NHS
North East and
North Cumbria

Board Meeting (in public)

MEETING

25 July 2023 10:30 BST

PUBLISHED
18 July 2023

Agenda

Location	Date	Time
The Auditorium, The Durham Centre, Belmont, DH1 1TN	25 Jul 2023	10:30

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1	Welcome and introductions	Chair	10:30	-
2	Apologies for absence	Chair		-
3	Quoracy	Chair		-
4	Declarations of Interest	Chair		-
4.1	A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship. In some circumstances, it could reasonably be considered that a conflict exists even when there is no actual conflict. In these cases it is important to still manage these perceived conflicts in order to maintain public trust			-
5	Minutes of the previous Board Meetings	Chair	10:35	-
5.1	30 May 2023			4
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6	Action log	Chair		28
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8	Chief Executive's Report	Chief Executive	10:45	29
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9.1	Integrated Delivery Report	Executive Chief of Strategy and Operations	11:30	47
9.2	Finance Report	Executive Director of Finance	11:45	83
10	Review of the Spring Covid Immunisation Programme (presentation)	Executive Medical Director	12:00	-
	BREAK		12:15	-
11	North East Ambulance Service (NEAS) Independent Investigation Report	Chief Executive / Executive Chief Nurse	12:35	103
12	Governance and Assurance			-
12.1	Governance Handbook (issue 7)	Executive Director Corporate Governance, Communications and Involvement	13:35	205

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12.2	Highlight reports and confirmed minutes of the Committees of the Board			-
12.2.1	Executive Committee - confirmed minutes 9 May and 13 June 2023	Committee Chair	13:40	294
12.2.2	Quality and Safety Committee (presentation only)	Committee Chair	13:45	-
12.2.3	Finance, Performance and Investment Committee - confirmed minutes 4 May 2023	Committee Chair	13:50	330
12.3	Questions from the Public on Items on the Agenda	Chair	13:55	-
13	Any Other Business from Members	Chair		-
14	Close	Chair	14:00	-

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NHS
North East and North Cumbria

North East and North Cumbria Integrated Care Board

Minutes of the meeting held on 30 May 2023 at 10:30, The Durham Centre, Belmont

Present:

Professor Sir Liam Donaldson, Chair
Samantha Allen, Chief Executive
Dr Hannah Bows, Independent Non-Executive Member
Ken Bremner, Foundation Trust Partner Member
David Chandler, Executive Director of Finance
David Gallagher, Executive Area Director (Central and South)
Professor Graham Evans, Executive Chief Digital and Information Officer
Tom Hall, Local Authority Partner Member
Annie Laverty, Executive Director of Improvement and Experience
Dr Saira Malik, Primary Medical Services Partner Member
Jacqueline Myers, Executive Chief of Strategy and Operations
Dr Neil O'Brien, Executive Medical Director
David Purdue, Executive Chief Nurse
Jon 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:

Deborah Cornell, Director of Corporate Governance and Board Secretary (deputising for Executive Director Corporate Governance, Communications and Involvement)
David Thompson, North East and North Cumbria Healthwatch Network Representative
Toni Taylor, Governance Officer (minutes)

The following colleagues were in attendance for item B/2023/08

Joseph Chandy, Director of Transformation (Primary Care)
Vanessa Connor, North Cumbria Integrated Care NHS Foundation Trust
Helena Gregory, Pharmacy and Medicines Lead
Edward Kunonga, Director of Population Health and Improvement

Item: 5.1

B/2023/01 Welcome and Introductions

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

The following individuals were in attendance under public access rules:

- Adam Brown, NHS Engagement Manager
- Stephen Doyle, Healthcare Partnership Manager, Pfizer Biopharmaceuticals Group
- Michelle Hudson, Coloplast Wound Care
- Dr Fadi Khalil, Medical Director, All Together Better Sunderland
- Gavin Morris, Regional Lead for Healthcare, Virgin Media O2 Business
- Roger Nettleship, Resident of South Tyneside
- Carolyn Smith, Senior Healthcare Partnership Manager, Pfizer Internal Medicine

The Chair made special mention to four members who were stepping down from the Board:

- Ann Workman, Local Authority Partner Member
- Cllr Shane Moore, Local Authority Partner Member
- David Thompson, Healthwatch Representative
- Jane Hartley, Voluntary and Community Sector Representative

The Chair thanked the members for their valuable input and service to the North East and North Cumbria Integrated Care Board.

New members of the Board will be identified subject to a selection and appointments process.

B/2023/02 Apologies for Absence

Apologies were received from Levi Buckley, Executive Area Director (North and North Cumbria), Catherine McEvoy-Carr, Local Authority Partner Member, Dr Rajesh Nadkarni, Foundation Trust Partner Member, Claire Riley, Executive Director of Corporate Governance, Communications and Involvement, Jane Hartley, Voluntary Organisations' Network North East (VONNE), Councillor Shane Moore, Local Authority Partner Member, Ann Workman, Local Authority Partner Member, Professor Eileen Kaner, Independent Non-Executive Member.

B/2023/03 Declarations of Interest

Members had submitted their declarations prior to the meeting which had been made available in the public domain.

A conflict under item 9.2.1 was noted with regards to Foundation Trust Partner Member, Ken Bremner.

Dr Hannah Bows highlighted a conflict under item 7 with regards to Dentistry Services, stating her spouse is a dentist.

The Chair noted the declarations but deemed it not to be material and therefore both members were able to take part in the discussions.

B/2023/04 Minutes of the previous meeting held on 28 March 2023

RESOLVED:
The Board **AGREED** the minutes from the meeting held on 28 March 2023 were a true and accurate record.

B/2023/05 Action log

There were no further updates to the action log.

B/2023/06 Matters arising from the minutes

There were no matters arising from the minutes.

B/2023/07 Chief Executive's Report

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

Financial Position
Overall, our growth in funding has been reduced by £19m this year and, as a result of a changing funding formula before Covid, it has been judged that the region has received too much funding in recent years – to rectify this position decisions have been made which see an overall reduction of the ICBs funding allocation to pay back what is deemed as an overpayment in funding and enable this to be redistributed to other parts of the country who may be seeing a growth in an ageing population. Over the past two years this has reduced funding by £100m and next year it is anticipated that a further loss of £60m will be seen.

Overall, a plan has been agreed which will see the system with a deficit plan of £49.9m by the end of the year.

It was noted that efficiency targets for all our providers ranging between 4% and 5.7% have been agreed; the development of a medium-term financial recovery plan for the next three years is a priority.

NHS Dentistry

The ICB took responsibility for the commissioning of NHS dentistry on 01 April 2023 with staff being TUPE transferred from NHS England to support this work as from 01 July 2023.

It was reported that significant concern has been expressed nationally, regionally and locally across the North East and North Cumbria in relation to the dissatisfactory situation regarding oral health and the immense challenges to the delivery of and access to NHS dentistry services. There is a clear need to review the current position across the region to inform a coherent strategy to manage the many challenges and opportunities.

The objectives of this initial work were noted as follows:

- To bring together existing intelligence and to work with key partners across the North East and North Cumbria to develop an in-depth understanding of the current issues regarding oral health and the commissioning and provision of oral health and care services. This is to include the views of residents and partners and an evaluation of current services

- Make recommendations which are aligned to our Better Health and Wellbeing for All Strategy, confirming both the strategic ambition and key actions to be delivered.

This review will report to the Executive Committee of the North East and North Cumbria Integrated Care Board no later than October 2023, the outcomes of which will inform future Board reporting. It was suggested that there may need to be further detailed work carried out which will be informed by the preliminary findings.

Given the immediate challenges there are some early steps that can be taken such as a campaign to ensure the public are aware of how and where to get help alongside influencing more broadly public behaviours regarding oral health.

ACTION:
The outcomes of the review of oral health to be reported to the Board in November 2023.

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

B/2023/08 Primary Care

The Executive Area Director (Central and South) and the Director of Transformation (Primary Care) presented General Practice in North East and North Cumbria to the Board.

The Integrated Care Board commissions primary care services under delegation from NHS England, working within a number of national regulations:

- Medical Services (General Practice)
- Dental Services
- Ophthalmic Services
- Pharmaceutical Services

The Board received an update on the respective areas as follows:

Medical Services (General Practice)

North East and North Cumbria have 347 practices in total, which are organised into 67 primary care networks.

Care Quality Commission ratings May 2023 unveiled that:
38 practices rated outstanding
304 rated good
4 required improvements
1 rated inadequate

Access to general practice in the North East and North Cumbria is compared favourably to the England average with 559 appointments per 1000, compared to the national average of 509.

General practice has overcome a number of challenges, specifically throughout the pandemic, and has successfully delivered the covid vaccination programme, post covid recovery and access to more GP appointments, flu vaccinations and provided greater digital opportunities.

NHS England's plan to recover access to primary care in England will introduce targets for improvement by March 2024, namely:

- 50 million appointments
- 6,000 new GPs
- 26,000 additional roles in general practice
- Tackle the "8am rush" and people experiencing difficulties contacting their practice
- Patients know on the day they contact their practice how their care will be managed

The plan includes four steps to recovery:

1. Empowering patients
2. Modern general practice access
3. Building capacity
4. Cutting bureaucracy

It was reported that there has already been significant investment in general practice to develop additional roles such as social prescribers, adult mental health practitioners and clinical pharmacists. This enables patient's to be signposted to the most appropriate primary care professional, whilst keeping GPs free to treat those with more specialist ongoing care needs.

Pharmaceutical Services

There are 650 community pharmacies across North East and North Cumbria, regulated by the General Pharmaceutical Council.

The Primary Care Access Recovery Plan provides the sector with significant challenge, by:

- Expanding 'Pharmacy First' role in the Recovery Plan – to be launched nationally by October 2023
- Expanding role of community pharmacy in independent prescribing for minor conditions and oral contraception
- Expanding list of minor conditions (UTI) which is successful in the North East and North Cumbria with short term funding; blood pressure monitoring, shingles, earache, sore throats etc.
- Workforce reform
- Potential hub and spoke model of dispensing.

Based upon data to the end of February 2023, the North East and North Cumbria prescribe more and spend more than the England average (6.42% year on year increase, versus 7.3% nationally).

The Board was advised that pharmacies are bound by a national contracting and funding model and noted that unplanned closures in addition to announced closures is a risk. Healthwatch England are working with the Integrated Care Board regarding potential pharmacy closures.

Primary and Secondary Care

There are opportunities to improve working between primary and secondary care:

- Production of one formulary for the ICS to be hosted on one website
- Development of one governance system for medicines within the ICS
- Trials of electronic transfer of prescriptions from hospitals within our ICS
- New perspectives on prescribing budgets and data sets.

Integrated Care Communities

North Cumbria has been divided into eight integrated care communities. By understanding the challenges that each area faces it is hoped that the community can work together with health and

care organisations to improve the health and wellbeing of local people.

A patient story was shared with the Board and highlighted the 17 different professionals the patient had contacted. This highlighted the complexities included within pathways and patient journeys.

Deep End Practices

Deep End Network is a national initiative with aims to engage general practitioners to change the way primary care is delivered in areas of blanket socioeconomic deprivation.

The Healthier and Fairer workstream has secured funding for deep end practices to enable an understanding of the different issues across the North East and North Cumbria and to give them some freedom to develop local action plans with some additional resource and the support of a community and practice approach, whilst learning from each other.

Data is being used to understand the disproportionate challenges patients face.

Primary Care Forward Plan

The developing Primary Care Forward Plan in the North East and North Cumbria includes five priorities, namely:

1. Resilience and suitability
2. Access
3. Integration
4. Workforce, Estates and Digital
5. Pharmacy, Optometry and Dentistry.

General practice continues to develop as a key component of care 'from cradle to grave'.

The Board received the presentation with thanks and acknowledged the importance to support the core purpose of general practice 'cradle to grave care'.

Discussion took place around current work underway with regards to the transformation of primary care.

Patient involvement

It was noted Healthwatch still receives a significant amount of communication regarding issues relating to access to primary care.

The NHS Choice Framework has been a national policy for the last 10 years and sets out some of the choices available to patients. NHS England, as part of the elective recovery plan, is reinforcing the framework to ensure choice is opened up for patients across all specialisms enabling the individual to choose their provider. It was reported that the ICB will be working with the Provider Collaborative

and colleagues on how to refresh plans to meet these national requirements.

Workforce

The Better Health at Work initiative is being rolled out across primary care which was previously not accessible to general practice staff. This enables them to nominate champions within practices on topics such as male health and mental health and allows opportunity to support staff and their wellbeing,

There are a number of initiatives funded by the System Development Funding looking at support for general practitioners and other clinicians to take time out for mentoring and supervision.

There is also a career start nursing scheme which encourages nurses in other parts of the NHS to retrain.

A place based clinical leadership structure is also in place.

National consideration is being given into including general practice staff, for the first time, in the NHS staff survey.

In terms of public communication, it was recognised that there is currently a considerable amount of negative press regarding general practice; however, the ICB will look at promoting the positive aspects of general practice, which would help and support the workforce.

Data and Digital

A great amount of data and information is available and some of the metrics reviewed by the ICB focusses specifically on quality performance. There is an opportunity for the ICB to start looking at data in a more rational way to enable a supportive approach to general practice, highlighting early warning signs and preventing practices getting to crisis point.

Pathways

Hospital pathways creates connectivity between consultants and general practices on a formalised basis. Work is underway to look at the complexities and improve pathways looking at continuity of care and reducing the number of visits for patients.

It was emphasised that collaboration is the future for the transformation of primary care services and that there is opportunity to explore working more closely with secondary care colleagues.

Diagnostic Tests

There is a variation in diagnostic testing across the North East and North Cumbria - an active piece of work is underway with the Diagnostic Network engaging with Foundation Trust providers.

ACTION:
Executive Medical Director to present the findings of this piece of work at a future Public Board.
RESOLVED:
The Board **RECEIVED** the presentation.

B/2023/09 Integrated Delivery Report

The report provided an Integrated Care System overview of quality, performance and highlighted any significant changes, areas of risk and mitigating actions as well as an overview of the Integrated Care System position on the NHS Oversight Framework and Care Quality Commission ratings of organisations.

It was noted that the format and content of the report is currently under review and further development is planned.

Key points were highlighted as follows:

NHS England Escalation
Two very positive changes in escalation in April:

- County Durham and Darlington NHS Foundation Trust were initially placed in Tier 2 for elective care in January 2023 as the trust was significantly behind plan on eliminating 78 week waits. The trust had a range of schemes in place and made significant progress to successfully deliver their plan of 0 at the end of March 2023. In addition, at the April Tier 2 meeting the trust outlined their plans to sustain the 78-week waiting position for 23/24 and to eliminate 65-week waiters. The ICB and NHS England felt assured that the plan was deliverable, and the trust has subsequently been removed from Tier 2.

- Newcastle Upon Tyne Hospital was placed in Tier 2 for cancer backlog in summer 2022, a significant amount of work has been undertaken since then and the trust successfully delivered within their plan at the end of March 2023. A cancer plan is in place for 2023/34 with support from the Northern Cancer Alliance; the trust has been removed from Tier 2 for cancer.

Accident and Emergency 4-hour target
Slight deterioration in performance. March 23 data shows A&E performance for England remained at 71.5%, however North East and North Cumbria performance dipped to 75.2% (from 76.7% the previous month). North East and North Cumbria continue to perform above the national position however the ICS rank position has deteriorated and North East and North Cumbria have moved from the top 25% to the upper middle 25%, ranking 14th (compared to 8th the previous month).

Cancer
As an Alliance/ICB the 28-day faster diagnosis (FDS) standard has been achieved in all eight Trusts for the first time and as a system achieved over 80% (local ambition), also for the first time.

78+ and 104+ waiters
Significant improvement has been made within Trusts during Q4 of 22/23 regarding the reduction of long waiters. Although the national ambition was not reached to eliminate 78+ and 104+ waiters within 22/23, North East and North Cumbria met the planned trajectories of 21 104+ waiters (30 plan) and 163 78+ waiters (180 plan) at the end of March 23. Plans are in place to eliminate all 78+ and 104 + throughout 23/24.

NHS England Escalation – urgent and emergency care
NHS England will be introducing a tiering system for urgent and emergency care (UEC) similar to the existing system for elective care. However, for UEC, ICBs will be allocated to Tiers rather than trusts. Like elective, Tier 1 involves national support and Tier 2 regional support from NHS England. It was confirmed that North East and North Cumbria ICB has not been recommended for Tiers 1 or 2 support.

Oversight Framework Metrics
It was raised that the performance measured against the oversight framework metrics was not clear in the report. Future reports will seek to make this clearer.

Infection Prevention Control
It was noted that this metric had worsened. Three deep dives had been undertaken in individual trusts to look at infection prevention control and the learning from these will be presented at a future Quality and Safety Committee.

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

B/2023/10 Finance Report

The Executive Director of Finance provided an update on the financial performance of the Integrated Care Board and Integrated Care System for the period to 31 March 2023. The Board noted the following key points:

ICB duty to break-even
As of 31 March 2023, the ICB is reporting an outturn surplus of £2.7m for the period (consistent with forecast reported last month

and in line with plan). This position remains subject to audit, with final accounts due to be signed in June 2023.

ICS duty to break-even
From an ICS perspective the outturn position is a surplus of £58.2m. NHS England has accepted technical adjustments in relation to this and does not pose any risk to the ICB due to break even this year.

ICS capital position
The ICS is reporting an outturn underspend against the confirmed ICS capital departmental expenditure limit (CDEL) of £5m.

ICB running costs
An outturn underspend has been delivered on ICB running costs, largely due to the impact of vacancies in the current year.

RESOLVED:
The Board **NOTED** the outturn financial position for 2022/23.

B/2023/11 ICB and ICS Financial Plan 2023/24

The paper provided the final financial plan for both the ICB and wider ICS for 2023/24, including a summary of changes made since the draft plan was presented to the Board previously.

The financial plan was submitted to NHS England on 4 May 2023 following agreement by the Chief Executive and Executive Director and Finance under delegated authority.

ICB duty to break-even
The final submitted financial plan for the ICB for 2023/24 shows a surplus position of £32.4m.

ICS duty to break-even
The final overall ICS position is a deficit plan of £49.9m (0.7% of funding).

