Each committee and sub-committee established by the ICB operates under terms of reference. All terms of reference are published in the Governance Handbook. For the avoidance of doubt, committees may not establish sub-committees without board approval.

4.6.4 The board remains accountable for all functions, including those that it has delegated to committees and sub-committees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub-committees that fulfil delegated functions of the ICB, will be required to:

a. submit to the ICB board a decision and assurance report following each Committee meeting, summarising key decisions. In the case of sub-committees, these will be submitted to their Parent Committee;

b. submit their confirmed Minutes to the ICB board for assurance. In the case of sub-committees, these will be submitted to their Parent Committee

c. comply with agreed internal audit findings and committee effectiveness reviews.

d. demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity

e. members will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

4.6.5 Any committee or sub-committee established in accordance with clause 4.6 may consist of, or include, persons who are not ICB Members or employees.

4.6.6 All members of committees and sub-committees that exercise the ICB commissioning functions will be approved by the Chair. The Chair will not approve an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

4.6.7 All members of committees and sub-committees are required to act in accordance with this constitution, including the standing orders as well as the SFIs and any other relevant ICB policy.

4.6.8 The following committees will be maintained:

a) **Audit Committee:** This committee is accountable to the board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit.

The Audit Committee will be chaired by a non-executive member (other than the Chair of the ICB) who has the qualifications, expertise or experience to enable them to

express credible opinions on finance and audit matters.

b) **Remuneration Committee:** This committee is accountable to the board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB.

The Remuneration Committee will be chaired by a non-executive member other than the Chair or the Chair of Audit Committee.

4.6.9 The terms of reference for each of the above committees are published in the Governance Handbook.

4.6.10 The board has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further information about these committees, including terms of reference, are published in the Governance Handbook.

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per 4.3.2 The ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

4.7.2 All delegations made under these arrangements are set out in the ICB Scheme of Reservation and Delegation and included in the Functions and Decision Map.

4.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement which sets out the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the board.

4.7.4 The board remains accountable for all the ICB's functions, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these are detailed in the delegation arrangements, summaries of which will be published in the Governance Handbook.

4.7.5 In addition to any formal joint working mechanisms, the ICB may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

5 Procedures for Making Decisions

5.1 Standing Orders

5.1.1 The ICB has agreed a set of standing orders which describe the processes that are employed to undertake its business. They include procedures for:

- conducting the business of the ICB
- the procedures to be followed during meetings; and
- the process to delegate functions.

5.1.2 The Standing Orders apply to all committees and sub-committees of the ICB unless specified otherwise in terms of reference which have been agreed by the board.

5.1.3 A full copy of the Standing Orders is included in Appendix 2 and form part of this Constitution.

5.2 Standing Financial Instructions (SFIs)

5.2.1 The ICB has agreed a set of SFIs which include the delegated limits of financial authority set out in the SoRD.

5.2.2 A copy of the SFIs is published in the Governance Handbook.

6 Arrangements for Conflict of Interest Management and Standards of Business Conduct

6.1 Conflicts of Interest

6.1.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest. These are contained within the Standards of Business Conduct and Declarations of Interest Policy which is published on the website.

6.1.3 All board, committee and sub-committee members, and employees of the ICB, will comply with the ICB policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

6.1.4 The ICB will, as a minimum, publish the registers of conflicts of interest and gifts and hospitality in line with the Standards of Business Conduct and Declarations of Interest Policy at least annually on the ICB website and make them available at our headquarters upon request.

6.1.5 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

6.1.6 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this constitution, the Standards of Business Conduct and Declarations of Interest Policy.

6.1.7 The ICB has appointed the Audit Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's governance lead, their role is to:

a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest;
b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;
c) Support the rigorous application of conflict of interest principles and policies;
d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;
e) Provide advice on minimising the risks of conflicts of interest.

6.2 Principles

6.2.1 In discharging its functions the ICB will abide by the following principles:

a) Safeguard system-led commissioning, whilst ensuring objective investment decisions;
b) Act in a way that demonstrates that they are acting fairly and transparently and in the best interests of their patients and ICB population;
c) Act in a way that upholds confidence and trust in the NHS and system partners;
d) Recognition that the ICB requires a diversity of perspectives in order for it to make good decisions; therefore interests will be managed sensibly and proportionately in line with NHSE Guidance and the ICB's Standards of Business Conduct and Declarations of Interest Policy.
e) Decision making will be made with a regard to the Triple Aim: considering the effects of the decisions on: the health and wellbeing of the people of England; the quality of services provided or arranged by both the ICB and other relevant bodies and the sustainable and efficient use of resources by the ICB and other relevant bodies.

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

a) Members of the ICB
b) Members of the board's committees and sub-committees
c) Its employees

6.3.2 In accordance with section 14Z30(2) of the 2006 Act registers of interest are published on the ICB website and are available on request from the ICB.

6.3.3 All relevant persons as per 6.1.3 and 6.1.6 must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.3.5 All declarations will be entered in the registers as per 6.3.1

6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually.

6.3.7 Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.

6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of Business Conduct

6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this constitution and be aware of their responsibilities as outlined in it. They should:

a) act in good faith and in the interests of the ICB;

b) follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles);

c) comply with the ICB Standards of Business Conduct and Declarations of Interest Policy.

6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct and Declarations of Interest policy.

7 Arrangements for ensuring Accountability and Transparency

7.1 Demonstrating Accountability

7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 11(2) of Schedule 1B to the 2006 Act.

7.2 Principles

7.2.1 Create an organisational culture that encourages and enables transparency and involvement.
7.2.2 Be inclusive and proactive in resolving barriers to effective involvement and participation.
7.2.3 Make clear the purpose of involvement and the extent to which people can expect their views to influence development of local health services.
7.2.4 Recognise the importance of providing feedback to people who have made their views known.
7.2.5 Work in partnership with other agencies.
7.2.6 Build upon best practice and be open to innovative and proven approaches from within and outwith the NHS.
7.2.7 Provide support and training to staff to equip them for this role.
7.2.8 Provide information that is clear and easy to understand, free of jargon and in plain language.

7.3 Meetings and publications

7.3.1 Board meetings, and committees composed entirely of board members or which include all board members, will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

7.3.2 Papers and minutes of all meetings held in public will be published.

7.3.3 Annual accounts will be externally audited and published.

7.3.4 A clear complaints process will be published.

7.3.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

7.3.6 information will be provided to NHS England as required.

7.3.7 The Constitution and Governance Handbook will be published including and supported by other key documents, including but not limited to:

a) Standards of Business Conduct and Declarations of Interest Policy
b) Registers of interests
c) Key policies
d) Functions and Decision Map
e) Scheme of Reservation and Delegation
f) Standing Financial Instructions
g) Committee Structure
h) Remuneration Guidance
i) Delegation Agreement Summaries

7.3.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. The plan will explain how the ICB proposes to discharge its duties under:

- sections 14Z34 to 14Z45 (general duties of integrated care boards), and
- sections 223GB and 223N (financial duties).

and

- proposed steps to implement the joint local health and wellbeing strategies for the population covered by the ICB.

7.4 Scrutiny and Decision Making

7.4.1 At least three non-executive members will be appointed to the board including the Chair; and all of the board and committee members will comply with the Nolan Principles of Public Life and meet the criteria described in the Fit and Proper Person Test.

7.4.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

7.4.3 The ICB will comply with the requirements of the NH Provider Selection Regime, including: complying with existing procurement rules until the provider selection regime comes into effect.

7.4.4 The ICB will comply with local authority health overview and scrutiny requirements.

7.5 Annual Report

7.5.1 The ICB will publish an annual report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year. An annual report must in particular

a) explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards)
b) review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan)
c) review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised), and
d) review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007

8 Arrangements for Determining the Terms and Conditions of Employees.

8.1.1 The ICB may appoint employees, pay them remuneration and allowances as it determines and appoint staff on such terms and conditions as it determines.

8.1.2 The board has established a Remuneration Committee which is chaired by a Non-Executive member other than the Chair or Audit Chair.

8.1.3 The membership of the Remuneration Committee is determined by the board. No employees may be a member of the Remuneration Committee but the board ensures that the Remuneration Committee has access to appropriate advice by:

a) Ensuring that HR advisers are in attendance as appropriate
b) Other officers, employees or advisors may be invited to attend all or part of meetings of the committee to provide advice or support particular discussion as appropriate
c) Receiving benchmarking information where available and appropriate

8.1.4 The board may appoint independent members or advisers to the Remuneration Committee who are not members of the board.

8.1.5 The main purpose of the Remuneration Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the board are published in the Governance Handbook on the ICB's website.

8.1.6 The duties of the Remuneration Committee include the following. Full details are set out in the Terms of Reference.

a) **For the Chief Executive, Directors and other Very Senior Managers:**

Determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, pensions and cars;
Determine arrangements for termination of employment and other contractual terms and non-contractual terms.

b) **For all staff:**
Determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change);
Oversee contractual arrangements;
Determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.

c) Oversee the arrangements for the performance review for directors/senior managers;

d) Receive assurance in relation to ICB statutory duties relating to people such as compliance with employment legislation including such as Fit and Proper Person Regulation (FPPR).

8.1.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

9 Arrangements for Public Involvement

9.1.1 In line with section 14Z45(2) of the 2006 Act the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

a) the planning of the commissioning arrangements by the Integrated Care Board

b) the development and consideration of proposals by the ICB for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them, and

c) decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.1.2 In line with section 14Z54 of the 2006 Act the ICB has made the following arrangements to consult its population on its system plan:

a) The ICB will engage or consult, as appropriate, with its population on its system plan and will have regard to NHS Guidance on consultation and engagement and the ICB's Communities and People Involvement and Engagement

Strategy for the North East and North Cumbria. This will include the involvement of each relevant Health and Wellbeing Board.

b) The ten principles set out by NHS England, and described at section 9.1.3 will apply

9.1.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities.

a) Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.

b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions.

c) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.

d) Reach out to and build relationships with excluded groups – especially those affected by inequalities.

e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners.

f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust.

g) Use community development approaches that empower people and communities, making connections to social action.

h) Use co-production, insight and engagement to achieve accountable health and care services.

i) Co-produce and redesign services and tackle system priorities in partnership with people and communities.

j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

9.1.4 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

9.1.5 These arrangements, include:

a) The Communities and People Involvement and Engagement Strategy for the North East and North Cumbria.

b) Ensuring sufficient resources and training are available to support effective engagement

c) Arranging system-wide or place-based public events

d) Appointment of a Non Executive Member with a specific role to seek assurance on the ICB's arrangements for discharging its duties in relation to patient and public involvement.

Appendix 1: Definitions of Terms Used in This Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022
ICB board	Members of the ICB
Area	The geographical area that the ICB has responsibility for, as defined in part 2 of this Constitution
Committee	A committee created and appointed by the ICB board.
Sub-Committee	A committee created and appointed by and reporting to a committee.
Executive Chief Nurse	Fulfils the role of the Director of Nursing as required in the Act
Executive Finance Director	Fulfils the role of the Director of Finance as required in the Act.
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.
Ordinary Member	The board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the Board are referred to as Ordinary Members.
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.

Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 having been nominated by the following: • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description • the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description • the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.
Healthcare professional	An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professional Act 2002.

Appendix 2: Standing Orders

1. Introduction

1.1. These Standing Orders have been drawn up to regulate the proceedings of the NHS North East and North Cumbria Integrated Care Board so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's constitution.

2. Amendment and review

2.1. The Standing Orders are effective from 1 July 2022.

2.2. Standing Orders will be reviewed on an annual basis or sooner if required.

2.3. Amendments to these Standing Orders will be made as per Clause 1.6 of the Constitution.

2.4. All changes to these Standing Orders will require an application to NHS England for variation to the ICB Constitution and will not be implemented until the Constitution has been approved.

3. Interpretation, application and compliance

3.1. Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB Constitution and as per the definitions in Appendix 1.

3.2. These standing orders apply to all meetings of the board, including its committees and sub-committees unless otherwise stated. All references to board are inclusive of committees and sub-committees unless otherwise stated.

3.3. All members of the board, members of committees and sub-committees and all employees, should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.4. In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the Executive Director of Corporate Governance, Communications and Involvement will provide a settled view which shall be final.

3.5. All members of the board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

3.6. If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the board for action or ratification and the Audit Committee for review.

4. Meetings of the Integrated Care Board

4.1. Calling Board Meetings

4.1.1 Meetings of the board of the ICB shall be held at regular intervals at such times and places as the ICB may determine.

4.1.2 In normal circumstances, each member of the board will be given not less than one month's notice in writing of any meeting to be held. However:

a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.
b) One third of the members of the board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the Board specifying the matters to be considered at the meeting.
c) In emergency situations the Chair may call a meeting with 24 hours notice by setting out the reason for the urgency and the decision to be taken.

4.1.3 A public notice of the time and place of the meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.1.4 The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting that is not likely to be open to the public.

4.2. Chair of a meeting

4.2.1. The Chair of the ICB shall preside over meetings of the board.

4.2.2. If the Chair is absent or is disqualified from participating by a conflict of interest the ICB Chair will nominate a deputy, which will normally

be the Senior Independent Non-Executive Member. If the nominated deputy is not present at a meeting, then the assembled members may appoint a deputy from the remaining Non-Executive Members.

4.2.3. The board shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent. The appointed Chair will be accountable to the Chair of the ICB.

4.3. Agenda, supporting papers and business to be transacted

4.3.1. The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.

4.3.2. Except where the emergency provisions apply, supporting papers for all items must be submitted at least ten working days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the board at least five calendar days before the meeting.

4.3.3. Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website at Home | North East and North Cumbria ICS

4.4. Petitions

4.4.1. Where a valid petition has been received by the ICB it shall be managed in accordance with the ICB Policy as published in the Governance Handbook.

4.5. Nominated Deputies

4.5.1. With the permission of the person presiding over the meeting, the Executive Directors and the Partner Members of the board may nominate a deputy to attend a meeting of the board that they are unable to attend. The deputy may speak and vote on their behalf.

4.5.2. The decision of person presiding over the meeting regarding authorisation of nominated deputies is final.

4.6. Virtual attendance at meetings

4.6.1. The board of the ICB and its committees and sub-committees may meet virtually using telephone, video and other electronic means when necessary, unless the terms of reference prohibit this.

4.7. Quorum

4.7.1. The quorum for meetings of the board will be 50% of the members, including:

a) Chair or Deputy Chair (or Non-Executive member presiding over the meeting as in 4.2.2)
b) Either the Chief Executive or the Executive Finance Director
c) Either the Executive Medical Director or the Executive Chief Nurse
d) At least one Non-Executive member
e) At least one Partner Member

4.7.2. For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.

b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

4.7.3. For all committees and sub-committees, the details of the quorum for these meetings and status of deputies are set out in the appropriate terms of reference.

4.7.4. In the event that the quorum cannot be achieved due to a member or members being disqualified from taking part in a vote or discussion due to a declared interest the Chair of the meeting will determine the action to be taken in accordance with the constitution.

In these circumstances, an alternative quoracy of one third of the non-conflicted members will apply. This must include at least one Non Executive Member and the Chief Executive or Executive Finance Director and one other member of the board.

4.8. Vacancies and defects in appointment

4.8.1. The validity of any act of the ICB is not affected by any vacancy among members or by any defect in the appointment of any member.

4.8.2. In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply:

Where temporary arrangements have been put in place to fill the vacancy or defect, then this individual will count towards the quoracy, including if they are temporarily acting in the roles of those members specifically listed in quoracy requirements (eg. Executive Chief Nurse, Executive Finance Director);

Where temporary arrangements have not been put in place, a reduced quoracy will be proposed to the board by the Chair and Chief Executive in conjunction with the Chair of the Audit Committee.

4.9. Decision making

4.9.1. The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

4.9.2. Generally it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

a) All members of the board who are present at the meeting will be eligible to cast one vote each.

b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.

c) For the sake of clarity, any additional Participants and Observers (as detailed within paragraph 2.3 of the constitution) will not have voting rights.

d) A resolution will be passed if more votes are cast for the resolution than against it.

e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.

f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Disputes

4.9.3. Where helpful, the board may draw on third party support to assist them in resolving any disputes, such as peer review or support from NHS England.

Urgent decisions

4.9.4. In the case urgent decisions and extraordinary circumstances, every attempt will be made for the Board to meet virtually. Where this is not possible the following will apply.

4.9.5. The powers which are reserved or delegated to the board, may for an urgent decision be exercised by the Chair and Chief Executive (or relevant lead director in the case of committees) subject to every effort having made to consult with as many members as possible in the given circumstances.

4.9.6. The exercise of such powers shall be reported to the next formal meeting of the board for formal ratification and the Audit Committee for oversight.

4.10. Minutes

4.10.1. The names and roles of all members present shall be recorded in the minutes of the meetings.

4.10.2. The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.

4.10.3. No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4. Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11. Admission of public and the press

4.11.1. In accordance with Public Bodies (Admission to Meetings) Act 1960 All meetings of the board and all meetings of committees which are comprised entirely of board members or are all board members, at which public functions are exercised will be open to the public.

4.11.2. The board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.11.3. The person presiding over the meeting shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the board's business shall be conducted without interruption and disruption.

4.11.4. As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time) the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

4.11.5. Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the board.

5. Suspension of Standing Orders

5.1. In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least two other members.

5.2. A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.3. A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit Committee for review of the reasonableness of the decision to suspend Standing Orders.

6. Use of seal and authorisation of documents.

The ICB may have a seal for executing documents where necessary. The seal will be kept securely in a locked facility. The following are authorised to authenticate its use by their signature:

- The Chief Executive
- The Chair of the ICB
- The Executive Finance Director

-- Ends --

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

NORTH EAST AND NORTH CUMBRIA ICB BOARD MEETING 29 November 2022	
Report Title:	**Highlight report and minutes from the Executive Committee meetings held on 13 September and 11 October 2022**

Purpose of report

To provide the Board with an overview of the discissions and decisions at the Executive Committee meetings in September and October 2022.

Key points

The key points from the meetings include:

- Tees Valley Integrated Urgent Case – Case for Change
- Cyber event update
- Urgent and Emergency Care Governance
- Health 50-64yr Old Flu Vaccination Options Paper
- Building a learning and Improvement Community for the North East and North Cumbria
- Primary Care Collaborative Business Case Proposal
- Place-based delivery reports
- Winter Plan
- Covid Medicine Delivery Unit Proposal
- Review of Health Inequalities Arrangements
- Proposal for the Health Inequalities Targeted Funding Allocation
- Learning Disabilities and Autism – Building the Right Support
- Proposed Oversight Framework and Memorandum of Understanding with NHS England
- Notification of Chairs Action: Decision in relation to GP IT Futures Procurement of Clinical Information Systems.

The confirmed minutes from the meetings held on 13 September 2022 and 11 October 2022 are attached at Appendix 1 and Appendix 2 respectively.

Risks and issues

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The Committee discussed the ICB risk register, noting the existing risks and the mitigating actions being put in place to address these, and following a discussion, identified the following risks and issues:

- A risk has been identified and added to the risk register in relation to cyber security
- A risk to be considered and added if appropriate in relation to the pay award

Assurances

The Committee also received a number of items for assurance and these included:

- An integrated delivery report – a high level overview of the key metrics across the system and internal to the ICB, covering access, experience, outcomes, people and finance
- A finance update reports – an overview of the current financial position
- ICB Development Plan updates on progress in relation to agreed actions
- An information governance update – an overview from the ICB's Senior Information Risk Owner of the current position in relation to data security and protection
- A risk management report and register – a position statement on the ICB's current risk
- A review of the financial sustainability checklist

Recommendation/Action Required

The Board is asked to:

- Receive the highlight report and confirmed minutes for the Executive Committee meetings held on 13 September and 11 October 2022 for assurance;
- Formally note the Chair's Action taken for an urgent decision needed in relation to GP IT Futures Procurement of Clinical Information Systems.

Sponsor/approving director	Samantha Allen, Chief Executive
Report author	Deborah Cornell, Director of Governance and Involvement

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

Relevant legal/statutory issues

Health and Care Act 2022

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

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If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	
Key implications						
Are additional resources required?	Identified as part of the committee minutes.					
Has there been/does there need to be appropriate clinical involvement?	Yes as part of the Executive Committee membership.					
Has there been/does there need to be any patient and public involvement?	Not applicable as highlight report only.					
Has there been/does there need to be partner and/or other stakeholder engagement?	Not applicable as highlight report only.					

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Executive Committee Highlight Report

Introduction

The principal purpose of the Executive Committee is to support the Board by:

- Overseeing the day-to-day operational management and performance of the Integrated Care Board (ICB) in support of the Chief Executive in the delivery of her duties and responsibilities to the Board
- Provide a forum to inform ICB strategies and plans and in particular, the committee will undertake any commissioning and planning activity on behalf of the Board, helping to secure continuous improvement of the quality of services
- Implementation of the approved ICB strategies and plans.

The Committee will contribute to the overall delivery of the ICB objectives by delivering its remit as set out in its terms of reference.

Summary report

The Executive Committee, chaired by Samantha Allen, Chief Executive, met on 13 September and 11 October 2022.

The key points to bring to Board's attention from each meeting are set out below.

13 September 2022

- **Tees Valley Integrated Urgent Case – Case for Change:** the paper set out the set out the recommendations and decisions made by the former Tees Valley Clinical Commissioning Group in relation to proposals for the implementation of a consistent model of integrated urgent care provision across Tees Valley. The Committee supported the recommendations, and it was hoped this would help address the issue of ambulance handover delays at South Tees.
- **Cyber event update:** an update was received in relation to the national cyber event that took place on 4 August 2022 and had affected some clinical information systems nationally. The impact locally for the ICB had been mainly to general practice (GP) out of hours services. The incident was being well managed for those affected areas and the learning from this event was the need for stronger continuity arrangements to be less reliant on one provider in the event this type of incident reoccurred.
- **Urgent and Emergency Care Governance**: the governance model underpinning the Urgent and Emergency Care Network (UECN) had been revised to enable further working at pace and scale and to support transformation of urgent and emergency services to focus on the ICB's priorities for change. There would be a focus on the accountability between the UEC Strategic Board and Local Area Delivery Boards (LADBs) to demonstrate a shared understanding of the work to be undertaken by LADBs at place and system-wide levels to provide strategic direction and ensure whole system integration.
- **Health 50-64yr Old Flu Vaccination Options Paper:** following the NHS England announcement in July 2022 that all healthy 50–64 year-olds would be offered a flu vaccination during the Autumn, the Committee considered different options as to how this could be delivered. The ICB is in a strong position for this and it was agreed to establish a clearing house for the region regarding vaccine movement to ensure the supply could be moved more easily to where it was needed.
- **Building a learning and Improvement Community for the North East and North Cumbria:** Plans were shared for an inaugural learning and improvement event to be held on 21 September

2022 and a discussion took place as to how this could be resourced appropriately and provide learning opportunities for staff as well as connecting with wider system learning opportunities.

- **Primary Care Collaborative Business Case Proposal**: The proposal introduced the concept of a primary care collaborative for the North East and North Cumbria. This was a welcomed first step in developing the collaborative and providing learning opportunities for primary care but assurance would be needed to demonstrate outcomes aligned with the ICB objectives. A memorandum of understanding (MOU) would be developed to ensure this.

11 October 2022

- **Place-based delivery reports:** The Committee is now starting to receive reports from both a North and North Cumbria and a Central and South perspective to ensure it is sighted on all key developments and programmes of work ongoing across the ICB footprint. The reports also include decision logs which are being maintained within each place to ensure we can demonstrate robust governance in relation to decision-making. The reports will continue to develop over the coming months to provide assurance to the Committee and the Board.
- **Winter Plan:** The Committee received the detailed Winter Plan which brings together all of the actions and arrangements the ICB is putting in place to ensure the system is prepared to deal with escalating operational pressures in the coming months. Oversight of the plan delivery will take place at the Urgent and Emergency Care Network.
- **Covid Medicine Delivery Unit Proposal:** a comprehensive model was outlined to address the requirements for the provision of Covid Medicine Delivery Units (CMDU) from October 2022 onwards. The model involves all eight acute NHS Foundation Trusts and will help to identify demand and service risks.
- **Review of Health Inequalities Arrangements:** following the approval by the Board to establish a task and finish group to review the ICS approach to health inequalities, the report set out recommendations for the formation of a Healthier and Fairer Advisory Group. The Group will have oversight of this multi-faceted area of work, encompassing health and healthcare inequalities, prevention and population health management. A further update on this will be brought to the Board as a separate agenda item in November.
- **Proposal for the Health Inequalities Targeted Funding Allocation:** The ICS has been allocated £13,604,000 recurrent revenue as a specific allocation to support targeted reductions in health inequalities. Key priority areas for utilisation of this resource over three financial years have been identified and a team will be established to coordinate activity to ensure health and healthcare inequalities are embedded throughout the ICS to drive forward activity to improve access, experience and outcomes for the population.
- **Learning Disabilities and Autism – Building the Right Support:** the Committee received an overview of the challenges and opportunities for the North Cumbria and North East ICS to deliver together with our Councils' Transforming Care for Autistic people, people with learning disabilities and people with both. A session is being arranged to discuss this in further detail to ensure the right infrastructure, capacity and leadership are in place. Consideration is being given for this to be a Board development session.
- **Notification of Chairs Action: Decision in relation to GP IT Futures Procurement of Clinical Information Systems:** The Chair reported that this item had required an urgent decision and was therefore agreed via a Chairs Action.

