

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

Part 3: All Age Continuing Care Update

Date of session: 26 August 2026 | Chair: Sir Liam Donaldson | Lead: Dr Hilary Lloyd, Chief Nursing Officer

1. Purpose and context

- 1.1 This briefing followed the two scheduled sessions on strategic commissioning and quality, and on safeguarding (see the companion notes).
- 1.2 All Age Continuing Care (AACC) brings together NHS Continuing Healthcare (CHC), NHS children's Continuing Care (CCC), and Complex Care (S117 Aftercare), which had previously operated as three separate functions. The Chief Nurse introduced it as one of the ICB's most challenging areas of direct operational responsibility: high risk to access, to quality, and financially. A significant improvement programme is under way and the Board was told the ICB is in a materially better position than eighteen months ago, while a great deal remains to be done.

2. National performance

- 2.1 Performance against national key performance indicators is steadily improving and the ICB is meeting or exceeding the national average on every measured indicator, with above-average performance on indicators that carry no formal target. There is, however, unwarranted variation across the ICB's 14 local authority areas, which the improvement programme is working to address.
- 2.2 Overall CHC activity - referrals, eligibility and spend - remains among the highest nationally, attributed to the area's rural and coastal geography combined with high levels of deprivation.
- 2.3 The ICB has joined a national pilot reviewing the top 5% of people on the most restrictive packages of care (for example, packages requiring five care staff to support one individual at all times), to inform alternative commissioning models. Members were clear this is not purely a cost question: such highly restrictive packages, however necessary they may currently be, are also a quality-of-life concern for the individuals living under them, and reducing reliance on them is a matter of individualised, less restrictive care as much as of cost.

3. LeDeR reviews

- 3.1 Reviews into the deaths of people with a learning disability (LeDeR) have carried a backlog since the COVID-19 pandemic. A focused 14-week recovery programme aims

to clear the backlog of 155 reviews and complete a further 116 reviews due by the end of December 2026; 40 of the 155 backlog reviews were completed within the programme's first two weeks.

- 3.2 A small number have been paused where the death is subject to an ongoing coroner's investigation. Progress is reported weekly to the executive team, reflecting the Board's earlier discussion (see the Part 1 note) that learning from mortality reviews is a core quality assurance requirement, not an optional extra.

4. Local performance and current risk areas

- Disputes: the backlog has been cleared and the volume of new disputes significantly reduced, following a concerted effort to resolve outstanding cases without recourse to legal challenge.
- Discharge to Assess (D2A): long waits for assessment in D2A beds have been largely resolved, protecting the Better Care Fund and helping to restore relationships with local Directors of Adult Social Care.
- Complaints: a structured triage and prioritisation process is now in place, with enhanced oversight of higher-risk concerns (staff behaviour, communication, professional conduct, patient experience and safety); the ICB is benchmarking its complaint volumes against other ICBs to establish whether it is an outlier.
- Appeals and previously unassessed periods of care (PuPoC): this remains the most significant area of risk. Appeals handling had been paused for a considerable period through successive restructures, which has driven complaint volumes up; a recovery plan is being developed, and additional case-management capacity has been procured, with mobilisation expected within five weeks. There is a material financial exposure attached to unassessed historical periods of care.
- Efficiency savings: 31% of the year-to-date cost improvement target has been delivered, with financial risk concentrated in the appeals and PuPoC workstream.

5. Learning from complaints

- 5.1 128 complaints were recorded in 2025/26, the largest categories being challenges to eligibility decisions and the appeals process (35), case management (25), communication (23), delay (14) and staff attitude and behaviour (11).
- 5.2 Risk-led triage now identifies and escalates higher-risk complaints promptly; clearer, standardised appeals information is being developed to reduce complainant confusion and free up investigating officer capacity for cases requiring detailed investigation; seven-minute briefings share key learning points with teams; and themes are reviewed quarterly in senior leadership forums. The Chief Nurse noted that many complaints could be prevented through better local resolution at first contact and that staff experience is fed back into reflective and restorative supervision alongside this work.