ICS capital position
Total capital funding allocation for 2023/24 amounts to £213.9m (£208.4m provider capital and £5.5m ICB capital allocation). This has increased by £10m from the position presented on 28 March 2023 following an additional capital allocation relating to required remedial works at one provider trust building.

Included within the ICB plan are a number of contracts/agreements with values in excess of £30m, listed in appendix 1 of the report. These comprise of contracts with local NHS Foundation Trusts (within the ICS), together with certain Section 75 Agreements with local authorities which are above £30m.

It was confirmed that these have all been agreed by Executive Committee as part of wider contract mandate approvals, but those contracts above £30m required approval by the Board in line with ICB delegated financial limits.

RESOLVED:
The Board **APPROVED** the final ICB and ICS financial plan for 2023/24, including those contracts which are above £30m as per appendix 1 in the report.

B/2023/12 Board Assurance Framework

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. The BAF is intended to provide a visible strategic risk summary, supported by the full detail of the corporate risk register.

The BAF was reviewed by the Executive Committee at its meeting held on 9 May 2023. As a result of the discussion the format of the BAF will be revised to help provide a more transparent and visual overview of the ICB's current position.

Further work is also being undertaken to continue to develop and embed the ICB's risk management approach and establish the ICB's overall risk appetite as well as individual appetites for each of the four main goals of the ICP strategy. This work will continue over the coming months and a further updated BAF will be brought back to the Board in September.

RESOLVED:
The Board **RECEIVED** the updated Board Assurance Framework for 2023/24 for assurance that it accurately reflects the strategic risks to achieving our objectives.

B/2023/13 Governance Handbook (issue 6)

As part of a process of ongoing review of the documents within the Governance Handbook, further amendments had been identified to ensure the documents remain fit for purpose.

The Board was asked to note the proposed changes to the governance documents and approve the updated versions for insertion into the Governance Handbook (issue 6) as follows:

- Scheme of Reservation and Delegation version 4.0
- Quality and Safety Committee terms of reference version 3.0
- Finance, Performance and Investment terms of reference – minor amendment.

It was noted, a further amendment was to be made to the Quality and Safety Committee terms of reference to include the Executive Director of Improvement and Experience in the membership.

The Board was also asked to approve the establishment of the Mental Health, Learning Disability and Autism Sub-Committee and associated terms of reference version 1.0.

RESOLVED:
The Board **NOTED** the proposed changes to the governance documents and **APPROVED** the updated versions for insertion into the Governance Handbook (issue 6).

The Board **APPROVED** the establishment of the Mental Health, Learning Disability and Autism Sub-Committee and associated terms of reference version 1.0.

B/2023/14 Constitution

The Constitution and supporting documents set out the framework for the ICB to delegate decision-making authority, functions and resources. The Constitution is fully compliant with NHS England requirements and was formally approved by NHS England on 27 May 2022. It was subsequently updated and approved by the Board at its meeting on 29 November 2022 and approved by NHS England on 22 December 2022.

The Board was advised that a further update is required following the constitutional changes to the establishment of the two unitary Local Authorities, Cumberland, Westmorland and Furness as from the 1 April 2023. The revision of the Constitution document reflects this change along with a small number of other minor amendments required.

A further update was noted under 2.2.3 to reflect the addition of a fifth Non-Executive Director role within the Board membership.

ACTION:
Section 2.2.3 of the Constitution to be updated to reflect the addition of a fifth Non-Executive Director role before submission to NHS England.

RESOLVED:
The Board **APPROVED** the amendments to the Constitution and **AGREED** the submission to NHS England for formal approval.

B/2023/15 Highlight Report and Minutes from the Executive Committee meetings held on 14 March and 11 April 2023

An overview of the discussions and decisions from the Executive Committee meetings held on 14 March and 11 April 2023 was provided.

The Board's attention was drawn to the following key points:

- Complex care packages
- 2023/24 operational plan submission
- Voluntary, Community and Social Enterprise Sector (VCSE) Engagement & Infrastructure Review
- Primary care workforce underspend

The Committee undertook an annual review of its effectiveness against its terms of reference to ensure delivery of the committees required roles and responsibilities for the period 1 July 2022 – 31 March 2023. The report presented to the Board included a review of attendance and any key issues and will be used to inform the accountability report within the ICB annual report for 2022-23.

RESOLVED:
The Board **RECEIVED** the highlight report and confirmed minutes from the meetings held on 14 March and 11 April 2023 for assurance.

The Board **RECEIVED** the Committee annual review for 2022/23 for information and assurance.

B/2023/16 Highlight Report and Minutes from the Quality and Safety Committee held on 15 December 2022 and 16 February 2023

An overview of the discussions at the meeting of the Quality and Safety Committee held in May 2023 and approved minutes from the meetings held on 15 December 2022 and 16 February 2023 was provided.

The Board's attention was drawn to the following key points:

- Patient Voice Subgroup terms of reference were agreed, which was established as a formal sub-group of the Quality and Safety Committee.

- Annual Review of the Committee was undertaken and the agenda re-shaped into three key aspects: patient safety, patient experience and clinical effectiveness.

RESOLVED:
The Board **RECEIVED** the highlight report for May 2023 and the approved minutes for the Committee meetings held on 15 December 2022 and 16 February 2023 for assurance.

The Board **RECEIVED** the Committee annual review for 2022/23 for information and assurance.

B/2023/17 Highlight Report and Minutes from the Finance, Performance and Investment Committee held on 5 January 2023, 2 February 2023 and 2 March 2023.

An overview of the discussions and decisions at the Finance, Performance and Investment Committee meetings held on 5 January, 2 February and 2 March 2023 was presented.

Significant work is being carried out to develop financial and operation plans 2023/24 within timescales.

RESOLVED:
The Board **NOTED** the contents of the highlight report and **RECEIVED** the confirmed minutes meetings held on 5 January 2023 and 2 February 2023 for assurance.

B/2023/18 Questions from the Public on Items on the Agenda

A question was received from Keep Our NHS Public North East (KONPNE).

"Keep Our NHS Public North East (KONPNE) is a group of people who strongly believe that the NHS should remain a public service.

Members of KONPNE are very concerned to read in the North East North Cumbria ICB: Integrated Delivery Report February 2023 (Agenda Item 8.1) that a number of services within the ICS are inadequate, according to the CQC.

We are aware that the Board have noted this. Please detail, specifically, what the Board's plans are for addressing this situation, given the requirement for the ICB to meet an overall efficiency target of £48.4 million."

In response, it was noted none of the 11 provider organisations in the ICB are rated as inadequate overall.

A recent inspection of North East Ambulance Service's (NEAS) rated the organisation as inadequate for Well Led but overall, as requires improvement. NEAS are being supported by the ICB to work through the actions identified by the Care Quality Commission.

ACTION:
A written response to be sent to Keep Our NHS Public North East (KONPNE) within 20 working days.

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B/2023/19 Any other business

There were no other items of business.
The meeting closed at 13:35

Item: 5.2

NHS
North East and North Cumbria

North East and North Cumbria Integrated Care Board

Minutes of the Extraordinary meeting held on 22 June 2023 at 14:00, Joseph Swan, Pemberton House / Microsoft Teams

Present:
Professor Sir Liam Donaldson, Chair
Samantha Allen, Chief Executive
Dr Hannah Bows, Independent Non-Executive Member
Ken Bremner, Foundation Trust Partner Member
Levi Buckley, Executive Area Director (North and North Cumbria)
David Chandler, Executive Director of Finance
Professor Eileen Kaner, Independent Non-Executive Member
Annie Laverty, Executive Director of Improvement and Experience
Dr Saira Malik, Primary Medical Services Partner Member
Catherine McEvoy-Carr, Local Authority Partner Member
Jacqueline Myers, Executive Chief of Strategy and Operations
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
Jon 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:
Richard Henderson, Director of Corporate Finance
Toni Taylor, Governance Officer (minutes)

B/2023/20 Welcome and Introductions

The Chair welcomed members to the extraordinary meeting of North East and North Cumbria Integrated Care Board.

The Chair confirmed the meeting to be quorate.

B/2023/21 Apologies for Absence

Apologies were received from David Gallagher, Executive Area Director (Central & Tees Valley), Professor Graham Evans, Executive Chief Digital and Information Officer, Tom Hall, Local Authority Partner Member, Deborah Cornell, Director of Corporate Governance and Board Secretary, David Thompson, Healthwatch.

Item: 5.2

B/2023/22 Declarations of Interest

Members had submitted their declarations prior to the meeting which had been made available in the public domain.

There were no declarations raised.

B/2023/23 CCG Annual Reports and Accounts 2022/23

The Executive Director for Corporate Governance, Communications and Involvement and the Executive Director of Finance presented the annual reports and accounts for three of the former CCG's covering the three-month period to 30 June 2022:

- County Durham CCG
- Tees Valley CCG
- North Cumbria CCG

The annual reports and accounts for all eight former CCGs had been prepared and are currently being audited by three audit firms (Ernst & Young, Grant Thornton, Mazars).

The reports had been prepared in accordance with the guidance issued by NHS England and the information included had been prepared by the relevant subject matter experts.

The annual reports and accounts for County Durham CCG, Tees Valley CCG and North Cumbria CCG, were presented to the Board for approval to allow Mazars, as auditors of the ICB, to gain access to their audit files before giving an opinion on the ICB annual report and accounts.

A summary of changes to the annual reports and accounts since circulation to the Board in readiness for the extraordinary meeting were noted as follows:

County Durham CCG:

<u>Annual Report</u>

- Formatting of contents page to highlight sections and sub-sections, removed duplicate reference to audit report
- Page 17 - slight amendment to narrative on national staff survey
- Page 114 - amendment to narrative following change in disclosure guidance for All pensions related benefits.

<u>Annual Accounts</u>

- Page 145 - Related parties, amendment to headers and values due to change to accruals basis (still subject to review, updated WP shared)

Tees Valley CCG:

Annual Report

- Formatting of contents page to highlight sections and sub-sections, remove duplicate reference to audit report
- Page 40 - removed paragraph referring to the 'annual audit plan' not relevant
- Page 46 - performance updated following refreshed information
- Page 86 - updated paragraph for disclosure of information to auditors
- Page 111 - VFM narrative updated
- Page 123 - amendment to narrative following change in disclosure guidance for All pensions related benefits
- Page 124 - disclosure amended to -4.24% average % change
- Page 124 - disclosure includes 'increase' in prior year % for clarity to reader
- Page 129 - number of employees updated and staff turnover % following HR review.

Annual Accounts

- Page 145 - Related parties, amendment to headers and values due to change to accruals basis.

North Cumbria CCG

Annual Report

- Page 84 - added comparator table re % change in remuneration of highest paid Director
- Page 83 - added extra note on pensions table re McCloud judgement.

The annual report and accounts for the remaining five CCGs, along with the ICB annual report and accounts will be presented to Board on 27 June 2023 for approval.

RESOLVED:
The Board **REVIEWED** and **APPROVED** the annual reports and accounts for the three former CCGs - County Durham CCG, Tees Valley CCG and North Cumbria CCG, for the three-month period to 30 June 2022.

The Board **AGREED** delegated authority for the ICB Chief Executive and Executive Director of Finance to agree any final amendments to the annual report and accounts with the ICB Audit Committee Chair.

Item: 5.2

B/2023/24 External Audit

The Executive Director of Finance presented the external audit completion reports for the audit of three of the former CCG accounts for the three-month period to 30 June 2022; County Durham CCG, Tees Valley CCG and North Cumbria CCG.

Given the reduced materiality for the three-month period (effectively a quarter of usual materiality levels) there is an increased risk of material misstatements being identified.

The majority of audit work had been completed and remaining outstanding areas are being progressed as priority.

RESOLVED:
The Board **NOTED** the status of each respective audit and considered the findings within the reports. The Board **NOTED** that certain areas of audit work remain in progress and final reports will be provided as soon as available.

B/2023/25 Internal Audit

The Head of Internal Audit, AuditOne, presented the report which detailed the final Head of Internal Audit Opinion for the ICB predecessor CCGs; County Durham, Tees Valley and North Cumbria covering the period 1 April – 30 June 2022.

The final opinion for each CCG provided an overall assurance level of Substantial Assurance.

RESOLVED:
The Board **RECEIVED** the opinions for information.

B/2023/26 Any other business

There were no other items of business.

The meeting closed at 14:10

Item: 5.3

NHS
North East and North Cumbria

North East and North Cumbria Integrated Care Board

Minutes of the Extraordinary meeting held on 27 June 2023 at 13:55, The Durham Centre, Belmont

Present:
Professor Sir Liam Donaldson, Chair
Samantha Allen, Chief Executive
Dr Hannah Bows, Independent Non-Executive Member
Levi Buckley, Executive Area Director (North and North Cumbria)
David Chandler, Executive Director of Finance
Professor Eileen Kaner, Independent Non-Executive Member
Professor Graham Evans, Executive Chief Digital and Information Officer
David Gallagher, Executive Area Director (Central and Tees Valley)
Tom Hall, Local Authority Partner Member
Annie Laverty, Executive Director of Improvement and Experience
Dr Saira Malik, Primary Medical Services Partner Member
Jacqueline Myers, Executive Chief of Strategy and Operations
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
Jon Rush, Independent Non-Executive Member
Dr Mike Smith, Primary Medical Services Partner Member
David Stout, Independent Non-Executive Member
David Thompson, Healthwatch Representative
Aejaz Zahid, Executive Director of Innovation

In Attendance:
Deb Cornell, Director of Corporate Governance & Board Secretary
Toni Taylor, Governance Officer (minutes)

B/2023/27 Welcome and Introductions

The Chair welcomed members to the extraordinary meeting of North East and North Cumbria Integrated Care Board.

The Chair confirmed the meeting to be quorate.

Item: 5.3

B/2023/28 Apologies for Absence

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

B/2023/29 Declarations of Interest

Members had submitted their declarations prior to the meeting which had been made available in the public domain.

There were no declarations raised.

B/2023/30 CCG Annual Reports and Accounts 2022/23

The Executive Director for Corporate Governance, Communications and Involvement and the Executive Director of Finance presented the annual reports and accounts for five of the former CCG's covering the three-month period to 30 June 2022:

- Newcastle Gateshead CCG
- North Tyneside CCG
- Northumberland CCG
- South Tyneside CCG
- Sunderland CCG

The reports had been prepared in accordance with the guidance issued by NHS England and the information included had been prepared by the relevant subject matter experts.

As a result of the potential for final changes required after the meeting on 27 June 2023, it was proposed that the Board delegated authority to the ICB Chief Executive and Executive Director of Finance to agree any final amendments with the ICB Audit Committee Chair.

RESOLVED:

The Board **RECEIVED** and **APPROVED** the annual reports and accounts for the five former CCGs; Newcastle Gateshead CCG, North Tyneside CCG, Northumberland CCG, South Tyneside CCG and Sunderland CCG for the three-month period to 30 June 2022.

The Board **AGREED** delegated authority for the ICB Chief Executive and Executive Director of Finance to agree any final amendments to the annual report and accounts with the ICB Audit Committee Chair.

B/2023/31 External Audit

Item: 5.3

The Executive Director of Finance presented the external audit completion reports for the audit of five former CCG accounts for the three-month period to 30 June 2022 - Newcastle Gateshead CCG, North Tyneside CCG, Northumberland CCG, South Tyneside CCG, Sunderland CCG.

Given the reduced materiality for the three-month period (effectively a quarter of usual materiality levels) there is an increased risk of material misstatements being identified.

The majority of audit work had been completed and remaining outstanding areas are being progressed as priority.

RESOLVED:
The Board **NOTED** the status of each respective audit and considered the findings within the reports. The Board **NOTED** that certain areas of audit work remain in progress and final reports will be provided as soon as available.

B/2023/32 ICB Annual Report and Accounts 2022/23

The Executive Director for Corporate Governance, Communications and Involvement and the Executive Director of Finance presented the ICB annual report and accounts for the nine-month period from 1 July 2022 to 31 March 2023.

The reports had been prepared in accordance with the guidance issued by NHS England and the information included had been prepared by the relevant subject matter experts.

It is not expected that any material issues will be identified from the ICB audit which would require adjustment in the ICB accounts, however audit work on the former CCG accounts is still to be finalised which could potentially impact on the ICB accounts.

As a result of the potential for final changes after 27 June 2023, it was proposed the Board delegates authority to the ICB Chief Executive and Executive Director of Finance to agree any final amendments with the ICB Audit Committee Chair.

RESOLVED:
The Board **RECIEVED** and **APPROVED** the ICB annual report and accounts 1 July 2022 – 31 March 2023.

The Board **AGREED** delegated authority for the ICB Chief Executive and Executive Director of Finance to agree any final amendments to the annual report and accounts with the ICB Audit Committee Chair.

Item: 5.3

B/2023/33 Finance, Performance and Investment Committee Annual Review

The Committee Chair presented the Annual Review report which outlined the achievements and assurances the Committee had gained throughout the year to demonstrate its roles and responsibilities and also included risks identified as part of this work.

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

B/2023/34 Remuneration Committee Annual Review

The Committee Chair presented the Annual Review report which outlined the achievements and assurances the Committee had gained throughout the year to demonstrate its roles and responsibilities and also included risks identified as part of this work.

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

B/2023/35 Any other business

There were no other items of business.