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Appendix 1

NHS
North East and North Cumbria

North East and North Cumbria Integrated Care Board

EXECUTIVE COMMITTEE

Minutes of the meeting held on Tuesday 13 September 2022, 9.30 – 1.00 at Pemberton House, Sunderland

Present:	Samantha Allen, Chief Executive (Chair) Dr Neil O'Brien, Medical Director Claire Riley, Executive Director of Corporate Governance, Communications and Involvement Jacqueline Myers, Executive Director of Strategy and System Oversight Professor Graham Evans, Executive Chief Information and Digital Officer David Gallagher, Executive Director of Place Based Delivery Annie Laverty, Executive Chief People Officer Aejaz Zahid, Executive Director of Innovation Nicola Bailey, Interim Executive Director of Place Based Delivery (North and North Cumbria) David Chandler, Interim Executive Director of Finance Julia Young, Director of Nursing (on behalf of David Purdue)
In attendance:	Deborah Cornell, Associate Director of Operations Tarryn Lake, Associate Director of Finance (item 15 -EC/2022/30 - only) Erin Harvey, Portfolio Lead Commissioning and Contracting (for item 25 – EC/2022/40 - only)
Observers:	Sir Liam Donaldson, ICB Chair Eleanor Wheeler, General Management Trainee

EC/2022/17 Welcome and introductions

The Chair welcomed everyone to the meeting of the Executive Committee.

It was noted that agenda items 15 (continuing healthcare fee setting), item 22 (home oxygen service procurement evaluation strategy); item 23 (termination of pregnancy procurement engagement strategy); and item 25 (Gateshead community contract procurement options) were confidential and

contained the protective marking of 'official: sensitive commercial' and therefore would be minuted separately as confidential.

EC/2022/18 Apologies for absence

Apologies for absence were received from David Purdue, Executive Chief Nurse however it was noted Julia Young, Director Nursing was attending as his nominated deputy.

EC/2022/19 Declarations of interest

The Executive Medical Director declared an interest regarding items 16 (capital plans 2022/23) and 18 (primary care collaborative business case proposal) on the agenda. The Chair confirmed he would be required to leave the meeting for these items and not take part in either the discussion or decision.

The Interim Executive Director of Finance declared a conflict for item 25 (Gateshead Community Contract Procurement Options) and the Chair confirmed he would be required to leave the meeting for this item and not take part in the discussion or decision.

EC/2022/20 Minutes of the previous meeting held on 12 July 2022

The minutes were agreed as a true record of the meeting.

EC/2022/21 Matters arising from the minutes

The action log was updated.

EC/2022/22 Tees Valley Integrated Urgent Care – Case for Change

The Executive Director of Place Based Delivery (Central and South) presented the paper which set out the recommendations and decisions made by the former Tees Valley Clinical Commissioning Group in relation to proposals around the implementation of a consistent model of integrated urgent care provision across Tees Valley.

Work had been started around public engagement but had been paused due to the sad death of Her Majesty Queen Elizabeth II. The Executive Director of Corporate Governance, Communications and Involvement queried whether a formal consultation process was needed and offered her support if this was the case. It was noted there was an Overview and Scrutiny Committee meeting due to take place which would help clarify this.

The ICB Chair noted it was hoped this case for change would help address the issue of ambulance handover delays at South Tees. It was noted that the initial service would be up and running in October and a verbal update on progress was requested at the next Committee meeting in October.

Action:
The Executive Director of Place Based Delivery (Central and South) to provide a verbal update on progress at the next Committee meeting in October meeting.

RESOLVED:
The Committee **NOTED** and **SUPPORTED** the recommendations and decisions made by the former Tees Valley Clinical Commissioning Group.

EC/2022/23 Teesside Procurement Exercise – External Support

The Executive Director of Place Based Delivery (Central and South) presented the paper which set out how North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust, were committed to working more closely together. The North East and North Cumbria Integrated Care Board (the ICB) had secured some external consultancy support to undertake an independent strategic review to engage with stakeholders and develop a case for change to support the aim of the two foundation trusts.

A progress report on this was requested for the Committee meeting in December.

Action:
The Executive Director of Place Based Delivery (Central and South) to bring a progress report to the December meeting.

RESOLVED:
The Committee **NOTED** the procurement process for securing external support and the timescales for this work.

EC/2022/24 Information Governance Update

The Executive Chief Information and Digital Officer (as the ICB's Senior Information Risk Owner - SIRO) presented an update and assurance report on data security and protection for the period July and August 2022. It was noted that consideration was being given to adding a data security and protection related risk to the ICB's risk register.

The report gave a high degree of assurance in all areas and would be presented to both the Committee and Board twice yearly for assurance purposes.

It was noted that the triangulation of information from a place-based perspective would be helpful to see key themes and trends and this would evolve over time.

It was clarified that the Freedom of Information (FOI) requests review process was currently managed on behalf of the ICB by the North of England Commissioning Support Service (NECS), along with any ministerial correspondence that was received, to enable the identification of any key themes and trends.

A further update would be brought back to the Committee at a later date following the internal audit review to provide additional assurance that these processes were robust.

RESOLVED:
The Committee **NOTED** the content and status of the report and **ACKNOWLDGED** and **SUPPORTED** the report content for assurance purposes.

EC/2022/25 Cyber Event Update

The Executive Chief Information and Digital Officer provided an update on the national cyber event that took place on 4 August 2022 and had affected some clinical information systems nationally. The event was continuing to have an impact up to the point of the report being prepared.

The impact locally for the ICB had been mainly to general practice (GP) out of hours services. The incident was being well managed for those affected areas in Tees, Esk and Wear Valley and it was hoped this would be resolved within the next two weeks.

It was noted that the learning from this event was the overall level of risk across the system and the need for stronger continuity arrangements to be less reliant on one provider in the event this type of incident reoccurred.

Action:
The Executive Chief Information and Digital Officer to bring a further update on the learning from the cyber event to a future meeting.

RESOLVED:
The Committee **NOTED** the content and status of the report including the regional response and approach; and **REVIEWED** and **CONSIDERED** the next steps and risks which would be formally registered once formal after-action reviews had concluded and appropriate lessons learned.

EC/2022/26 Urgent and Emergency Care Network Governance

The Executive Medical Director presented the paper which set out the governance model underpinning the Urgent and Emergency Care Network

(UECN). The model had been revised to enable further working at pace and scale and to support transformation of urgent and emergency services to focus on the ICB's priorities for change.

The UEC Strategic Board was to be co-chaired by the ICB Medical Director and a foundation trust chief executive and would be supported by a Professional Reference Group in an advisory capacity. There would be a focus on the accountability between the UEC Strategic Board and Local Area Delivery Boards (LADBs) to demonstrate a shared understanding of the work to be undertaken by LADBs at place and system-wide levels to provide strategic direction and ensure whole system integration.

It was noted that further clarity was needed in relation to what authority the UEC Strategic Board would have regarding decision making.

A review process would be put in place to address any issues that may arise and there were ongoing discussions regarding the Central Area (Durham, South Tyneside and Sunderland) having two existing LADBs. The suggested model did not necessarily resolve this but would help support the Central Area to become more symmetrical.

The ICB Chair raised the term of 'ICP' (integrated care partnership) was an old definition in this context of the ICB's areas and should be removed to avoid confusion. The reference to Executive Board in the paper should also be corrected to read the ICB Executive Committee.

Actions:
The Executive Medical Director to bring the terms of reference for the LADBs to the next Committee meeting to ensure there was correct accountability, membership and clarity on authority for strategic decision making.

RESOLVED:
The Committee **NOTED** the UECN governance model.

EC2022/27 Healthy 50-64 year old Flu Vaccination 2022/23 Option Paper

The Executive Medical Director presented the paper which outlined the NHS England announcement in July 2022 that all healthy 50–64 year-olds would be offered a flu vaccination during the Autumn. General practices had requested underwriting of additional flu vaccine orders for this cohort and the paper outlined different options for consideration by the Committee.

Assurance was given that the ICB was in a strong position as there was sufficient supply to offer the same level of vaccines as in the previous year. There would also be additional vaccines available in community pharmacies.

The proposal was to establish a clearing house for the region regarding vaccine movement to ensure the supply could be moved more easily to where it was needed at a cost of £40,000.

It was noted there was additional funding available of approximately £12-£13m from NHS England to develop a vaccination plan and details of this would be circulated to Committee members for agreement.

Actions:
The Executive Medical Director to circulate the details of the vaccination plan to Committee members for agreement.

RESOLVED:
The Committee:

- **SUPPORTED** the creation of a flu vaccine clearing house for vaccine movement across the ICB and fund the movement of vaccine via a specialist refrigerated courier across the ICB at a cost of £40,000
- **SUPPORTED** the development of a collaborative engagement scheme for covid and flu vaccinations in healthy 50-64 year-olds across primary care networks (PCNs) and community pharmacies for 2022/23. If this was not possible due to timescales, support was given for the development of a collaborative engagement scheme for covid and flu vaccinations for the 2023/24 season for all cohorts across PCNs and community pharmacy contractors.

EC/2022/28 Building a Learning and Improvement Community for the North East and North Cumbria

The Executive Chief People Officer presented the paper to update the Committee on plans for the inaugural learning and improvement event to be held on 21 September 2022 and to request approval for an initial investment of £350,000 to support phase one of the implementation plan.

The additional pressure on running costs was highlighted and a request made for this to be discussed at the North of England Commissioning Support Service (NECS) Customer Board as they may be keen to invest in this area to support transformation. This would be raised at the next Customer Board meeting by the Executive Director of Place Based Delivery (Central and South) who was the Co-Chair of the Board. It was confirmed that there were transformation resources available and access to these should be explored.

It was discussed that the implementation of phase one presented opportunities for current staff and should be encouraged, as well as connecting with wider learning opportunities. It was agreed that the paper positioned the ICB well from a local, regional and national perspective and the outputs from this work would generate efficiency savings.

It was agreed that all available positions set out in the paper would be advertised internally and for this to be raised at the next senior leaders meeting.

Actions:
The Executive Director of People to raise the opportunities for staff as set out in the paper at the next ICB senior leaders meeting and explore access to transformation monies were appropriate.

RESOLVED:
The Committee **NOTED** and **ENDORSED** the approach, and **APPROVED** the initial investment required to support phase one of the implementation plan.

EC/2022/29 Tactical on Call Rota

The Executive Director of Strategy and System Oversight presented the paper which set out the proposed arrangements for establishing four ICB tactical on call rotas with effect from 1 November 2022 and setting out key workforce and financial considerations.

The ICB currently operated a single tactical on call covering the whole organisation and the proposal was to move to four rotas aligned to the four ICB areas (North Cumbria, North, Central and South areas) which broadly matched the local resilience forum geographies.

A formal consultation with staff would be needed to work through the logistics of the proposal but concerns were raised that this would be another consultation on top of the forthcoming phase 2A consultation process with clinical members of staff.

It was also noted that there were national discussions taking place on system coordination centres for each ICB. It was agreed this should not affect the move to 4 tactical rotas.

The risk of human resources (HR) capacity was raised in relation to the HR Team within NECS who were very stretched due to sickness at present. This would place additional pressure on the team as potentially another consultation alongside others already ongoing. Assurance was given that there would be group briefings held along with individual 1:1 meetings with those affected to help alleviate this pressure.

Clarification was needed as to whether participation in the on-call rota would be voluntary or mandatory, along with clarification as to whether all medical directors would be included as they currently were not. This would mean there would still be variations on implementation in each of the four areas in the short term.

The Committee broadly supported the proposal but there were some details still to work through as well as identifying appropriate HR support and capacity. It was noted that a number of staff already participated in the on call rota but an initial briefing would be held next week with all affected staff to explain the consultation process if the proposal was approved.

Actions:
The Executive Director of Strategy and System Oversight and the Executive Chief People Officer to discuss HR support and capacity.

The Executive Director of Strategy and System Oversight to bring an update on the outcome of the consultation process with staff to the December meeting.

RESOLVED:
The Committee **APPROVED** the recommendations as set out in the paper.

EC/2022/30 2022/23 Capital Plans

The Executive Medical Director left the meeting for this item due to his previously stated conflict of interest.

The paper sought approval for the allocation of business as usual (BAU) capital to cover BAU primary care premises improvement grant schemes and primary care digital within the ICB.

The ICB had been allocated capital funding of £5.469m in 2022/23 to support improvement grant and primary care digital schemes. It was imperative that capital funding was utilised efficiently and effectively to continue to support the maintenance and development of estates and digital infrastructure in primary care.

RESOLVED:
The Committee:

- **NOTED** the early adopter premises improvement schemes previously approved totalling £307k
- **APPROVED** to progress with quotes for larger value premises improvement grant schemes totalling £1,507
- **APPROVED** to progress with quotes and project initiation document preparation for primary care digital capital totalling £3,403k
- **DELEGATED** authority to the Interim Executive Director of Finance to approve further prioritisation of capital schemes to utilise the remainder of the capital funding available and mitigate against any potential slippage arising in year.

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EC/2022/31 ICB Development Plan

The Executive Medical Director rejoined the meeting at this point.

The Director of Transition presented the paper which provided the Committee with visibility of the ICB's development plan, describing the process taken to develop the plan and proposed actions to monitor progress and assurance on its delivery.

It was reported that Northumberland place currently did not have any schemes in the plan but had been engaged with and offered support around this.

It was agreed that a highlight report would be included as a standing agenda item for each Committee meeting.

The ICB Chair wanted to thank Mrs Ali Wilson for her work in supporting the ICB transition and a letter would be sent from himself and the Chief Executive to this effect.

Actions:
The Director of Transition to bring a highlight report to each monthly Committee meeting.

RESOLVED:
The Committee:

- **AGREED** the content of the ICB development plan
- **AGREED** the approach to monitor the plan through informal arrangements with executive directors/directors.

EC/2022/32 Primary Care Collaborative Business Case Proposal

The Executive Medical Director left the meeting for this item due to his previously stated conflict of interest.

The Executive Director of Place Based Delivery (Central and South) presented the paper which introduced the concept of a primary care collaborative for the North East and North Cumbria, seeking funding to support establishment of the collaborative.

The paper was welcomed as a first step in developing the collaborative but assurance would be needed to demonstrate outcomes if the funding was provided. The Executive Director of Innovation added that this collaborative was a space where opportunities for innovation could develop in next few years aligned with the ICB objectives.

The Committee agreed to support the proposal but further details were needed as to how this would work as it was important that this was seen as part of the system. The collaborative needed to link with learning

opportunities for primary care and it was hoped the learning and improvement event would inform this.

The Interim Executive Director of Finance noted that the financial resources were available to support this.

A memorandum of understanding (MOU) would be developed reflecting the discussion from today and shared with the Committee to demonstrate the ICB's support for practices.

Actions:
The Executive Director of Place Based Delivery (Central and South) to share the MOU with the Committee once this had been developed.

RESOLVED:
The Committee **SUPPORTED** the development of a Primary Care Collaborative as described in the paper.

EC/2022/33 Winter Access and Winter Security Funding 2021/22

The Executive Medical Director rejoined the meeting at this point.

The Executive Director of Place Based Delivery (Central and South) presented the report which provided a final position to the ICB regarding the 2021/22 winter access and winter security funding.

The Winter Access Fund (WAF) was made available for the period November 2021 to March 2022, of which £13.554m was allocated to the North East and North Cumbria Integrated Care System.

NHS England finance teams had reported spend to budget only, therefore in order to ascertain an actual final position, locality (previous CCG) finance teams were asked to report their final outturn figures which included outstanding invoices / portal claims post April 2022.

The final WAF spend for 2021/22 was £12.461m, resulting in an actual underspend of £979K compared to the (previously reported) anticipated figure of £113.5K.

North Cumbria and Sunderland reported significant underspends whereas County Durham reported an overspend.

There was a large amount learning to be taken from this at both local and national levels.

RESOLVED:
The Committee **REVIEWED** the contents of the report and **NOTED** the final funding and programme position for winter access and winter security funding schemes 2021/22.

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EC/2022/34 Finance Update

The Interim Executive Director of Finance shared a presentation which showed an overview of month four. Highlights from the presentation included:

- Continuing healthcare – there were a high number of high cost cases and increases in other packages
- Prescribing – an underspend was being predicted at present
- There was an overspend in acute care

It was noted that month five would look very similar and discussions were ongoing with providers regarding the pressures. There were also pressures around the pay award for 2022/23.

The ICB Chair observed that as yet, there was not a process of how the ICB would handle budgetary pressures as a system and this would need to be considered.

Regarding cost improvements, it was noted by month six this would be clearer and consideration would need to be given to any risks associated with these.

A request was also made for agency spend to be included in the next report to the Committee.

Actions:
The Interim Executive Director of Finance was to establish an efficiency workstream and include agency spend in next month's report to the Committee.

RESOLVED:
The Committee **RECEIVED** the presentation for information.

EC/2022/35 Integrated Delivery Report

The Executive Director of Strategy and System Oversight presented the report which provided an ICB overview of quality, performance and outcomes, along with a high level and parallel view of performance and quality to ensure oversight and delivery of the 2022/23 planning priorities.

It was acknowledged that several areas in the report needed further development and work was underway to produce a single integrated delivery report going forward, looking at every level of reporting, and a version of which would go to the ICB Board. It was noted however that there were capacity constraints within the team at present to develop the

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A request was made for some covering narrative to be included in the integrated delivery report for the Board and to utilise the Board development sessions for potential focussed sessions on certain topics.

Actions:
The Executive Director of Strategy and System Oversight to produce a high level summary report for the next meeting.

RESOLVED:
The report was **RECEIVED** for information and the Committee recognised the capacity issues within the team.

EC/2022/36 Contracting of Clinical Waste Services for the North East and North Cumbria Integrated Care System

The Executive Director of Place Based Delivery (Central and South) presented the paper which set out the current contracting position for the collection of clinical waste for general practices across North East North Cumbria (NENC) and to seek support for the national re-procurement of future clinical waste services in primary care.

It was noted that this service was procured by NHS England. The proposal was to extend the service and procure on behalf of the ICB but the process needed to ensure value for money and ICB staff would be working with NHS England on this.

RESOLVED:
The Committee:

- **SUPPORTED** the national procurement exercise for a clinical waste service, including the system and contract configurations noted in 3.3.1 and 3.3.2; noting a contract start date of 1 April 2023
- **NOTED** and **ENDORSED** the inclusion of Northumberland practices as part of the system contract.

EC/2022/37 NENC Compliance with NICE Technology Appraisals

The Interim Executive Director of Finance rejoined the meeting at this point.

The Executive Medical Director presented the paper which had been prepared following a discussion at the previous Committee meeting. The paper outlined the current challenges in complying with NICE technology appraisals for new medicines and options for addressing these challenges.

Under the former clinical commissioning group model, providers and commissioners at place would negotiate how these were to be funded, resulting in either non-adoption of these new technologies or inequities in access. This had become more acute since the widespread introduction of block contracts with providers.

It was noted that this was not a new issue but there needed to be further work carried out regarding this and clarity gained as to what level of decision making needed to come to the Committee and what could be agreed locally.

RESOLVED:
The Committee **AGREED** to the recommendation of option B as set out in the paper - ensure NICE technology appraisals were only adopted once accompanied by a system finance commitment to identify an existing funding source through prioritisation prior to approval to allow newly approved NICE technologies to be passed through on a cost and volume basis in year. Where this financial arrangement could not be obtained and the drug not made available to patients, this would be supported by Executive Committee agreement.

EC/2022/38 Any other business

Pre-Delegation Assessment Framework (PDAF) for Pharmaceutical, Ophthalmic and Dental Services (primary, secondary and community services)

The Executive Director of Place Based Delivery (Central and South) reported that a task and finish group had been set up as part of the PDAF process to complete the framework.

This was an ongoing piece of work which had to be submitted to NHS England by the end of September 2022, the detail of which would be shared electronically beforehand and discussed in more detail at the next informal executive team meeting.

Bank Holiday Arrangements for 19 September 2022

It was noted that the national requirements for this had now been received and all general practices would close. Contact had been made with out of hours providers.

Assurance was being sought from foundation trusts that their arrangements were also in hand and a further meeting was planned the following day to identify any gaps.

Vaccination clinics had been asked to continue.

The meeting closed at 12:59.

Signed:

Position: Chief Executive (Chair)
Date: 11 October 2022

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Appendix 2

NHS
North East and North Cumbria

North East and North Cumbria Integrated Care Board

EXECUTIVE COMMITTEE

Minutes of the meeting held on Tuesday 11 October 2022, 9.00 – 12.45 at Pemberton House, Sunderland

Present:
Samantha Allen, Chief Executive (Chair)
Dr Neil O'Brien, Medical Director
Claire Riley, Executive Director of Corporate Governance, Communications and Involvement
Jacqueline Myers, Executive Director of Strategy and System Oversight
Aejaz Zahid, Executive Director of Innovation
Nicola Bailey, Interim Executive Director of Place Based Delivery (North and North Cumbria)
David Chandler, Interim Executive Director of Finance
David Purdue, Executive Director of Nursing

In attendance:
Deborah Cornell, Board Secretary
Joseph Chandy, Director of Transformation (Primary Care)
Sarah Burns, Director of Place (Durham)

EC/2022/39 Welcome and introductions

The Chair welcomed colleagues to the meeting of the Executive Committee.

It was noted that item 3 (North and North Cumbria Place Based Delivery Report App5) and item 18 (Report from NECS Customer Board Meeting held 27 July 2022) were confidential and contained the protective marking of 'official: sensitive commercial' and therefore would be minuted separately.

EC/2022/40 Apologies for absence

Prof Graham Evans, Executive Chief Information and Digital Officer
David Gallagher, Executive Director of Place Based Delivery
Annie Laverty, Executive Chief People Officer

EC/2022/41 Declarations of interest

With respect to item 19 on the agenda, Enhanced Access Provision Update – Network Contract DES, the Executive Medical Director expressed a conflict of interest as a GP, and the Director of Transformation (Primary Care), in attendance, expressed a conflict of interest as a provider of services. It was confirmed that they would remain present for this item and therefore the meeting would still be quorate.

EC/2022/42 Minutes of the previous meeting held on 13 September 2022

The minutes were agreed as a true record of the meeting with one amendment to item EC/2022/29 Tactical On Call Rota – to note that the rota will come into effect on 1 of December not November.

EC/2022/43 Matters arising from the minutes

It was agreed that further work was required on the information detailed within the action notes. This will be refined and shared at a future meeting.

EC/2022/44 Central and Tees Valley Place Based Delivery Report

The Executive Director of Place Based Delivery (Central and South) was not present but the Director of Place (Durham) attended on his behalf to present the report which provided a brief highlight of current work underway in Central and Tees Valley areas. It was noted that this report did not highlight any finance, quality or performance issues as they were covered as separate items later on the agenda.

Discussion took place regarding social impact bonds and it was agreed to explore how they have been developed and how successful they have been to see if it is worth exploring across the region.

The Executive Director of Corporate Governance, Communications and Involvement added that this was a helpful report which will give us content to drive place based communications. Regarding additional funding it was noted that north of the river, the combined authority is looking at areas for substantial investment linked to work they are doing with a large investment company. It was confirmed that the Executive Director of Place Based Delivery (Central and South) is involved in similar conversations in the south.

Work regarding the end of life project was referenced. The Executive Medical Director highlighted that there is a region wide end of life network which needs to be connected.

ACTIONs:

- **The Interim Executive Director of Finance to explore social impact bonds**

- **Ensure there are stronger links with the combined authority in the South – particularly Darlington area**
- **Connect the end of life work to the work of the network.**

RESOLVED:
The Committee **NOTED** the update.

EC/2022/45 North and North Cumbria Place Based Delivery Report

The Interim Executive Director of Place Based Delivery (North & North Cumbria) presented the report which provided an update on matters considered within the North and North Cumbria area – including a summary of the decisions made at local delivery groups in each place. Decision logs from each area were noted.

These are the first place based reports and it was **AGREED**, going forward, to have a common format and for decision logs to continue to be shared with the executive committee.

RESOLVED:
The Committee **NOTED** the update report.

EC/2022/46 Terms of Reference for the Urgent and Emergency Care Strategic Board and Local A&E Delivery Boards

The Executive Medical Director presented the paper which noted the terms of reference for the Urgent and Emergency Care (UEC) Strategic Board and the ICP Local A&E Delivery Boards (LADBs) which have been agreed by the Strategic Board.

The Committee was asked to focus on the accountability between the Strategic Board and the LADBs which demonstrates a shared understanding of the work that should be undertaken by the LADBs, at place, and what should be carried out system-wide providing strategic direction and ensuring whole system integration.

The Committee was advised that all LADB Chairs attend the UEC Board at Chief Executive / Chief Operating Officer level. The first meeting has taken place with the consensus that there is appropriate high-level representation.

RESOLVED:
The Committee **NOTED** the content of the report.

EC/2022/47 Winter Plan

The Executive Director of Strategy and System Oversight presented the Winter Plan which brings together all of the actions and arrangements the ICB is putting in place to ensure the system is prepared to deal with escalating operational pressures in the coming months. Oversight of the plan delivery will take place at the ICB Urgent and Emergency Care Network.

A Rapid Process Improvement Workshop (RPIW) has been scheduled for 12 October; the model agreed at this event will then be put in place. Regarding surge, a review of different responses required for the varied situations will be undertaken. It was noted that this will be seen as a system co-ordination not a command centre unless there is required escalation to Opel level 4.

It was suggested that chief executives may wish to discuss the plan around agreed actions, who makes those calls, what a command centre will carry out and what the triggers are, at the forthcoming chief executive strategic session.

It was discussed if there should be a summary slide to show 'action delivered by'. It was also raised where do we tackle cultural issues, offers to providers not being taken up and capacity issues.

The Executive Director of Strategy and System Oversight raised that consideration is being given regarding a role to manage the daytime coordination of surge.

It was noted that one of the most significant issues is the collaboration between providers, however it was raised that what has currently been achieved should be acknowledges including the three key priority areas everyone has signed up to.

The Executive Medical Director suggested a network bulletin may be a useful source of information.

Regarding finance within the plan, it was noted that although there are some areas for review, the executive committee was assured that it is covered within the budget. They are also looking to repatriate some communications funding from Northumbria.

The Executive Director of Nursing commented that there looks to be a gap regarding mental health and we need to review what the core 24 hour offer is as it is not what it should be and varies across the patch.

The Chair concluded that although there is still work to be carried out, a significant amount of effort has already been undertaken and thanked all those involved. Further discussion will take place at the chief executives' strategic session on Friday 14 October. National metrics, and most probably local ones, will start to be included in the performance report, but no targets have been received as yet.

There was a request to add a resource slide to show where the funding is coming from.