6. Workforce and culture

- 6.1 The Chief Nurse was candid that the AACC workforce has for some time been under-resourced and overworked, with resulting gaps in capability and capacity, compounded by the absence of any national training and development pathway specific to all-age continuing care. An independent cultural review is under way, led by an external facilitator running staff focus groups, with a report due by mid-September; the Chief Nurse has deliberately asked for a small number of immediately actionable points rather than a long list of recommendations requiring further months of work to implement.
- 6.2 Opening up an honest, open culture has had the effect that staff are now voicing concerns more freely across the board - a positive development that nonetheless needs to be channelled into supportive but candid team-level conversations rather than becoming unmanageable, alongside a restorative rather than punitive approach to raising concerns.
- 6.3 The Chief Nurse also flagged, as a wider system point, that ICB nursing and allied health professional staff do not receive the continuing professional development funding (around £1,000 per clinician every three years) that colleagues in NHS provider organisations receive, a gap she attributed to how funding was originally allocated nationally.

7. Discussion themes

7.1 External dependency and the case for proactive commissioning

- 7.1.1 Members noted that outcomes are frequently constrained by factors outside the ICB's direct control - for example, delays where local authority housing providers are not yet on a commissioning framework, illustrated by a case in which a patient spent an extended period in hospital awaiting a suitable placement.
- 7.1.2 There was broad agreement that the most complex and restrictive packages of care (such as 5:1 support) will sometimes remain unavoidable, and that the priority is to shift from reactive, crisis-driven commissioning of these packages toward proactive market engagement - identifying likely future need and shaping suitable, quality-assured provision in advance, which members noted tends to be both cheaper and better quality than commissioning under pressure.

7.2 Growth in context

- 7.2.1 Members observed that ICB and predecessor spend on all-age continuing care was minimal two decades ago and has grown very substantially since, largely displacing inappropriate hospital-based care - a positive underlying shift, even though the pace of growth means the system is still working to catch up with it.
- 7.2.2 Workforce was reported to have been actively protected through a period in which other areas absorbed substantial staffing cost reductions, with a shift over time toward delivering more services in-house rather than through external providers, although vacancies and capacity pressures remain.

7.3 Tension with local authority partners over cost allocation

- 7.3.1 A significant and growing source of friction was described as the ICB has become more timely in completing statutory eligibility reviews, some individuals who had previously remained on NHS-funded packages of care for longer than they were eligible are now correctly transferring to local-authority-funded care. This has produced a reported 26% year-on-year increase in local authority AACC-related costs, which some local authority partners have characterised as the ICB "cost-shunting" onto them, rather than as a correction of previous over-provision, underlining a structural tension in how the two systems' finances interact as both face growing pressure.
- 7.3.2 The Board's stated approach is to manage this transparently, sharing data openly with partners on what is being spent and why, rather than allowing the disagreement to be conducted through assertion alone.

7.4 Operational improvement: shared IT systems

- 7.4.1 For the first time, all continuing healthcare teams are now working on a single, shared IT system, replacing a previously fragmented set of systems - a practical step expected to support more consistent practice and reporting across the footprint.

7.5 The emotional and reputational load on assessing staff

- 7.5.1 Members discussed the particular strain on staff who carry out eligibility assessments - applying robust criteria, including declining eligibility, in emotionally difficult conversations with families, sometimes resulting in staff experiencing abuse. This workforce was described as relatively "hidden" within the wider NHS nursing workforce, reinforcing the case for the cultural and developmental work already under way.

7.6 Housing as a lever to reduce future demand

- 7.6.1 A recently announced national funding programme for council and social housing (with a substantial allocation reported for Newcastle) prompted discussion of whether the ICB could influence the specification of new housing stock - for example, building in supported-housing provision suitable for people with complex needs - to reduce future reliance on hospital and high-cost care packages.
- 7.6.2 Members cited a specific local example where a local authority reported no available suitable housing for a person with a learning disability awaiting hospital discharge, while a housing association contact separately confirmed it held vacancies of exactly that kind in the same area - illustrating a disconnect in how housing need and supply are currently being matched. A previous, only partially funded round of capital bids for supported housing (concentrated in Durham and Hartlepool) was identified as a starting point that could be revisited for the new funding round.
- 7.6.3 Members agreed the housing link should be raised at local, regional and national level, including in connection with NHS England's New Hospital Programme, with

one member volunteering to lead a more coordinated approach to making the case.

8. Closing note

- 8.1 The Chair thanked the Chief Nurse for what he described as a clear and well-scoped account of the problem, the progress made, and the direction of travel, and closed what had been an addition to the planned programme as a valuable extension of the day's discussions. This was the third and final item of the development day; the companion notes to this set cover the two scheduled sessions on strategic commissioning and quality, and on safeguarding.