The meeting closed at 14:10

Item: 6

Board (public)

NHS
North East and North Cumbria

Log updated: 17 July 2023

No:	Date of meeting	Minute reference	Agenda Item	Action Point	Lead	Timescale	Comments	Current status
2	01/07/2022	B/2022/10	Adoption of key policies	All policies to be reviewed within the first six months following the establishment of the ICB to ensure they reflect an ICB perspective	All Executive Directors	February 2023	**July 2023 update** All corporate policies have been approved by the Executive Committee, as part of the first year forward plan. People policies still under review.	Ongoing
10	28/03/2023	B/2023/93	Chief Executive's Report	Tees, Esk and Wear Valleys NHS Foundation Trust independent reports A report will be presented at a future Board meeting in the next six months with regards to progress against recommendations and actions.	S Allen	26 September 2023		Ongoing
11	28/03/2023	B/2023/94	Chief Executive's Report	An update to be given at future Board meeting with regards to progress on running cost reduction.	S Allen	25 July 2023	Update to be included in Chief Executive Report 25 July 2023	Complete
12	28/03/2023	B/2023/95	Healthier and Fairer Advisory Group Progress	Update data on the Waiting Well Project to be brought to a future Board meeting	N O'Brien	28 November 2023		Ongoing
13	28/03/2023	B/2023/96	Integrated Delivery Report	Reducing reliance on inpatient care for people with learning disabilities action plan to be brought to a future Board meeting.	~~J Myers~~ L Buckley	26 September 2023		Ongoing
17	30/05/2023	B/2023/07	Chief Executive's Report	The outcomes of the review of oral health to report into Board in November 2023.	S Allen	28 November 2023		Ongoing
18	30/05/2023	B/2023/08	Primary Care	There is a variation in diagnostic testing across the North East and North Cumbria - an active piece of work is underway with the Diagnostic Network engaging with Foundation Trust providers. Executive Medical Director to present the findings of this piece of work at a future Public Board.	N O'Brien	TBC		Ongoing
19	30/05/2023	B/2023/14	Constitution	Section 2.2.3 of the constitution to be updated to reflect the addition of a fifth Non-Executive Director role before submission to NHS England.	C Riley	25 July 2023		Complete
20	30/05/2023	B/2023/18	Questions from the Public	A written response to be sent to Keep Our NHS Public North East (KONPNE) within 20 working days.	D Purdue	21 April 2023		Complete

Item: 8

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 25 July 2023	
Report Title:	**Chief Executive Report**

Purpose of report

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

Key points

The report includes items on:

- The independent review published on the North East Ambulance Service
- NHS 75
- The NHS Workforce Plan
- Industrial Action
- The development of the Integrated Care Board
- An update on the System Leadership Group
- The Integrated Care Partnership
- An update on our winter plan
- Our progress with supporting people who are waiting for elective treatment
- The Gateshead Local Area Partnership Special Educational Needs and Disability inspection

Risks and issues

Note the risks linked to the longest period to date of industrial action and impact of elective waiting times.

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Assurances
The report provides an overview for the board on key national and local areas of interest and highlights any new risks.
Recommendation/action required
The Board is asked to receive the report for assurance and ask any questions of the Chief Executive.
Acronyms and abbreviations explained
CQC - Care Quality Commission HRD – Human Resource Development HMI – His Majesty's Inspectors ICB – Integrated Care Board ICP – Integrated Care Partnership ICS – Integrated Care System NENC – North East and North Cumbria SEND – Special Educational Needs and Disability SCC – System Coordination Centre UEC – Urgent and Emergency Care

Sponsor/approving executive director	Sir Liam Donaldson, Chair
Report author	Samantha Allen, Chief Executive

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

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

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

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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?	None noted.					
Has there been/does there need to be appropriate clinical involvement?	Not applicable – for information and assurance only.					
Has there been/does there need to be any patient and public involvement?	Not applicable – for information and assurance only.					
Has there been/does there need to be partner and/or other stakeholder engagement?	Engagement has taken place throughout the assurance process with NHS England and provider organisations.					

Item: 8

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 The Independent Review Published on the North East Ambulance Service

Following a high profile whistleblowing case relating to the coronial process within the North East Ambulance Service and subsequent criticism of the handling of the whistleblowing process, Government commissioned Dame Marianne Griffiths to independently investigate the issues identified. The issues identified pre dates the creation of the ICB. Prior to this Northumberland Clinical Commissioning Group acted as lead commissioners for this service.

The report was published on the 12 July 2023 and was shared with the families referenced within the report on 11 July 2023.

As part of the publication process, NHS England stipulated the requirement for NEAS and NENC ICB to share the final report with Boards in private in advance of the publication date. In addition, Boards were asked to approve a required Assurance Statement.

The Chair and Chief Executive of NEAS will attend the Board and share the learning from the report and give an oversight on the progress with the recommendations from the report.

2.2 NHS 75

The NHS marked its 75th anniversary on Wednesday 05 July. Over the last 75 years the NHS has continued to grow and innovate to meet the changing needs of the population. The milestone was a day of celebration and opportunity to reflect on all those who have contributed to the NHS. It was also a day to consider the importance of needing to adapt and change to meet the needs of the population and maintain a universal, tax funded health service free at the point of delivery. As Anuerin Bevan said in 1948, " the service must always be changing, growing and improving" and those words ring true today.

ICB colleagues, alongside partners from across our region, attended a special service in celebration of the 75th NHS birthday at Westminster Abbey. The service was attended by over 1,500 NHS staff, Royal Highnesses The Duke and Duchess of Edinburgh, senior government leaders and health leaders. Several other celebrations including the Big Tea,

Monuments across the region turning blue and a special NHS Park Run on the 8 July were enjoyed across the region and country.

2.3 The NHS Term Workforce Plan

The long-term NHS workforce plan was published on the 30 June 2023, the plan is the first time that there has been a funded plan (2.4 billion) for NHS workforce and is focused on three main areas.

1. **Train:** significantly increasing education and training, as well as increasing apprenticeships from 7% to 22% and alternative routes into professional roles, to deliver more multi-professionals, including new roles designed to better meet the changing needs of patients and support the ongoing transformation of care.
2. **Retain:** ensuring that we keep more of the staff we have within the health service by better supporting people throughout their careers, boosting the flexibilities we offer our staff to work in ways that suit them and work for patients, and continuing to improve the culture and leadership across NHS organisations.
3. **Reform:** improving productivity by working and training in different ways, building broader teams with flexible skills, changing education and training to deliver more staff in roles and services where they are needed most, and ensuring staff have the right skills to take advantage of new technology that frees up clinicians' time to care, increases flexibility in deployment, and provides the care patients need more effectively and efficiently.

The ICB People Plan mirrors the national plan with our priorities on supply, retention, new ways of working, wellbeing, inclusion and leadership**.** The ICB People Plan is scheduled to be published in September and will be one of the first items to be considered by the newly formed System Leadership Group.

2.4 Industrial Action

At time of writing, junior doctors are undertaking their longest period of industrial action to date. This covers five days from the morning of Thursday 13 to the morning of Tuesday 18 July 2023. Consultant Medical Staff have two days of industrial action planned for the morning of Thursday 20 to the morning of Saturday 22 July.

The provider trusts have made detailed plans to manage the impact of this action and the ICB's Strategic Coordination Centre has been running with enhanced staffing to coordinate across the ICB and support the Trusts with any operational difficulties that arise. The main impact of this and other recent strikes is the loss of elective (planned) patient appointments and operations, as fewer are scheduled on the days of action due to the reduced availability of medical staff. I know our patients will feel the impact of this and we are grateful for their ongoing support during this time.

2.5 Health and Safety Executive - Recommendations for Managing Violence and Aggression and Musculoskeletal Disorders in the NHS

The ICB received a letter from the Health and Safety Executive regarding managing violence and aggression and musculoskeletal disorders in the NHS. The letter has been sent to every ICB and we have shared it with the Directors of Human Resource at all of our NHS provider organisations for them to take appropriate action.

Actions include reviewing the current levels of staff absence related to both areas and the Trust plans to address the impact on staff and workplace wellbeing. The progress will be monitored through the ICS network for Human Resource Directors. The letter is also being discussed at the People Group on the 20 July to engage the wider system.

ICB staff all undergo a risk assessment for their office environment and home working on commencement of employment. The risk assessment identifies the ergonomic requirements for healthy working and any adaptations for musculoskeletal issues are available. The staff survey is a good indicator for assessing violence and aggression in the workplace and we will use the outputs to ensure staff feel safe in their work.

Appropriate HR policies are in place in the ICB to allow any incidents of violence and aggression to be addressed both in and out of work.

2.6 ICB Development

2.6.1 ICB Running Cost Reduction

The ICB is required to make a 30% running cost reduction by 2025/26 with the first 20% of this delivered by the start of 2024/25. The ICB has established a programme to deliver this and this has started with engaging with staff across the ICB to enable our staff to have the opportunity to be part of reshaping the ICB, transforming our ways of working and developing our operating model.

Throughout June we have held engagement sessions with over 300 people across the ICB. 90% of this engagement was face to face with over 44 hours dedicated to listening to staff views. The key themes from the engagement have been shared with staff and will be drawn on in the next phase of the programme. The feedback will enable us to develop and transform the organisation as well as meet the nationally required reduction to the running costs. I anticipate I will be able to share more detail regarding the further development of the ICB operating model with the Board by the end of September.

2.6.2 ICB One Year Anniversary

On 01 July, we marked one year since the NENC ICB became a statutory organisation. Our first year has been focused on the transition from eight organisations in to one and there remains more to do to get to a position where we have addressed some of the legacy issues inherited. There is also a significant amount to be proud of and I was delighted the work of our Communications and Finance Teams has recently been recognised nationally with award winning success.

3. North East and North Cumbria

3.1 Integrated Care Partnership Update

I was pleased to attend the third meeting of Strategic Integrated Care Partnership in June, where we received updates from the chairs of our four Area ICPs. These partnerships have now each met twice and are playing a vital role in identifying shared priorities based on the needs assessment process led by the Health and Wellbeing Boards in their areas. Each of the Area ICP chairs gave thoughtful presentations covering the challenges of tackling deep-seated health inequalities as well as the opportunities of working across

places, organisations and policy domains to make fast progress on issues such as drugs, tobacco and alcohol dependency, mental health and suicide, as well as how we improve equitable access to high quality local services.

We also received presentations on our emerging 'work and health strategy' which we are developing with the North of Tyne Combined Authority (but will have applicable learning across our entire ICS area), and the development of an integrated information system for the North East and North Cumbria – as we know from our masterclass with Mark Britnell, accurate and accessible data are vital tools for all the most successful integrated care systems so that we can measure the impact of our interventions in real time and support the design of effective care pathways.

Finally, we also received an update on the engagement our teams are undertaking on the development of our Joint Forward Plan. The is the document that sets out in detail how we will implement the strategic ambitions set out in our Integrated Care Strategy which the ICP is responsible for signing off. It was therefore useful for ICP members to understand this process and how they and other key stakeholders can continue to shape how we deliver our priorities.

3.2 System Leadership Group

The development of a leadership group from across the system was supported at the last Joint Management Executive Group and nominations for membership have been received. The first System Leadership Group is scheduled to take place on 26 July. The inaugural meeting will be a facilitated workshop to allow the group to come together and co-produce the purpose and way of working to ensure a collective and proactive role in shaping and delivering a vision for our health and care system is achieved. I am delighted Sir David Pearson is supporting us with this to support our coproduction with partners on how the group will work.

3.3 Our Winter Plan Preparation

System priority setting for winter 2023/24 is in its final stages following a system-wide event and three co-design sessions across the ICS covering a wide spectrum of professions and geographies. This work is being led by our ICS Urgent and Emergency Care Board and they have identified three priority areas for our focus this year :

1. Getting people to the right place first time
2. Flow (how people move through the health and care system)
3. Improving discharges and transfers of care

Working with system partners we have undertaken pre and post intervention analysis of winter 2022/23 and our learning is being drawn on as we consider the interventions we will target this winter. Areas under consideration include Clinical Assessment Services, Urgent Community Response services, ambulance handovers, High Intensity Users, Front End Streaming at Emergency Departments and Urgent Treatment Centre developments.

Enabling workstreams such as communications and engagement, evaluation and data sharing; and prioritised business cases where funding is identified, and effective use of current clinical and funding models will support effective delivery of the final priorities. A sustainable longer-term model for the System Coordination Centre (SCC) and Directory of

Service developments will also augment and strengthen navigation to alternative dispositions outside of hospital and introduce predictive modelling to support system flow and escalations. A supporting Escalation Framework is in the late stages of development and will incorporate the Mutual Aid Policy, the repatriation policy, the national review of Opel levels and 'in extremis' system planning, and the operating model for the SCC.

The Urgent and Emergency Care Board working with Local Accident and Emergency Delivery Boards has refreshed the roles and responsibilities of each part of the system emphasising local communities and places as the main part of the system that makes the decisions and delivers care relating to UEC. This is supported by more robust communication channels, dedicated work to understand the public's needs and behaviours with regard to their care, and a suite of metrics reports at every level of the system and covering all geographies that will drive improvements and transformation.

From a current performance perspective, although the ICS is overall in a relatively strong position, one of the greatest opportunities for the UEC system is to reduce unwarranted variation across services and geographies, whilst tailoring services to meet local need. The current UEC operational plan for 2023/24 and the emerging five-year plan are both focused on achieving this for our population.

3.4 Waiting Well

The waiting well project supports patients across the ICB on routine lists for surgery to prepare physically and psychologically ahead of their procedure.

Using the data we have available has allowed us to take a population health management approach to identify and risk stratify patients, then deliver targeted support through place-based delivery teams. The key components of our model are:

- Data-driven identification of target cohort
- Assertive outreach to contact patients
- Holistic personalised care and assessment
- Tiered support dependent on patient need.

A hybrid quantitative and qualitative evaluation plan has been established to assess the benefits of the programme for patients, staff, and the system as the programme becomes embedded. A comprehensive health economic evaluation is embedded within this and we will report the outcome of this work to the Board. Though in its infancy of delivery, direct patient feedback has been incredible, and it is clear we are improving patients' quality of life; quotes we have received include:

Patient 1: *"Before your intervention I thought I just wanted to die, now I realise life is worth living."*

Patient 2: *"It has taken me months to leave the house, I would choose to stay at home rather than socialising with friends - although I know that socialising would be good for me, I could not bring myself to leave the house. Since being asked to take part in this incentive I have left the house three times a week even if it is to go to the gym and back. I look forward to doing my exercise classes."*

721 patients were contacted with 161 accepting support. Early data reported improvements in overall quality of life, reflecting the five dimensions of mobility, self-care, usual activities, pain/discomfort, and anxiety/depression.

Our Executive Medical Director recently attended the World Congress of Peri-Operative Medicine to present on this work.

3.5 Area SEND inspection of Gateshead Local Area Partnership

A joint CQC, OFSTED and HMI Gateshead SEND Local Area Partnership Inspection took place between the 09 - 26 May 2023. Inspectors met with children and young people with SEND, parents and carers, local authority and NHS officers. Inspectors visited a range of providers and spoke to leaders, staff and governors about how they were implementing the SEND requirements. The report recognised that leaders across Gateshead have a determination to provide high-quality education and support to all children and young people with SEND.

The outcome of the inspection is a three year follow up and areas for improvement which include:

- Inconsistent educational psychological support
- Transition plans shared too late
- Waiting times for access to children's therapies
- Access and oversight for children's mental health services
- Specialist secondary school access to some qualifications
- Parents struggle to secure educational health care plan assessments
- Need for holistic social work assessments
- Long waits for short breaks.

The Gateshead ICB Place team have developed a steering group and action plan with partners to address the health commissioned service issues and will work with all partners to respond to the report recommendations to improve outcomes for children and families with SEND in Gateshead.

4. Recommendations

The Board is asked to:

- Receive the report and ask any questions of the Chief Executive.

Name of Author: Samantha Allen
Name of Sponsoring Director: Sir Liam Donaldson
Date: 14 July 2023

Item: 8.1

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 25 July 2023	
Report Title:	**Primary Care Dental Access Recovery : First steps**

Purpose of report

The purpose of this report is to provide an update to the Board on the approach and initial actions undertaken to help manage the current pressures on dental services in the North East and North Cumbria.

The report outlines the proposed approach and next steps in relation to the plan for 2023-24 that will attempt to 'protect, retain and stabilise' local NHS primary care general dental services from its current state with a particular focus on CORE20 localities where need and inequality is greatest, noting that a more detailed paper outlining the full plan is being developed.

This includes extension of project support and a Unit of Dental Activity (UDA) hand-back and termination standard operating procedure with associated pricing strategy.

This approach is the first of three phases:

- Immediate actions to stabilise services
- A more strategic approach to workforce and service delivery
- Developing an oral health strategy to improve oral health and reduce the pressure on dentistry

Key points

(1) A dental development planning session with a focus on primary care general dental access was held on 11 May 2023 to share the current position on general dental access and to seek initial views/thoughts on key priorities, potential options/immediate actions required in 2023-24 to stabilize and build reliable general dental access across the NENC.

(2) Following the meeting a commitment was given to work with the dental commissioning team to take forward the outputs from the session and work up the detail of the 2023-24 operational recovery plan.

(3) The operational recovery plan will propose a draft menu of potential supportive options that could be offered and applied 'individually' or 'in combination' to ***'protect, retain and stabilise'*** local dental practices and dental access provided to local communities ensuring prioritisation of ICS CORE20 populations and localities, with practices that fall within the ICB's most deprived areas being offered a broader range of options including greater thresholds for flexible commissioning for targeted schemes and potentially financial support.

(4) Discussions have taken place with the Dental Public Health Consultants to map current dental practices against the CORE20 areas to inform the options that would be offered, focusing on areas of greatest need, and some of the potential options that are currently being explored are included in this paper which includes proposals that are out-with current NHS England guidance/policy where further discussion may need to take place between the ICB and the NHSE Regional and National Team.

(5) The initial initiatives will only be contracted on a 'year by year' and 'non-recurrent' financial short-term basis to ensure that once National Reforms are known, introduced and begin to take effect they can be easily withdrawn if needed and to ensure that local NHS Dentistry will become fully compliant with all new regulatory, legal and policy guidance associated with the National Reforms.

(6) Whilst this work is ongoing this paper sets out some further interim risk mitigation actions to support practices/providers to maintain access for patients costing £2.9m funded from slippage on contract baseline budget within the ring-fenced dental budget allocation.

Non-recurrent funding requirement 2023-24	**£**
NHS 111 DCAS Out of Hours (clinical triage)	£39,766
Out of Hours Dental Clinical Treatment Capacity Additional clinical treatment sessions from remainder of 2023-24 (July to end of March 2024)	£292,500
Access Sessions Extend current Q1 access scheme arrangements (UDA Substitution or Additional Payment) as a minimum until end of September 2023 with an option to extend on a 'quarter by quarter' basis until the end of March 2024 if required	£2.574m
Project Management Support Extension to the NECs support supporting the management and administration of the access scheme	£57,645
TOTAL	**£2,963,911**

(7) A local commissioning and pricing strategy to mirror the previously agreed formal procurement range has been agreed aimed at ensuring that any capacity lost from contract hand-backs is commissioned with increased likelihood of success and as soon as possible by offering up to existing NHS dental providers within the defined geographical area who can demonstrate that they have the surgery capacity and workforce to deliver this above their contracted levels.