<u>Communications</u>
The Executive Director of Corporate Governance, Communications and Involvement had previously shared a presentation regarding the key actions

required to ensure the system is robust for winter and beyond and updated the committee on current actions.

ACTION:
The Executive Director of Corporate Governance, Communications and Involvement and the Executive Medical Director to follow up regarding a network bulletin.

RESOLVED:
The Committee **CONSIDERED** and **APPROVED** the proposed Winter Plan subject to any further refinements identified by the Committee.

EC/2022/48 ICB Programme Plan Update

The Executive Director of Strategy and System Oversight presented the paper which provided the executive committee with visibility of the current ICB programme plan and provide assurance on progress against key deliverables. It described the interim process taken to gain assurance from leads and propose further actions needed to streamline the process and provide outputs.

It was explained that the programme plan captures progress against key deliverables which have then been allocated to an executive lead. It was agreed that the report will be discussed in detail at an informal executive team meeting followed by submission to a formal executive committee meeting for final approval.

ACTION:
To be added to the forward agenda plan for an executive team meeting.

RESOLVED:
The Committee **NOTED** the content and the interim process in the plan to gain assurance and **AGREED** the approach for further development of the process and outputs.

EC2022/49 Covid Medicine Delivery Unit Proposal

The Executive Medical Director presented the paper which set out the requirements for the provision of Covid Medicine Delivery Units (CMDU) from October 2022 onwards, outlining a comprehensive model involving all eight acute NHS Foundation Trusts as well as identifying demand and service risks.

Due to time constraints, the Committee was advised that the proposal had been initially agreed by the Chief Executive, Executive Medical Director and the Interim Executive Director of Finance. The executive committee was therefore asked to ratify the approval of the proposal.

The Interim Executive Director of Finance confirmed that the funding has been received.

RESOLVED:
The Committee **SUPPORTED** the recommendations outlined in the paper.

EC/2022/50 Review of Health Inequalities Arrangements

The Executive Medical Director presented the paper which explained that following the recommendation to the ICB Board on 1 July to establish a task and finish group to review the ICS approach to health inequalities, the report set out recommendations for the formation of a Healthier and Fairer Advisory Group reporting to the ICB.

The formation of this advisory group will allow clarification of the oversight of this multi-faceted area of our work, encompassing health and healthcare inequalities, prevention and population health management.

The proposed advisory group has been formed to provide both the direct oversight of the ICB's core programmes of work, including CORE20PLUS5 and prevention programmes, as well as providing leadership and guidance to the wider system through an advisory role to the Integrated Care Partnerships.

This has been co-produced by the NHS and Directors of Public Health to establish a new group with a broad remit. There will be a co-chair arrangement with system partners. It will look at what can we do once, how can we learn from each other and how do we use the collective power of the ICB/ICP.

During discussion it was identified that there is work potentially needed to link in around, how as a group of NHS organisations, we can influence broader local policies and procedures and it was noted that there is collective work going on regarding child poverty.

The Executive Director of Strategy and System Oversight added that everything needs to connect into the work of this group and into the strategy.

The Chair concluded that in relation to membership, the group should be as diverse as possible, which may be challenging, but recognised that there is strong support.

RESOLVED:
The Committee **APPROVED** the formation of this advisory group as a sub-group of the Committee, based on the proposed terms of reference and membership; an update on this work will be submitted to the ICB Board in November.

EC/2022/51 Proposal for the Health Inequalities Targeted Funding Allocation

The Executive Medical Director presented the paper which explained that NHS North East and North Cumbria ICS had been allocated £13,604,000 recurrent revenue as a specific allocation to support targeted reductions in health inequalities. The report proposed key priority areas for utilisation of

this resource over three financial years. The proposals mainstream existing work, maximise opportunities to scale activity in partnership with the Local Authorities (LAs) and Voluntary, Community and Social Enterprise (VCSE), as well as support the corporate aims of the ICB.

It was reported that a team will be established to coordinate activity to ensure health and healthcare inequalities are embedded throughout the ICS and drive forward activity to improve access, experience and outcomes for the population.

The Executive Director of Corporate Governance, Communications and Involvement raised funding for communications and highlighted that as an ICB there needs to be a mechanism to ensure oversight of the various campaigns the communication team are involved in.

It was noted that everyone involved in the previous group have been collaborative in pulling this together. There is an underspend this year and it should not be viewed as only funding for health inequalities.

It was **AGREED** that a report will be submitted to a future Board meeting.

The Chair concluded that there will be a need for transparency regarding ringfenced monies however prioritisation will require consideration in time due to austerity measures collaboratively.

ACTION:
To be added to the cycle of business for discussion at a future Board meeting.

RESOLVED:
The Committee **SUPPORTED** the recommendations outlined in the paper.

EC/2022/52 Learning Disabilities and Autism – Building the Right Support

The Interim Executive Director of Place Based Delivery (North & North Cumbria) presented the paper which provided the Committee with an overview of the challenges and opportunities for the North Cumbria and North East Integrated Care System (NCNE ICS) to deliver together with our Councils' Transforming Care for Autistic people, people with Learning Disabilities and people with both.

It was highlighted that that we must not lose sight of this group of people which, although a small group, does involve high costs – a further report around autism will be submitted to the executive committee at a later date.

It was confirmed that the providers will be registered through CQC to ensure we can regulate community and at home provision to make sure it is safe and a better experience from that of being in hospital.

The executive committee AGREED to receive the report as an update but requested that a further session be arranged to discuss, in further detail, the

right infrastructure, capacity and leadership. It was also discussed whether this should be debated at a Board development session to consider the scope, learning and sharing of best practice.

The Interim Executive Director of Finance acknowledged that a lot of work has been carried out to date and we are now at the more challenging end of the spectrum. There is a requirement for a strategy and financial plan, which includes providers and local authorities to ensure important collaboration. It was AGREED that a risk share agreement should be put in place.

The Chair concluded that this is a population health inequalities issue and individuals should be known to all organisations.

ACTION:
It was AGREED that further discussion will take place at a Board development session or a future Board meeting in public. To be confirmed.

RESOLVED:
The Committee **SUPPORTED** the recommendations outlined in the paper.

EC/2022/53 Intellectual Property Management and Revenue Sharing Policy Draft

The Executive Director of Innovation presented the paper which sought comment from the executive team on the proposed IP disclosure process and suggested revenue share levels stated within the policy draft. The policy has been adapted from a previous CCG strategy.

Following discussion it was **AGREED** to seek legal advice and soft intelligence in relation to other organisations approach across the country before formalising the draft.

The Interim Executive Director of Finance stated that the policy outlines 'income' which should be changed to 'profit'.

ACTIONS:
The Board Secretary to follow up IP registers in relation to previous CCG arrangements.

RESOLVED:
It was **AGREED** to bring this policy back to the Committee in December for approval.

EC/2022/54 Enhanced Access Provision Update – Network Contract DES

The Executive Medical Director expressed a conflict of interest as a GP and the Director of Transformation (Primary Care), in attendance for this item, expressed a conflict of interest as a provider of services. It was confirmed that they would remain present and therefore the meeting would be quorate.

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The Director of Transformation (Primary Care) presented the paper which provided information to the executive committee regarding the current status and risks associated with Enhanced Access provision as part of the Network Contract DES. Specifically noting the issues and risks regarding the gap in access provision on Sundays and Bank Holidays from 1 October 2022. NENC ICB has been highlighted by NHS England Regional team as an outlier and therefore seeking an understanding on the ICB current position and assurance on how the gaps are being addressed

The Interim Executive Director of Finance stated that there appears to be consistency across all areas however there are three or four areas who are unable to self fund. It was noted that it is unlikely that the identified funding of c. £750k will be fully spent and is a one off for this year. It was also added that it would be useful to see a breakdown of the Durham costs.

The Executive Medical Director raised that consideration is being given around enhancing access to primary care and co-location of emergency departments but there is a requirement to join everything together. It was recognised that 111 access also has to improve to ensure these services are robust.

The Chair concluded that this is an immense piece of work to get on an equitable footing. As part of the additional funding there is a requirement to extend access to 111.

ACTION:
It was requested that Director of Transformation (Primary Care) share an update as soon as possible.

RESOLVED:
The Committee **SUPPORTED** the recommendations outlined in the paper.

EC/2022/55 Finance Update

The Interim Executive Director of Finance presented a report which provided the committee with an update on the financial performance of the North East and North Cumbria Integrated Care Board (NENC ICB) and NENC Integrated Care System (ICS) in the financial year 2022-23 for the period to 31 August 2022.

The report proposed a number of options and recommendations for the management of the running cost budgets across the ICB, including a proposed process for control of staffing posts and the staffing establishment of the ICB.

The summary report gave an overview of the financial position which was noted by the Committee.

Regarding the pay award shortfall, this will be added to the risk register.

It was noted that next year will be very challenging due to a difficult starting position. Efficiency work has commenced for next year; there is a requirement for an ICB Efficiency Group to be established.

In relation to ICB running cost budgets, work is ongoing – the Interim Executive Director of Finance requested comments from colleagues on the paper so far.

Regarding the staff establishment control process, it was requested that it should be made clear that the use of agency admin staff is not permitted.

ACTION:
Pay award shortfall to be added to the risk register.

RESOLVED:
The Committee **SUPPORTED** the recommendations outlined in the paper.

EC/2022/56 Finance Sustainability Checklist

The Interim Executive Director of Finance presented the report which updated the committee on work required to complete a self-assessment against a financial sustainability checklist and presented the latest draft completed self-assessment for review and approval.

Subject to agreement by the executive committee, the actions will be developed into a formal action plan, progress against which will be reported and managed through the Audit Committee. This will incorporate any findings and actions arising from the internal audit review as appropriate.

The Chair queried if there are any training and development needs to increase the capability of budget holders. To be considered.

RESOLVED:
The Committee:

- **NOTED** the requirement to complete a self-assessment and subsequent internal audit review
- **REVIEWED** and **AGREED** the draft completed self-assessment and actions identified which will be collated into a formal action plan.

EC/2022/57 Integrated Performance Report

The Executive Director of Strategy and System Oversight gave a verbal update. The Committee noted that because of timings in relation to the receipt of information a full performance report will be submitted on a bi-monthly basis, and a high level report will be to the Board.

ACTION:
Meeting schedule to be reviewed.

RESOLVED:
The Committee **RECEIVED** the update.

EC/2022/58 Proposed Oversight Framework and Memorandum of Understanding with NHS England

The Executive Director of Strategy and System Oversight presented the paper which explained that the framework had been developed by a task and finish group, chaired by the Executive Director of Strategy and System Oversight, which included members from across the ICB representing Place, Quality, Workforce and Finance, partners from the Regional Team and representing providers.

It was noted that the responsibility for maintaining effective oversight arrangements resides with the executive committee. Once the Oversight Framework is approved, it will be reviewed after one year and thereafter every three years.

Once agreed, work will be undertaken to implement the Oversight Framework which, it is hoped, will commence by the end of the month and will work within the resources that already exist.

With regards to the MOU, the two documents need to be taken together although the National Framework is still awaited.

In response to a query raised by the Interim Executive Director of Place Based Delivery (North and North Cumbria) in relation to the development of committees at place and where formal review regarding delivery may be received.

It was **AGREED** to add a holding statement that this is still in development and would be incorporated when arrangements for place based meetings are finalised.

RESOLVED:
The Committee:

- **AGREED** that the MOU will be discussed at the upcoming Chief Executives Strategy Session and will be shared with the Directors of Place, senior leaders and Chief Operating Officers
- **CONSIDERED** the proposed Oversight arrangements set out within the Oversight Framework and advise of any required changes
- **APPROVED** the 2022/23 MOU with NHSE NEY in relation to oversight
- **APPROVED** the Oversight Framework subject to any further refinements identified by the committee
- **AGREED** that the Board will be sighted in due course.

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EC/2022/59 Notification of Chairs Action: Decision in relation to GP IT Futures Procurement of Clinical Information Systems

The Chair reported that this item had required an urgent decision and was therefore agreed via a Chairs Action.

RESOLVED:
The Committee **RATIFIED** the decision.

EC/2022/60 Strategy and Partnerships

There were no items for discussion in this section.

EC/2022/61 Corporate Risk Register

The Executive Director of Corporate Governance, Communications and Involvement presented the paper which provided the executive committee with an updated position on the risks for the period 7 July 2022 to 30 September 2022.

It was highlighted that the financial plan is detailed within the register, but the following areas require consideration for inclusion:

- Items from the ICP Strategy
- Pay awards
- Learning disabilities and autism
- Winter pressures
- HR capacity
- Social care

Work is ongoing to review all risks that transferred from the former CCGs to ensure these remain relevant to the ICB both at place and corporate level.

There will be a named lead responsible for reviewing each risk on a regular basis and will be a standing agenda item on the executive committee agenda going forward.

The Committee wished to acknowledge its thanks to the corporate governance team for all their work on this.

ACTION:
To be added to the executive committee cycle of business as a standing agenda item.

RESOLVED:
The Committee **RECEIVED** and **REVIEWED** the risk register for assurance.

Item: 9.3

EC/2022/62 Review of Corporate Policies

The Executive Director of Corporate Governance, Communications and Involvement presented the paper which provided the executive committee with a six-month policy review schedule and updated policies for information access and serious incident management.

It was agreed that the Executive Director of Strategy and System Oversight will bring her policies back to be agreed in January.

ACTION:

- **The Incident Response Plan, Business Continuity Plan and the EPRR On-Call Policy will be brought to the January 2023 meeting for approval**
- **It was requested to add Patient Safety Framework to the Serious Incidents Management Policy and submit to the meeting of the Committee in November.**

RESOLVED:
The Committee **NOTED** the review schedule and **APPROVED** the revised Information Access policy.

EC/2022/63 Governance Assurance Report - August 2022

The Executive Director of Corporate Governance, Communications and Involvement presented a paper which provided the executive committee with an overview of the governance activity provided by North of England Commission Support (NECS) during August 2022.

It was reported that the format of the report is currently being reviewed to ensure it provides a more detailed breakdown and analysis of key themes and trends arising from these areas to enable the ICB to monitor its performance and address any areas of concern.

The report will be presented to the executive committee on a quarterly basis to support this.

It was noted that a review of health and safety measures in all ICB buildings is required.

RESOLVED:
The Committee **RECEIVED** the report for assurances purposes.

EC/2022/64 Committee Cycle of Business

The Chair presented the Committees cycle of business for the remainder of the financial year. It was emphasised that the cycle of business is still currently a draft/live document; the Committee was asked to submit comments e.g., frequency of reports to the Board Secretary.

It was raised that the sub-groups of the executive committee need to be mapped and the reporting cycle scheduled. It was requested that this is coordinated with the workstream work being undertaken by the Director of Transformation System Wide

It was requested that any gaps and/or duplications, along with the frequency of each item be sent to the Board Secretary.

RESOLVED:
The Committee **REVIEWED** the cycle of business.

EC/2022/65 Any other business

i) The Interim Executive Director of Place Based Delivery (North and North Cumbria) requested a future discussion regarding place based governance, looking at how it will work, delegation arrangements etc.

ACTION:
Future agenda item

The Board Secretary reported that on a regional call it had been noted that many places will have ICB sub committees and not joint committees.

ii) The Executive Director of Innovation Research queried if a forthcoming innovation stakeholder event could still go ahead due to the rising Covid numbers, potentially taking some delegates away from clinical commitments. Following discussion, it was agreed that the event should go ahead as planned.

iii) The Executive Director of Corporate Governance, Communications and Involvement informed the Committee of a Northumberland case of the female homicide through domestic violence. There is learning for primary care to help spot domestic violence.

The meeting closed at 12.50.

Signed:

Position: Chief Executive (Chair)

Date: 15 November 2022

Item: 9.4

NHS
North East and North Cumbria

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

NORTH EAST AND NORTH CUMBRIA ICB BOARD MEETING 29 November 2022	
Report Title:	**Highlight Report from the Quality and Safety Committee held on 20 October 2022**

Purpose of report

To provide the Board with an overview of the discissions at the first meeting of the Quality and Safety Committee held in October 2022.

Key points

The Committee considered a number of issues and supporting papers including:

- An introduction from Sir Liam Donaldson on the Quality and Safety agenda
- Terms of reference, cycle of business and risks
- Clinical quality exception report
- Patient Safety Incident Response Framework (PSIRF)
- National cancer patient experience survey (2021) and the GP patient survey (2022)
- Quality and safety of inpatient services
- North East Quality Observatory Service (NEQOS) regional mortality data
- Medicines overview

Risks and issues

The Committee received the first report concerning corporate risks aligned to the quality and safety portfolio. Members suggested additional risks and changes to risks including risks for workforce; children and adults mental health services; and prescribing.

The Committee will continue to receive and review the corporate risks aligned to the quality and safety portfolio to provide assurance to the Board that the quality and safety risks contained within the corporate risk register reflect the current environment.

Assurances

- The risks considered also include the internal and external assurances against each risk.
- The clinical quality exception report and other supporting reports provide the Committee with further data and assurance sources.

Item: 9.4

Recommendation/Action Required	
The Board is asked to receive the Committee highlight report for October 2022 for assurance.	
Sponsor/approving director	Eileen Kaner, Chair of the Quality and Safety Committee and Non-Exec Director
Report author	Neil Hawkins, Head of Corporate Affairs

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

Relevant legal/statutory issues						
Health and Care Act 2022						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓

Key implications	
Are additional resources required?	None at this stage – membership and terms of reference of the Committee are under review.
Has there been/does there need to be appropriate clinical involvement?	Appropriate clinical representation within the membership of the Committee.
Has there been/does there need to be any patient and public involvement?	N/A
Has there been/does there need to be partner and/or other stakeholder engagement?	N/A

Item: 9.4

NHS
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Quality and Safety Committee Highlight Report – October 2022

Summary

The Quality and Safety Committee, Chaired by Eileen Kaner, met on the 20 October 2022 for the inaugural meeting of the Committee.

The Committee considered a number of issues and supporting papers including:

An introduction from Sir Liam Donaldson on the Quality and Safety agenda – setting the scene for the Committee's workplan and posing some questions for the Committee's role within the system for quality and safety, including - programmatic areas to consider; the quality and safety synergies with other areas (e.g. social care); assessment, metrics and data; and, culture.

Terms of reference – the Committee considered the current terms of reference and agreed that further discussions and work would be required to refine the terms of reference as the Committee develops into its role. Consideration is being given to including social care representation within the Committee membership and also public/lay representation. The terms of reference will remain on the agenda and any suggested amendments will be brought to the Board for approval.

Cycle of business – the Committee considered the emerging cycle of business which detailed some of the reports and assurance items that will be considered throughout the year. The Committee recommended additional items should be captured for inclusion – including regular public and patient experience items (including complaints) as well as more strategic, forward looking business. The cycle of business will remain under review and updated as the Committee's business and remit develops.

Quality and safety risks – the Committee received a report on the corporate risks aligned to the Quality and Safety Committee. Further work is required to refine risks concerning workforce, child and adult mental health and prescribing.

Clinical quality exception report – the Committee received a presentation from David Purdue concerning quality and safety exceptions and performance. The report covered infection prevention and control; never events; serious incidents; maternity; and an update on the NEAS independent enquiry. The Committee also received a presentation concerning work to implement the Patient Safety Incident Response Framework (PSIRF).

National cancer patient experience survey (2021) and the GP patient survey (2022) – reports received for information.

Items also received were:

- Quality and safety of inpatient services
- North East Quality Observatory Service (NEQOS) regional mortality data

Item: 9.4

- Medicines overview – including the role of the regional medicine's committee and reporting to the Quality and Safety Committee (via minutes and annual reporting).

Item: 9.5

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

NORTH EAST AND NORTH CUMBRIA ICB BOARD MEETING 29 November 2022	
Report Title:	**Finance, Performance and Investment (FPI) Committee Highlight Report**

Purpose of report

To provide Board members with an overview of items considered and discussed at the FPI committee.

Key points

A summary of the October and November FPI committee meetings.

Risks and issues

There is a potential risk that the committee does not have a terms of reference that enables it to carry out its business effectively. This is currently in the process of being finalised for consideration at the next FPI Committee meeting on 1 December before being presented for approval at the next Board meeting in January.

Assurances

For the Board to gain assurance that the FPI Committee is undertaking the relevant discussions and approvals in line with its terms of reference.

Recommendation/Action Required

The Board is asked to:

- Note the contents of the committee highlight report;
- Receive the approved September and October minutes for information.

Sponsor/approving director	Jon Rush, Committee Chair/Non Executive Director David Chandler, Interim Executive Director of Finance

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Report author	Jen Lawson, General Manager

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

Relevant legal/statutory issues						
Note any relevant Acts, regulations, national guidelines etc						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓

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

Item: 9.5

Finance, Performance and Investment (FPI) Committee Highlight Report

Introduction

The purpose of the FPI Committee is to provide oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable, system financial plan. The committee reviews and scrutinises the financial performance of both the ICB and NHS organisations within the ICB footprint, as well as having an overview of overall operational performance and investments.

Summary report

The FPI Committee, chaired by Jon Rush, Non-Executive Director, has met on 1 September and 6 October (approved minutes attached). It also met on 3 November, albeit that these minutes will not be approved until the next meeting scheduled for 1 December, hence why they are not circulated with this report.

As the Board received an update at its meeting on 27 September regarding the FPI meeting held on 1 September, this update will cover the meetings held on 6 October and 3 November.

6 October

The interim Executive Director of Finance had set up a monthly meeting schedule with all the ICS Directors of Finance to support the communication and NHS partnership working linked to the role of the Committee. This was assisting in the balancing of surpluses and deficits across the system which was currently at a breakeven level.

The nature of historical surpluses or payments made to former CCG's was raised and this was an issue that needed further research and discussion.

Further discussions were held about the revision of the terms of reference but one of the main issues was to emphasise the utilisation of an integrated performance and finance report, that could also include quality issues.

3 November

The first ICB performance position update was presented by the Director of Strategy and System Oversight. This report provided members with a detailed overview of areas including primary care; urgent and emergency care; ambulance performance; A&E 4hr wait; length of stay and bed occupancy. The challenges faced in waiting lists and emergency care, plus diagnostics in cancer treatment and actions taken to resolve these were discussed.

An important update was provided on the Allocations task and finish group following a review of the ICBs allocation for 2022/23. The update report also recommended establishing a Resource Allocations subgroup, with two further technical sub groups, Coding Improvement sub group and Technical Allocation sub group to further review the allocations work collaboratively and collectively across the system to improve data and be given a fair share of the allocation. All the sub groups will be time limited.

This recommendation was approved, and draft terms of reference will be developed for the FPI Committee to consider and approve at the December meeting.

Governance and assurance

Reports received at the committee were:

- *ICB Finance Update*
- *ICB Performance Position Update*
- *Draft Terms of Reference*
- *Future meeting cycle*
- *Proposed Allocations Task & Finish Group update*

Item: 9.5

Recommendation
The Board is asked to: • Note the contents of the committee highlight report; • Receive the approved September and October minutes for information.

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North East and North Cumbria Integrated Care Board

Finance, Performance and Investment Committee

Minutes of the meeting held on Thursday 1 September 2022, 09:30hrs at Joseph Swan Suite, Pemberton House, Colima Avenue, Sunderland

Present:	Jon Rush, Chair Jon Connolly, Executive Director of Finance Graham Evans, Executive Chief Digital and Information Officer Eileen Kaner, Vice Chair Annie Laverty, Executive Director of People David Purdue, Executive Chief Nurse – via MS Teams
Apologies for absence:	Samantha Allen, Chief Executive Mark Adams, Executive Director of Place Based Delivery Dave Gallagher, Executive Director of Place Based Delivery Jacqueline Myers, Executive Director of Strategy and System Oversight Neil O'Brien, Medical Director Aejaz Zahid, Executive Director of Innovation
In attendance:	David Chandler, Director of Finance Richard Henderson, Director of Finance Jennifer Lawson, Governance Lead Peter Rooney, Director of Transformation David Stout, ICB Audit Committee Chair Gillian Sheppard, Executive Assistant (minutes)

FPI/2022/01	**Welcome and introductions** The Chair welcomed everyone to the first meeting of the Finance, Performance and Investment committee and introductions were provided.
FPI/2022/03	**Declarations of Interest** There we no declarations of interest declared.
FPI/2022/04	**Notification of urgent items of any other business** There were no urgent items of any other business raised.