Risks and issues

- The risk mitigation proposals outlined in this paper are for short-term non-recurrent schemes for 2023-24 with no recurrent cost implications.
- The total non-recurrent funding is within the ring-fenced dental allocation and will be funded from slippage on the contract baseline.

- It should be noted that offering access sessions as an UDA substitution of up to 20% of the annual contract value is above the nationally agreed threshold of 10% which was set based on legal advice in 2019 as being the agreed level to avoid the appearance that commissioners were changing contract surreptitiously.

- Local commissioning process procurement risks mitigated by ensuring the ICB acts fairly, equally and transparently by openly advertising to all NHS dental practices across the identified geographical areas and undertaking a risk assessment prior to the recommendation of the award of the UDAs.

Assurances

The measures in this paper were recommended by the ICB's Primary Care Strategy and Delivery Committee and supported by the Executive Committee.

Delivery will be overseen by the primary Care Strategy and Delivery Committee.

Recommendation/action required

The Board is asked to note the content of the report and the initial measures funded to help manage current service pressures in the context of developing a wider oral health strategy.

Acronyms and abbreviations explained

UDA – Units of Dental Activity
DCAS – Dental Clinical Advisory Service
NDH DEC – Newcastle Dental Hospital Dental Emergency Clinic
GDS – General Dental Services

Executive Committee Approval	Executive Committee approval on Tuesday 11th July 2023
Sponsor/approving executive director	David Gallagher – Executive Area Director (Tees Valley and Central)
Date approved by executive director	14th July 2023
Report author	Pauline Fletcher, Senior Primary Care Manager (Primary Care Dental Commissioning Lead for NENC), NHS England Stuart Youngman, Senior Primary Care Manager (Dental), NHS England

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

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

Relevant legal/statutory issues

Note any relevant Acts, regulations, national guidelines etc

Item: 8.1

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, as outlined in the paper – use of £2.9m non recurrently from slippage in the dental budget.
Has there been/does there need to be appropriate clinical involvement?	Yes – proposals developed in discussions with clinical advisors
Has there been/does there need to be any patient and public involvement?	Proposals are responding to patient feedback regarding challenges in accessing NHS dental care.
Has there been/does there need to be partner and/or other stakeholder engagement?	

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Primary Care Dental Access Recovery Plan – First Steps

1. Purpose of the Report

The purpose of this report is to outline the agreed approach and next steps in relation to the recovery plan for 2023-24 that will attempt to 'protect, retain and stabilise' local NHS primary care general dental services from its current state of decline with a particular focus on CORE20 localities where need and inequality is greatest, noting that a more detailed paper outlining the full plan is being developed.

2. Background

A dental development planning session with a focus on primary care general dental access was held on 11 May 2023. The focus of the session was to share the current position on general dental access and to seek initial views/thoughts on key priorities, potential options/immediate actions required in 2023-24 to stabilize and build reliable general dental access across the NENC.

Following the meeting a commitment was given to work with the dental commissioning team to take forward the outputs from the session and work up the detail of the 2023-24 crisis plan. In the interim this paper outlines agreed risk mitigation actions/proposals building on the approvals that were previously secured in February 2023 relating to extensions to some legacy NHSE schemes.

3. Summary of proposed approach – Crisis Plan (2023-24)

Fundamental to managing patients, the public and local politicians over the coming 12 -month local NHS Dental recovery period will be the development and implementation of a pro-active stakeholder engagement and communication strategy and plan. This must therefore be at the forefront of our planning and response for 2023-24 with ICB strategic leaders, communications and engagement expertise and capacity pro-active and re-active commitment secured.

The separate operational recovery plan draws upon learning from both the National Government £50m Dental Initiative (Q4 2021-22) and Local Risk Mitigation initiatives attempted by NHS England throughout the COVID Pandemic-Recovery periods together with new opportunities and learning that has been identified by the wider ICB primary care and transformation teams over recent months.

The operational recovery plan ultimately seeks to optimise local flexibility and innovation to protect, retain and stabilise local NHS General Dental provision and workforce recruitment and retention from its current state of decline, whilst we await National step change reforms and new National mandatory guidance and tools that will seek to resolve the 'root cause' regulatory, workforce and payment mechanism issues that are adversely impacting NHS Dentistry.

The plan's focus is therefore towards delivery of a menu of supportive, innovative and flexible initiatives that will seek to protect all vulnerable practices in a fair and transparent manner, whilst ensuring that we support the ICS Strategic priorities associated with targeting reduction in health and access inequalities impacting our local CORE20plus5 populations.

These initiatives will only be contracted on a 'year by year' and 'non-recurrent' financial short term basis to ensure that once National Reforms are known, introduced and begin to take effect they can be easily withdrawn so that local NHS Dentistry can become fully compliant with all new regulatory, legal and policy guidance associated with the National Reforms.

The intention is to develop a draft menu of potential supportive options that could be offered and applied 'individually' or 'in combination' to ***'protect, retain and stabilise'*** local dental practices and dental access provided to local communities ensuring prioritisation of ICS CORE20 populations and localities, to inform the final crisis plan.

Discussions have taken place with the NHSE Dental Public Health Consultants to map current dental practices against the CORE20 areas to inform the options that would be offered, focusing on areas of greatest need.

In addition, and to ensure continued stability of the Dental 111 Emergency and Urgent Out of Hours provisions we will work with lead providers to ensure that additional and on-going resilience can be provided to ensure that the increasing 111 demand can be managed for those most in need. This will involve additional unscheduled urgent care 'risk mitigation' initiatives which are summarised in section 4 of this report.

4. Summary of further interim short-term (2023-24) actions

4.1 NHS111 Dental Clinical Assessment Service (Out of Hours)

Initially the ICB allocated non-recurrent funding (£61,000) to increase the dental clinical workforce capacity within the NHS111 Dental Clinical Assessment for 2023-23 to improve the service's ability to safely manage and respond to dental call volumes, clinical complexity and safety risks associated with increased and fluctuating call volumes. Since the initial funding was agreed the volume of dental calls into 111 continue to be high and are likely to increase further over coming months as the potential for contract hand backs and capacity rebasing impacts post 2022-23 End of Year. Additional non-recurrent funding of £39,766 has been allocated to further increase the 111 DCAS call handling workforce.

4.2 Dental Out of Hours Treatment Services

A small amount of non-recurrent funding was allocated to increase the out of hours dental treatment capacity to cover the additional King's Coronation Bank Holiday in May 2023. Due to the increased demand for urgent dental treatment out of hours increased capacity has been commissioned for the remainder of 2023-24 to ensure that patients who have been assessed as "clinically urgent" by NHS111 DCAS can be managed within the primary care out of hours treatment services, and thereby prevent the risk of patients having to be admitted to hospital due to lack of capacity. Additional non-recurrent funding has been allocated for Out of Hours Treatment services for additional 'Fixed Clinical Treatment Sessions' from July 2023 to March 2024 to manage anticipated peak demand periods within North of Tyne, South of Tyne, North Cumbria, Durham & Darlington, Teesside at a total cost of £292,500

4.3 Access sessions (2022-23)

ICB approval was given in February 2023 to extending the access session scheme previously put in place by NHS England to ensure that patients in greatest need were prioritized by general dental practices within the workforce capacity that they have available. This scheme included offering additional funding or equivalent UDA offset of £654 per access session delivered with the priority groups for access into these sessions as follows:

- Patients requiring **urgent or emergency dental care** treatment presenting via NHS 111 direct booking and/or through local practice walk in, where an urgent FP17 course of treatment will be provided under regulation.
- Patient presenting with a **dental complaint 'perceived urgent presentations'** via NHS 111 signposting and/or through local practice walk in, where an examination and banded course of treatment (Band 2 or Band 3) under regulation will be provided. Where a patient presenting has high oral health needs that have been identified as part of the clinical examination undertaken it is also expected that the patient will be offered the choice of engaging within a phased treatment plan in accordance with National Chief Dental Officer (CDO) Avoidance of Doubt Guidance unless the patient formally declines that offer.
- It is also a requirement that practices participating within this arrangement prioritise Looked After children who require oral health support.

An allocation of £654k was approved to fund the continuation of additional access session until the end of June 2023 from those practice that had signed up to deliver the sessions in Q4 2022-23 only. The spend against this allocation is £408,750 due to not all practices taking up the offer to continue with the sessions.

The plan was to undertake an independent review of the NHSE Access scheme to inform further commissioning arrangements. Unfortunately, there has been a delay in completing the review due to the availability of the dental public health colleague identified to lead on this work. Due to the on-going access issues across the patch, it is proposed that the scheme be extended as a minimum until the end of September 2023 (Q2) with a view to further extensions on a' quarter by quarter' basis until the end of March 2023 should this be required to maintain access for patients, subject to any dental system reform initiatives that may negate the need for these to continue. It is also proposed that practices be offered the sessional rate as a UDA substitution up to a maximum threshold of 20% of their contract activity noting that this level of substitution is above the usual nationally agreed threshold of 10% which was set based on legal advice in 2019 as being the agreed level to avoid the appearance that commissioners were changing contract surreptitiously.

A maximum non-recurrent allocation has been agreed of £858k per quarter (total maximum value for the remainder of 2023-24 of £2.574m) to enable the opening up of the offer to all practices across the NENC.

This funding will facilitate the commissioning of 1,312 sessions (circa 9000 patient treatments) per quarter - total of 3,936 sessions (27,500 patient treatments) for the remainder of the financial year 2023-24, targeted at patients with urgent dental care complaints and complex high care needs as well as looked after children to help reduce oral health inequalities. The funding will also facilitate the expansion of the additional sessions commissioned from NDH DEC which is not only supplementing local dental practice access in North of Tyne, but also acting as a contingency for patients within North Northumberland to ensure that clinical urgent and perceived urgent presentations can be managed until formal procurement of new contracts are secured in Berwick.

5. Project Management Support

Project management support is currently being provided by NECS to support the re-procurement of some specialist contracts and procurement of a Dental Electronic Referral Management services as well as providing transactional project support in relation to implementation, administration and management of the access sessions that were approved for Q1 (2023-24).

This transactional project support be extended on a rolling 'quarter by quarter' basis until the end of March 2024 due to staffing pressures within the dental commissioning team.

6. Contract/UDA hand back SOP and Pricing Strategy

NHSE North East and Yorkshire Regional team approved a local commissioning process (offering UDAs released from contract hand-backs to NHS providers within the surrounding geographical areas at a rate of £30.40 per UDA), as the quickest way to replace any lost capacity. This was following a commitment given to MPs that activity released from contact hand backs would be re-commissioned within the area as quickly as possible where this was deemed to be required.

A local commissioning process was agreed with a new pricing strategy that allows the additional UDAs to be offered either via a local commissioning process or as part of a formal procurement of a new contract at a range of between £30 and £37.

Where this commissioning process is undertaken, expressions of interest would be invited from current NHS providers within the defined geographical area for bids within this range to improve the chance of success (price and proximity/accessibility for patients being taken into account when awarding the additional UDAs).

The number of UDAs offered from a contract hand back will be determined by the funding released unless a case can be made to increase the funding for the area which is approved by the Primary Care Strategy and Delivery sub-committee.

UDAs would be offered to existing practices on a recurrent basis. However, a decision could be taken to offer on a non-recurrent basis in the first instance to give full assurance that the provider can deliver the additional activity, with it being made recurrent once delivery has been confirmed.

Practices can express an interest to provide up to an additional 50% of their annual contract activity (UDAs). Commissioning above this percentage may be done in exceptional circumstances subject to a risk assessment being undertaken and agreed via the ICB Primary Care Strategy and Delivery sub-committee.

Legal advice shared by an NHSE Regional commissioning Team flagged the risk of exceeding the 50% expansion rule set out in Regulation 72 (1) (a). It further went on to state that as GDS contracts are contracts without end dates, and therefore have an indefinite value, the 50% limit would be difficult to quantify and therefore successfully challenge under the PCR rules. Likelihood of challenge could be mitigated by ensuring the ICB acts fairly, equally and transparently in determining whom may be interest in the additional UDAs. It is therefore proposed that the UDAs are openly advertised to all NHS dental practices across the identified geographical areas and a risk assessment be undertaken prior to the recommendation to the Committee to the award of the UDAs.

The supporting rationale for the funding is:

- No/low uptake from practices in response to previous local commissioning processes (failed local commissioning process in Sunderland and North Tyneside and limited update in Durham from practices which were outside of the identified geographical boundaries).
- Local market feedback from a recent request for information undertaken in May 2023 indicates that the current rate is between £30.40 and £37 (lower range of £30 broadly in line with current average NENC UDA rate of £29.88).
- Local commissioning is the quickest route to replace the lost capacity to maintain access for patients and mitigate the delay and cost incurred from undertaking a formal procurement.

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Recommendations

The Board is asked to note the content of the report and the initial measures funded to help manage current service pressures in the context of developing a wider oral health strategy.

Name of Authors:

- Pauline Fletcher, Senior Primary Care Manager (Primary Care Dental Commissioning Lead – NENC)
- Stuart Youngman, Senior Primary Care Manager (Dental)

Sponsoring Director: David Gallagher, Executive Area Director (Tees Valley & Central)

Date: 14 July 2023

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

BOARD 25 July 2023	
Report Title:	**North East & North Cumbria (NENC) ICB: Integrated Delivery Report June 2023**

Purpose of report

The NENC Integrated Delivery Report provides an overview of quality and performance, highlighting any significant changes, areas of risk and mitigating actions. The report also provides an overview of the ICS position on the NHS Oversight Framework and CQC ratings of organisations.

The report uses published performance and quality data covering April 2023 for most metrics and May 2023 for others, unless otherwise specified. Finance data is for May 23 (Month 2).

Key points

Executive summary

The executive summary of the report notes key changes from the previous report, other areas of note/risk and includes a dashboard that provides an overview of current objectives in 3 parts:

Part 1 - Recovering core services and improving productivity – national objectives 2023/24
Part 2 - NHS Long Term Plan and transformation – national objectives 2023/24
Part 3 – National safety metrics

A broad range of metrics are reviewed and monitored through strategic programmes and through ICB oversight and contracting arrangements. This report includes a sub-set of those metrics, primarily focused on the national objectives for 2023/24. Other metrics, not routinely included in this report, will be added by exception if there is significant improvement, deterioration or concern about progress. These will be escalated via programme or oversight routes.

System Oversight

This section provides an overview of the NHS Oversight Framework segmentation and CQC ratings for trusts and GP practices. This month's report includes for the first time a summary of CQC ratings for social care to provide a broader system view of the position for health and care services. An overview of ICB complaints and themes from Healthwatch is include on a quarterly basis.

Delivery of objectives
This section provides an overview by programme area of key metrics, risks/actions, quality implications and recovery.

Progress against longer term objectives underpinning the Integrated Care Partnership Strategy and Joint Forward Plan will be reported via a separate report to Board, possibly on a six monthly basis and will incorporate the ICBs Better Health Fairer Health programme objectives in more detail.

Finance, Performance and Investment Committee (6th July) – comments/actions
The committee received the report with no additional actions noted. The committee previously had requested specific work in relation to children and young people's waiting times for mental health services. This work continues to progress with additional data being secured from trusts in order to provide a system view of long waits routinely as part of the IDR going forward.

ICB Executive Committee (11th July) – comments/actions
The committee received the report.

Quality and Safety Committee (13th July) – comments/actions
The committee received the report.

Further updates noted since the publication of this report in relation to North East Ambulance Services (NEAS) NHS FT

Independent Review
The Report of the Independent Review into alleged failures of patient safety and governance at the North East Ambulance Service (NEAS) written by Dame Marianne Griffiths DBE was published on 12 July 2023. NENC ICB has complied an assurance statement and fully accept the findings of the report, acknowledging the work in investigating the serious issues identified. The North East Ambulance Services leadership team continue to work hard to address the serious findings detailed within the report and the ICB will continue to support them, alongside having oversight of their progress with the delivery of an improvement plan created to address the recommendations in the report and the CQC inspection findings.

Update to CQC ratings
The CQC has found some improvements following an unannounced inspection of Emergency and urgent care services run by NEAS NHS FT in April and May. Following this inspection, the overall rating for Emergency and Urgent Care has improved from inadequate to requires improvement.

Risks and issues

- Please see above

Assurances

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

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Recommendation/action required

The Committee is asked to receive this report for information and assurance. Actions are being undertaken at a local level or as part of the ICB strategic work programmes.
The Committee is invited to note any observations or suggested actions including identifying any areas where a more detailed review of assurance would be helpful.
The format and content of the report is currently under review and further development is planned, any suggestions in this regard are also welcome.