FPI/2022/05	**ICB Finance update (enclosure 1)** Jon Connolly presented a high-level finance update for the North East and North Cumbria Integrated Care Board (ICB). The ICB financial framework was summarised, noting that 2022/23 is a transitional year for the ICB with an aim of maintaining as much stability as possible throughout the system following temporary financial arrangements in place during the COVID-19 pandemic and the change in organisations to one ICB. The ICB financial strategy is being developed throughout 2022/23, this work is challenging as at present the allocation for the 2023/24 financial year is currently unknown and a move to multiyear planning would be welcomed. The financial governance arrangements including Standing Financial Instructions (SFI) and financial delegations was approved at the ICB Board on 1 July 2022. These will continue to be reviewed as place-based governance arrangements are developed and to ensure they are fit for purpose. In practice, further consideration does need to be given as to who is best placed to make decisions to approve budgets at place or corporate, manage contracts and reporting. A formal process is being considered to enable the ICB and Integrated Care System (ICS) providers and stakeholders to communicate effectively, with monthly meetings arranged between the Executive Director of Finance, ICB and ICS Directors of Finance. There is ongoing work to develop an ICS estates strategy and to agree a coordinated approach to capital plans. A finance staff development strategy is to be developed across the ICB and ICS to ensure that staff have the right skills to achieve in their roles and support the ICB effectively. At month 4 the ICB is forecasting that it will achieve the overall planned position and efficiencies required. The two main areas of efficiency targets for the ICB are dominated by continuing healthcare (CHC) £20.2m and prescribing at £13m. There is also a pressure for future year's efficiency targets due to the non-recurrent funding across the ICS of circa £31m and further work to address the efficiencies will need to be undertaken. Eileen Kaner asked for an explanation of the services which would fall under recurrent funding. David Chandler provided a brief outline and it was suggested a development session in specific areas be given to committee members to provide a better understanding of any financial issues. Jon Connolly continued the presentation and summarised the risks and mitigations for the ICB, which totals £37m. The two most volatile areas are

	CHC with the risk of high-cost packages of care and prescribing, as a result of high cost, highly effective drugs compared to drugs traditionally used. A further risk in prescribing is a result of a 2-month delay in receiving data from the NHS Business Services Authority (BSA) to report accurately. There is extensive work carried out by the finance teams in both of these areas, supported by national guidance on funding and local experts reviewing the allocation. There is a risk of no additional Elective Recovery Fund (ERF) income to cover independent sector spend, the plans across the ICS had assumed an excess of 104% increase in activity where further monies could be earned, however the ERF funding rules have not been applied to date. A further COVID-19 related risk is with the COVID-19 medicines delivery unit and the potential surge in new variants, this is also reflected in the changes in treatment for patients with medicines being delivered for home treatment. There is non-recurrent benefits and other contingencies within plan amounting to £20m, with further work required in this area of risk, there is confidence that this will be reduced and the ICB will be able to manage its financial performance this financial year. A summary of the NENC ICS provider position was given, all providers have worked closely to achieve a balanced plan, the target of which is to break even. There are 2 providers with long standing financial issues and forecasting a combined surplus deficit of £64.14m, which the remaining providers will need to cover in order to deliver the system plan. There is a current overspend on capital limits and conversations with the national NHSE team are ongoing and the committee will be updated once further information is known. There is an overspend of £27.46m over Capital Departmental Expenditure Limit (CDEL) in the capital plan due to a provider requesting to make a greater capital spend and linked to increase in inflation costs. David Stout commented that it may be difficult to deliver a surplus in the ICS provider position in future years as safety of patients must always be the priority and the ICB does not control performance management of providers. Jon Connolly acknowledged there is continued work to be done with providers to produce a balanced plan. Eileen Kaner asked what communications are in place for ICB discussions with providers and provider collaboratives. Jon Connolly confirmed that regular meetings are in place between the executive teams of ICB and providers to ensure ongoing discussions take place on system working and discuss areas of focus. Graham Evans commented that digital investment is needed across organisations within the ICS and there is a need for informatics to be upskilled and workforce. Eileen Kaner asked that consideration be given to digital

	poverty and digital exclusion across the population for any future transformation agenda. David Stout asked if an internal audit was needed to confirm the robustness of the new organisations financial management systems. Jon Connolly said internal audit have a full programme in place for the ICB and have been involved in all of the transition work and assurance will be provided mid-year. A general discussion took place on the need for development sessions for members of the committee to provide an understanding of the financial risks associated with each topic. It was agreed a 30 minute development session on specific topics would be given ahead of each committee. **Action:** **The Executive Director of Finance to work with leads and provide a development session for committee members on:** • **Understanding CHC** • **Understanding Prescribing** • **ERF** • **How planning & strategy process works** • **ICS Provider position** • **Capital updates** • **Digital funding and lessons learned across system** • **Transformation** • **Estates** **RESOLVED:** The committee **RECEIVED** the report for assurance.
FPI/2022/06	**Review Terms of Reference (enclosure 2)** The Chair presented the Terms of Reference (ToR) for a review by the committee to ensure it is able to deliver its delegated duties effectively on behalf of the Board. The following points of the ToR were highlighted by the Chair for discussion: • The part 1 and part 2 membership of the committee is difficult to manage. • The name of the committee is ambiguous, further clarification is needed as to its purpose and consider a name change. • There is a disparity on attendees for part 1 of the committee and an oversight document. Confirmation is needed as to whether the Executive Director of Innovation and the Executive Chief Digital and Information Officer should be included in the ToR.

	With regard to part 1 and part 2 membership of the committee, it was felt that the 2 parts of the meeting would be difficult to manage and is a duplication of meetings already taking place between the ICB Executive Director of Finance and ICS Provider Sector Directors of Finance. The combination of both meetings and to include the ICB Board NHS FT Partner members and conflicts of interest should be managed carefully by the Chair. The purpose and function of the committee was discussed, and the view was that the title of the committee was ambiguous. The consensus was the committee should focus on financial strategy, financial governance, financial performance, planning and the wider performance. This would enable discussion on how to deliver the financial plan of the ICB, understanding the financial position, the risks and mitigations. The meeting should also include discussions on investment, business cases, SFI's so assurance and recommendations could be given to the ICB Board. Any performance quality issues that would impact financial decisions would be considered in the committee but should be detailed further in the Quality committee. **Action:** **The committee recommend the following changes and amendments to the terms of reference and recommend submission to the Board for formal approval:** • Part 1 and part 2 of the meeting be combined into one and include the ICB Board NHS FT Partner members • Conflicts of interest to be managed appropriately by the Chair • ICB Provider Sector Finance Director reps x 3 be removed, as this is a duplication of meetings already taking place between the ICB Executive Director of Finance and ICS Directors of Finance. • The title of the committee is ambiguous and suggest a name change to Finance Committee – the performance element will be covered within the Quality Committee. • The inclusion of the Audit Chair as a regular, non-voting attendee to the Committee under section 4.3 • The addition of section 6.1.7 to reflect an additional responsibility of the Committee in relation to sustainability **RESOLVED:** **The committee APPROVED the suggested changes to the terms of reference and AGREED the submission of the amendments to the Board for formal approval.**
FPI/2022/07	**Future meeting cycles** Jon Connolly requested a review of the meeting cycle of the committee. The current scheduling of the committee will mean that the finance update provided to the ICB Board will be one month in arrears and asked that the members

	consider amending future dates in line with the availability of the most recent finance data. A general discussion took place and agreed the future meeting cycle needs to be reconsidered in line with the availability of finance data and potential governance issues in the cycle of reporting. **Action:** **Governance lead to work with Executive Director of Finance to ascertain suitable dates for the finance committee to ensure the most recent reporting is provided to the ICB Board.**
FPI/2022/08	**Any Other Business** Annie Laverty suggested a brief reflection/debrief at the end of each meeting would be useful. All members agreed. **Action:** A meeting debrief is to be added as a standing agenda item to future meetings. **Meeting closed at 11.00am**

Signed:

Position:
Date:

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North East and North Cumbria Integrated Care Board
Finance, Performance and Investment Committee

Minutes of the meeting held on Thursday 6 October 2022, 10:00hrs at Joseph Swan Suite, Pemberton House, Colima Avenue, Sunderland

Present:	Jon Rush, Chair Nic Bailey, Interim Executive Director of Place Based Delivery Ken Bremner, Chief Executive, South Tyneside and Sunderland NHS FT David Chandler, Interim Executive Director of Finance Dave Gallagher, Executive Director of Place Based Delivery Jacqueline Myers, Executive Director of Strategy and System Oversight Rajesh Nadkarni, Executive Medical Director CNTW Neil O'Brien, Executive Medical Director
Apologies for absence:	Samantha Allen, Chief Executive Graham Evans, Executive Chief Digital and Information Officer Eileen Kaner, Vice Chair Annie Laverty, Executive Director of People David Purdue, Executive Chief Nurse Aejaz Zahid, Executive Director of Innovation
In attendance:	Richard Henderson, Director of Finance Jennifer Lawson, Governance Lead David Stout, ICB Audit Committee Chair Emma Harris, Executive Assistant (minutes)

FPI/2022/10/01	**Welcome and introductions** The Chair welcomed everyone to the Finance, Performance and Investment Committee (FPIC) meeting and introductions were provided. This was the first meeting which have been merged to make it more streamlined. It was noted that there was no representation for the Chief Personnel Officer.
FPI/2022/10/03	**Declarations of interest** There we no declarations of interest declared. Other than the ones that exist for the two Provider Representatives of the ICB, which will be dealt with by the Chair if a specific conflict is evident during the course of the meeting.
FPI/2022/10/04	**Minutes of the previous meeting (1 September 2022)** It was AGREED that an amendment should be made regarding the purpose

	of the meeting on page 5, paragraph 2, sentence 3 to state that "the Committee should focus on financial strategy, financial governance, financial performance, planning and the wider performance".
FPI/2022/10/05	**Matters arising from the minutes (enclosure 1)** Jen Lawson suggested that the current meeting dates, set on the first Thursday of each month, should remain as have been confirmed in members diaries and due to reporting periods, although could be monitored and reviewed at a later date. David Chandler described finance reviewing process to ensure good governance. **ACTION:** **Jen Lawson agreed to circulate meeting dates.** Jon Rush said that a meeting had been scheduled with Sir Liam Donaldson regarding overlaps of Committee responsibilities.
FPI/2022/10/06	**Action log updates (enclosure 2)** (see separate action log) The Chair asked if there could be IT available from November to run the 30 minute development sessions via MS teams to enable wider non exec participation. **ACTION:** **Emma Harris / Gillian Sheppard to work with IT to see if IT equipment can be available to run development sessions via MS teams from November onwards.**
FPI/2022/10/07	**Notification of urgent items of any other business** There were no urgent items of any other business raised.
FPI/2022/10/08	**ICB Finance update (enclosure 3)** David Chandler presented a high-level finance update for the North East and North Cumbria Integrated Care Board (ICB) and the Integrated Care System (ICS). A reminder of the four duties of the ICB was given and public dividend capital and capital departmental expenditure limit (CDEL) was briefly explained. Meetings with ICS Directors of Finance (DoFs) have been set up on a monthly basis as part of the financial reviewing process. An overview of the financial position was given which had forecast a

	breakeven position for the ICS with an ICB surplus of £2.6m. This offsets a forecast deficit across relevant NHS providers of £2.6m. The main factors driving this performance were listed. For the ICB £9.4m has been offset from programmes reserve to balance the overall ICB position. David Chandler explained that the need for contingency reserves are difficult to predict due to ongoing system and winter pressures. Rajesh Nadkarni queried the areas of overspend in Mental Health and David Chandler replied that it was generally within the independent sector and S117 packages of care. Ken Bremner asked how much had been committed against programmes slipping versus contingency. David Chandler replied that approximately £6m had been allocated. Neil O'Brien queried the status of historical surpluses. David Chandler explained that there had been different financial positions across the former CCGs. When the ICB was formed, it had been agreed by NHSE that all CCG positions would be netted off after accounting for 1% cumulative surpluses resulting in a small deficit for the ICB. At Place level underspends would be offset by areas with overspends. It was highlighted that a letter of guarantee around protected underspends had been issued and gave an example of guaranteed draw down in Sunderland. It was noted that there had been limited NHSE guidance received to date, and it would be the responsibility of the ICB on how to allocate monies. There was a further discussion regarding communication and transparency of the overall net position, delegation to place and system draw down which would require a 1% surplus. Jon Rush asked how surplus risks would be managed and Neil O'Brien said that a response plan would be required. Dave Gallagher added that it could provide an opportunity for the ICB to carry out an accurate needs-based assessment for allocating resources. The Chair summarised that there was an action required to address concerns of previous surpluses and asked if a financial strategy update for historic surpluses could be provided at the next meeting scheduled on 3 November. **ACTION:** **The Interim Executive Director of Finance to work with Finance Directors and Place Based Directors to review historic surpluses and provide a strategy update at the next FPIC meeting scheduled on 3 November 2022.** When table 1.1: ICB Financial Position at Place was presented, it was requested that the word 'Place' be removed from text and slides and state the area for example: Newcastle, Gateshead etc.

	It was clarified that table 2: Overall ICS (Surplus) / Deficit for commissioning services forecast position was breakeven. Independent sector activity which was driven by elective recovery highlighted in Table 3: ICB Acute Services. David Stout queried the Elective Recovery (ERF) fund and Foundation Trust (FT) activity levels. In response, David Chandler described the ERF funding allocation of approximately £120m for the full year, of which approximately £113m is allocated to providers (to get to and above 104% activity levels) and £7m within the ICB for extra activity over baseline. It was explained that due to COVID-19, NSHE had indicated there would be no ICS clawback on allocated resources for the first six months of the year. There was a further discussion regarding the risk of clawbacks from NHSE and agreement that a collective response would be required if a clawback from NHSE was required after six months. David Chandler said that Performance Leads and DoF's will work together on a recommended approach. The Chair requested that a Task and Finish group update on proposed allocations be provided at the next meeting scheduled on 3 November 2022. **ACTION:** **The Interim Executive Director of Finance to provide an update from the Allocation Task and Finish Group at the next FPIC meeting scheduled on 3 November 2022** There was a discussion regarding expectations of organisations who may not achieve plan for M6. David Chandler confirmed that ICS DoF's are working on achieving consistent methods of forecasting, how to collectively bridge gaps, ERF and pay award risks. At least two organisations have indicated risks are likely to become actual forecast overspends which has been shared with NHSE colleagues to ensure transparency for M6 returns. The Chair asked if an update would be available for the next meeting. Rajesh Nadkarni left the meeting. The Committee were asked if there were any particular questions to be raised based on the remainder of the presentation slides. There was a discussion regarding system assurance and Neil O'Brien referred to Table 8: which highlighted a total ICB Primary Care overspend of £5m and asked if it would be a strategic aim to level it off. Jacqueline Myers replied that an explanation would be included in the Health and Care Strategy but pointed out that it was challenging to demonstrate how to react with only one year's set of accounts and a longer term set of data was ideally required.

	There was a more in depth conversation regarding tariffs and block contracts, which David Chandler said had been agreed on a short term basis, and a meeting with DoF's had been scheduled in the forthcoming week regarding planning assumptions for the following year. The general consensus was that there were many dynamics and challenges across different places and agreement that the next financial year will be challenging. The Chair summarised that using the mix of skills, expertise and knowledge within the FIPC would help to achieve the best financial strategy and position. Jen Lawson queried why North West Ambulance Services (NWAS) was not listed as an NHS Provider in Table 3. Richard Henderson explained that it was due to the ICS area in their main contract and activity but noted that it should be highlighted as a footnote. The Chair provided a summary of the financial update: David Chandler and DoF's will link in with the wider system and that there would be an opportunity to carry out a needs based assessment.
FPI/2022/10/09	**Review Terms of Reference** The Chair presented the report and revised Terms of Reference (ToR) for a review by the Committee. The Committee **APPROVED** the changes to the 3 bullet points highlighted on the front cover sheet of the revised ToR. Jon Rush and David Stout are to discuss the inclusion of the Audit Chair as a regular, non-voting attendee to the Committee under section 4.3. David Stout confirmed that a conversation had taken place with Deb Cornell and the following change should be made to Section 6: Responsibilities of the Committee: Financial Framework: Bullet point 5 "to recommend SFIs and financial delegations and limits to the Board for approval" should be removed and added to the ToR for the Audit Committee. A discussion took place regarding nominated deputies. It was agreed that one ICB Board NHS FT Partner Member would attend each meeting to ensure a point of view on behalf of providers and Ken Bremner made a plea for flexibility if a Deputy was required. There was a discussion regarding the number of Executive Directors duplicated in various Committee memberships. The general consensus was that a follow up conversation with Sam Allen would take place regarding Executive Director Committee membership and updates could be reported back to the Executive Committee, and Jon Rush confirmed that a meeting had been scheduled with Sir Liam Donaldson in mid-October when it could be raised.

	Jacqueline Myers queried the paragraph "People" on page 9 in Section 6 "Responsibilities of the Committee" which stated "to develop a finance staff development strategy to ensure excellence by attracting and retaining the best finance talent". David Chandler replied and confirmed that it was not a responsibility of the Committee to develop finance staff and it was agreed that it would be **REMOVED** from the ToR. A Forward Plan of the meeting content schedule will assist in identifying early attendance to meetings. The following actions were summarised by the Chair: **ACTIONS:** **Jacqueline Myers to discuss a review of ICB Executive Director Committee membership with Sam Allen.** **Remove paragraph titled "People" in Section 6 on page 9 from the ToR.** The meeting continued with a discussion regarding how Performance would be integrated into the Committee meeting agenda going forwards. The Chair gave an overview of discussions from the previous meeting and asked the Committee if there had been wider discussions since. Jacqueline Myers confirmed that the Executive Committee received an Integrated Delivery Report on a monthly basis and the Committee **AGREED** that Performance should sit within the Finance, Performance and Investment Committee remit as performance and financial activity are linked and work is already in place which could be produced for review at FPIC meetings. **ACTION:** **Jacqueline Myers to revise the ToR and include a section on Performance.** There was a discussion regarding the development of Task and Finish groups. David Chandler gave a description of the groups and said that the Allocations working group and ICS DoF meetings will function as network meetings. It was **AGREED** that these groups will provide financial reports, verbal updates and recommendations to the FPIC for review or noting.
FPI/2022/10/10	**Any Other Business** No other business was raised for discussion.
FPI/2022/10/11	**Review of the Meeting** The Chair thanked the attendees and said that input from FT partners in attendance had been very useful. It was noted that in Section 8: Accountability and Reporting: Bullet point 4: referenced private and public Minutes when the meeting was previously split

	into two meetings. As this was now one meeting it could still contain items that would be regarded as private if/when the minutes are reported to the ICB. Therefore, consideration would have to be given when publishing the minutes as to what was still deemed private. The date of the next meeting was confirmed to take place at 10.00am on Thursday 3 November at Pemberton House. Meeting closed.

Signed:

Position:
Date:

Item: 9.6

NHS
North East and North Cumbria

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

NORTH EAST AND NORTH CUMBRIA ICB BOARD MEETING 29 November 2022	
Report Title:	**Recommended addendum to the Scheme of Reservation and Delegation in relation to Individual Funding Requests**

Purpose of report

The Board are asked to approve an addendum to the ICB Scheme of Reservation and Delegation in relation to Individual Funding Requests.

Key points

- The Board approved the Scheme of Reservation and Delegation (SoRD) on 1 July 2022
- A recent review of the SoRD identified that delegated authority to approve individual funding requests was not specified. This paper therefore recommends an addendum to v1-0 of the SoRD to address this gap
  As it stands subject to policy, a panel may support and advise the authoriser in their deliberations, however, the panel has no authority to approve individual funding requests.
- An interim process has been put in place so that recommendations are made to Dr Neil O'Brien, Executive Medical Director for ratification until the SoRD is amended
- The paper was discussed at the ICB Executive Committee on the 15 November and agreed to recommend to the Board for approval.

Risks and issues

Without clear delegated authority decision making is unclear and invalid and erroneous decisions may be made.

Assurances

Approval of this recommendation assures the Board that the necessary delegated authority is in place.

Subject to Board retrospective approval of this delegation, all decisions relating to individual funding requests since ICB inception to date have been ratified by the Executive Medical Director.

Item: 9.6

Recommendation/Action Required	
The Board is asked to approve for a retrospective addendum to the SoRD from 1 July 2022, providing the following delegated authority to approve individual funding requests. The suggested amendment can be found in Appendix 2 and the full SoRD in Appendix 3 containing the amends.	
Sponsor/approving director	Dr Neil O'Brien, Executive Medical Director
Report author	Deb Cornell, Director of Governance and Involvement Kate Sutherland, Head of Corporate Services

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

Relevant legal/statutory issues
N/A

Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
None identified						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓

Key implications	
Are additional resources required?	No
Has there been/does there need to be appropriate clinical involvement?	Executive Medical Director Consulted.
Has there been/does there need to be any patient and public involvement?	No
Has there been/does there need to be partner and/or other stakeholder engagement?	No

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NHS
North East and
North Cumbria

Recommended addendum to the Scheme of Reservation and Delegation (SoRD) in relation to Individual Funding Requests

1. Introduction

1.1. The NENC ICB has a statutory responsibility for commissioning services for patients in accordance with the Health & Social Care Act 2012. As part of these duties, there is a need to commission services which are evidence based, cost effective, improve health outcomes, reduce health inequalities and represent value for money. Whilst the majority of service provision is commissioned through established service agreements with providers, there are occasions when services are excluded or not routinely available within the NHS.

1.2. The Individual Funding Request (IFR) process provides a mechanism to allow drugs/treatments that are not routinely commissioned by the ICB to be considered for individuals in exceptional circumstances.

1.3. The purpose of this report is to provide the Board with a position statement on the approval process for individual funding requests, with a recommendation to the Board for an addendum to the ICB Scheme of Reservation and Delegation (SoRD).

2. Position Statement

2.1. The Board approved the SoRD for the ICB on 1 July 2022.

2.2. A recent review of the SoRD identified that delegated authority to approve individual funding requests was not specified. An extract of the current SoRD has been included in Appendix One, detailing the current entry in relation to the arrangements for managing individual funding requests.

2.3. The ICB must identify via its scheme of delegation one or more individuals given authority to act as decision maker for IFRs made to the ICB. These individuals will generally be senior clinicians working for the ICB and will follow the IFR Policy.

2.4. For the period 1 July -12 October 2022, 378 individual funding requests have been processed across the ICB.

3. Remedial Action

Cases processed since 1 July 2022

3.1. Subject to the retrospective approval of this delegation, all decisions relating to individual funding requests since ICB inception to date have been ratified by the

Executive Medical Director. It was paramount that any changes and interim measures put in place ensured there will be no impact on patient care.

3.2. An interim measure on the Check+ system was introduced in October 2022 so that the existing clinical decision makers aligned to the IFR process can recommend to the Executive Medical Director for approval. This will exist until the SoRD has been amended. All decision makers have been contacted via the NECS IFR Team and are aware of the interim process.

3.3. IFR Panels will become sub-committees of the Executive Committee and the anonymised minutes will be brought to the Executive Committee going forward.

Suggested SoRD Amendment

3.4. A revised entry to the SoRD can be found in Appendix Two. This addition will allow for clear delegation to the individuals given authority to act as a Decision Maker for Individual Funding Requests.

3.5. Further work around the IFR Policy and IFR Panel Terms of Reference is underway and will be brought to the Executive Committee.

4. Recommendations

The Board is asked to approve the retrospective addendum to the SoRD from 1 July 2022.

Name of Author:	D Cornell, Director of Governance and Involvement K Sutherland, Head of Corporate Services
Name of Sponsoring Director:	N O'Brien, Executive Medical Director
Appendices:	Appendix One - Current NENC ICB SoRD Extract detailing the management of individual funding requests Appendix Two – Extract of the suggested amendments to NENC ICB SoRD on the approval of Individual Funding Requests Appendix Three – NENC SoRD in full
Date:	28 October 2022

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Appendix One

Current NENC ICB SoRD Extract detailing the management of individual funding requests

Policy Area	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/Financial Limits)	Supporting Notes
REGULATION AND CONTROL	Approve arrangements for managing individual funding requests	✓ (Approves)				Note: the Executive Committee oversees the application of commissioning policies including those relating to individual funding requests (IFR)

Appendix Two

Extract of the suggested amendments to NENC ICB SoRD on the approval of Individual Funding Requests

Policy Area	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/Financial Limits)	Supporting Notes
~~**REGULATION AND CONTROL**~~	~~Approve arrangements for managing individual funding requests~~	~~✓ (Approves)~~				~~Note: the Executive Committee oversees the application of commissioning policies including those relating to individual funding requests (IFR)~~
New Entry: **REGULATION AND CONTROL**	Approval of individual funding requests in accordance with the ICB Policy		✓ IFR Panels[1]		✓ Individual members appointed as decision makers (as approved by the Executive Medical Director) to make decisions on	[1]The IFR Panels are sub-committees of the Executive Committee (as approved by board)

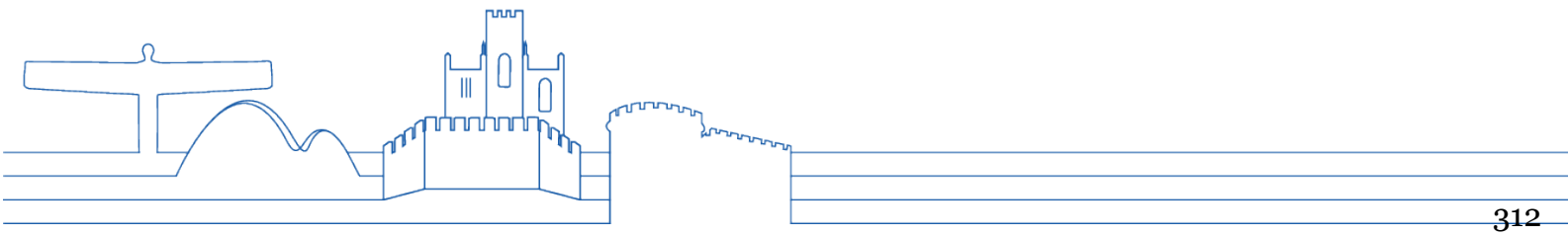
Policy Area	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/Financial Limits)	Supporting Notes
					behalf of the ICB via individual funding requests, in line with ICB Policy[2]	[2]Appointed decision makers may make decisions not reserved to the IFR Panels.
POLICIES	Approve Value Based Commissioning Policy	✓ (Approves)				

NHS North East & North Cumbria

NHS North East and North Cumbria Integrated Care Board

Scheme of Reservation and Delegation

Version 1-1, approved DATE (TBC)



Schedule of Matter Reserved to the North East and North Cumbria Integrated Care Board and Scheme of Delegation

1. Introduction

The arrangements made by the North East and North Cumbria Integrated Care Board (NENC ICB) for the reservation and delegation of decisions are set out in this scheme of reservation and delegation.

The NENC ICB remains accountable for all its functions, including those that it has delegated.