Acronyms and abbreviations explained

- **AMR** - Antimicrobial resistance
- **CAS** – Central Alerting System
- **C. Difficile** – Clostridium Difficile
- **CDDFT** – County Durham and Darlington NHS Foundation Trust
- **CNST** – Clinical Negligence Scheme for Trusts
- **CNTWFT** – Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
- **CQC** – Care Quality Commission – independent regulator of health and social care in England
- **CYPS** – Children and Young People Service
- **E.Coli** – Escherichia coli
- **FFT** - Friends and Family Test
- **FT** - Foundation Trust
- **GHFT** - Gateshead Health NHS Foundation Trust
- **GNBSI** – Gram-Negative bloodstream Infections
- **GP** - General Practitioner
- **HCAI** – Healthcare Associated Infections
- **IAPT** – Improving Access to psychological Therapies – NHS service designed to offer short term psychological therapies to people suffering from anxiety, depression and stress.
- **IPC** - Infection Prevention and Control
- **MRSA** – Methicillin-resistant Staphylococcus aureus
- **MSSA** – Methicillin-sensitive Staphylococcus aureus
- **NCICFT** – North Cumbria Integrated Care Foundation Trust
- **NEAS** – North East Ambulance Service Foundation Trust
- **NENC** - North East and North Cumbria
- **NHCFT** – Northumbria Healthcare NHS Foundation Trust
- **NHS LTP** – Long Term Plan – the plan sets out a number of priorities for healthcare over the next 10 years, published in 2019.
- **NHS OF** – NHS Oversight Framework which outlines NHSE`s approach to NHS Oversight and is aligned with the ambitions set in the NHS Long Term Plan
- **NTHFT** – North Tees and Hartlepool NHS Foundation Trust
- **NuTHFT** – Newcastle upon Tyne Hospitals NHS FT
- **PSIRF** – Patient Safety Incident Response Framework
- **SPC** – Statistical Process Control – An analytical technique which plots data over time, it helps us understand variation and in doing so guides us to take the most appropriate action.
- **STSFT** South Tyneside and Sunderland NHS FT
- **STHFT** – South Tees Hospitals NHS FT
- **TEWVFT** – Tees, Esk and Wear Valleys NHS FT
- **TTAD -** Talking Therapies for Anxiety and Depression
- **QIPP** – Quality, Innovation, Productivity and prevention – Large scale programme introduced across the NHS to ensure the NHS delivers more for the same funding
- **QRG** – Quality Review Groups
- **RCA** – Root Cause Analysis

- **SI** – Serious Incident
- **SIRMS** – Safeguard Incident Risk Management System
- **UEC** – Urgent and Emergency Care
- **YTD** – Year to date

Executive Committee Approval	11/07/2023
Sponsor/approving executive director	Jacqueline Myers, Executive Chief of Strategy and Operations
Date approved by executive director	13/07/2023
Report author	Coordinated by Claire Dovell, Performance and Planning 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

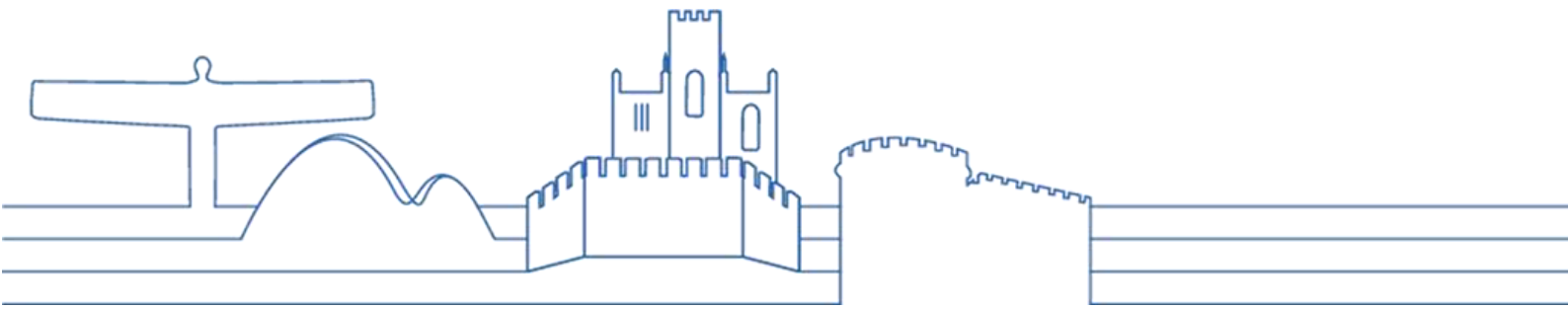
NHS
North East and North Cumbria

Integrated Delivery

Report

June 2023

(Reporting period April/May 2023)



Contents

Executive Summary

The NENC Integrated Delivery Report provides an overview of quality and performance, highlighting any significant changes, areas of risk and mitigating actions. The report also provides an overview of the ICS position on the NHS Oversight Framework and CQC ratings of organisations.

The report focusses on the objectives specified within the 2023/24 operational planning requirements; this encompasses a wide range of recovery objectives as well as some NHS Long Term Plan (LTP) and NHS People Plan commitments. The report is discussed in detail at the Finance Performance and Investment Committee and the Quality and Safety Committee. The report is also received by the ICB Executive Committee and the NENC ICB Board.

Reporting period covered:
May 2023 – A&E metrics, bed occupancy, handover delays, ambulance response times, cancer 62 day backlog and metrics for learning disability and autism services.
April 2023 – all other standards unless otherwise specified.

Key changes from previous report

NHS E escalation

A positive change in escalation in May - NCIC was placed in Tier 2 for cancer backlog in summer 2022, a significant amount of work has been undertaken since then and the trust successfully delivered within their plan at the end of March 2023. A cancer plan is in place for 2023/34 with support from the ICB and the Northern Cancer Alliance and the trust has been removed from Tier 2 for cancer.

CQC

South Tees NHS FT has been rated as "Good". The CQC carried out unannounced inspections of a number of areas within the Trust (November 2022 – January 2023). The inspection found that the Trust had made significant improvement since the last CQC inspection and throughout the pandemic, particularly in critical care. As a result, the Trust overall rating improved from "requires improvement" to "good". The CQC however identified 13 "must-do" actions. An interim improvement plan was developed which will now be reviewed following publication of the final report.

The CQC has recently visited North East Ambulance Service (April/May 2023) to re-inspect unscheduled care services and the outcome is awaited.

NUTH Maternity services rated as "Requires Improvement":
The CQC has rated the Trust's maternity services as *'requires improvement'* following a two-day inspection in January 2023 as part of their national maternity inspection programme looking at maternity care provided across the country. The report published on 12 May 2023 identified three areas of improvement that the Trust 'must' take action to improve and a further seven areas were action 'should' be taken.

A number of other maternity inspections have taken place as part of the CQC's maternity inspection programme and reports are awaited:

- Gateshead Health NHS FT inspection (February 2023)
- North Cumbria Integrated Care Hospital (NCIC) (March 2023)
- County Durham and Darlington FT (March 2023)
- Northumbria Healthcare NHS FT inspection (April 2023)

	CQC also inspected the Emergency Department and Medical wards at NCIC in June 2023 and Well-led interviews are planned early in July 2023. British Pregnancy Advisory service (BPAS) – CQC published a report published in June 2023, following a well-led inspection of their Head Office in February 2023, the report identified 5 'must do' improvements and a further 4 'should' do. BPAS is working closely with NHSE through an assigned Improvement Director to develop and deliver a comprehensive improvement plan.
Oversight Segmentation	NUTH has been moved from segment 1 to segment 2 due to ongoing challenges in relation to elective recovery.
Cancer Backlog	Although the 2022/23 target for backlog reduction was achieved in NENC, April 23 into May has become more pressured with only 3/8 Trusts achieving their planned backlog in April. Backlog as at 11/06/23 is 1,123 against a June plan of 1,007. Main specialities in cancer backlog are gastrointestinal patients and urology patients. This is mirrored nationally.
65+ week waits	NENC is ahead of plan in April on reducing the number of people that wait over 65 weeks for an elective procedure with 1,550 vs 2,426 plan. At trusts level only South Tees NHS FT are notably adrift of plan.
Waiting list	An internal RRT reporting error has been identified and corrected which relates to the outpatient element of RTT and has resulted in the automatic exclusion of patients from some areas in error. This will cause a notable jump in the waiting list number though is not present in the latest published data included in this report (Apr23); weekly data suggests a step change from circa 6,000 that will appear in data to published in coming months

Other areas of note/risk

CYP waiting times	Pressures in Children and Young People's mental health services have been noted in previous reports and work continues to secure routine visibility of waiting times, support children and families while waiting and transform services.
NHS E escalation – elective/ cancer	NUTH remains the only NENC trust in the elective tiering system, currently in Tier 1 for elective care.
NHSE Cancer Alliance Assurance meeting	An NHSE Cancer Alliance assurance meeting took place on 11th May. The outcome of the meeting was the NCA was fully assured. Key highlights noted were: the reduced backlog in Q4; NCA has been the top alliance in the last 3 months for Faster Diagnosis Standard performance; and plans finalised for age extension bowel screening for year 3. Challenges were noted around treatment variation work (lung project) due to team capacity; non-specific symptoms pathway under trajectory in 22/23; best practice timed pathway data collection. Plans are in place for 23/24 to address these challenges, with risks also highlighted by the NCA in relation to capacity (Alliance core team) and workforce (particularly for diagnostics, non-surgical oncology and specialist cancer nursing).
Trust Quality Accounts	Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce Quality Accounts if they deliver

	services under an NHS Standard Contract, have staff numbers over 50 and NHS income greater than £130k per annum. Providers are required to publish their Quality Accounts for 2022/23 by 30 June 2023. ICBs have the responsibility for the review and scrutiny of Quality Accounts and providers are currently sharing these with area quality teams within the NENC ICB for comment prior to these being published. Quality Accounts are discussed at the ICB Quality Review Groups and a separate paper on quality accounts will also be received at each Area Quality and Safety Sub-Committee.
ICB Focus meeting	An ICB focus meeting has taken place with NHSE on 22nd May. It was noted that good system working will be key to support the delivery of operational plans during 2023/24 including finance, activity and workforce plans.
2023/24 operational planning	The ICB has received a formal letter from NHS E acknowledging receipt of the final operating plan for 2023/24. The letter highlighted issues for the ICB to keep under review and/or that require specific action including delivery of key objectives linked to UEC, elective and cancer and an ask to improve the rigour of outpatient transformation plans. The letter noted that ICB mental health plans did not meet several national objectives and that these will be areas of ongoing oversight and focus. As expected, with a deficit plan, the letter confirmed a number of conditions linked to finance and the requirement to develop a medium term financial plan.

Comments and actions from Finance Performance and Investment Committee 4 May 2023 (no meeting in June)

The committee noted that small numbers of patients in ophthalmology were experiencing long waits due to the limited availability of corneal tissue nationally.

Ongoing work in relation to a broader range of metrics was referenced. Progress against longer term objectives underpinning the Integrated Care Partnership Strategy and Joint Forward Plan will be reported via a separate report to Board, possibly on a six monthly basis and will incorporate the ICBs Better Health Fairer Health programme objectives.

Comments and actions from Quality and Safety Committee 11th May (no meeting in June)

The report was received for information and assurance; it was agreed that a detailed review, from a quality perspective, would be undertaken in one trust linked to C Difficile.

Operational plan delivery - summary dashboard

A broad range of metrics are reviewed and monitored through strategic programmes and through ICB oversight and contracting arrangements. This supports the delivery of standards and improvement. Where appropriate this is underpinned using a Statistical Process Control (SPC) approach which is considered best practice to enable systems to understand where there is significant variation and most risk and therefore focus attention on those areas that require improvement support.

This report includes a sub-set of those metrics primarily focussed on the national objectives for 2023/24. The metrics are reported at ICB level, and the narrative refers to place or organisations by exception. Other metrics, not routinely included in this report, will be added by exception if there is significant improvement or deterioration or concern about progress. These will be escalated via programme or oversight routes.

The dashboard is in three parts:

Part 1 - Recovering core services and improving productivity – national objectives 2023/24
These are the key metrics specified in the 2023/24 priorities and operational planning guidance for the NHS to support recovery of core services and improve productivity. They predominantly link to access or responsiveness of services and patient experience but some link to effectiveness/outcomes e.g., cancers diagnosed at an earlier stage are more likely to result in a better outcome. Others have a link to safety e.g., the maternity metrics. Use of resources is also included in this section given the importance of delivering a balanced net position to recovery and sustainability.

Part 2 - NHS Long Term Plan and transformation – national objectives 2023/24
These metrics are also specified in the 2023/24 priorities and operational planning guidance but link to commitments from the NHS Long Term Plan and service transformation. Many of these link to access to services, effectiveness, improving outcomes and personalisation.

Part 3 – National safety metrics
This includes important metrics/data linked to patient safety.

The dashboard Part 1 and 2 only include the metrics that are listed as objectives in the national planning guidance, however the delivery section later in the report also includes some additional metrics, either associated with the actions in the operational planning guidance or local priorities.

DASHBOARD KEY

National objective	Brief description of the national objective and associated timeframe, most aim for achievement by end of March 2024 and have a local month by month trajectory. Some objectives have a longer time frame. A full description of the objectives is included in Appendix 1. The dashboard also includes 2022/23 objectives linked to elective care long waits that have not yet been achieved (104 and78 week waits).
Plan – March 2024	NENC's plan for end of March 2024 (From the final operational planning submission in May 2023)
Plan – month	This specifies the NENC operational planning trajectory or national required standard for the month that is reported against in the report. The reporting period varies between metrics e.g., UEC metrics have more recently published data than other metrics
Actual	The number represents the actual performance in the most recent reported month. In this report it is May data for Urgent and Emergency Care and learning disability and autism service metrics and April data for other standards unless otherwise specified. This is primarily monthly published data, where more recent unpublished data is available the narrative later in the report often uses this to provide an indication of the direction of travel. The colour shading in the 'actual' column draws attention to those metrics that are well ahead or well behind plan in that month. Colour coding is not applied where the plan has been met or missed by a small margin. Met – well ahead of plan Not met – well behind plan
Trend	This indicates whether performance over time is **improving** or **worsening.** Where Statistical Process Control (SPC) is used, the trend category relates to the variation output generated by SPC and therefore indicates significant improvement or deterioration. Where SPC is not appropriate a number of data points are used to ensure it reflects a trend rather than normal variation.
Benchmark	Where possible the NENC performance is compared with the England or North East and Yorkshire (NEY) position as a benchmark. The number represents the England position unless otherwise stated and the colour shading indicates: NENC compares favourably NENC does not compare favourably No comparative data available

Please note - data flow is not yet established against some of the new objectives and will be included as soon as possible.

Part 1 Recovering core services and improving productivity – national objectives 2023/24

	National objective 2023/24	March 24 Plan	Plan (month)	Actual	Trend	Bench-mark
Urgent and emergency care	A&E waiting times within 4 hours (76% by March 2024)	80.8%	77.7%	77.1%	Worsening	74%
	Category 2 ambulance response times (average of 30 minutes)	30 min	34.0m	33.9m		7/11
	*Adult general and acute bed occupancy to 92% or below	92.1%	91.7%	90.5%	Worsening	94.5%
Community health services	2-hour urgent community response (standard 70%) April 23 provisional	70%	70%	82.9%		
	Reduce unnecessary GP appointments: a) Direct referral from community optometrists and b) Self referral routes					
Primary care	a) GP practice appointments within two weeks and			81.9%		79.9%
	b) Urgent appointments the same or next day			64.3%		63.3%
	More appointments in general practice by March 2024	1.57m	1.5m	1.30m		
	Additional Roles Reimbursement Scheme by March 2024 (March 23)	1526		1246		
	Improving units of dental activity (to pre-pandemic levels)	100% 2.13m		May 23 74.4%	Improving	76.8%
Elective care	*Eliminate waits of over 104 weeks (by July 2022)	0	13	20		
	*Eliminate waits of over 78 weeks (by April 2023)	0	114	169		
	*Eliminate waits of over 65 weeks (by March 2024)	14	2426	1550		
	Eliminate waits of over 52 weeks (by March 2025)	5142	8379	8112		
	Deliver 109% value weighted activity * 4/6/23	109%	107%	81%		
Cancer	Reduce the number of patients waiting over 62 days w/e /11/6/23	800	1007	1123		
	Cancer faster diagnosis standard 75% by March 2024	77.6%	76%	75.3%		71.3%
	Early diagnosis ambition 75% by 2028					
Diagnostics	Diagnostic test within six weeks 95% by March 2025	89.4%	85.1%	83.3%	Improving	
	Diagnostic activity levels to support recovery 4/6/23	109%	103%	103%		
Maternity	Maternal mortality rate per 1000					
	Still births per 1000 births			3.39	Improving	3.52
	Neonatal deaths per 1000 live births			1.86	Improving	1.6
	Increase fill rates for maternity staff					
Use of Resources	Deliver a balanced net system financial position for 2023/24	£49.87 m	£28.66 m	£30.46m		

*NENC Plan does not meet or exceed the national objective

Reporting period covered:
May 2023 – A&E metrics, bed occupancy, handover delays, ambulance response times, cancer 62 day backlog and metrics for learning disability and autism services.
April 2023 – all other standards unless otherwise specified.