2. Contents

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
REGULATION AND CONTROL	Constitution 1.6	Consideration and approval of applications to NHS England on any matter concerning changes to the ICB's constitution, including arrangements for taking urgent decisions, and standing orders	✓ Approval of proposed changes		✓ Chair and/or Chief Executive may periodically propose amendments to the constitution		
REGULATION AND CONTROL	Constitution 1.6.2	Approve Constitution (including Standing Orders)	✓ Approves (subject to NHSE approval)			✓ NHSE	
REGULATION AND CONTROL	Constitution 4.4.2	Approve the ICB scheme of reservation and delegation (SoRD) and amendments to the SoRD	✓ Approves		✓ Chief Executive (recommends)		

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
REGULATION AND CONTROL	Constitution Appendix 2, Section 5	Suspension of Standing Orders			✓ Chair in discussion with at least two other members		
REGULATION AND CONTROL	Constitution Appendix 2, 4.9.4	Urgent Decisions			✓ Chair and Chief Executive (or relevant lead director in the case of committees)		In the first instance, every attempt will be made for the Board to meet virtually. Where this is not possible, the delegation to the Chair and Chief Executive (or relevant lead director in the case of committees) applies. The exercise of such powers shall be reported to the next formal meeting of the board for formal ratification and the Audit Committee for oversight

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
REGULATION AND CONTROL		Establish governance arrangements to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations.	✓				
REGULATION AND CONTROL	Constitution 4.6	Approve terms of reference and membership for ICB Committees & Sub Committees	✓				Definition: A Committee is established by and accountable to the ICB Board. A Sub-Committee is accountable to its parent Committee. Parent Committees Audit Committee; Finance, Performance & Investment Committee; Quality & Safety Committee; Remuneration Committee; and Executive Committee

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
REGULATION AND CONTROL		Approve the ICB operating framework	✓ (Approves)		✓ Chief Executive (Recommends)		
REGULATION AND CONTROL		Approve the ICB operating structure	✓ (Approves)		✓ Chief Executive (Recommends)		
REGULATION AND CONTROL	Constitution 1.4 Health & Care Act 14Z32 to 14Z44 & 14Z49	Approve the arrangements for discharging the ICB's functions including but not limited to: a) Having regard to and acting in a way that promotes the NHS Constitution (14Z32) b) Exercising its functions effectively, efficiently, and economically (14Z33)	✓				

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
		c) Securing continuous improvement in the quality of services (14Z34) d) Reducing inequalities (14Z35) e) Promote involvement of each patient (14Z36) f) Patient choice (14Z37) g) Obtaining appropriate advice (14Z38) h) Promote innovation (14Z39) j) Research (14Z40) k) Education & training (14Z41) l) Promote integration (14Z42)					

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
		m) Duty to have regard to effect of decisions (14Z43) n) Duties as to climate change etc (14Z44) o) Duty to keep experience of members under review (14Z49)					
REGULATION AND CONTROL	Constitution 3.3.1	Appointment of ICB Chair				✓ NHSE, with the approval of the Secretary of State	
REGULATION AND CONTROL	Constitution 3.4.1 & 3.4.2	Appointment of ICB Chief Executive			✓ Appointed by ICB Chair in accordance with any guidance issued by NHS England*		*Appointment subject to approval of NHSE in accordance with any procedure published by NHS England

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
REGULATION AND CONTROL		Exercise or delegation of those functions of the ICB which have not been retained as reserved by the ICB Board, delegated to a committee or sub-committee or specified individual			✓ ICB Chief Executive		
REGULATION AND CONTROL	Constitution 3.5.4, 3.6.5, 3.7.4	Appointment of Partner Member/s: • Trusts • Primary Medical Services • Eligible Local Authorities			✓ Approval ICB Chair*		*Supported by an Appointment Panel

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
REGULATION AND CONTROL	Constitution 3.8.3, 3.9.3, 3.10.3, 3.12.3	Appointment of: • Executive Medical Director • Executive Chief Nurse • Executive Director of Finance • Other Executive Board Members			✓ Appointed by ICB Chief Executive* ✓ Approval ICB Chair		*Supported by an Appointment Panel
REGULATION AND CONTROL	Constitution 3.11.2	Appointment of Independent Non-Executive Member/s			✓ Approved by ICB Chair*		*Supported by an Appointment Panel
REGULATION AND CONTROL		Approve the System Collaboration and Financial Management Agreement	✓ (Approves)	✓ Finance, Performance & Investment Committee			In consultation with partners

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
				(Recommends)			
REGULATION AND CONTROL	Constitution 1.7.3 (c)	Approve Standing Financial Instructions (SFIs)	✓ (Approves)	✓ Finance, Performance & Investment Committee (Recommends)	✓ Executive Director of Finance (Prepares)		
		Approval of individual funding requests in accordance with the ICB policy		✓ IFR Panels[1]		Individual members appointed as decision makers (as approved by the Executive Medical Director) to make decisions on behalf of the ICB via individual funding requests, in line with ICB Policy[2]	[1]The IFR Panels are sub-committees of the Executive Committee (as approved by board) [2]Appointed decision makers may make decisions not reserved to the IFR Panels.
REGULATION AND CONTROL	Standing Orders, Section 6	Set out who can execute a document by signature / use of the seal	✓ In approving Standing Orders		✓ Authorised to authenticate the use of the seal by their signature: - ICB Chair - Chief Executive		

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
					- Executive Director of Finance		
REGULATION AND CONTROL		Determine governance arrangements at Place (taking into account any requirement from ICB Board Committees)			✓ Executive Director of Place Based Delivery		
REGULATION AND CONTROL	Constitution 4.7	Propose terms of reference for place based partnership arrangements for approval by the ICB Board and Partners	✓ Approval ICB Board and Partners		✓ Proposed by Executive Director of Place Based Delivery		
REGULATION AND CONTROL		Appoint ICB Caldicott Guardian			✓ ICB Chief Executive		
REGULATION AND CONTROL		Appoint ICB Conflicts of Interest Guardian			✓ ICB Chief Executive		
REGULATION AND CONTROL		Appoint ICB Senior Information Risk Officer			✓ ICB Chief Executive		

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
REGULATION AND CONTROL		Appoint ICB Data Protection Officer			✓ ICB Chief Executive		
REGULATION AND CONTROL		Appoint ICB Chief Information Officer			✓ ICB Chief Executive		
REGULATION AND CONTROL		Appoint ICB EPRR Accountable Emergency Officer			✓ ICB Chief Executive		
REGULATION AND CONTROL		Approve Patient Group Directions			✓ ICB Medical Director, following review by the Quality & Safety Committee		
STRATEGY AND PLANNING		Agree the vision, values, and overall strategic direction of the ICB	✓				
STRATEGY AND PLANNING		Approving the strategy for improving population health and reducing health inequalities	✓				Having regard to the Integrated Care Partnership

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
							integrated care strategy
STRATEGY AND PLANNING		Approve the Commissioning Strategy	✓ (Approves)	✓ Executive Committee (Recommends)			
STRATEGY AND PLANNING	Health & Social Care Act 2022,14Z52	Agree a system plan [with partner trusts] to meet the health and healthcare needs of the population within the North East and North Cumbria	✓ (Approves)	✓ Executive Committee* (Recommends)			*The Executive Committee will consult the Finance, Performance & Investment Committee in the development of the plan
STRATEGY AND PLANNING		Complementary to the System Plan, agree a plan to meet the health and healthcare needs of the population within each place	✓ (Approves)		✓ Executive Director of Place Based Delivery		

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
STRATEGY AND PLANNING		Approval of the ICB's non-programme budgets	✓ (Approves)	✓ Finance, Performance & Investment Committee (Recommends)			
STRATEGY AND PLANNING		Approval of the ICB's programme budgets	✓ (Approves)	✓ Executive Committee (Recommends)			
STRATEGY AND PLANNING		Develop an approach to distribute ICB resources through commissioning and direct allocation to drive agreed change based on the ICB strategy	✓ Approve	✓ Finance, Performance & Investment Committee (Recommends)	✓ Executive Director (Implementation of agreed resource allocation)		

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
STRATEGY AND PLANNING		Approve all ICB programme costs	✓ Approved by the Board or as delegated in accordance with financial delegations and financial limits	✓ Executive Committee*	✓ Refer to financial delegations*		*Contracts will be approved by either the ICB Board, Executive Committee, or relevant individual in accordance with the financial delegations and financial limits
STRATEGY AND PLANNING		Approve all ICB non programme costs	✓ Approved by the Board or as delegated in accordance with financial delegations and financial limits	✓ Finance, Performance & Investment Committee*	✓ Refer to financial delegations*		* Non-programme contracts will be approved by either the ICB Board, Finance, Performance & Investment Committee, or relevant individual in accordance with the financial delegations and financial limits

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
STRATEGY AND PLANNING		Approve the strategic financial framework of the ICB, and manage overall resources, manage financial risk, monitor system financial performance and report material exceptions to the Board	✓ (Approves the strategic financial framework)	✓ Finance, Performance & Investment Committee (Recommends)			
STRATEGY AND PLANNING		Approve a Performance and Outcomes Framework for Providers	✓ (Approves)	✓ Executive Committee (Recommends)			
STRATEGY AND PLANNING		Monitor provider performance against contract and report material exceptions to the Board		✓ Executive Committee			
STRATEGY AND PLANNING		Agree arrangements regarding the System Oversight Framework		✓ Executive Committee			

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
STRATEGY AND PLANNING		Approval of variations to annual planned budgets	✓ Approved by the Board or as delegated in accordance with financial delegations and financial limits	✓ Finance, Performance & Investment Committee*	✓ Refer to financial delegations*		*Variations to budgets will be approved by the Board, or Finance, Performance & Investment Committee, or an individual, in accordance with financial delegations and financial limits
STRATEGY AND PLANNING		Approval of variations to non-programme contracts	✓ Approved by the Board or as delegated in accordance with financial delegations & limits	✓ Finance, Performance & Investment Committee*	✓ Executive Director*		*Variations to non-programme contracts will be approved by the Board, or Finance, Performance & Investment Committee, or an Executive Director, in accordance with financial delegations and financial limits

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
STRATEGY AND PLANNING		Approval of variations to programme contracts	✓ Approved by the Board or as delegated in accordance with financial delegations & limits	✓ Executive Committee*	✓ Executive Director*		*Variations to programme contracts will be approved by the Board, or Executive Committee, or an Executive Director, in accordance with financial delegations and financial limits
STRATEGY AND PLANNING		In accordance with ICB policy, lead significant service reconfiguration programmes to achieve agreed outcomes	✓ (Approves)	✓ Executive Committee (Assurance)	✓ Executive Director (Recommends)		In leading service reconfiguration, the ICB will work with providers at scale and place
STRATEGY AND PLANNING		Planning and commissioning of services (to include Procurement & Evaluation Strategies and Recommended Bidder Reports).	✓ Approved by the Board or as delegated in accordance with financial	✓ Executive Committee*	✓ Executive Director*		* Approval by the Board, or Executive Committee, or an Executive Director. in accordance with financial

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
			delegations & limits				delegations and financial limits
STRATEGY AND PLANNING	Delegation agreement	<u>Specialist Commissioning delegation from NHSE</u> Approve decisions on the review, planning and procurement of specialist commissioned services (consistent with the terms of the delegation agreement with NHSE)		✓ Executive Committee			
STRATEGY AND PLANNING	Delegation agreement	<u>Primary Medical Services delegation from NHSE</u> Approve decisions on the review, planning and procurement of primary medical services (consistent with the terms of the delegation agreement with NHSE)		✓ Executive Committee (Except for those items delegated to the Executive Director of Place Based Delivery as shown in Appendix 2)	✓ Executive Director of Place Based Delivery (Except for those items delegated to the Executive Committee, or other ICB Committee, as shown in Appendix 2)		

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
STRATEGY AND PLANNING		Workforce planning		✓ Executive Committee			
STRATEGY AND PLANNING		Agree system implementation of people priorities including delivery of the People Plan and People Promise by aligning partners across the ICS to develop and support 'one workforce' including through closer collaboration across the health and care sector, with local government, the Voluntary and Community Sector (VCS) and volunteers	✓ (Approves strategy)	✓ Executive Committee (Monitors)	✓ Executive Chief People Officer (System leadership)		

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
STRATEGY AND PLANNING		Agree system-wide strategy and action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services	✓ (Approves strategy)	✓ Executive Committee (Monitors)	✓ Executive Chief Digital and Information Officer (System leadership)		
STRATEGY AND PLANNING		Agree joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability	✓ (Approves strategy)	✓ Finance Committee	✓ Executive Director (System leadership)		
ANNUAL REPORTS AND ACCOUNTS		Approval of the ICB's annual report and annual accounts	✓ (Approves)	✓ Audit Committee (Assurance)			

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
HUMAN RESOURCES		Code of Conduct for staff (title: Standards of Business Conduct Policy/Conflicts of interest policy and procedures)	✓ Approves	✓ Executive Management Committee (Recommends)			
HUMAN RESOURCES	Constitution 3.14	Approve the arrangements for determining the terms and conditions, remuneration and travelling or other allowances for Board members, employees and others who provide services to the ICB, including pensions and gratuities	✓ In approving Terms of reference of Remuneration Committee			✓ NHSEI (Terms of appointment of the Chair will be determined by NHS England)	
HUMAN RESOURCES	Constitution 3.14	Approve the terms and conditions, remuneration and travelling or other allowances for Board members, including pensions and gratuities (subject to Prime Minister limit)	✓ (The Panel of the Board determines Remuneration for Non-Executive Members)	✓ ICB Remuneration Committee (Approves all except those delegated to the		✓ NHSEI (Remuneration for the Chair will be set by NHS England)	The Panel of the Board comprises the Chair, Chief Executive and Executive Chief People Officer

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
				Panel of the Board or NHSEI)			
HUMAN RESOURCES		Approve the terms and conditions, remuneration and travelling or other allowances for employees of the ICB and to other persons providing services to the ICB		✓ ICB Remuneration Committee			
HUMAN RESOURCES		Approve arrangements for staff appointments		✓ Executive Committee	✓ Executive Chief People Officer (Prepares)		
QUALITY AND SAFETY		Approve arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes		✓ Quality and Safety Committee			

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
QUALITY AND SAFETY		Provide the ICB with assurance that it is delivering its functions in a way that delivers high quality safe patient care in commissioned services and secures continuous improvement in the quality of services		✓ Quality and Safety Committee (assures the Board)			Local Quality Groups will review quality & safety issues and escalate any concerns or issues to the Quality and Safety Committee
OPERATIONAL AND RISK MANAGEMENT		Approve the appointment of Internal Auditors	✓ (Approves)	✓ Audit Committee (Consulted on recommendation)	✓ Executive Director of Finance (Recommends)		
OPERATIONAL AND RISK MANAGEMENT		Approve the appointment of External Auditors	✓ (Approves)	✓ Auditor Panel (Recommends)			Note the Auditor Panel is made up wholly of Audit Committee members (see Audit Committee Terms of Reference)

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
OPERATIONAL AND RISK MANAGEMENT		Approve the ICB's counter fraud and security management arrangements	✓ (Approves)	✓ Audit Committee (Recommends)			
OPERATIONAL AND RISK MANAGEMENT		Approve the ICB's risk management arrangements	✓ (Approves)	✓ Executive Committee (Recommends)			
OPERATIONAL AND RISK MANAGEMENT		Approve the ICB's arrangements for managing conflicts of interest	✓				In proposing ICB Constitution to NHSE
OPERATIONAL AND RISK MANAGEMENT		Establish a comprehensive system of internal control across the ICB		✓ Executive Committee			
OPERATIONAL AND RISK MANAGEMENT		Approve arrangements for action on litigation against or on behalf of the ICB		✓ Executive Committee			

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
OPERATIONAL AND RISK MANAGEMENT		Approve arrangements for planning, responding to and leading recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England and NHS Improvement		✓ Executive Committee			
OPERATIONAL AND RISK MANAGEMENT		Approve the ICB's arrangements for handling complaints		✓ Executive Committee			
OPERATIONAL AND RISK MANAGEMENT		Approve arrangements for ensuring the ICB has an integrated approach to the management standards of health and safety and has appropriate strategy and policies in place		✓ Executive Committee			

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
OPERATIONAL AND RISK MANAGEMENT		Approve arrangements for complying with the NHS Provider Selection Regime		✓ Executive Committee			
OPERATIONAL AND RISK MANAGEMENT		Approve Communications and Engagement Strategy	✓ (Approves)	✓ Executive Committee (recommends)			
OPERATIONAL AND RISK MANAGEMENT		Approve and implement the ICB's information governance policies, including handling Freedom of Information requests, ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data		✓ Executive Committee			

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
POLICIES		Approval of policies not specified elsewhere in this scheme of reservation and delegation	✓				
POLICIES		Approve human resources policies for employees and for other persons working on behalf of the ICB	✓ (Approves)	✓ Executive Committee (Recommends)	✓ Executive Chief People Officer (Prepares)		
POLICIES		Approve clinical, quality and safety policies		✓ Quality and Safety Committee			
POLICIES		Approve ICB Corporate Policies (unless specified elsewhere)		✓ Executive Committee			
POLICIES		Approve ICB Standard Operating Procedures (SOPs)		✓ Executive Committee			

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
POLICIES		Approve the ICB's risk management policy		✓ Executive Committee			
POLICIES		Determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change)		✓ Remuneration Committee			
POLICIES		Approve the ICB's complaint's policy		✓ Executive Committee			
POLICIES		Approve health and safety policies		✓ Executive Committee			
POLICIES		Approve information governance policies		✓ Executive Committee			

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
		Approve Value Based Commissioning Policy	✓ (Approves)				
PARTNERSHIP WORKING	Integrated care boards Guide to developing a SoRD, page 9	Approve arrangements for coordinating supra* commissioning arrangements with other ICBs or with local authorities, where appropriate	✓ (Approves)	✓ Executive Committee (Recommends)			*Where one service provider spans more than one ICB
PARTNERSHIP WORKING	Constitution 4.3.2 – 4.3.3 and 4.7	Authorisation of arrangements made under section 65Z5 or section 75 of the 2006 Act	✓ Approved by the Board or as delegated in accordance with financial delegations and financial limits	✓ Executive Committee*	✓ Refer to financial delegations*		*Arrangements will be approved by either the ICB Board, Executive Committee, or relevant individual in accordance with the financial delegations and financial limits See Foot Note 1
PARTNERSHIP WORKING		Approve decisions that individual members or employees of the ICB participating in joint arrangements on behalf of the ICB can make	✓				Such delegated decisions must be disclosed in this scheme of reservation and delegation

Policy Area	Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes

FOOT NOTES

1. Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund. Where arrangements are made under section 65Z5 or section 75 of the 2006 Act the board must authorise the arrangement, which must be described as appropriate in the SoRD.

Appendix 1

Committee and Sub Committees of NHS North East and North Cumbria Integrated Care Board (ICB)

1. Committees

The ICB has determined to establish the following Committees

- Audit Committee
- Remuneration Committee
- Finance, Performance, and Investment Committee
- Quality and Safety Committee
- Executive Committee

2. Sub-Committees

The ICB has determined to establish the following Sub-Committees:

To be determined

Appendix 2

Primary Medical Services:
Allocation of Roles & Responsibilities within the ICB

In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England hereby delegates the exercise of the Delegated Functions to the ICB to empower it to commission a range of services for the people of the Area, as described in the Delegation Agreement relating to Primary Medical Services.

The ICB Board has determined the following delegations within this Scheme of Reservation & Delegation.

Number	Responsibility and Decision Making Delegated to the Executive Management Committee (or other ICB Committee where stated)	Responsibility and Decision Making Delegated to the Executive Director of Place Based Delivery	Recommendation by the Executive Director of Place Based Delivery to the Executive Committee for Action/Decision
1	Decisions in relation to the commissioning and management of Primary Medical Services, unless delegated to the Executive Director of Place Based Delivery		
2	Planning Primary Medical Services for the NE&NC, including carrying out needs assessments		Carrying out primary care needs assessments at place and making recommendations to the Executive Management Committee
3	Undertaking reviews of Primary Medical Services across the NE&NC		Undertaking reviews of Primary Medical Services at Place and escalating any material issues to the Executive Management Committee for consideration/action
4	Management of the Delegated Funds in relation to Primary Medical Services (See ICB Financial Limits for authorisation limits)		Management of delegated funds where these are delegated to the Executive Director of Place Based, within the limits shown in the ICB's Financial Limits.
5	Co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies in respect of the NE&NC, where appropriate		

Number	Responsibility and Decision Making Delegated to the Executive Management Committee (or other ICB Committee where stated)	Responsibility and Decision Making Delegated to the Executive Director of Place Based Delivery	Recommendation by the Executive Director of Place Based Delivery to the Executive Committee for Action/Decision
6	Identifying and implementing changes to meet any unmet needs across the NE&NC which may be met through the delivery of Primary Medical Services		The Executive Director of Place Based Delivery, identifies and recommends to the Executive Management Committee any changes to meet any unmet needs at place which may be met through the delivery of Primary Medical Services
7	To manage the Primary Medical Services Contracts and perform all of NHS England's obligations under each of the Primary Medical Services Contracts in accordance with the terms of the Primary Medical Services Contracts as if it were named in the contract in place of NHS England		
8	Actively manage the performance of the Primary Medical Services Providers across the NE&NC in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support	Actively manage the performance of the Primary Medical Services Provider at place Non-material performance lapses may be managed at place by the Executive Director of Place Based Delivery	Actively manage the performance of the Primary Medical Services Provider at place Escalate to the Executive Management Committee any material performance issues for action
9	Ensure that the ICB obtains value for money on behalf of NHS England, and avoids making any double payments under any Primary Medical Services Contracts		
10	Notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's		

Number	Responsibility and Decision Making Delegated to the Executive Management Committee (or other ICB Committee where stated)	Responsibility and Decision Making Delegated to the Executive Director of Place Based Delivery	Recommendation by the Executive Director of Place Based Delivery to the Executive Committee for Action/Decision
	obligations under the Primary Medical Services Contracts		
11	Undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints		
12	Keep a record of all of the Primary Medical Services Contracts that the ICB manages setting out the details shown in Schedule 2A of the para 2.4.6 of the delegation agreement		
13	Reviewing the performance of the relevant Primary Medical Services Contract, including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance	Reviewing the performance of the relevant Primary Medical Services Contract, at place including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance Non-material performance lapses may be managed at place by the Executive Director of Place Based Delivery	Reviewing the performance of the relevant Primary Medical Services Contract, at place including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance Escalate to the Executive Management Committee any material performance issues for action
14	<u>Delegated to ICB Quality & Safety Committee</u> Assessing quality and outcomes (including clinical effectiveness, patient experience, patient safety and addressing inequalities)	Assessing quality and outcomes (including clinical effectiveness, patient experience, patient safety and addressing inequalities) Non-material performance issues relating to accessing quality and outcomes may be managed at place by the Executive Director of Place Based Delivery	Assessing quality and outcomes (including clinical effectiveness, patient experience, patient safety and addressing inequalities) Escalate to the ICB Quality & Safety Committee any material performance issues for action
15	Managing variations to the relevant Primary Medical		

Number	Responsibility and Decision Making Delegated to the Executive Management Committee (or other ICB Committee where stated)	Responsibility and Decision Making Delegated to the Executive Director of Place Based Delivery	Recommendation by the Executive Director of Place Based Delivery to the Executive Committee for Action/Decision
	Services Contract or services in accordance with national policy, service user needs and clinical developments		
16	Agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit)		
17	Delegated to the Finance, Performance & Investment Committee Agreeing local prices, managing agreements or proposals for local variations and local modifications		
18	Conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes		
19	Compliance with and implementing any relevant Mandated Guidance issued from time to time		
20	**Information, Planning and Reporting** Compliance with Delegation agreement Schedule 2A, Section 2.6 as it relates to Information, Planning and Reporting		
21	**Primary Medical Services Contract Management** Compliance with any future national Mandated		

Number	Responsibility and Decision Making Delegated to the Executive Management Committee (or other ICB Committee where stated)	Responsibility and Decision Making Delegated to the Executive Director of Place Based Delivery	Recommendation by the Executive Director of Place Based Delivery to the Executive Committee for Action/Decision
	Guidance on equitable funding as may apply from time to time		
22	**Enhanced Services** Compliance with actions in Delegation agreement Schedule 2A, Section 5 as it relates to Enhanced Services)		
23		**Local Enhanced Services** The Executive Director of Place Based Delivery may consider any local enhanced services entered into with Primary Medical Services Providers at place using NHS Standard Contracts. Where these would continue to be beneficial to the place, the ICB (at place) may manage the ongoing design and commissioning (including re-commissioning) of these services via a Local Incentives Scheme. This is to be in conjunction and coordination with the other Executive Director of Place Based Delivery to ensure a consistent approach is taken across the ICB	
24		**Local Enhanced Services design** The Executive Director of Place Based Delivery may design and offer Local Incentive Schemes for Primary Medical Services Providers and comply with the Delegation agreement Schedule 2A, Section 6 as it relates to Local Incentive Schemes. This is to be done in conjunction and coordination with the other Executive Director of Place	

Number	Responsibility and Decision Making Delegated to the Executive Management Committee (or other ICB Committee where stated)	Responsibility and Decision Making Delegated to the Executive Director of Place Based Delivery	Recommendation by the Executive Director of Place Based Delivery to the Executive Committee for Action/Decision
		Based Delivery to ensure a consistent approach is taken across the ICB	
25		**Discretionary Payments** The Executive Director of Place Based Delivery may make decisions on Discretionary Payments or Support (subject to available budget) and comply with the Delegation agreement Schedule 2A, Section 7 as it relates to discretionary payments. This is to be done in conjunction and coordination with the other Executive Director of Place Based Delivery to ensure a consistent approach is taken across the ICB	
26		**Making Decisions about Commissioning Urgent Care for Out of Area Registered Patients** Design and commissioning of urgent care services (including home visits as required) for its patients registered out of area (including re-commissioning these services annually where appropriate) and compliance with the Delegation agreement Schedule 2A, Section 8. This to be done in conjunction and coordination with the other Executive Director of Place Based Delivery to ensure a consistent approach is taken across the ICB	
27	**Transparency and freedom of information** Compliance with the Delegation agreement		