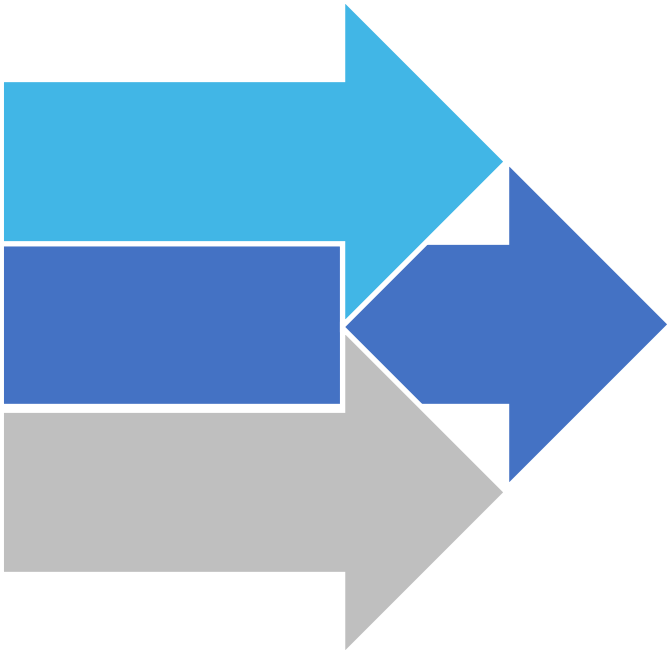
Part 2 NHS Long Term Plan and transformation – national objectives 2023/24

	National objective 2023/24	March 24 plan	Plan	Actual	Trend	Bench mark
Workforce	Improve retention (turnover)	12.1%		12.7		
	Improve staff attendance (sickness)	5.6%		5.5%		5%
Mental health	*Improve access to mental health support for CYP (Apr 23)	53,245	51,343	54,105	Improving	
	Increase the number of people accessing Talking Therapies for anxiety (TTAD) (Apr 23)	22,540	7,246	4,930		
	*Community mental health services (5% increase) 2+ contacts	34,855	33,208	35,645		
	*Out of area placements (March)	162		900		
	Recover the dementia diagnosis rate to 66.7% (Mar 23)	67%	66.7%	67.5%	Improving	
	Access to perinatal mental health services (Apr 23)			2,245	Improving	
People with a learning disability and autistic people	Annual health check and plan for people on GP LD registers (75% March 2024) (Cumulative)	77%	3.9%	2.7%		
	*Reduce reliance on inpatient care -adults (ICB) 26/5/23	52	80	84		
	*Reduce reliance on inpatient care -adults (secure)26/5/23	61	77	77		
	Reduce reliance on inpatient care – under 18s 26/5/23	8	8	9		
Prevention and health inequalities **Adults Children & Young People (CYP)**	Hypertension (77% by March 2024) Mar 22	77%		65.9%		60.4%
	Use of lipid lowering therapies (60%)	60%				
	Increase uptake of COIVD vaccines (Winter programme ended 12/2/23)			64.7%		
	Increase uptake of flu vaccines (Flu season programme ended 5/2/23)			63%		
	Increase uptake of pneumonia vaccines					
	Increase uptake of SMI health checks (Cumulative)		16,325	14,592	Improving	
	Ensure continuity of care for women from BAME communities and the most deprived groups					
	75% Cancers Diagnosed at stage 1&2 by 2028					
	CYP: Asthma – address over reliance of medications					
	CYP: Decrease the number of asthma attacks					
	CYP: Increase access to glucose monitors and insulin pumps					
	CYP: Proportion of diabetes patients receiving 8 NICE care processes for type 2			46.5%		46.7%
	CYP: Access to epilepsy specialist nurses					
	CYP: Reduce tooth extractions due to decay children admitted as IP in hospital aged +10					
	Improve access rates to CYP mental health service for 0-17 years		100%	94.6%		

*NENC Plan does not meet or exceed the national objective

Part 3 – Core safety metrics – April/May 23

	National objective	Mar 24 plan	Plan (YTD)	Actual Month	Actual YTD	Trend	Benchmark
Never events	Zero	0	0	1	2		
Serious incidents	Number of SIs reported (May)			70	152		
	Proportion of SIs reported within 2 days	Range from 36.4% to 100% across our FTs					
Infection prevention control	MRSA (Apr 23)	0	0	4	4	Worsening	
	C Diff (Apr 23)		50	50	50		
	E Coli (Apr 23)		75	96	96		
Mortality		**All trusts are within expected range.**					



System oversight

NHS Oversight Framework (NHS OF) Summary

This section of the report provides an overview of the current oversight segmentation and support arrangements and the ICB position against the NHS Oversight Framework metrics.

NHS Oversight Framework Segmentation and CQC ratings

ICSs and trusts were allocated to one of four 'segments' in 2021/22. A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4) and influences the oversight arrangements that are established. NHS England holds the responsibility to review and change segmentation, this is undertaken regularly by the North East and Yorkshire Regional Support Group. Oversight of trusts in segment 1 and 2 is led by the ICB and oversight of trusts in segment 3 or 4 is undertaken by NHS England in partnership with the ICB.

NENC ICB is in segment 2, the table below shows the trust level overview of segmentation, CQC rating and any other support/escalation in place.

Provider	NHS OF segment	Oversight arrangements	Additional escalation/support	CQC overall rating/recent warning notices. Other external reviews of significance.
Cumbria, Northumberland, Tyne and Wear NHSFT	1	ICB led	*Action plan monitored via the Quality Review Group.	Outstanding (2022) (Learning disability and autism services - requires improvement Aug 2022*)
Northumbria Healthcare NHSFT	1	ICB led		Outstanding (2019)
County Durham and Darlington NHSFT	2	ICB led	Removed from Tier 2 Elective (12.4.23).	Good (2019)
Gateshead Health NHSFT	2	ICB led	Enhanced finance oversight/ support.	Good (2019)
Newcastle Upon Tyne Hospital NHSFT	2	ICB led	Tier 1 – Elective Removed from Tier 2 Cancer (April 2023) Northern Cancer Alliance and GIRFT support in place.	Outstanding (2019) (Warning notice Dec 22 re healthcare provided to patients with a mental health need, learning disability or autism). Maternity services rated as requires improvement (May 23).
North Tees and Hartlepool NHSFT	2	ICB led		Requires improvement (2022)
Sunderland and South Tyneside NHSFT	2	ICB led	Progress against CQC action plan provided through the Quality Review Group.	Requires Improvement (2023)
North Cumbria Integrated Care NHSFT	3	NHSE Quality Board	Removed from Tier 2 Cancer to ICB/NCA monitoring and support (May 23). NHS E Intensive Support Team input associated with segment 3.	Requires Improvement (2020)
North East Ambulance Service NHSFT	3	NHSE Quality Improvement Board	Range of support including NECS support for incident reporting.	Requires improvement (2023) Awaiting outcome of independent review
South Tees NHSFT	3	NHSE/ICB oversight of finance	Quality - supported by ICB and NHSE	Good (May 2023)
Tees, Esk and Wear Valleys NHSFT	3	NHSE Quality Board	Support and additional capacity from the wider NHS to progress programme of improvement work across services.	Requires Improvement (2021)

CQC Inspections for Adult Social Care, Primary Medical Care and Hospitals Services

The Care Quality Commission now publish a weekly report on services which have been inspected by specialist teams of inspectors. The report lists those inspections by CQC sector, i.e. Adult Social Care, Hospitals, and Primary Medical Care and include any additional detail in relation to enforcement. An overview of CQC ratings for General Practice, residential and community social care is given below.

General Practice CQC ratings overview as at 1 June 2023
The table below shows the current range of CQC ratings for general practice by area. This is reported on the previous CCG footprints but hopefully will change to align with new ICB arrangements in time.

The picture is generally very positive with 35 practices rated as Outstanding, 308 as Good and only one rated as Inadequate and 6 as Requires Improvement. Support arrangements are in place for those rated as Inadequate or Requires Improvement.

	Outstanding	Good	Requires improvement	Inadequate
NHS Northumberland	5	32	0	0
NHS North Cumbria	8	25	1	0
NHS North Tyneside	4	19	0	0
NHS Newcastle Gateshead	4	51	1	0
NHS South Tyneside	1	20	0	0
NHS County Durham	6	52	2	1
NHS Sunderland	3	35	1	0
NHS Tees Valley	4	74	1	0
ICB total	**35**	**308**	**6**	**1**

Residential Social Care Provider Overall Rating by Local Authority as at 1 June 2023
The table below shows the current range of CQC ratings for residential social care provider by Local Authority. Residential care providers include care home services with nursing (CHN), care home services without nursing (CHS), and Specialist college service (SPC). Examples of providers which fit under the residential social care provider category are Nursing home, Residential home, rest home, convalescent home with or without nursing, respite care with or without nursing, mental health crisis house with or without nursing.

The picture is generally very positive with 47 LAs rated as Outstanding, 719 as Good and 6 rated as Inadequate and 76 Requires Improvement.

	Outstanding	Good	Requires improvement	Inadequate
Cumbria	5	121	14	0
Northumberland	5	74	14	2
North Tyneside	2	37	3	0
Newcastle upon Tyne	6	51	6	2
Gateshead	4	38	6	0
South Tyneside	1	30	2	0
Sunderland	6	77	1	0
County Durham	10	128	7	1
Stockton-on-Tees	3	37	10	1
Hartlepool	0	24	2	0
Darlington	3	26	3	0
Middlesbrough	2	40	2	0
Redcar and Cleveland	0	36	6	0
Total	**47**	**719**	**76**	**6**

Community Social Care Provider Overall Rating by Local Authority as at 1 June 2023
The table below shows the current range of CQC ratings for residential social care provider by Local Authority. Community Social care category includes Domiciliary care services including those provided for children (DCC), Extra house services (ECX), Supported living services (SLS), and Shared Lives (formerly known as Adult Placement) (SHL).

The picture is generally very positive with 33 LAs rated as Outstanding, 390 as Good and only 1 rated as Inadequate and 19 Requires Improvement.

	Outstanding	Good	Requires improvement	Inadequate
Cumbria	2	68	4	0
Northumberland	9	38	2	0
North Tyneside	3	22	2	0
Newcastle upon Tyne	5	38	0	0
Gateshead	0	39	2	0
South Tyneside	2	14	1	0
Sunderland	2	38	2	0
County Durham	5	44	2	0
Stockton-on-Tees	1	26	2	1
Hartlepool	0	12	0	0
Darlington	2	16	0	0
Middlesbrough	1	18	2	0
Redcar and Cleveland	1	17	0	0
Total	**33**	**390**	**19**	**1**

ICB position on oversight framework metrics

The NHS Oversight Framework includes a large number of metrics across the domains of preventing ill health and inequalities; people; and quality, access and outcomes. ICBs are ranked according to their performance on individual metrics and reported as being in the highest quartile, interquartile or lowest quartile range for each indicator. There is a large cross over between the oversight framework metrics and the objectives in the executive summary dashboards so individual metrics are not repeated here but the high-level summary in the table below outlines the distribution across the quartiles by domain and notes how many standards were met in this latest data period.

Domain (Total number of indicators)	Number of indicators in highest quartile	Number of indicators in Interquartile range	Number of indicators in lowest quartile	Number met against those with identified standard
Preventing ill health & reducing inequalities (11)	7	5	0	1 of 8
People (9)	4	2	2	0 of 0
Quality, access and outcomes (50)	9	28	7	12 of 29
Leadership	0	1	0	0 of 2

Actions
Trust oversight meetings provide an important mechanism to discuss and understand challenges associated with delivery of oversight framework metrics as well as identify any common themes and actions. Recent meetings are noted in the section below. Work is underway to extend this

mechanism to strategic programmes and places with the intention to begin oversight meetings in quarter 2 now that plans have been developed.

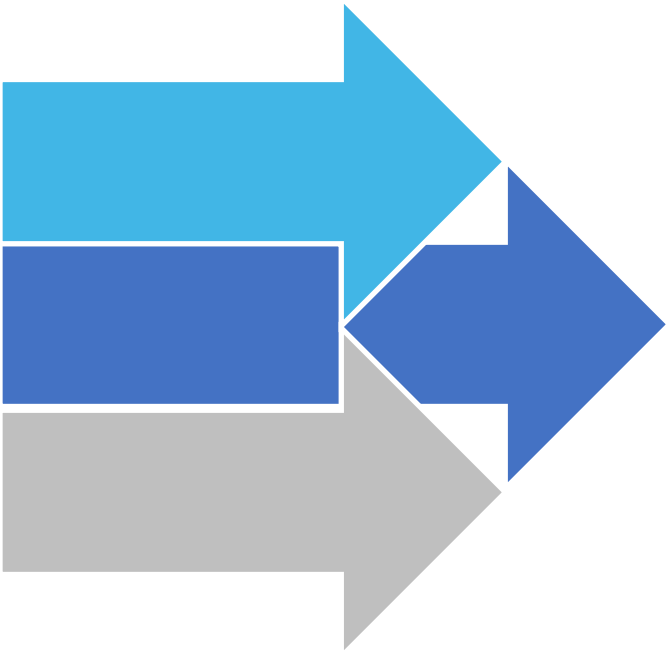
Recent oversight meetings

An oversight meeting was held with Gateshead Health NHS FT on 20 April, and with North Tees NHS FT on 19 May. At Gateshead Health discussions were positive, and many areas of good practice recognised including a new operating model developed across unscheduled care and elective/planned recovery, and ongoing transformation in elective theatre utilisation and diagnostics. The meeting attendees recognised the need for the development of the Trust Health Inequalities ambitions using the Health Inequalities toolkit. A discussion was held over the two year financial recovery plan and its associated pressures, with a further meeting to be organised between Trust and ICB to understand plans in more detail.

At North Tees discussions were also positive, with a very strong performance in relation to elective care waiting times and activity noted. The Trust also shared its good practice in relation to identifying and addressing inequalities in access to its services.

ICB Complaints and Healthwatch Themes

Complaints and themes from Healthwatch are reported quarterly and will be included in the August Integrated Delivery Report.



Delivery of 2023/24 objectives

Urgent and Emergency Care - April/May23 (except *data)

Objective	Plan (Mar 24)	Plan (month)	Actual	Trend	Benchmark
A&E waiting times < 4hrs May	80.8%	77.7%	77.1%	Worsening	74% ENG
Cat2 ambulance response May (NEAS)	30 min	34m	33.9m		7/11
Adult G&A bed occupancy May	92.1%	91.7%	90.5%	Worsening	94.5%
Patients not meeting the criteria to reside (CtR)* w/e11/6/23		9%	14.9%		
Ambulance handovers >59mins:59s*w/e 5/6	0	0	129		
111 Call Abandonment (NEAS plan)	3%	27%	14.8%		
Mean 999 call answering time*	<10s	<20s	9.8s		8.8 ENG

Observations

- **A&E 4 hour performance** Whilst SPC highlights this metric as worsening since Q4 20/21, more recent trends over the past year show this to be relatively static. NENC has improved performance ranking from 15th in April to 14th out of 42 ICSs in May. Trust level performance ranges from 72% - 92%.
- **Handover delays** - continue to improve from Mar23 to May 23 for delays 30-60mins and 60+ minutes after a challenged winter period.
- **NEAS Response Times** – NEAS remains a strong performer nationally, ranking 1/11 of ambulance providers for Cat1 and Cat4 response. However, Cat 2 mean response has deteriorated slightly in May 23 and NEAS is ranked 7/11 of all ambulance providers nationally.

Actions/learning

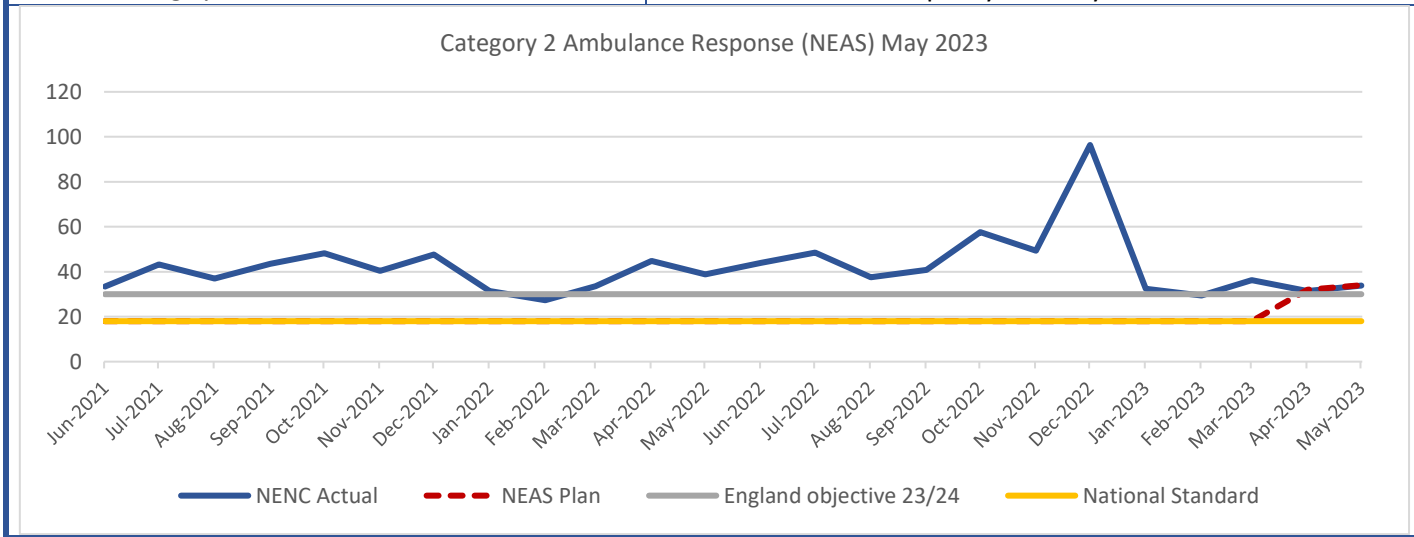
- **National UEC Ten Point Recovery Framework** now launched. ICB is fully participating
- **Variation -** priority to understand and then reduce inappropriate variation at Place, LADB and Organisational levels through a learning and improvement approach
- **Setting the top 3 system planning priorities** for Winter 2023/24 is now underway with plans for a laser-like focus on what will deliver the best pathways for patients across the system
- **Transfers of care programme** main work areas will be:
  1. Improving joint discharge processes
  2. Scaling up intermediate care
  3. Scaling up social care services
- **Major focus on neuro rehabilitation** to streamline pathways and explore capacity needs.

Quality implications

- Reduction in ambulance handover delays and the improvement in Cat 2 responses will significantly increase the quality and safety of care for patients.
- Reducing patients who no longer meet the CtR will reduce stranded patients in hospital and the harmful effects of long stays; whilst increasing system flow.

Recovery/ delivery

- **Handover delays -** work requires further focus to reduce to 15 minutes national target – working with three outlier Trusts to improve local positions
- **Cat 2 response** – handovers, extra staff and healthcare professional call improvements required
- **Virtual wards** – plan for Community of Practice event to improve utilisation of this resource and support better flow and bed occupancy in the system



Primary and Community Care - April 23

Objective	Plan (Mar 24)	Plan (month)	Actual	Trend	Benchmark
2-hour urgent community response* (UCR) (Jan 23)	70%	70%	82.9%		
Reduce unnecessary GP appts: direct referral community optometrists/self-referral					
Proportion of GP practice appointments within two weeks			81.9%		79.9%
More appointments in general practice by March 24	1.57m	1.5m	1.30m		
Additional Roles Reimbursement Scheme (ARRS)	1526		1246		
Improving units of dental activity (UDA) to pre-pandemic levels	100% 2.13m		May 23 74.4%	Improving	76.8%
Proportion of appts the same or next day			64.3%		63.3%
2-hour UCR first care contacts delivered		4160	2515	Improving	

Observations

- GP appointment numbers continue to increase.
- NENC above NE&Y for same day appointments in general practice, but lower for % of patients seen next day.
- NENC performs better than the benchmark for patients seen within 2 weeks for an appointment, above NEY.
- NENC on trajectory to deliver more appointments by March24.
- Large underspend for ARRS against 22/23 funding.
- Challenges due to dental contracting model leading to reduction in dental UDAs.
- UCR exceeding 70% threshold – data for one trust yet to be published via the national dashboard, expected to be resolved for future data release. Increase in activity levels expected in April reporting due to inclusion of additional service type codes, including district nursing.

Actions/learning

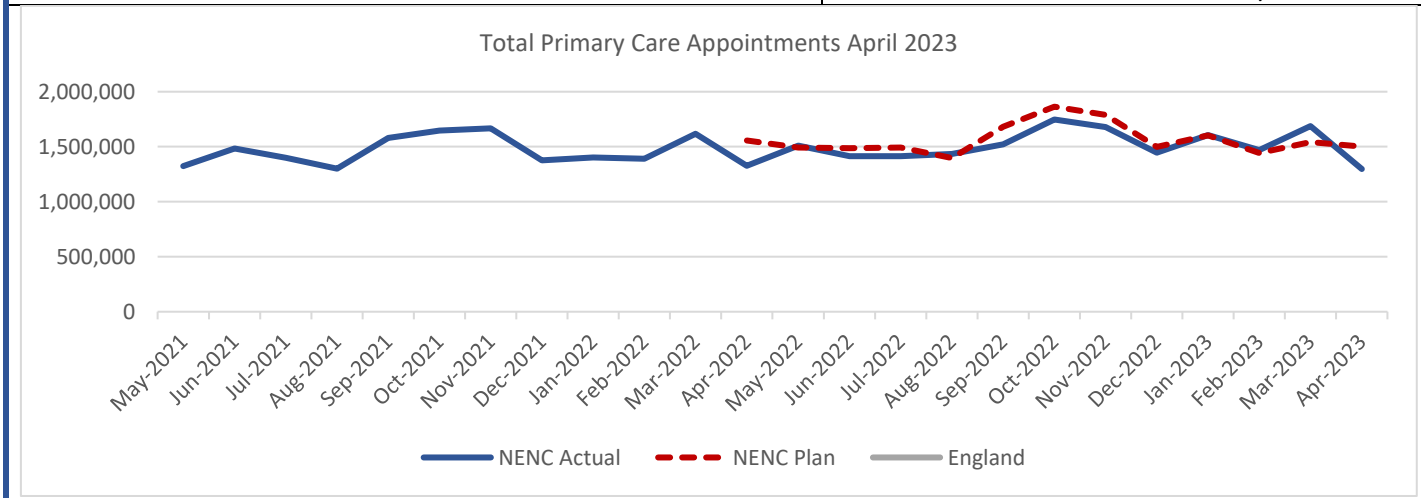
- Work to improve data quality of GP appt/UCR
- Challenges to PCNs maximising use of funding including workforce, estates, on-costs, clincial supervision requirements, emplyment models.
- ICB engaging with national dental reform programme to improve usage.
- Risk identified of dental contracts being given up where contractual obligations cannot be fulfilled.
- Data on UCR 2-hr standard - low data completeness and quality; work ongoing.
- UCR Monitoring Report developed for NENC ICB

Quality implications

- Project to develop standardised quality metrics in progress.
- Issues with access can result in poor patient experience.

Recovery/delivery

- Work underway to reduce barriers facing PCNS and increase employment in 23/24
- Focus on increasing UCR referrals, including from 999/111, TEC responders and care homes.
- UCR forecast a 13% increase 23/24.



Elective care - April 23

Objective	Plan Mar24	Plan (Month)	Actual	Trend	Benchmark
52 week waits (eliminate by March 2025)	5142	8379	8112		
65 week waits (0 by end of Mar24)	14	2426	1550		
Value weighted Activity levels **FOP** (109%) 4/6/23	109%	107%	81%		
78 week waits (0 by end Mar 23)	0	114	169	Improving	
104 week waits (0 by end of Mar 22)	0	13	20		
Reduce outpatient follow ups by 25% * (4/6/23)	75%	96%	79%		
FFT – outpatients (trust range)			94.7% - 100%		
FFT – inpatient care (trust range)			89.8% - 99%		

Observations

- Waiting lists continue to increase month on month across NENC and are above plan.
- Demand continues to outpace capacity in majority of providers and specialities.
- Activity was affected by Industrial Action and bank holidays in April.
- Specific risk at Newcastle upon Tyne Hospitals (NUTH) including spines, Orthopaedics, Dermatology and Ophthalmology.
- April plan for 78 weeks waits at NUTH is 114, the trust is behind plan at 164. In addition there were a small number of 78ww at South Tees FT and 1 at South Tyneside and Sunderland (due to national supply issues of corneal tissue) bringing the April total to 169.

Actions/learning/risks

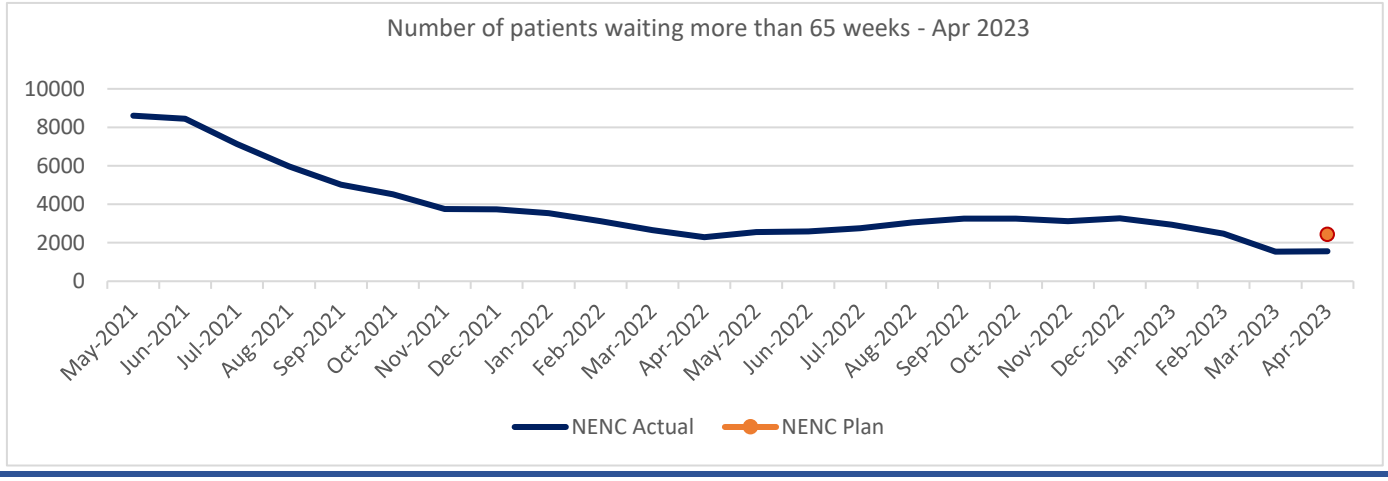
- **Workforce and industrial action –** risk pressures being managed through CEOs and COOs and an agreement that allows staff to move between Trusts.
- **Children and Young People (CYP)** – national campaign now underway supported by Trust specific data to ensure recovery in CYP is equitable to adult services.
- **Spinal services** – June event to develop standard Single Point of Access Pathways for Spinal Services across NENC.
- **Outpatient (OP) transformation** – July workshop planned to share learning and consider how to maximise opportunities across the ICS, further event planned for September.
- **Patient Choice –** national letter published in May outlining actions for primary care, secondary care and ICBs. This will be considered as part of OP transformation.

Quality implications

- All providers assess risk in the management of their waiting list
- Patient choice may result in treatment being deferred and impact on the ability to improve the overall waiting list position.
- Patient access policies to be agreed across the system which are inclusive and recognise potential Health Inequalities.

Recovery/delivery

- Recovery impacted by Industrial action in April.
- Work on validation continues across trusts and learning in relation to use of robotics and Artificial Intelligence underway.
- Work continues through the Tier 1 elective meetings with NUTH to monitor trajectories to clear 78+ and 104+ waiters throughout 23/24. Reliance on mutual support across the system to support this.



Cancer and Diagnostics - April 23

Objective	Plan (Mar 24)	Plan (month)	Actual	Trend	Benchmark
Reducing 62 Day Backlog (11/06/23)	800	1007	1123		
Faster Diagnosis Standard (FDS)	77.6%	76%	75.3%	Improving	71.3%
Early Diagnosis ambition					
Monthly Cancer 62 Day Performance	85%	85%	63%	Worsening	61%
% Receiving diagnostic test < 6 weeks (by Mar25)	89.4%	85.1%	83.3%	Improving	
Diagnostic activity against plan *4/6/23	109%	103%	103%		

Observations

- Cancer backlog remains above the 19/20 average.
- May 2023 ICB continues to be behind plan for backlog reduction, only 3/8 Trusts are achieving trajectory.
- Main specialities in cancer backlog are Urology patients, and upper and lower GI patients.
- FDS performance continues to be strong in April at 77.6% (*through local reporting), compared to a national position of 71.3%.
- FDS has been archived 7 months in a row.
- Best Practice Timed Pathway data collection for prostate and Colorectal completed for April.

Diagnostics

- >6 week waiters deteriorated in April, driven by reduction in capacity due to industrial action.
- Trusts reporting referral growth, particularly imaging.
- Activity 6% above trajectory in all modalities except Endoscopy.

Actions/learning/Risk

- Significant effort in backlog recovery to be sustained into 23/24 from Trusts with support from NCA and ICB and NHS England.
- No organisations in NHS E tiering system therefore local ICB processes in place to ensure oversight.
- *Data submission issues for FDS for Newcastle and Northumbria, FDS position of 75.3% reported nationally is incorrect. Local reports updated to 77.6%.
- Continue to share best practice amongst providers.

Diagnostics

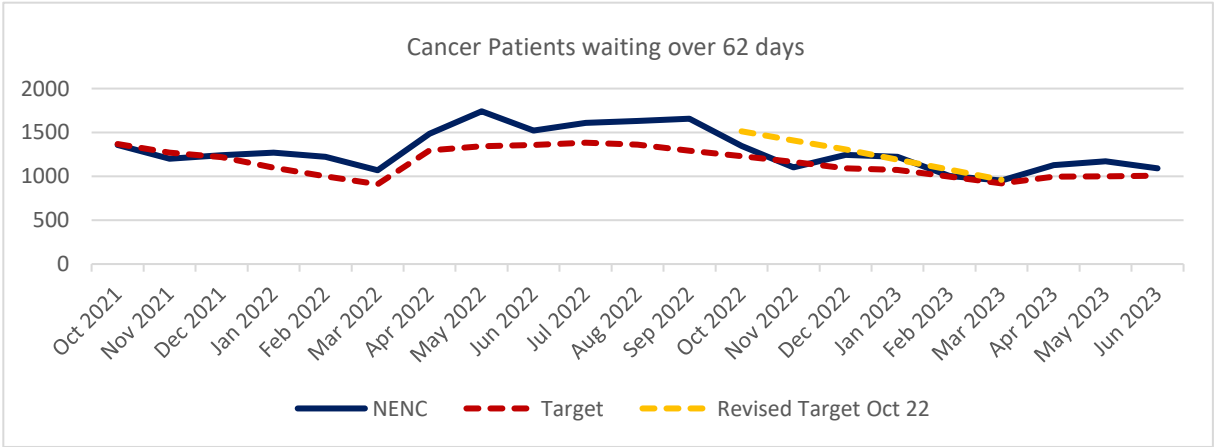
- NENC audiology group established.
- Focus on mutual aid for diagnostics with large backlogs.
- FT diagnostic recovery plans in place supported by diagnostic performance meetings.
- Proposals to increase echocardiographer training.

Quality implications

- Reducing long waits and the cancer backlog improves quality of life for patients.
- FDS provides a timely diagnosis and improves opportunity for treatments.
- Improved equity in access to diagnostic services.
- Availability of diagnostics impacts on cancer waits and elective recovery.

Recovery/delivery

- 2022/23 cancer backlog trajectory met but April behind plan - provider assurance of improvement.
- FDS strong performance expected to continue.
- Recovery expected Mar 25 for diagnostics standard.
- Implementation of diagnostic workforce strategies, working to identify expansion in training.
- Improving position expected 23/24.



Maternity – March 2023

Objective	Plan Mar24	Plan (month)	Actual	Trend	Benchmark
Maternal mortality					
Still births per 1000 births			3.13	Improving	3.29
Neonatal deaths per 1000 live births			1.5	Improving	1.5
Increase fill rates for maternity staff					
Proportion of maternity settings offering tobacco dependence			50%	Improving	18.7%
FFT: Maternity services	Range from 63.6% to 96.6% who would recommend the service across our providers.				

Observations

- The Local Maternity and Neonatal System (LMNS) has developed a dashboard.
- Still births, neo-natal deaths and proportion of our providers offering tobacco dependence services compare favourable to national and demonstrate an improving position.
- Two maternity units (North Tees & Sunderland & South Tyneside) remain under the National Maternity Support Scheme. Five other maternity units have been inspected during 2023 so far with only South Tees awaiting their inspection. NUTH report was published in May receiving a rating of 'Requires Improvement' for maternity.

Actions/Learning/risks

- Non-recurrent funding streams require continuous financial planning and modelling and flexible staff resources.
- Recruitment and retention of multi-disciplinary team (MDT) maternity and neonatal staffing is a pressure; collaboration across NENC in workforce capacity underway.
- Introduction of the Independent Senior Advocate Role in NENC, a requirement from the first Ockenden Report. Contract awarded to People First Independent Advocacy, the service is due to commence on the 1st August 23.
- The 'Help shape our Maternity & Neonatal Services' event was held on 10th May. Eight common key themes were identified.
- Outputs currently being mapped against the NHS England Maternity and Neonatal Three Year Delivery Plan.
- Coordination of Enhanced Continuity of Care data for 3 Trusts for submission to NHS England National Team to enable 23/24 funding to be issued.

Quality implications

- Continued focus to provide safe and compassionate care of women and babies
- All 8 Trusts have now agreed a date for their 2023 Ockenden visits, which will be carried out by the LMNS and led by ICB Executive Director of Nursing between Sept – Nov 23.
- National guidance on maternity incident reporting system (PSIRF) awaited. LMNS have organised a maternity/neonatal workshop in Durham planned for 12th July.
- The CNST Year 5 Core Competency Framework was released on the 31st May 23.
- Saving babies lives care bundle v3 published 1st June 2023, adding a 6th element 'Management of pre existing diabetes in pregnancy' .

Recovery/delivery

- A Maternity and Neonatal Alliance has been created
- Continue to the use the learning health system model to combine data, collaboration and quality improvement techniques towards collective improvement.
- Look to improve NENC maternity and neonatal services, evaluate projects using a research approach by working with the Academic Health Science Network and local universities.
- Work closely with other LMNSs across the country.
- Partnership arrangements being strengthened with Higher Education Institutes that provide maternity courses in an aim to reduce midwifery student attrition rates.

Use of resources Data period M2 (May 23)

	Month 2 YTD plan	Month 2 YTD actual	2023/24 Annual plan	2023/24 Forecast Outturn
ICS financial position (surplus)/deficit	£28.66m	£30.46m	£49.87m	£49.87m
ICB financial position (surplus)/deficit	(£5.40m)	(£5.38m)	(£32.40m)	(£32.40m)
Running cost position	£9.57m	£9.57m	£57.41	£57.41m
Capital funding	£33.16m	£34.73m	£198.95m	£208.39m
QIPP/Efficiency savings	£47.64m	£43.64m	£408.36m	£408.14m
Mental health investment standard	6.73%	6.73%	6.73%	6.73%

Observations

- As at 31 May 2023, the ICS is reporting a year to date deficit of £30.46m compared to a planned deficit of £28.66m, an adverse variance of £1.8m. The forecast position for the year is a deficit of £49.87m, in line with plan.
- The £1.8m year to date overspend compared to plan reflects pressures in provider positions relating to costs associated with strike action and achievement of elective recovery funding.
- The ICB is reporting a year to date surplus of £5.38m, broadly in line with plan, with a forecast surplus for the year of £32.4m.
- Running costs - the ICB is reporting a breakeven position against running cost budgets. Additional funding has now been confirmed to reflect the final 2023/24 pay award, this is being reviewed to consider any impact on the reported position.
- Capital spending forecasts are currently in line with plan, however this includes an allowable 5% 'over-programming', hence the forecast is £9.44m in excess of the ICS capital allocation. This will need to be managed over the remainder of the year.
- The ICS is reporting efficiency savings of £43.64m at month 2, which is slightly below original planned levels. Forecast savings for the year remain broadly in line with plan. The ICB is currently forecasting delivery of efficiencies in line with plan although this remains a considerable risk.
  The ICB is expecting to achieve the MHIS target for 2023/24 (growth in spend of 6.73%).

Actions/risk

- At this stage of the year there is always very limited data available which creates a level of risk and uncertainty in the forecast outturn position.
- The submitted 2023/24 plan including significant unmitigated financial risks across the ICS, which remains the case at month 2.
- At month 2, total unmitigated risks of £101.6m are being reported (compared to £102.5m in plan). This includes unmitigated net risks of £26m for the ICB, predominantly relating to prescribing, CHC and delivery of efficiencies, along with £75.6m unmitigated net risk across providers.
- In response to these risks, additional financial controls have been agreed by ICB Executive Committee including a pause on discretionary non-staff spend (alongside vacancy controls already in place) and identification of additional risk mitigations
- Across the system, additional financial controls are being reviewed in line with NHSE requirements following submission of a deficit plan.
- Work continues on the development of the ICB in response to the forthcoming 30% real terms reduction in running cost allowances.

Quality implications

Good financial management supports delivery of high quality services and reduction of health inequalities. All programme areas have a named finance to support programme delivery.

Recovery/delivery

As referenced above, financial controls are being reviewed across the system, with additional controls implemented where necessary to manage potential financial risks.

Work is continuing across the system on the development of a medium term financial strategy and appropriate financial recovery plans.

Workforce – January/February 2023

Objective	Plan Mar 24	Plan (Month)	Actual	Trend	Benchmark
Improve staff retention (turnover systemwide NENC Providers)	12.1%		11.2% Feb23		
Improve staff attendance (sickness systemwide NENC Providers)	5.6%		6.4% Jan 23		

Observations

Sickness

- Sickness absence continue to progress on a positive trajectory with an in month position 0.4% below plan at the end of March which is an improvement on the latest published data above where it improved further to 5.5%.