Number	Responsibility and Decision Making Delegated to the Executive Management Committee (or other ICB Committee where stated)	Responsibility and Decision Making Delegated to the Executive Director of Place Based Delivery	Recommendation by the Executive Director of Place Based Delivery to the Executive Committee for Action/Decision
	Schedule 2A, Section 9 as it relates to transparency and freedom of information		
28	**Planning the Provider Landscape** The ICB must plan the primary medical services provider landscape in the Area, including considering and taking decisions in relation to: Establishing new Primary Medical Services Providers in the NE&NC; The procurement or award of new Primary Medical Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time); Compliance with the Delegation agreement Schedule 2A, Section 10.2	**Planning the Provider Landscape** Manage Primary Medical Services Providers providing inadequate standards of patient care at place Take decisions relating to closure of practices and branch surgeries at place Take decisions relating to dispersing the patient lists of Primary Medical Services Providers at place Take decisions relating to agreeing variations to the boundaries of Primary Medical Services Providers at place.	
29	**Primary Care Networks** Compliance with the Delegation agreement, Schedule 2A, Section 11	Supporting Primary Care Networks at place, subject to any budget allocation, in conjunction and coordination with the other Executive Director of Place Based Delivery to ensure a consistent approach is taken across the ICB	
30		**Approving Primary Medical Services Provider Mergers and Closures** Compliance with the Delegation agreement, Schedule 2A, Section 12	
31	**Making Decisions in relation to Management of Poorly Performing Primary Medical Services Providers**		

Number	Responsibility and Decision Making Delegated to the Executive Management Committee (or other ICB Committee where stated)	Responsibility and Decision Making Delegated to the Executive Director of Place Based Delivery	Recommendation by the Executive Director of Place Based Delivery to the Executive Committee for Action/Decision
	Compliance with Delegation Agreement Schedule 2A, Section 13		
32	Delegated to Finance Performance & Investment Committee **Premises Costs Directions Functions** Compliance with Delegation Agreement, Schedule 2A, Section 14		
33	**Maintaining the Performers List** Compliance with Delegation Agreement, Schedule 2A, Section 15		
34	**Procurement and New Contracts** Compliance with Delegation Agreement, Schedule 2A, Section 16		
35	**Complaints** Handle complaints made in respect of Primary Medical Services in accordance with the Complaints Regulations (Delegation agreement, Schedule 2A, Section 17)		
36	**Commissioning ancillary support services** Compliance with Delegation Agreement, Schedule 2A, Section 18.		
37	**Finance** Further requirements in respect of finance will be		

Number	Responsibility and Decision Making Delegated to the Executive Management Committee (or other ICB Committee where stated)	Responsibility and Decision Making Delegated to the Executive Director of Place Based Delivery	Recommendation by the Executive Director of Place Based Delivery to the Executive Committee for Action/Decision
	specified in Mandated Guidance		
38	**Workforce** Compliance with Delegation Agreement, Schedule 2A, Section 20		

GLOSSARY

2006 Act	National Health Service Act 2006
2012 Act	Health and Social Care Act 2012 (this Act amends the 2006 Act)
Chief Executive	An individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act (as inserted by Schedule 2 of the 2012 Act), appointed by the NHS Commissioning Board, with responsibility for ensuring the ICB: • complies with its obligations under: o sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act), o sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act), o paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), and o any other provision of the 2006 Act (as amended by the 2012 Act) specified in a document published by the Board for that purpose. • exercises its functions in a way which provides good value for money.
Area	The geographical area that the ICB has responsibility for, as defined in Chapter 2 of the Constitution
Audit Committee	A committee of the Board
Board	The body appointed under section 14L of the NHS Act 2006 (as inserted by section 25 of the 2012 Act), with the main function of ensuring that an ICB has made appropriate arrangements for ensuring that it complies with: • its obligations under section 14Q under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), and • such generally accepted principles of good governance as are relevant to it.
Board Member	Any member appointed to the Board of the ICB
Budget	A resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any, or all of the functions of the ICB.
Budget Holder	The director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.
C***hair of the Board***	The individual appointed by the ICB to act as chair of the Board

Executive Director of Finance	The qualified accountant employed by the ICB with responsibility for financial strategy, financial management and financial governance
Commissioning	The process for determining the need for and for obtaining the supply of healthcare and related services by the ICB within available resources.
Committee	A committee created and approved by the ICB Board
Sub-Committee	A sub-committee created by ICB Board or a committee of the ICB Board, and approved by the Board
Committee Members	Persons formally appointed by the Board to sit on or specific committees.
Constitution	A Constitution is the set of principles and rules by which an organisation is governed and managed.
Board Secretary	A person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the ICB's compliance with the law, Standing Orders, and Department of Health guidance.
Contracting and Procurement	The systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
Director of Public Health	A health care professional who is a specialist in Public Health or a Consultant in Public Health medicine who may hold the post of Director of Public Health.
Financial Directions	Any and all Directions made by the Secretary of State from time to time which relate to financial entitlements and or requirements.
Financial Year	This usually runs from 1 April to 31 March, but under paragraph 17 of Schedule 1A of the 2006 Act (inserted by Schedule 2 of the 2012 Act), it can for the purposes of audit and accounts run from when an ICB is established until the following 31 March.
Health and Wellbeing Board	The role of the Health and Wellbeing Board is to bring together the Local Authority, Voluntary Sector, Local Healthwatch, NHS and Public health to work together to improve the health and wellbeing of local people.
Health and Wellbeing Strategy	A strategy developed with Local Authorities for the purpose of purpose of advancing the health and wellbeing of the people in its area and implemented by the Health and Wellbeing Board

Healthcare Professional	An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.
Integrated Care System (ICS)	The ICS is a geographical partnership that brings together providers and commissioners of NHS services across the North East and North Cumbria.
Non – Executive Members	Independent members of the Board.
NHS England	NHS England (operating as the National Health Service Commissioning Board Authority prior to its formal establishment as a non-departmental public body).
Officer	Employee of the ICB or any other person holding a paid appointment or office with the ICB.
Officer Member	A member of the ICB who is either an officer of the ICB or is to be treated as an officer (i.e., the Chair of the ICB, or any person nominated by such a committee for appointment as an ICB member).
Registers of Interests	Registers an ICB is required to maintain and make publicly available under section 14O of the 2006 Act (as inserted by section 25 of the 2012 Act), of the interests of: • the members of the ICB. • the members of its Board. • the members of its committees or sub-committees and committees or sub-committees of its Board; and • its employees.
Remuneration Committee	A Committee of the Board
Scheme of Reservation and Delegation	Delegates powers and authority to the various elements of the ICB.
Standing Orders	The standing orders of the ICB
Standing Financial Instructions	They are part of the ICB's control environment for managing the organisation's financial affairs as they are designed to ensure regularity and propriety of financial transactions. They define the purpose, responsibilities, legal framework, and operating environment of the ICB.
Vice-Chair	The non-officer member appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

Item: 9.7

NHS
North East and North Cumbria

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

NORTH EAST AND NORTH CUMBRIA ICB BOARD MEETING 29 November 2022	
Report Title:	**Towards a Healthier and Fairer North East and North Cumbria: Review of Our Strategic Approach to Tackling Health Inequalities**

Purpose of report

Following the recommendation at the ICB on 1 July to establish a task and finish group to review our ICS approach to health inequalities, this report sets out an update on the formation of a Healthier and Fairer Advisory Group reporting to the ICB.

Key points

The formation of this advisory group will allow us to clarify the oversight of this multi-faceted area of our work, encompassing health and healthcare inequalities, prevention and population health management.

The proposed advisory group has been formed to provide both the direct oversight of the ICB's core programmes of work, including CORE20PLUS5 and our prevention programmes, as well as providing leadership and guidance to the wider integrated care system through an advisory role to the Integrated Care Partnerships.

A proposed terms of reference for the advisory group is attached at Appendix 1.

Risks and issues

This group has been developed to oversee both the ICB's own obligations around delivery of the national CORE20 PLUS5 programme, and shaping the wider strategic priorities of the ICS via the Strategic ICP and Area ICPs.

Assurances

The ICB will ensure that the work programme of the advisory group is appropriately balanced, and that the governance of the group is aligned to the ICB via direct reporting to the ICB Executive Committee.

Item: 9.7

Recommendation/Action Required	
The Board is asked to: • Note the formation of the Healthier and Fairer Advisory Group based on the terms of reference attached at Appendix 1, and its important role in advising both the ICB and the Integrated Care Partnership; • Request updates on the work of this advisory group as it reviews existing work programmes and agree its priorities for the year ahead; • Support the principle that the ICB and the ICB Executive will always have regard to the recommendations of this group when making their decisions.	
Sponsor/approving director	Dr Neil O'Brien, Executive Medical Director
Report author	Dan Jackson, Director of Policy, Public Affairs and Stakeholder Affairs.

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

Relevant legal/statutory issues						
This work aligns to all the ICB's corporate aims, but especially to 'tackle inequalities in outcomes, experience and access', as well as the NHS obligations to deliver the CORE20PLUS5 programme.						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**	✓	**N/A**	
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**	✓	**No**		**N/A**	

Key implications	
Are additional resources required?	Administrative support the advisory group

Has there been/does there need to be appropriate clinical involvement?	Yes, via the Executive Lead for this work, and the involvement of clinicians in the steering group
Has there been/does there need to be any patient and public involvement?	Yes, via the involvement of Healthwatch on the advisory group
Has there been/does there need to be partner and/or other stakeholder engagement?	Yes, this paper has been drafted following a multi-agency engagement exercise.

Towards a Healthier and Fairer North East and North Cumbria: Reviewing our Strategic Approach to Tackling Health Inequalities

1. Context

1.1 At our inaugural Integrated Care Board on 1 July, it was agreed to convene a task and finish group to review our current coordination arrangements for reducing health inequalities across our system, and to make recommendations to the ICB and ICP for the formation of a multi-agency expert advisory group to drive this work going forward.

1.2 Such a group would play a key role in advising the North East and North Cumbria Integrated Care Board and challenging our collective approach to tackling the health inequalities that we face in the region, including raising our life expectancy (and healthy life expectancy), as well as the prevalence of cancer, heart disease, liver disease, premature mortality from substance misuse and mental illness, learning disability premature mortality and respiratory conditions. The paper received by the ICB outlined some of the key risk factors impacting on these inequalities in health outcomes, including the role of tobacco and alcohol, and unhealthy weight, as well as acknowledging the underpinning social and economic factors – those 'wider determinants' – that influence our resident's health and wellbeing.

1.3 Taken alongside our higher levels of suicide and mental ill health, as well as the variable access to healthcare faced by some of communities (and exacerbated by the pandemic) this requires responses that will lead to sustainable impact, for these inequalities and inequities in health outcomes are unjust, unfair and avoidable.

2. Work of the Task and Finish Group

2.1 A task and finish group drawing on expertise from across our system was convened by Dr Neil O'Brien and reviewed a range of key issues that the proposed advisory group would need to consider. These included:

- Reviewing all our current governance arrangements to ensure clarity and consistency, including the future roles of the Prevention Board, Health Inequalities Advisory Group, and Population Health Management Group
- Strengthened oversight of our current priority areas and programmes – including the delivery of the national Core20Plus5 framework, our

programmes dedicated to tobacco and alcohol control and child and adult obesity, and our 'Deep End' GP practices network
- Agreeing a consistent Population Health Management (PHM) methodology, and how our PHM tools and analytical capacity are best utilised at both system-wide and place level.
- What capacity we need to effectively analyse latest national thinking from government, universities and thinktanks
- How we measure, evaluate and audit the outcomes and improvement that our joint work delivers so that we understand what works and how we can share spread best practice
- How we resource and coordinate this work with partners including the joint work we will need to coordinate with Local and Combined Authorities.
- How we develop an effective engagement strategy, supported by layered data analytics from multiple sectors, to enable citizens to both identify their priorities and lead the changes that will enable them to create their own healthy lives and healthy communities.
- How we might utilise think differently regarding funding streams to support the delivery of our health inequalities priorities, including via a charitable foundation or other income-generating mechanisms.

3. A Call to Action

3.1 As we strive to achieve the integration of health and care across the North East and North Cumbria we need to galvanise action on health inequalities, bringing partners together to lead, collaborate and advocate to achieve the change that's needed to reduce these unfair differences in health outcomes, not least through the use of population health management tools, concerted action to reduce tobacco dependency, alcohol-related harm, and obesity and through a smarter targeting of the ICB's £6billion spending power in support of broader social and economic development.

3.2 Therefore, any advisory group looking at Health Inequalities would need to advise both the Integrated Care Partnership (ICP) and its work on the development of an Integrated Care Strategy for the ICS, and the statutory responsibilities of the ICB. This group will need to draw on the skills and insights of key partners across our ICS, including those with lived experience, to provide strategic leadership, support, and challenge across the system to shape our strategic approach to health inequalities for the North East and North Cumbria, oversee our ongoing programmes of work in this area and ensure the delivery of key local and national priorities.

3.3 Having considered these issues, the attached proposal recommends the formation of a strategic 'Healthier and Fairer Advisory Group' as a sub-group of the ICB Executive clarifying the coordination of our public health and health inequalities work, with both a clear reporting line to the ICB, and an advisory relationship with our Strategic ICP and Area ICPs to emphasise what a cross-cutting and system-wide challenge this is.

4. The Proposal: A Healthier and Fairer Advisory Group

4.1 To establish a Healthier and Fairer Advisory Group to the ICB which would provide evidence, advice, analytical support and oversight of the health inequalities priorities across the integrated care system. This group would build on a long-established history of collaboration to bring about change and also an acknowledgment that there is much to be done where previous initiatives have sometimes fallen short of delivering on our joint aspirations.

4.2 In recognition of the importance of this work, it is recommended that the ICB commits to always having regard to the recommendations of the Healthier and Fairer Advisory Group, so that it promotes equitable health and wellbeing across the North East and North Cumbria and ensures that the ICB does not widen health inequalities through the health services that it commissions.

5. Areas of Focus for the Group

5.1 This advisory group would seek to identify the key areas where the ICS should lead, collaborate and advocate, and utilise the expertise across the North East and North Cumbria to provide an advisory, oversight and development function, focused on the following areas:

Strategic leadership of our approach to health inequalities:

- Establishing a single ICB Executive Lead and Programme SRO for health inequalities to ensure we deliver our collective objectives:
- Use the best evidence and data to inform a population health approach for action across all aspects of the ICS including finance, risk, quality as well as workstream delivery
- Provide advice and input to the development of our Integrated Care Strategy
- Build on existing Joint Strategic Needs Assessments and Joint Local Health and Wellbeing Strategies to identify common themes which would benefit from action at an ICS level
- Promote the engagement of people and communities to describe their own needs and lead their own health transformation.
- Strengthen links with the Applied Research Collaborative to embed a research and evaluative approach to the interventions we invest in
- Developing our workforce so that all our staff can make a difference to reducing health inequalities

Programme oversight and delivery:

- Ensure the ICB delivers NHS England and NHS Improvement's 'Core20PLUS5' approach to reducing health inequalities, by ensuring the services commissioned by the ICB are inclusive and accessible to all of communities in the North East and North Cumbria, and do not widen any disparities in access to services.
- Provide oversight and strategic direction to the priority workstreams jointly led by the ICB and its statutory partners, including treating tobacco dependency, reducing alcohol harm, healthy weight and treating

obesity, population health management, the Deep End Network, Prevention in Maternity, promotion of the Anchor Institutions network and community asset-based approaches.
- Ensure fair and equitable use of the health inequalities funding allocated to the ICB, identify opportunities to secure further resources into the ICS as well as review how the ICB's core NHS resources are best utilised to prevent ill health and target health inequalities

Develop and innovate:
- Extend existing innovations, including hospital-based Consultants in Public Health, and share and spread good practice in how to tackle health inequalities
- Generate proposals to expand the NHS's contribution to addressing the social determinants of health – including procurement, environmental initiatives, employment opportunities and workforce development
- Advocate for changes in policy that will address the social determinants of health and improve health outcomes for our communities

Enable:
- Utilise all relevant data and evidence to improve fair access to healthcare and delivery of joined up programmes of health improvement
- Build networks and alliances that connect health and care organisations to the VCSE sector, patient voice organisations, schools and universities, the business sector, and others in the pursuit of healthier and fairer outcomes for our communities.

6. Recommendations

6.1 The Board is asked to:
- Note the formation of the Healthier and Fairer Advisory Group based on the terms of reference attached at Appendix 1, and its important role in advising both the ICB and the Integrated Care Partnership;
- Request updates on the work of this advisory group as it reviews existing work programmes and agree its priorities for the year ahead;
- Support the principle that the ICB and the ICB Executive will always have regard to the recommendations of this group when making their decisions.

Report Author: **Dan Jackson**
Director of Policy, Public Affairs and Stakeholder Affairs

Sponsoring Director: **Dr Neil O'Brien**
Executive Medical Director

Date: **17 November 2022**

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Appendix 1

North East and North Cumbria Healthier and Fairer Advisory Group

TERMS OF REFERENCE

1. Purpose

1.1 The purpose of the North East North Cumbria (NENC) Healthier and Fairer Advisory Group is to provide strategic advice across the Integrated Care System (ICS) to ensure that action on population health, prevention and health inequalities is embedded into our planning and decision-making arrangements.

1.2 This advice will be focussed on supporting the ICB to deliver its four core statutory obligations:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

1.3 Respecting the role of Health and Wellbeing Boards in setting local priorities, the Group will also provide strategic oversight and direction for our shared programmes of work that will benefit from a North East and North Cumbria (NENC) wide approach. These programmes will be based on those with the strongest evidence base, the biggest impact over the shortest time period, and their potential to be delivered at scale across the ICS by:

- Identifying opportunities to explore regional collaboration across the North East and North Cumbria to address health inequalities.
- Ensuring links back to local delivery via Health and Wellbeing Boards, ICP Boards and other local Boards and forums

2. Objectives

2.1 The NENC Healthier and Fairer Advisory Group will:

- Analyse the latest data, evidence and policy on health inequalities to provide strategic advice and guidance to the ICB and ICP, building our learning capacity and ensuring a health inequalities approach is embedded across our whole ICS
- Develop a consistent Population Health Management methodology and data sharing arrangements to ensure we have access to the best evidence to inform action

- Review ICS policies, strategies and plans to ensure they all contribute to reducing heath inequalities.
- Support the development of a consistent, joined up strategic health inequalities narrative across the ICS, including but not exclusively core20PLUS5
- Provide strategic support and guidance for identified health inequalities leaders in organisations across the North East and North Cumbria ICS
- Facilitate conversations across health and care organisations, clinical and non-clinical staff, patients, members of the public, carers and other key stakeholders in the voluntary and private sectors to raise the profile of our work on health inequalities
- Provide advice on health inequalities, prevention and population health to other ICS work streams and sub-committees
- Provide advice and guidance to those engaging our population to ensure that we empower all our communities to identify and lead local action on health improvement
- Identify opportunities for further research and building our evidence base through strong links with our research partners in universities

2.2 The Healthier and Fairer Advisory Group will also have strategic oversight of the following priority programmes at a NENC level:

- Population Health Management
- Treating tobacco addiction as part of a whole NHS smoke-free model
- Reducing alcohol related harm across the whole population
- Supporting GP practices working in the most deprived areas of the region (‘Deep-End’)
- Public Health Prevention in Maternity ('Best Start in Life')
- Healthy Weight and Treating Obesity
- Embedding Community asset-based approach across the ICS
- Our emerging work with partners on addressing the wider determinants of health, and the ICB's contribution to broader social and economic development

3. Communications

3.1 The Advisory Group will also develop a framework for communications, marketing and engagement to support the delivery of the group's priorities. This framework will be developed with input from all partners and will be coordinated by the ICB's Corporate Governance, Communications and Involvement team. All press or social media activity is to be coordinated by the advisory group who will receive updates on this work at each of its meetings.

4. Resourcing

4.1 Nationally £200 million has been made available to ICBs through the 2022/23 ICB allocations, targeted towards areas with the greatest health inequalities using an avoidable mortality measure. This funding will support the implementation of the Core20PLUS5 approach outlined in NHS England's

2022/23 Priorities and Operational Planning Guidance including their five priority actions for addressing health inequalities:

- Strengthening leadership and accountability
- Restoring NHS services inclusively
- Mitigating against 'digital exclusion'
- Ensuring datasets are complete and timely
- Accelerating preventative programmes

4.2 NHS North-East and North Cumbria ICB has been allocated £13,604,000 recurrent revenue to support targeted reductions in health inequalities. Going forward, the Advisory Group will play a key role in recommending to the ICB Executive how this funding is allocated, based on robust analysis and evaluation of what makes the biggest impact on public health and health inequalities. The group will also seek to identify opportunities to shift NHS spend on prevention and inequalities which they will recommend to the ICB Executive for final approval. This is in line with the ICB's Financial Scheme of Reservation and Delegation set out in the table below.

Limit	Authoriser
Over £30,000,000	Integrated Care Board
Up to £29,999,999	ICB Executive Committee
Up to £4,999,999	ICB Chief Executive **and** ICB Executive Director of Finance **and** ICB Chair
Up to £2,999,999	ICB Chief Executive **and** ICB Executive Director of Finance; **or** ICB Chief Executive **and** Executive Directors of Place Based Delivery

4.3 A summary of funding allocations for 2022-23 is attached at Appendix 2.

5. Governance, Accountability and Reporting Arrangements

- The NENC Healthier and Fairer Advisory Group will report to the ICB Executive Committee, and will also contribute advice and guidance to the Integrated Care Partnership (ICP)
- The chair of the group is a member of the ICB Executive Committee, and will be supported by a Programme SRO
- The Group is authorised to instigate any activity within its terms of reference and to seek information as necessary ensuring delivery within agreed budgets and governance arrangements.
- Regular reports will be submitted to the ICS Executive and signed off by the group chair, including a highlight report on the work of the Group which shall be submitted to each meeting of the ICB Executive
- Relevant sub-groups of the advisory group will report to the group on a regular basis e.g., the reducing tobacco dependency task force
- The group will seek to reach consensus in deciding its recommendations, and any consensus decision will constitute a recommendation.

- Where consensus cannot be reached, views which are divergent from the majority view will be recorded and presented with the report/advice to the appropriate forum.
- Making recommendations to Health and Wellbeing Boards, the Strategic ICP and Area ICPs, and other local Boards and forums where appropriate.

6. Principles

- The primary focus of the group is the needs of the population and local communities it serves and group members will focus on this rather than any organisational agendas.
- For the group to realise its potential, it will need to be enabled to deliver change. The group will align and co-ordinate with the outputs of local statutory organisations, and not take any authority away from them. For any decision that is beyond the level of delegated authority, the group will provide a recommendation to the appropriate leadership group.
- Members are expected to act as ambassadors for the work and engage others within their organisations in the development.
- All rights, title and interest in, or to, any intellectual property relating to outputs created through the work of the group shall be jointly owned by members of the group with a presumption that all parties can publish material from this work in journal articles and at conferences and that these may be joint publications.

7. Membership

7.1 Membership of the NENC Healthier and Fairer Advisory Group will include representatives from:

- ICB Executive team
- Clinicians from primary, community and secondary care
- NHS Foundation Trusts
- North East Directors of Public Health Network/North Cumbria Director Public Health
- Local Authority Adult and Local Authority Children's Services
- North East Office for Health Improvement and Disparities (OHID)
- ICS VCSE Partnership
- ICS Healthwatch Network
- ARC (Applied Research Collaborative) Health Inequalities Theme
- North East Quality Observatory Service (NEQO)
- North East and Yorkshire NHSE/I representative

Other interested organisations as agreed with the Chair.

8. Quorum

8.1 Where the Chair has determined – and has given two weeks' notice to Group members – that a key decision will be made then the quorum shall include members (or their proxies) of all organisations that the Chair determines should be present unless that organisation has instead chosen to make a

written submission. For other meetings, to constitute a quorum, a minimum of half the core members must be present, including the following ICB executives (or their nominated deputies):

- ICB Executive Medical Director
- ICB Executive Director of Corporate Governance, Communications and Involvement
- ICB Executive Director of Finance

9. Declarations of interest

9.1 The Advisory Group will actively implement standards of good conduct and management of conflicts of interest through a register of interests of all members (either pecuniary or non-pecuniary). All members must declare if they have a personal interest and the nature of that interest before a matter is discussed or as soon as it becomes apparent. They shall not take part in the discussion or decision-making on that item.

9.2 A conflict of interest will include:

- A direct pecuniary interest: where an individual may financially benefit from the consequences of a decision;
- An indirect pecuniary interest: for example, where an individual is a partner, member or shareholder in an organisation that will benefit financially from the consequences of a decision;
- A non-pecuniary interest: where an individual holds a non-remunerative or not-for-profit interest in an organisation, that will benefit from the consequences of a commission decision;
- A non-pecuniary person benefit: where an individual may enjoy a qualitative benefit from the consequence of a decision which cannot be given monetary value;
- Where an individual is closely related to, or in a relationship, including friendship, with an individual in the above categories.

10. Meetings and Support

10.1 The NENC Healthier Fairer Advisory Group will meet monthly, and all members of the group will receive meeting papers and minutes one week in advance. Support to the group will be provided by staff from NECS and from the programme leads/workstream sponsors

10.2 This support will include:

- Agreement of the agenda with the Chair
- Timely preparation and circulation of papers
- Ensuring minutes and papers for meetings are stored appropriately
- Oversight of finance, commissioning and reporting of sub-groups

10.3 The Board will ensure the following are in place to support the programme:

- Appropriate workstreams/sub-groups to drive forward the agreed priorities.

- Specific work plans for each priority with identified outcomes and monitoring arrangements.

Appendix 2

Summary of Funding Allocations to Health Inequalities Programmes

1. Overview

1.1 The following funding allocations were proposed by the previous Health Inequalities Advisory Group (which has now been superseded by the Healthier and Fairer Advisory Group), the Directors of Public Health Network, and the Chairs of the Population Health and Prevention Board. This was approved by the ICB Executive on 11 October 2022.

1.2 The initiatives being funded are grouped under the five key national priorities for health inequalities:

- Strengthening our leadership and accountability
- Restoring our NHS Services Inclusively
- Mitigating against 'digital' exclusion
- Ensuring datasets are complete and timely
- Accelerating preventative programmes

2. Strengthening our leadership and accountability

2.1 System capacity and infrastructure

Capacity is required to support system leadership and capability to address health and healthcare inequalities across NENC. This includes funding a small core team comprising a strategic manager, workforce development officer, communications and engagement officer (joint with the Population Health and Prevention Board) and senior analytical support. These posts are currently funded via the NECS Transformation Fund for 22/23 but funding is required beyond March 2023.

The team will coordinate activity to ensure health and healthcare inequalities are embedded throughout the ICS. They will drive forward activity to improve access, experience and outcomes for the population. They will ensure we are data and evidence informed, promote activity and share practice across NENC, lead a NENC Anchor Institutions Network across our public sector organisations and ensure we meet requirements to implement the Core20PLUS5 approach.

2.2 A Health Inequalities Academy

It is proposed that a Health Inequalities Academy be created to improve health inequalities skills, knowledge, and training across the whole NENC workforce. The Academy will create a Community of Practice, embed existing

health inequalities training and resources as well as deliver bespoke training programmes across the ICS. Development funding has already been secured from HEE for 2022/23.

3. Restoring our NHS Services Inclusively

3.1 Waiting Well

3.1.1 Waiting Well establishes a co-ordinated Population Health Management approach to supporting patients to prepare well for surgery, improve outcomes, and optimise surgical capacity. It will introduce a tiered support package for patients awaiting surgery, targeting those on the P4 list with the longest projected waiting times, as well as those from clinically and socially vulnerable groups who are most likely to suffer from poor surgical outcomes, postponements, and cancellations and who have been disproportionately affected by the COVID-19. The offer will include a universal digital offer, a tailored digital offer, and a complex, bespoke offer for those with the greatest need to support them to prepare physically and psychologically, whilst waiting for their procedure. The model was developed in collaboration with clinicians from different specialties, with representatives from both primary and secondary care.

3.1.2 The Waiting Well Programme focuses on equity, not just equality of pre-surgery support. It supports patients to make changes to optimise their surgical outcomes and reduces inequality of surgical outcome for Priority 4 patients in deciles 1 and 2, people with learning difficulties, people in ethnic minority groups and other categories deemed as vulnerable, compared to all other patients within Priority 4.

3.1.3 A model has been developed which will involve the introduction of a Central Hub to coordinate a tiered support package for these patients on the P4 list. Data from a Dashboard developed by NECS will be used to stratify patients into groups receiving either a universal offer if motivated and digitally able, a targeted offer if requiring a greater level of support, and a face-to-face offer for those patients requiring the most support. The approach also involves strengthening capacity at place, allowing a complementary rather than duplicate offer that drawing on existing services and local, place-based connections. An evaluation of the programme will also be in place.

4.2 Supporting people with multiple and complex health and healthcare needs ('Plus' programme)

4.2.1 A key part of the Core20PLUS5 framework is the need to target specific action to Inclusion Health Groups. This programme will be delivered at place, designed locally to support people with multiple and complex health needs associated with drug, alcohol and mental ill health to access healthcare. It will build on the £12.5m secured across NENC Councils to support people with drug and alcohol issues with housing, employment, treatment and enforcement as part of the national Drugs Strategy.

4.2.2 The proposal is to identify interventions to increase access to general health care for people with multiple and complex needs. Priorities for service development will need to be identified and implemented at local place, between LAs and their NHS partners, to ensure that critical gaps and areas for improvement are tailored to local needs. Examples of suggested interventions based on current gaps include respiratory in-reach clinics, hepatology in-reach clinics, improved access to primary care for physical healthcare needs, wound care, improved access to screening, immunisations and oral health programmes, assessment of mental health needs and work with pharmacies to reduce over the counter prescribing of opioids.

4.2.3 Further work is required to undertake mapping and scale healthcare interventions of for people from other inclusion health groups, in particular people who are homeless, vulnerable migrants, Gypsy Roma and Traveller communities, people with learning disabilities, people from ethnic minority communities and carers. We will utilise the existing expertise of people with lived experience, from networks and services already in place across NENC, to ensure we respond to the healthcare needs and barriers identified.

4.3 Deep End

4.3.1 The aim of the Deep End project is to establish a network for the 'Deep End' GP practices in the NENC, serving the 20% socio-economically deprived populations in our ICS. The aim is to improve care provided to these patients and reversing the Inverse Care Law by improving capacity and resources. To date Deep End has focused on practices operating within the 10% most deprived areas across the ICS using the WEAR approach (Workforce, Education, Advocacy & Research).

4.3.2 The aim is to provide additional capacity and resource for Deep End practices, attract new primary care professionals to work in Deep End Practices and develop new ways of working to address need. Initially this will focus upon clinical psychology, review of Opioid / Gabapentinoid prescriptions, screening & Immunisations and Social Prescribing. However, opportunities to build on the current AHSN proposal focused on increasing healthy heart checks in Middlesbrough and linking with the work of the CVD prevention workstream, we will look to increase hypertension case-finding amongst the Deep End practices. It will also develop primary care training to improve understanding of inequalities and attract staff to work in Deep End practices which will link with the wider Health Inequalities Academy (see 3.1.2). This will include a Deep End Fellowship Programme, increasing the number of Deep End Practices that are training practices, overseas graduates visa support and a Deep End extended Integrated Training Post.

4.3.3 NENC ARC have already provided research advice to ensure an evaluation framework to the Deep End network however an embedded Deep End Researcher Post will be appointed to build the evidence-base around 'what works' to reduce health and care inequalities and publish key findings.

4.4 Healthy Communities and Social Prescribing

4.4.1 The aim of the healthy communities and social prescribing approach is to build sustainable and effective community-centred approaches to support tackling the prevention and health inequalities agenda within the NENC ICS. This includes connecting with communities to promote health messages, engaging with various communities to gather local intelligence to inform local planning and enhancing work through the VCSE sector to increase access to healthcare. During the pandemic, significant work was developed jointly between the NHS, LAs, VCSE and Faith communities to increase access to vaccines. The approach of working with community champions to ensure accurate information was shared, dispelling myths and taking the vaccine to communities led to the Vaccine Inequalities Group across NENC captured the lessons and developing a vaccine inequalities toolkit. We will use some of the funding to enhance access to vaccines including covid, flu and pneumonia.

4.4.2 Additionally we will expand the NENC Core20plus5Connector pilot which has built on the Covid Champions Programme. Its initial focus has been on developing Cancer champions but will expand to other clinical areas. The programme will also enhance social prescribing infrastructure and delivery through the VCSE as well as strengthen the evidence base for social prescribing through the Building Research Partnerships & Collaboration, sharing best practice at local, regional and national level.

4.5 Poverty Proofing Clinical Pathways and developing a CYP Core20PLUS5

4.5.1 The Child Health and Wellbeing Network have been working with Children North East by applying a method used in education settings to poverty proof clinical pathways. The work ensures the voice of people living in poverty are able to influence the design and delivery of pathways so that they are more culturally appropriate, accessible and targeted at those that need it most. The work will expand on the current pilot underway in CCDFT and expand to other organisations/clinical specialties. Additionally, in order to prepare for the developing Core20PLUS5 framework for Children and Young People, an element of funding will contribute to the health inequalities advisors to ensure that children and young people from the most deprived communities and inclusion health groups are considered in the planning.

4.6 Maternity – Continuity of Carer

4.6.1 As a result of the Ockenden report, Trusts are not currently expected to deliver against a target level of Maternity Continuity of Carer, and this will remain in place until maternity services can demonstrate sufficient staffing levels to do so.

4.6.2 We will, however, continue to work with the LMNS to understand the implications of this for our Core20Plus group and support implementation of the recently published Equality Action Plan to ensure healthcare inequalities are addressed.

5. Mitigating against ‘digital’ exclusion

5.1 Digital Inclusion

5.1.1 The pandemic created the conditions to fast-track the delivery of a wide range of digital services. Whilst technology enabled different ways of working and interacting, it also highlighted that not everyone can access digital solutions for a range of reasons and illustrated the unintended consequences of a 'digital by default' ambition. Following a review and gap analysis of the NENC ICS Digital Strategy, against the What Good Looks Like Framework, areas of further focus were identified. One of those areas of focus was Digital Inclusion. Plans are underway to formulate the NENC ICS Digital Care Programme and Digital Inclusion Strategy. The resource will be used to address immediate priorities with focus upon access to equipment, support to community hubs. Increased skills to use the internet/apps/devices, support for those with a learning disability and removing language barriers.

5.2 Health Literacy

5.2.1 The vision of the NENC Health Literacy Approach is to ensure the ICS communicates all information to people in a way that is easy for them to understand and that is accessible to them. Providing information and communicating with people in a way that is meaningful for them is fundamental to delivering safe and effective care and reducing health inequalities. This programme will ensure there is an ICS wide approach to health literacy. It will raise awareness and empower staff via training, the development of a health literate toolkit and providing Information that people understand, enabling them to make active decisions in their care and their experience of this. Evaluation of the pilot in ST&S NHS FT is currently being supported by the University of Sunderland.

6. Ensuring datasets are complete and timely

6.1 Improved Morbidity Coding

6.1.1 Following the announcement of allocations for 2022/23 a task and finish group was established to identify the reasons for the relative decrease in need for general and acute services in the NENC identified in the national allocation formula. Inconsistencies with regards to the depth of morbidity coding across local NHS trusts and clinical concerns highlighted that local datasets do not reflect accurately the morbidity of their patients. Capacity to support driving forward improvements based on the approach adopted in NT&H NHS FT and in clinical coding teams will drive data improvements, including ethnicity coding.

6.1.2 This includes funding to establish networks, additional training and targeted capacity to support activities in identified specialties for improvement across NHS FTs. As part of this approach NEQOS aggregate data on comorbidity coding for all FTs will be summarised, with a particular interpretation around how the variation and changes by trust affect the regional position compared to the national average. NEQOS will also analyse, by FT, the depth of coding

which has been used in the funding allocation and compare this to the England average, identifying where the largest opportunities for improvement are (e.g., admission methods, diagnosis groups etc).

7. Accelerating preventative programmes

7.1 Tobacco Control

7.1.1 Smoking remains a leading cause of health inequalities across NENC. Smoking continues to cost the region approximately £887m per year, with circa. £190m attributed to health and social care costs. However, there is an evidence-based approach to reduce prevalence and deliver health benefits through increasing wider tobacco control. It is proposed that the NENC ICS identifies recurrent health inequalities funding to support wider tobacco control at both a system and place level. This would be part of a joint approach with the LAs that is in addition to all existing LA commissioned smoking cessation and NHS LTP acute tobacco dependency services.

7.1.2 The additional funding would support all other elements of evidence-based tobacco control including reducing exposure to second-hand smoke, development and delivery of bespoke media, communications and education campaigns which underpin population wide behaviour change; reducing availability and supply of illicit and legal tobacco; reducing tobacco promotion; tobacco regulation and research. This would be delivered through the existing NENC tobacco control office (Fresh) currently funded by 7 LAs, creating a strong NENC voice and the capacity to influence at scale. This would ensure that the regional tobacco control office is funded jointly between LAs and the NHS.

7.2 Alcohol Care Teams

7.2.1 Alcohol causes a wide range of conditions including cardiovascular disease, cancers, and liver disease, as well as contributing to harm from accidents, violence, and self-harm. Data recently released shows a 20.5% increase in alcohol related deaths in the North-East since 2012. These are a significant contributing factor to inequality in life expectancy between the region and the rest of England. The NE region has the highest rate of alcohol specific admissions and there are 14 times as many alcohol specific unplanned admissions for those living in the top 10% most deprived areas of NENC than within the least deprived, many of which are preventable. The evidence base for effective alcohol interventions in hospital is set out in three NICE guidelines.

7.2.2 The LTP allocation for Alcohol Care Teams (ACTs) has ensured that most of the NENC Acute Trusts are now resourced to deliver a 24/7 ACT. There are 3 Trusts that did not receive the national allocation – County Durham and Darlington Foundation Trust, North Cumbria Integrated Care Trust and Northumbria NHS Healthcare Foundation Trust (though the latter already had a team that aligned most closely to the ACTs though not delivered 7 days a week). There was only sufficient national resource for 50 hospital sites but

with additional investment of £945k the ACT plus model (includes recovery navigators) would ensure the whole of the ICS footprint has an evidence-based alcohol team. The Implementation of ACT provision at scale across the ICS gives an opportunity to ensure a consistency of approach, ensuring equity of access and provision to a vulnerable population who often suffer from complex needs.

7.3 Healthy Weight and Treating Obesity

7.3.1 Obesity is a leading cause of preventable morbidity and mortality, representing one of the most immediate health challenges for the NHS. A regional obesity analysis highlighted that there are approximately 151,101 patients that would be eligible for Tier 3 and 4 services of which 63% are from the 20% most deprived areas of the ICS. A Healthier Weight and Treating Obesity workstream sub-group was developed to focus on the recovery/expansion plans and agree minimum delivery and staffing standards for Tier 3 weight management services. The proposal is to provide Tier 3 weight management services to approx. 1000 patients that meet the agreed minimum standards targeting patients living in the 20% most deprived areas within the North-East and North Cumbria ICS footprint.

8. Financial Summary

8.1 The ICB received an allocation in 2022/23 for health inequalities of £13,604k. In the initial allocation announcement it was noted this funding was non-recurrent however further clarification provided by the NHS England Health Inequalities Policy team has confirmed the funding will form part of the recurrent baseline of the ICB moving forward. As such, proposals have been developed covering the period 2022/23 to 2024/25. It is expected that going forward health inequalities funding will form part of the ICB's baseline allocation rather than be separately identified. We will ensure that this funding is ringfenced in future years to support health inequalities and not be reallocated as part of baseline funding decisions.

8.2 An overview of the current proposed allocation of resources for the period 2022/23 to 2024/25 is shown in the table below. As it stands proposals for 2022/23 are currently below the available allocation and funding of £4,239k is still available to support the programme. The ICB strategy in relation to health inequalities which is still in development is expected to identify other priority investment areas and further consideration will be given on the allocation of the available resources following this. A further investment priority area in relation to the cost-of-living crisis to identify at risk patients and navigate them to appropriate support is currently being developed.

Health Inequalities ICB Allocation Utilisation Proposal	Additional Funding Requirements from HI Allocation 2022/23 £000's	2023/24 £000's	2024/25 £000's
System capacity and infrastructure	-	250	250
Health Inequalities Academy	-	100	100
Waiting Well programme	2,671	3,000	1,500
Plus Programme	3,000	3,000	3,000
Deep End programme	986	2,929	3,043
Healthy Communities and Social Prescribing	883	300	300
Poverty Proofing and CYP CORE20PLUS5	156	366	366
Implementing digital exclusion plan	100	400	400
Health Literacy	98	390	390
Improved FT Morbidity Coding	25	100	100
Accelerating Prevention Programmes: Tobacco	486	810	810
Accelerating Prevention Programmes: Alcohol	356	945	945
Accelerating Prevention Programmes: Obesity	101	1,000	1,000
Evaluation	500	-	-
Grand Total	**9,361**	**13,590**	**12,204**

9. Evaluation

9.1 Evaluation of the programmes within this proposal is central to demonstrating their impact. Some already have a strong evidence based and are recommended in NICE guidance. However, we not only want to translate evidence into practice but continue to build the evidence base.

9.2 Of the thirteen schemes within this proposal, six already have a funded evaluation in place or planned, for example Deep End is being evaluated by an embedded researcher. Funding of £500k is built into this proposal in 2022/23 to ensure that the evaluation framework for the programmes is developed and can contribute to addressing healthcare inequalities.

9.3 The strong and effective partnership already in existence with the NENC Applied Research Council (ARC) will be further developed to ensure consistent and effective evaluation of the schemes.

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

NORTH EAST AND NORTH CUMBRIA ICB BOARD MEETING 29 November 2022	
Report Title:	**Board Assurance Framework 2022/23**

Purpose of report

To provide the Board with a first version of the Board Assurance Framework for 2022/23.

Key points

The Board has overall responsibility for ensuring systems and controls are in place and sufficient to mitigate any significant risks which may threaten the achievement of the ICB's strategic aims and objectives. The Board achieves this primarily through the work of its committees, through use of audit, independent inspections and by systematic collection and scrutiny of performance data.

The Board Assurance Framework (BAF) is used to provide assurance on the management of key risks to the delivery of the ICB's strategic aims and objectives and is intended to provide a visible strategic risk summary and oversight of assurance, supported by the full detail of the corporate risk register.

A copy of the BAF for 2022/23 is attached at Appendix 1 and a copy of the corporate risk register is available at Appendix 2.

Risks and issues

The principal risks have been mapped to the risk assessment matrix for the delivery of the ICB's current strategic aims as follows:

1. Improve outcomes in population health and healthcare is rated red (extreme)
2. Tackle inequalities in outcomes, experience and access is rated red (extreme)
3. Enhance productivity and value for money is rated amber (high)
4. Help the NHS support broader social and economic development is rated amber (high).

Assurances

The attached BAF details the assurances for each strategic aim at this point in time.

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A further review of the ICB's strategic aims will be undertaken once the goals and ambitions as set out in the draft Integrated Care Strategy are finalised.
Recommendation/Action Required
The Board is asked to: • Review the committee oversight of risks and confirm that this is appropriate, and • Satisfy itself that the BAF reflects the principal risks to achieving the ICB's objectives at this point in time.

Sponsor/approving director	Claire Riley, Director of Corporate Governance, Communications and Involvement
Report author	Deborah Cornell, Director of Governance and Involvement

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

Relevant legal/statutory issues
Health and Care Act 2022

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

Key implications	
Are additional resources required?	No financial or additional capacity needed.
Has there been/does there need to be appropriate clinical involvement?	Not applicable.
Has there been/does there need to be any patient and public involvement?	Not applicable.
Has there been/does there need to be partner and/or other stakeholder engagement?	Not applicable.

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Board Assurance Framework 2022/23

1. Introduction

1.1 The Board has overall responsibility for ensuring systems and controls are in place and sufficient to mitigate any significant risks which may threaten the achievement of the ICB's strategic aims and objectives. Evidence may be gained from a wide range of sources, but it should be systematic, supported by evidence, independently verified and incorporated within a robust governance process. The Board achieves this primarily through the work of its committees, through use of audit, independent inspections and by systematic collection and scrutiny of performance data.

2. Board Assurance Framework process

2.1 Current Structure

North East and North Cumbria Integrated Care Board (the ICB) manages risk across various levels (as set out below) with the principal risks to achieving the ICB's forming the Board Assurance Framework at:

- Place
- Area
- Directorate
- Executive directors (corporate risks)
- Board Assurance Framework (BAF)

Risks are considered at their corresponding committee(s) to provide the Board with assurance that they are reviewed individually by risk owners and also collectively by the relevant oversight committee (see section 2.2 for further details).

All risks are aligned to an ICB strategic aim enabling risks to be aggregated to show the main areas of risk. The BAF is structured to show how risks align to each current strategic aim as follows:

1. Improve outcomes in population health and healthcare
2. Tackle inequalities in outcomes, experience and access
3. Enhance productivity and value for money
4. Help the NHS support broader social and economic development

A copy of the first version of the BAF is attached at **Appendix 1** for consideration by the Board.

2.2 Developing an Integrated Care Strategy for NENC

Engagement work is currently underway to develop an Integrated Care Strategy for the NENC. All Integrated Care Partnerships are required to publish their strategies by December 2022, as set out in the Department of Health and Social Care guidance published in July 2022.

The draft strategy sets out the proposed vision, goals and key commitments for the NENC, along with key enabling programmes in achieving these. Once these have been finalised, a further review of the strategic objectives in the BAF will be undertaken to ensure they reflect what has been agreed in the strategy.

2.3 Committee Oversight of Risks

All risks are reviewed by an oversight committee. Table one below sets out which committee will focus on which risks:

Table 1 risk oversight

Committee name	Remit of the committee	Frequency	Risk reports
Audit Committee	Responsible for oversight and assurance of the effectiveness of the risk management strategy and its supporting process	Quarterly	Full risk register Corporate risk register
Executive Committee	Responsible for day to day running of the ICB (operational and strategic)	Monthly	Executive Committee risk register Full risk register Place-based directorate risk register (extreme risks)
Finance, performance and investment committee	Specific responsibility for financial and performance risks	Quarterly	Finance, performance and investment risk register
Quality and Safety Committee	Risks specific to quality, safety and patient care	Quarterly	Quality and safety risk register
Board	Overall accountable for the delivery of the ICB's strategic priorities.	Quarterly	Assurance Framework Corporate risk register

Risks are also aligned to an Executive Director as appropriate and are rated in line with the risk assessment matrix:

	Likelihood				
	1	2	3	4	5
Consequence	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Low	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

	1 - 6	Low risk
	8 - 10	Moderate risk
	12 - 16	High risk
	20 - 25	Extreme risk

2.4 Corporate risks

A risk is determined to be a corporate risk if it has a residual (current) score of 12 and above.

The ICB currently has 16 risks with a residual score of 12 and above relating to its strategic objectives. As risk management processes become more embedded, the ICB may wish to review this criterion to a threshold of 12 and above for risks that are within partial or limited control of the ICB (i.e., strategic or externally driven risks) and a higher threshold for risks that are in full control of the ICB (i.e., internal, operational risks).

The corporate risk register is attached at Appendix 2 and shows risks in descending order of residual score.

2.5 Principal risks to achieving our strategic aims

Each strategic aim has been risk assessed to determine the overall consequence and likelihood of failure to achieve and there are risks to the achievement of each objective:

	Risk rating				
Strategic Aim	**Red**	**Amber**	**Yellow**	**Green**	**Total**
1. Improveoutcomes in population health and healthcare	1	8	2	0	**11**
2. Tackle inequalities in outcomes, experience and access	1	3	1	0	**5**
3. Enhance productivity and value for money	0	2	2	2	**6**
4. Help the NHS support broader social and economic development	0	1	0	0	**1**
Overall totals	**2**	**14**	**5**	**2**	**23**

All risks are reviewed to establish overarching controls and assurances and to ensure that any gaps in controls or assurances are documented.

The risk review considers any gaps in controls or assurances identified and this is taken into account when the overall risk to the achievement of the strategic objective is assessed. In addition to the review of the risks' residual (current) rating, consideration is also given to the inherent risk assessment as this gives an indication of the impact of the risk should controls fail.

2.6 Strategic aims and objectives

Risks are also aligned to the ICB's eight strategic objectives and **Appendix 3** sets out the total number of risks against each of these objectives by consequence and likelihood.

Work is underway in relation to the around the Integrated Care Strategyu which iwlllt is important to

2.7 Risk detail and monitoring

The Board Assurance Framework is monitored through the Executive Committee and the Audit Committee to give oversight to the controls.

2.8 Next steps

In the next performance period, a key piece of work will be to test the target risks with the lead committees.

3. Recommendations

The Board is asked to:

- Review the proposed committee oversight of risks and confirm that this is appropriate;
- Satisfy itself that the BAF reflects the principal risks to achieving the ICB's objectives at this point in time.

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Report authors:	**W Marley, Senior Governance Officer** **D Webber, Senior Governance Officer** **North of England Commissioning Support**
Reviewed by:	**Deborah Cornell** **Director of Governance and Involvement**
Sponsoring Director:	**Claire Riley** **Executive Director of Corporate Governance, Communications and Involvement**
Date:	**16 November 2022**

Appendix 1

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NHS North East and North Cumbria Integrated Care Board

Board Assurance Framework 2022-23

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Strategic Aim 1 – Improve outcomes in population health and healthcare			
Risk rating by quarter			
Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
N/A		◀▶	
Principal risks	NENC/0001 Risk of lack of robust planning for surges, outbreaks and business continuity incidents could result in rises in A&E and an inability to provider emergency care and core services NENC/0009 Risk that primary care is unable to provide long term, sustainable and reliable quality services NENC/0014 Failure to comply with good clinical practice, policies and procedures could mean the ICB is unable to manage safeguarding duties appropriately NENC/0021 Risk of respiratory infections affecting public health and putting pressure on health and care services NENC/0023 Risk that ambulance handovers impact negatively on patient safety and flow NENC/0024 Risk that the ICB commissions services that fall below required standards NENC/0025 Significant workforce pressures in maternity services across the system NENC/0026 Funding allocation for local maternity and neonatal system (LMNS) is only guaranteed up to 22/23 NENC/0029 Antimicrobial stewardship to reduce and prevent antimicrobial resistance		

Controls	Assurances	Gaps in controls and assurance
System wide surge and escalation plan EPRR compliance All providers to notify ICB if OPEL status is escalated Place based delivery Urgent and Emergency care groups	Plan reviewed regularly Annual EPRR signed off by ICB	
Workforce pressures are monitored via Strategic Data collection Service PCN transformation agenda linked to long term plan	SDCS reporting PCN transformation agenda linked to NHS long term plan	
Place based partnerships working with Local Safeguarding Adults Boards Robust policies and procedures across ICB	Minutes from Quality and Safety Committee Minutes from LSCB and SAB meetings	
Local A&E delivery boards in place ICB winter surge plan	System SitReps during surge periods.	National issue which will have knock on effect to region
Main provider contracts contain clear performance expectations	Quality and Safety minutes CQC exception reports	
Workforce steering group with membership from NHS England LMNS leads and Co-ordinators will work closely with providers	Regional Maternity Transformation Board oversight Nation tool – Birth rate plus in place with providers	
Indication funding will continue	Financial reporting feeds into Maternity Transformation team	

Place groups overseeing antimicrobial prescribing ICB wide antimicrobial stewardship group that reports directly to Healthcare Acquired Infection (HCAI) board	Local action plans in place Minutes from groups and HCAI board	
Establishment of a Healthier and Fairer Advisory Group to oversee the health and healthcare inequalities, prevention and population health management agendas.	Minutes and outputs from the meetings	Group not yet formally established, subject to Board approval in November 2022.
Progress		
What's going well including future opportunities	**What are the current challenges including future risks**	**How are these challenges being managed**
Engagement is taking place on development of a multi-professional clinical leadership framework. This process will inform the ICB clinical leadership structure. Recruitment process to run early November ICB to establish a task and finish group to meet the challenge of Health Inequalities. Surge management workshop has taken place and highlighted key areas of focus Actions to be implemented following Ockenden report		

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Strategic Aim 2 – Tackle inequalities in outcomes, experience and access			
Risk rating by quarter			
Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
N/A		◀▶	
Principal risks	NENC/0006 Risk that adults do not receive the treatment and access to mental health services NENC/0007 Delivery of NHS Constitutional Standards NENC/0027 Risk that children and young people are unable to access mental health services NENC/0028 Widespread challenges to recruitment and retention leading to a risk to delivery of safe services and increased workload pressures on existing workforce		

Controls	Assurances	Gaps in controls and assurance
Standard NHS contracts in place with two main providers Regional ICS mental health workstream	Contract management process Minutes and actions from meetings	
Contract management processes in place Performance management processes in place Elective recovery plans have been developed with main providers	Performance monitored by Exec committee	
CAMHS partnership board in place Contract review meetings with main providers Joint commissioning with local authorities	Performance updates to ICB	
Establishment of a Healthier and Fairer Advisory Group to oversee the health and healthcare inequalities, prevention and population health management agendas.	Minutes and outputs from the meetings	Group not yet formally established, subject to Board approval in November 2022.
Workforce steering group	Health Education England	Health Education England will merge with NHS England in April 2023 which may lead to a period of disruption

Progress		
What's going well including future opportunities	**What are the current challenges including future risks**	**How are these challenges being managed**
ICB Executive team members held workshop with Association of Directors of Adult Social Services where principles of future working, shared priorities and focussed actions were discussed and how this can be supported across the region		

ICB led initiatives regarding EFRA committee on Rural Mental Health. Engaging with local communities to develop good mental health and suicide prevention.		

Strategic Aim 3 – Enhance productivity and value for money

Risk rating by quarter

Quarter 1	Quarter 2	Quarter 3	Quarter 4
N/A		◀▶	

Principal risks	NENC/0004 Risk that the ICB does not meet its statutory financial duties NENC/0012 Risk that organisational planning fails to address the need for robust leadership, engagement, partnership working and workforce development leading to an inability to deliver the ICB's strategy.

Controls	Assurances	Gaps in controls and assurance
Financial plan QIPP in place Financial monitoring and reporting Mechanisms to identify CHC packages of care Financial governance arrangements Monthly forecasting and variance reporting in place	Monthly finance reports Financial plan to show breakeven position Scheme of delegation approved annually	
Assurance Framework Staff appraisal Statutory and mandatory training Board development sessions	Six monthly reviews of Assurance Framework Appraisal development plans Training report highlights non-compliance Programme of development sessions to be devised	

Progress

What's going well including future opportunities	What are the current challenges including future risks	How are these challenges being managed
	NHS England have put a cap on using agency staff. ICB will have to reduce the level of spend by 30%	

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Strategic Aim 4 – Help the NHS support social and economic development			
Risk rating by quarter			
Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
N/A		◀▶	
Principal risks	NENC/0013 A lack of effective engagement with partners, stakeholders and members of the public would reduce input and buy-in for key service changes and population health management initiatives across the system.		

Controls	Assurances	Gaps in controls and assurance
Communications and engagement strategies Active involvement in regional health and wellbeing boards PCNs are established across the region	Strategy approved by board	

Progress		
What's going well including future opportunities	**What are the current challenges including future risks**	**How are these challenges being managed**
ICB on track to deliver the Mental Health Investment Standard		

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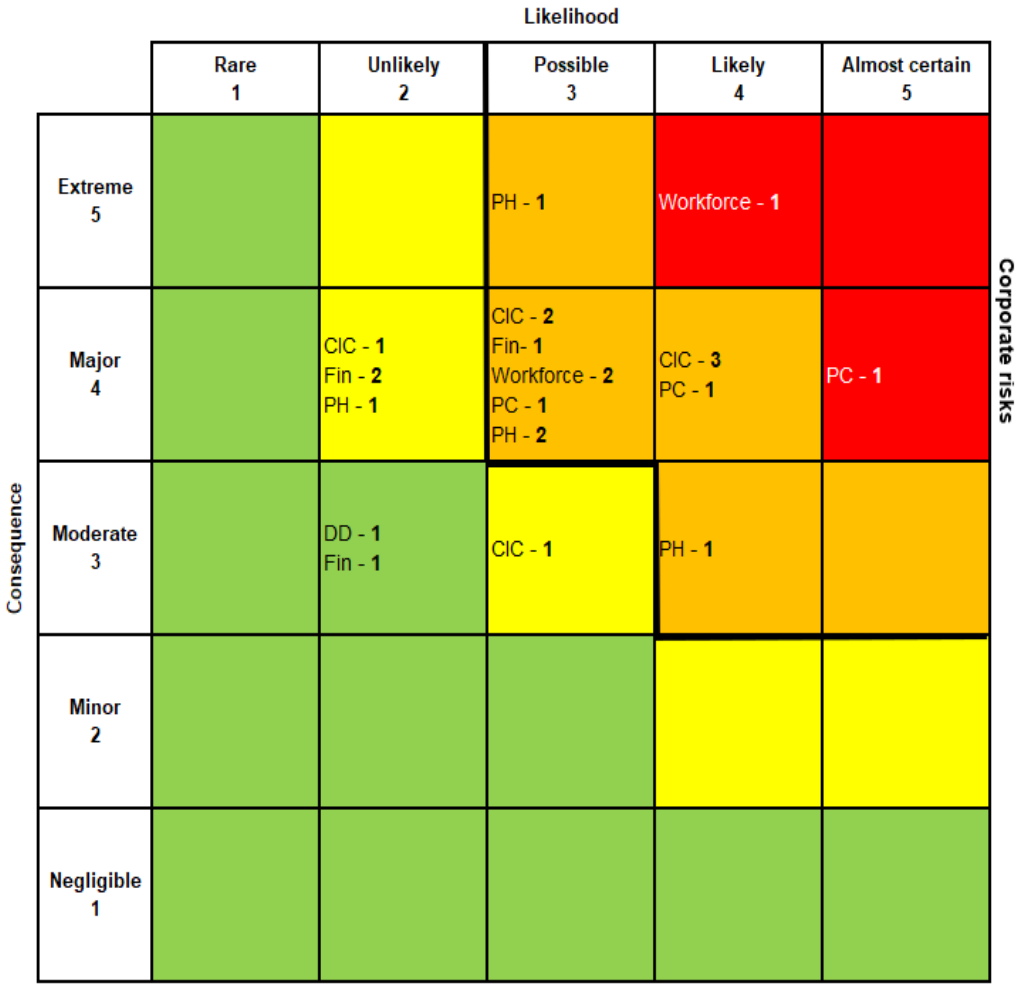
Appendix 3

Risk Totals by Strategic Objective



Commissioning For Integrated Care (CIC)	
NENC/0002	Commissioning of services with potential for legal challenge
NENC/0003	Implementation of MCA (Amended) 2019 Liberty Protection Safeguards
NENC/0007	Delivery of NHS Constitutional Standards.
NENC/0014	Safeguarding duties
NENC/0024	ICB commissioned services fall below the required standards, putting patient health, safety and welfare at risk.
NENC/0027	Risk that children and young people are unable to access mental health services they need in a timely manner.
NENC/0006	Access to adult mental health services
Data and digital (DD)	
NENC/0008	Risk of cyber-attack
Finance (FIN)	
NENC/0004	Achievement of economy, efficiency, probity and accountability in the use of resources
NENC/0005	Conflicts of interest
NENC/0010	ICB public accountability duties
NENC/0022	Fraud undermines the financial position/reputation of the ICB
Population health (PH)	
NENC/0001	System Resilience and Escalation Planning
NENC/0011	Prescribing pressures
NENC/0013	Communications and Engagement.
NENC/0021	Risk of rising respiratory infections
NENC/0029	Anti microbial stewardship
Provider collaboratives (PC)	
NENC/0009	Primary care services
NENC/0023	Risk that delayed ambulance handovers impact negatively on patient safety and patient flow
NENC/0025	Significant workforce pressures in maternity services across the system
Workforce	
NENC/0012	Organisational development
NENC/0026	Funding allocation for Local Maternity and Neonatal System (LMNS)
NENC/0028	Clinical and social care workforce across the region

N.B: No risks have been identified against Sustainability / Net Zero or Innovation and Research as yet.

NHS North East and North Cumbria corporate risk register (residual score 12 and above)

15/11/2022

NHS North East & North Cumbria

Strategic aim	Risk ref	Date identified Director Risk owner	Directorate Level of control Committee	Description	Initial C	Initial L	Initial Score	Controls	Gaps in control	Internal assurances	External assurances	Gaps in assurance	Actions Action owner Details Start date - target date Progress	Residual C	Residual L	Residual Score	Reviews	Target C	Target L	Target Score
1. Improve Outcomes In Population Health And Healthcare	NENC/ 0023	06/09/2022 David Purdue David Purdue	NENC Strategy And System Oversight NENC ICB Partial Control 3. NENC Quality And Safety Committee	Risk that delayed ambulance handovers impact negatively on patient safety and patient flow There could also be negative media attention generated which could damage the ICB's reputation and cause the public to lose confidence in the NHS.	4	5	20	Local A&E Delivery Boards at place ICB winter plan and surge plan		System SitReps during surge periods System-wide Surge exercise				4	5	20	(3). Monthly **27/10/2022** Quality and Safety Committee advised the residual likelihood should be increased to reflect the current situation across the region	4	1	4
2. Tackle Inequalities In Outcomes, Experience And Access	NENC/ 0028	21/10/2022 David Purdue David Purdue	NENC Chief Nurse Directorate NENC ICB Partial Control 3. NENC Quality And Safety Committee	Clinical and social care workforce across the region There are widespread challenges to recruitment nationally and particularly of clinical and social care staff as a result of many factors including EU exit, COVID and post COVID burnout, ageing workforce. This will impact on the delivery of safe services and could lead to lack of access to specific services, drive up waiting times leading to poorer outcomes for patients. This will cause further workload pressures on existing staff which could cause retention issues and potentially lead to staff ill health.	5	4	20	Workforce steering group Health Education England (HEE)	HEE will be merged into NHSE in April 2023 which could disrupt existing programmes of work	Terms of reference, meeting notes, action plans. Meeting notes and reports				5	4	20	(3). Monthly **21/10/2022** Risk identified at Quality and Safety Committee	3	2	6
1. Improve Outcomes In Population Health And Healthcare	NENC/ 0024	01/07/2022 David Purdue David Purdue	NENC Chief Nurse Directorate NENC ICB Partial Control 3. NENC Quality And Safety Committee	The ICB commissions services that fall below the required standards, putting patient health, safety and welfare at risk. Quality of commissioned services: a structured and co-ordinated process of assurance is not in place for commissioned services (including acute, mental health, learning disability and community services), meaning that the ICB remains unaware of any quality issues or concerns and associated action plans to address them.	5	4	20	Main provider contracts contain clear performance expectations. All large providers on NHS Standard Contract and therefore have CQUIN schemes. ICB designated posts to drive quality agenda with further support from NECS. CQC inspections		1. Quality and Safety committee agenda and minutes. 2. ICB Board agenda and minutes. 3. Audit Committee agenda and minutes. 4. Executive Committee agenda and minutes	CQC inspection reports			4	4	16	(5). Quarterly **04/10/2022** Risk identified by Head of Governance (Newcastle Gateshead Place)	4	2	8
1. Improve Outcomes In Population Health And Healthcare	NENC/ 0025	19/10/2022 David Purdue Nicola Jackson	NENC Chief Nurse Directorate NENC ICB Partial Control 3. NENC Quality And Safety Committee	Significant workforce pressures in maternity services across the system If maternity services do not have adequate staff to provide safe services there is a risk to patient safety and patient experience. Inadequate workforce will also mean that it will be difficult to implement the actions identified in the Ockenden report and could lead to poor CQC inspections. This could lead to the ICB failing to commission safe services with consequent damage to reputation and potential loss of public confidence in wider NHS service delivery.	4	4	16	Workforce steering group with membership from providers and NHS England LMNS Leads and LMNS Coordinators will work with providers to identify alternative ways of working and looking at sharing good practice Health Education England and regional maternity transformation team support with workforce	Workforce lead role currently being recruited to No implementation plan in place and therefore no clear measures in place	Terms of reference Meeting notes and action plans Workforce vacancy rates received by LMNS team Meeting notes and reports	Regional Maternity Transformation Board oversight Regional Perinatal Quality Oversight Board National tool - Birth Rate Plus in place with providers	Fragmentation within ICB around workforce planning means that information is not always fed into LMNS	Nicola Jackson Task and Finish Group to bring together key people to be convened with first piece of work to be completed by 31/12/2022 19/10/2022 - 31/12/2022	4	4	16	(5). Quarterly **19/10/2022** Nicola Jackson New risk added	3	2	6
2. Tackle Inequalities In Outcomes, Experience And Access	NENC/ 0027	21/10/2022 David Purdue David Purdue	NENC Chief Nurse Directorate NENC ICB Partial Control 3. NENC Quality And Safety Committee	There is a risk that children and young people are unable to access mental health services they need in a timely manner. As a result of unclear mental health pathways for children and young people (CYPS, CAMHS, neurodisability), alongside service pressures and capacity, increased demand and inconsistencies in treatment threshold there is a risk that children and young people do not receive appropriate treatment which could result in negative outcomes for children, young people and their families. This	4	4	16	CAMHS Partnership Board in place Contract review meetings with main foundation trusts Joint commissioning with local authorities		Performance updates to ICB TBC				4	4	16	(5). Quarterly **21/10/2022** Risk disaggregated from	3	3	9

NHS North East and North Cumbria corporate risk register (residual score 12 and above)

15/11/2022

NHS North East & North Cumbria

Strategic aim	Risk ref	Date identified Director Risk owner	Directorate Level of control Committee	Description	Initial C	Initial L	Initial Score	Controls	Gaps in control	Internal assurances	External assurances	Gaps in assurance	Actions Action owner Details Start date - target date Progress	Residual C	Residual L	Residual Score	Reviews	Target C	Target L	Target Score
				could also lead to damage to the ICB's reputation and there is a potential for legal challenge.																
2. Tackle Inequalities In Outcomes, Experience And Access	NENC/ 0007	06/07/2022 Jacqueline Myers Jacqueline Myers	NENC Finance Directorate NENC ICB Partial Control 2. NENC Finance, Performance And Investment Commit	Delivery of NHS Constitutional Standards. There is a risk of failure to achieve NHS Constitutional Standards for our patients. Significant pressures are evident in certain standards, particularly in respect of A&E 4 hour waits, cancer waiting times, HCAI targets and ambulance response times. Any failure to deliver the standards has the potential to adversely impact on patient care, as well as posing a reputational risk for the ICB.	4	5	20	Contract management processes in place to manage delivery of constitutional standards. Performance management processes in place Elective recovery plans have been developed with main providers.		Performance monitored by Executive Committee (ICB TBC) Performance monitored by ICB Activity monitored by ICB (TBC)				4	4	16	(5). Quarterly **15/11/2022** Richard Henderson 15/11/2022 - realigned to strategy directorate.	2	2	4
1. Improve Outcomes In Population Health And Healthcare	NENC/ 0001	06/07/2022 Aejaz Zahid Aejaz Zahid	NENC Strategy And System Oversight NENC ICB Full Control 1. NENC Executive Committee	System Resilience and Escalation Planning, business continuity and outbreak management There is a risk that a lack of robust planning for surges, business continuity incidents and outbreaks, mean that urgent and emergency care pressures increase, resulting in rises in A&E activity and multiple demands on ambulance, community, acute and primary care services, and an inability to deliver core services.	5	4	20	System-wide surge and escalation plan agreed between all stakeholders NENC ICB Business Continuity Plan Emergency Planning, Resilience and Response (EPRR) compliance Requirement for providers to notify ICB if OPEL status is escalated Place Based Delivery Urgent and Emergency Care groups		Plan reviewed and regularly tested Annual business continuity cycle Refresh BCP Annual EPRR self-assessment signed off by ICB ICB requires written report if OPEL status is escalated. Addressed in contract meetings if OPEL status is repeatedly escalated ICB escalation process (TBC)	Annual assurance undertaken by NHSE/I EPRR submission to NHSE/I			5	3	15	(5). Quarterly **06/07/2022** risk added	3	2	6
3. Enhance Productivity And Value For Money	NENC/ 0012	06/07/2022 Annie Laverty Annie Laverty	NENC People Directorate NENC ICB Full Control 1. NENC Executive Committee	Organisational development If organisational planning fails to address the need for robust leadership, engagement, partnership working and workforce development this will lead to a poorly led organisation that is unable to deliver its strategy	4	4	16	Assurance framework Staff appraisal process Statutory and mandatory training Board development sessions		Six monthly review of the assurance framework Assurance framework approved by Board Appraisal programme Personal development plans Training reports highlight non compliance CSU manages statutory and mandatory training through ESR CSU IG team arranges specialist training for Caldicott Guardian and SIRO Programme of development sessions to be devised	NHS National staff survey	Delivery of training reports to committee/groups to be agreed		4	3	12	(5). Quarterly **06/07/2022** Risk added	4	2	8
4. Help The NHS Support Broader Social And Economic Development	NENC/ 0013	06/07/2022 Claire Riley Claire Riley	NENC Corp Gov, Comms And Involvement NENC ICB Full Control 1. NENC Executive Committee	Communications and Engagement. As a result of a lack of effective engagement with partners, stakeholders and members of the public there is a risk of reduced input and buy-in for key service changes and population health management initiatives from across the system. This may result in sub-optimal service design and delivery and poor patient experience.	4	4	16	Communications and engagement strategies Active involvement in the regional Health and Wellbeing Boards Primary Care Networks are established across the region and offer additional means to promote and further enhance key messages and two way communications		Strategy approved by Board Communication and engagement strategy	Minutes from HWB meetings HWB terms of reference			4	3	12	(4). 2 Monthly **06/07/2022** Risk added	3	2	6
1. Improve Outcomes In Population Health And Healthcare	NENC/ 0026	19/10/2022 David Purdue Nicola Jackson	NENC Chief Nurse Directorate NENC ICB Partial Control 3. NENC Quality And Safety Committee	Funding allocation for Local Maternity and Neonatal System (LMNS) is guaranteed up to 22/23 but not yet agreed for future years If funding is not available or reduced for 23/24 and onwards the ICB will be faced with a decision to fund LMNS from internal funding or look to reduce the service. Some of the funding is already targeted and therefore any reduction in this funding would have a serious impact on delivery	4	3	12	Funding allocation agreed for 22/23 and although indication is that this will continue for 23/24 this has not been guaranteed.	Nationally there is uncertainty about funding for public services including the NHS leading to concerns that there could be cuts to this funding	Robust financial reporting	Financial reporting feeds into Regional Maternity Transformation team			4	3	12	(6). 6 Monthly **19/10/2022** Nicola Jackson New risk added	2	2	4

NHS North East and North Cumbria corporate risk register (residual score 12 and above)

15/11/2022

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Strategic aim	Risk ref	Date identified Director Risk owner	Directorate Level of control Committee	Description	Initial C	Initial L	Initial Score	Controls	Gaps in control	Internal assurances	External assurances	Gaps in assurance	Actions Action owner Details Start date - target date Progress	Residual C	Residual L	Residual Score	Reviews	Target C	Target L	Target Score
				of services and could lead to patient harm.																
2. Tackle Inequalities In Outcomes, Experience And Access	NENC/0006	06/07/2022 David Purdue David Purdue	NENC Chief Nurse Directorate NENC ICB Partial Control 3. NENC Quality And Safety Committee	Access to adult mental health services There is a risk that do not receive the right treatment and access to services, at the right time as a result of lack of capacity, discrepancies in treatment thresholds, poor communication and referral processes. Increased demand for services as a result of the pandemic and additional service pressures where workforce capacity is reduced contributes to the risk. This would result in patients having poor access to timely and effective treatment, or escalate to crisis. There is an an additional risk of damage to reputation damage to the ICB.	4	4	16	Standard NHS contracts in place with two main providers: Cumbria, Northumberland, Tyne and Wear (CNTW) FT and Tees Esk and Wear Valleys (TEWV) FT Regional ICS mental health workstream		Contract management process Performance management process OPEL status Minutes and actions from workstream meetings	NHS England quarterly assurance meeting Workforce planning from NHS E and providers			4	3	12	(5). Quarterly **21/10/2022** Quality and Safety Committee recommended risk be focussed on Adult MH services with new risk to capture CYP MH services (Ref NENC/0027)	4	2	8
1. Improve Outcomes In Population Health And Healthcare	NENC/0029	03/11/2022 Neil O'Brien Ewan Maule	NENC Medical Directorate NENC ICB Partial Control 3. NENC Quality And Safety Committee	Antimicrobial stewardship Reducing and preventing antimicrobial resistance is a global health priority and this is reflected in the NHS Oversight Framework and the NHS Standard Contract. There is a risk that if antimicrobial prescribing is not appropriate the risk of antimicrobial resistance is increased which threatens the effective prevention and treatment of infections	4	3	12	National guidance and supporting education are available and accessible to all prescribers. All places have a group overseeing antimicrobial prescribing and local action plans ICB wide antimicrobial stewardship group reports directly in to the HCAI board	Implementation at a practice/provider level may vary Local groups are usually secondary care led but with primary care input	Local action plans		NENC ICB is still an outlier, with all our places and all but one of our FTs failing to meet the standards set		4	3	12	(5). Quarterly **07/11/2022** Ewan Maule New risk added	3	3	9
1. Improve Outcomes In Population Health And Healthcare	NENC/0009	06/07/2022 Neil O'Brien Neil O'Brien	NENC Medical Directorate NENC ICB Limited Control 3. NENC Quality And Safety Committee	Primary care services As a result of workforce pressures, increased demand, infrastructure or technology issues, failure of or challenges to PCNs' ability to meet transformation agenda there is a risk that primary care is unable to provide long term, sustainable and reliable quality care services to patients and is not able to support people in a community based setting and provide a point of ongoing continuity of care. This could result in patient harm, increased attendance at hospital settings and compromised patient flow and damage the reputation of the ICB.	4	4	16	Workforce pressures are monitored via the Strategic Data Collection Service (SDCS) reporting system Primary Care Network (PCN) transformation agenda linked to Long Term Plan Practices now report OPEL status via UEC-RAIDR App		Monitored at Place Based Delivery primary care commissioning groups Placed based delivery primary care teams provide reactive support to practices	Strategic Data Collection Service (SDCS) reporting NHS Long Term Plan			4	3	12	(5). Quarterly **20/10/2022** David Purdue Risk reviewed at QSC.	3	2	6
1. Improve Outcomes In Population Health And Healthcare	NENC/0014	06/07/2022 David Purdue David Purdue	NENC Chief Nurse Directorate NENC ICB Full Control 3. NENC Quality And Safety Committee	Safeguarding duties Failure to comply with good clinical practice, policies and procedures, would mean that the ICB is not able to manage safeguarding duties appropriately, including deprivation of liberty safeguards, liberty protection safeguards and delivery of the learning disabilities transformation programme. This could result in the safety of vulnerable adults, young people and children being compromised, a derogation of patient care, and legal challenge resulting in both reputational and financial damage to the ICB.	4	4	16	Quality and Safety Committee Place based partnerships work with Local Safeguarding Children Boards and Local Safeguarding Adults Boards Designated and Named professions in post across Place Based Partnerships Robust Safeguarding Children/Adult Policies and Procedures in place in the ICB, provider organisations and other agencies.		Minutes from Quality and Safety Committee Minutes from LSCBs and SABs				4	3	12	(5). Quarterly **20/10/2022** David Purdue Risk reviewed at QSC	2	2	4

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1. Improve Outcomes In Population Health And Healthcare	NENC/ 0021	06/09/2022 David Purdue David Purdue	NENC Medical Directorate NENC ICB Partial Control 3. NENC Quality And Safety Committee	Risk of respiratory infections affecting public and patients' health and putting pressure on health and care services ,	4	4	16				Public Health Intelligence Health Protection Reports National Flu and COVID surveillance reports			3	4	12	(3). Monthly **20/10/2022** David Purdue Risk reviewed at QSC	3	2	6
3. Enhance Productivity And Value For Money	NENC/ 0030	11/11/2022 Claire Riley Deborah Cornell	NENC Corp Gov, Comms And Involvement NENC ICB Limited Control 1. NENC Executive Committee	Records Management No single records management system or process is used within ICB. There are potentially inconsistent versioning, templates, or documents being used. This could lead to non-conformity of the Records Management: NHS Code of Practice 2021 and consequently the Data Security and Protection Toolkit.	3	4	12	Records Management project underway to unify ICB records from former CCGs Broadcare system in place for CHC records in Newcastle Gateshead, Sunderland and the areas where NECS provides the service (Durham, Tees Valley and North Cumbria)						3	4	12	(5). Quarterly **14/11/2022** Deborah Cornell New risk entered	3	3	9
3. Enhance Productivity And Value For Money	NENC/ 0004	06/07/2022 David Chandler Richard Henderson	NENC Finance Directorate NENC ICB Partial Control 2. NENC Finance, Performance And Investment Commit	Achievement of economy, efficiency, probity and accountability in the use of resources There is a risk that the ICB does not meet its statutory financial duties. There is a risk in 2022/23 that the ICB does not achieve financial balance due to pressures in areas such as Prescribing, Packages of Care and ERF totalling c£20m There is a risk in 2022/23 that the ICS does not achieve financial balance due to pressures in addition to the above related to unfunded pay award £20m and general financial pressures in trusts such as ERF, Agency and non-delivery of efficiencies totalling c£80m.	4	4	16	Financial plan QIPP plan in place Financial reporting and monitoring process Mechanism to monitor and identify CHC packages of care, including backdated, current and future forecasted impact. Financial governance arrangements, financial policies and scheme of delegation Monthly forecasting and variance reporting and plan to date		Financial plan to show breakeven position QIPP delivery included in monthly finance reports. Monthly finance reports Process for approving packages of care in place at each Place. Scheme of Delegation approved annually Financial policies reviewed and update annually Audit committee review Reported to Finance, Performance and Investment committee.	Reported to NHSE each month. Review of position with NHSE/I			4	3	12	(5). Quarterly **15/11/2022** Richard Henderson 15/11/2022 - risk updated with assurances added to controls.	3	2	6