Turnover

- National methodology has changed. Definition of turnover is leavers, plus other staff who remain in the NHS but who have changed profession or employer in the last 12 months.
- NENC continue at the lower end of the regional picture at 12.7% March 23 (utilising more timely data).

Actions/learning/risk

- Work commenced to review the approach to operational planning ensuring ongoing dialogue between ICB and providers linked to budgets and activity.
- There is a risk if this work is not taken forward that plans will not be realised. This would be mitigated by a better understanding of issues affecting sickness and turnover through ongoing dialogue with providers.
- Pressure on remaining staff due to sickness and turnover having a detrimental impact on health and wellbeing. This has been identified as a key priority within the ICB People Strategy.
- Event held on 8th June to bring together key stakeholders across NENC supporting the development of strategic priorities: supply, retention and health and wellbeing.
- Gateshead Heath FT have undertaken work that has successfully resulted in the reduction of agency staff.

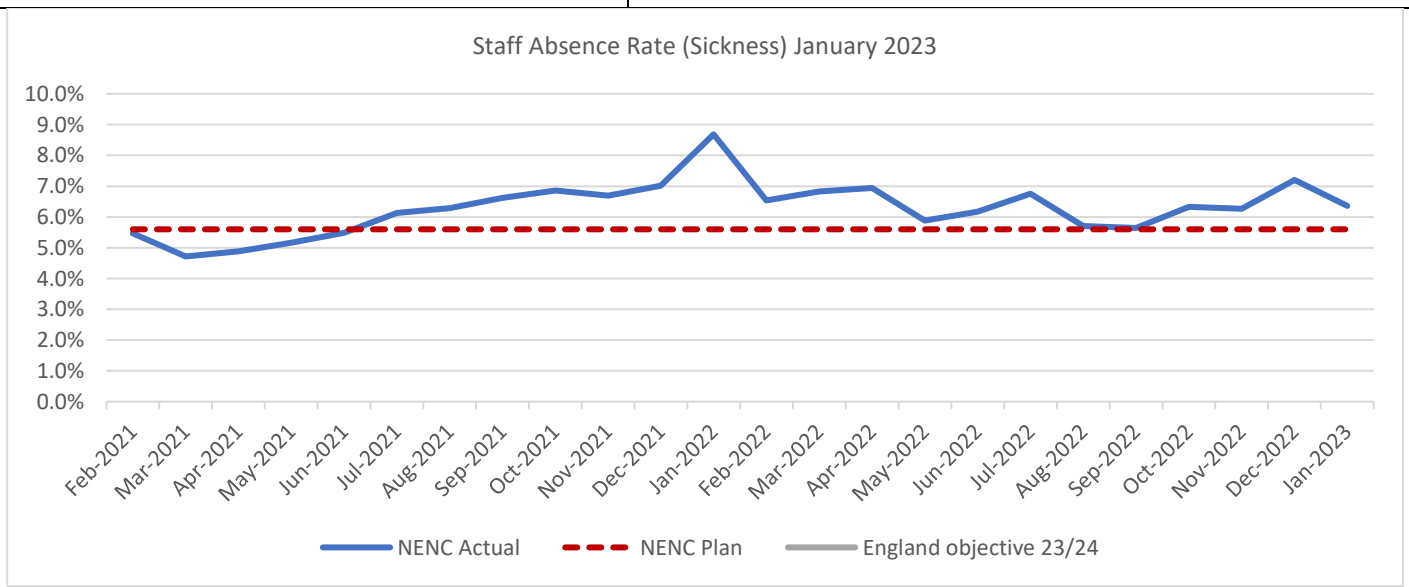
Quality implications

- Higher levels of sickness affect quality as there less staff available to undertake their duties.
- Lack of continuity of care, staff shortages through vacancies putting pressure on remaining staff, time and effort involved in recruiting, training and inducting new staff members adding further pressure to existing staff.

Recovery/delivery

- The operational planning round has indicated that overall, Trusts are aiming to achieve the following from March 23 to March 24:
  - to reduce sickness absence by 0.33%
  - to reduce turnover by 0.38%

Assurances from Trusts that plans in place to reduce sickness absence, improve retention and reduce turnover. Agreement to provide mutual support across all organisational boundaries where there are particular pressures on service areas.



Mental Health: Adults - March 23

Objective	Plan Mar 24	Plan (month)	Actual	Trend	Benchmark
TTAD access (March 23)	22,540	7246	4930		
Community mental health (CMH) 2+ contacts 5% increase	34,855	33,208	35,645		
Number of out of area (OOA) placements (March 23)	162		900		
Dementia diagnosis rate (March 23)	66.7%	66.7%	67.9%	Improving	
Improve access to perinatal mental health services (Mar)			2245	Improving	

Observations

- **NHS Talking Therapies for Anxiety and Depression (TTAD) access (the new national terminology for IAPT)** remains below plan and target. This is due to workforce pressures, increased acuity, inappropriate referral levels, waiting list backlogs and investment/procurement challenges.
- **CMH –** Locally 22/23 targets were met across County Durham and Tees Valley
- **OOA placements -** Inappropriate bed days have seen an overall decline but numbers remain above the target of 147 by Q4 23/24.
- **Dementia**- improvement throughout 22/23, end of year plan met.
- **Perinatal** below plan in NENC, recovery plan in place - demand lower than LTP projections and investment challenges. Further impacted by the inability to recruit and lack of Maternal MH Services in County Durham and Tees Valley.

Actions/learning

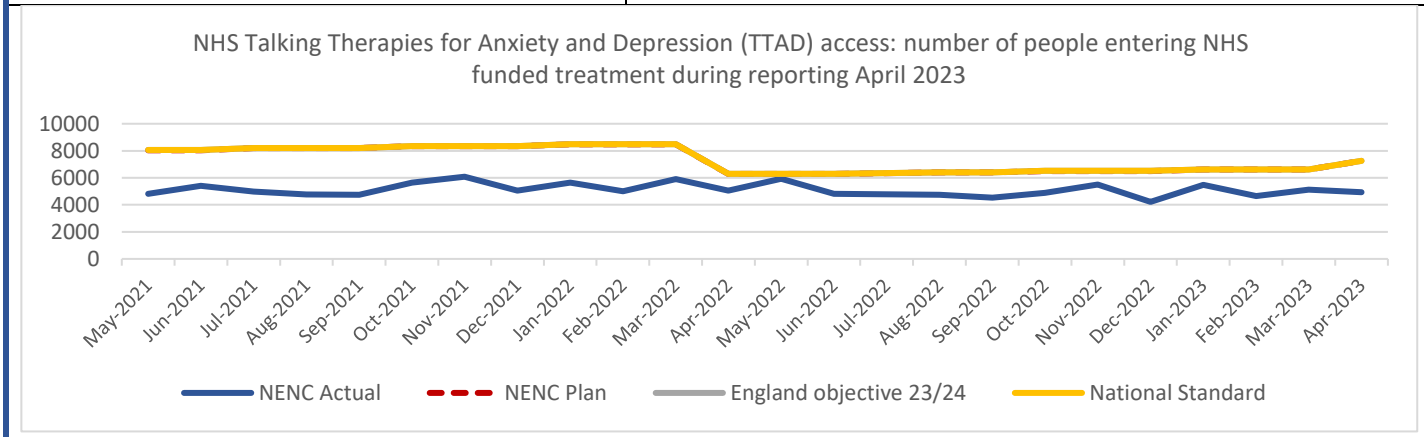
- **TTAD** -Actions include: publicity, system-wide recruitment event in July, engagement with PCNs and primary care referring agents, waiting list and DNA initiatives and exploring recruitment opportunities, engagement with primary care services and utilisation of digital sub-contractors for gaps in service delivery and online booking options. 23/24 ICB review of all delivery contracts and commissioning model underway
- **CMH -** Access to community mental health services has increased and caseloads have been getting larger. NENC achieving revised community contacts target.
- Possible shift in activity to Voluntary and Community Sector now CMHT is being progressed within localities. System and data interoperability workstream underway to improve capture of contacts across multiple support providers.
- **OOA** Placements pressures within the adult acute pathways. Work currently with partners to facilitate discharges back into the community.
- **Perinatal** staffing pressures and DNAs are being reviewed; in the South 1 vacancy filled with teams awareness raising to increase referrals.

Quality implications

- Increased waiting times have a negative impact on mental health conditions whilst they are waiting.
- Patients awaiting repatriation to their home area have poorer outcomes and less likely to receive frequent family visits due to distance.
- Resettlement/rehabilitation may not be as timely as when placed in home area.

Recovery/delivery

- Challenges in the delivery of key community transformation ambitions in 22/23, linked to financial/workforce pressures, limiting capacity in community to prevent admission and hasten discharge of people clinically ready for discharge.
- The ICB is working hard to improve mental health pathways for patients, and continuing to invest in community support.
- The ICB is making progress in improving services, with further work underway to address any variation within the region.



Mental health: Children & Young People – Dec 22/Apr 23

Objective	Plan 24	Plan (month)	Actual	Trend	Bench mark
Improve access to mental health support for CYP (Apr)	53,245	51,343	54,105	Improving	
CYP Eating disorders (ED) - urgent within 1 week (Dec 22 data)	95%	90%	89.9%		
CYP Eating disorders (ED) – routine within 4 weeks (Dec 22 data)	95%	91.1%	74.3%		

Observations

CYP Access

- CYP access remains above operational plan trajectory but below Long Term Plan (LTP) target.
- Need has increased beyond LTP projections combined with an inability to recruit and retention of staff.
- Challenges in reporting accurate data is also noted.
- Services for CYP eating disorders are not meeting the 95% standard (12 month rolling).
- Waiting times for children and young people entering treatment for mental health problems have shown an increase in NENC.
- This pressure has exacerbated since the pandemic, due to the increased demand and the shortage of qualified mental health staff in the region.
- Local data indicates excessively long waits for some children referred for assessment for autism and attention deficit hyperactivity disorder (ADHD).

Actions/learning

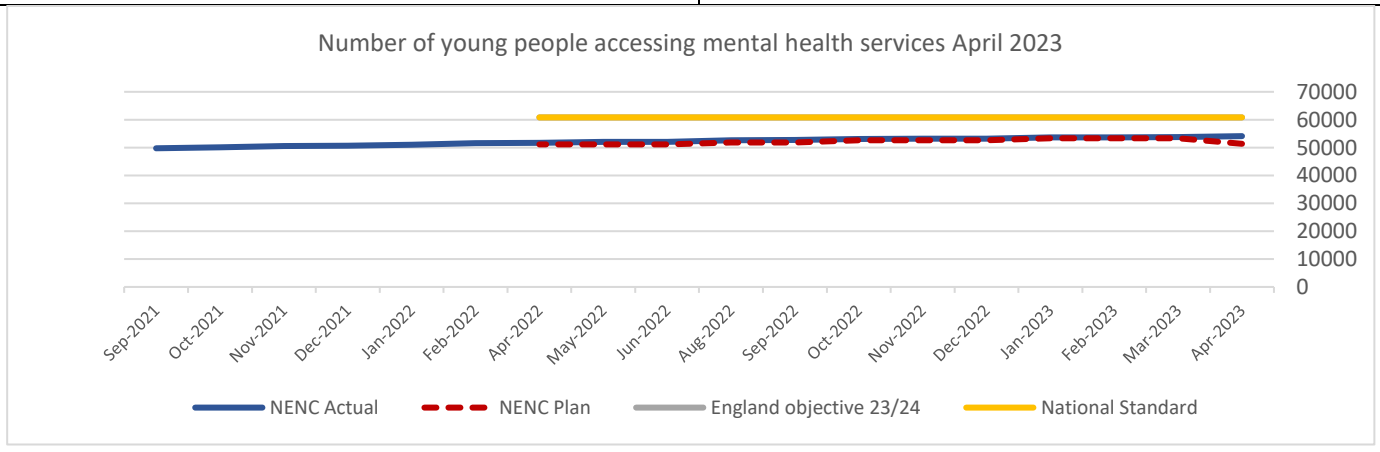
- Place based actions to review pressure points and determine need underway.
- CYP access achieved and an exercise planned in the South to improve outcomes and equity of access.
- Specific actions include: waiting list initiative/recovery plans, commissioning additional support for particular presentations, single point of access evaluations.
- Workshop took place in the South in January to look at risk/escalation and creation of a decision making matrix to assist acute and MH hospitals in relation to nasogastric feeding in young people with eating disorders.
- Data quality standard operating procedure developed.
- The ICS MH workforce group will share positive practice and drive initiatives to address workforce pressures.

Quality implications

Children, young people and families may experience exacerbation of difficulties/problems as they wait to start treatment.

Recovery/delivery

- 22/23 performance for CYP patients accessing services is currently exceeding planned operational plan trajectory for 22/23, however Long Term Plan trajectory will not be achieved.
- The ICB is working hard to improve the pathway for our patients, as well as investing in extra support to help children who have additional emotional, mental health and wellbeing needs. The ICB is making progress in improving services, with further work underway to address any variation within the region.



People with a learning disability and autistic people - April 23

Objective	Plan (Mar 24)	Plan (month)	Actual	Trend	Benchmark
Annual health check and plan for people on GP LD registers (Cumulative 75% March 24)	77%	Cum to 75%	3% Apr		
Reduce reliance on inpatient care adults (ICB) – *chart below*	52 (21.9 per/m)	80 (June 23)	82 26/5/23		
Reduce reliance on inpatient care -adults (Secure)	61 (25.7 per/m)	72 (June 23)	76 26/5/23		
Reduce reliance on inpatient care – under 18s	8 (13.6 per/m)	8	9 8/5/23		
Care and Treatment Reviews (adults)	Fully Compliant		Apr 23		
Care Education and Treatment Reviews (CYP)	Fully Compliant		Apr 23		
Learning from death review (LeDeR) compliance	Fully Compliant		97%		

Observations

- During May 2023, 11 people were discharged from inpatient care and 8 people admitted.
- 2 ICB discharges and 4 secure setting needed to achieve end of Q1 trajectory

Actions/learning

Case Management development sessions held to:

- Standardise approaches across the ICB
- Implement the dynamic support register/care education and treatment review revised process

Meeting with NEY NHSE Chief Nurse 19th June to review people with no discharge plan/date.

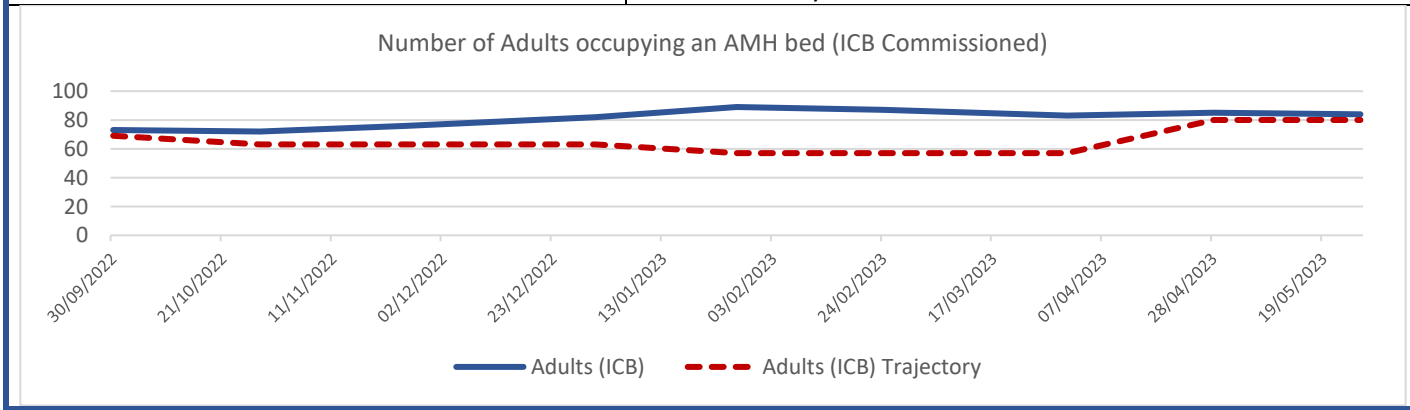
NEY NHSE Programme Oversight and Support Meeting 7th June – performance review meeting. Feedback pending.

Quality implications

- Oliver McGowan Mandatory Training
- Peer support workers
- Autism Framework and Operating Guidance
- Sensory friendly environments
- Care model review; including inpatient assessment and treatment location and effectiveness
- Care Education and Treatment Review Oversight Panels being set up;
- Mental Health, Learning Disability and Autism Quality Transformation Programme; planning for next session on the 30th June 2023

Recovery/delivery

- Revised governance structure in development
- Forward View draft priority areas – leads assigned
- Senior Intervenor support; 14 people identified requiring external support to discharge; action planning.
- Complex Commissioning Framework drafted, consultation to begi
- Inpatient population data project; priorities clarified
- Housing Strategy and Population Analysis lead – NHSE NEY Housing specialist; aim to meet the needs locally
- Assessment of enhanced community model – action planning in progress; review models at place in relation to consistency and ability to keep people safe and well in the community.



Prevention and Health Inequalities including Core20+5: Adults - Mar 2023

Objective	Plan Mar 24	Plan (Month)	Actual	Trend	Benchmark
Hypertension (77% by March 2024)	77%		65.9%		60.4%
Use of lipid lowering therapies (60%)	60%				
60% SMI Health checks		16,325	14,592		
Increase uptake of COVID vaccines			64.7%		
Increase uptake of flu vaccines			63%		
Increase uptake of pneumonia vaccines					
Continuity of carer for women from BAME communities and most deprived groups					
75% cancers diagnosed at stage 1 or 2 by 2028					

Observations

- The development of a NENC Health Inequalities Dashboard covering a range of measures has been undertaken.
- The dashboard supports assessment against the national objectives – providing a broader context to key performance measures.
- The dashboard metrics will be used by both the workstreams and the overarching Healthier and Fairer Advisory Group to monitor progress against plans and support the development of approaches going forward.
- Many of the national objectives do not state specific dates or targets and therefore a NENC approach to develop a defined trajectory to measure the overarching programme against has been undertaken.

Actions/learning

- The Healthier and Fairer Advisory Group was formally established as a subcommittee of the ICB Executive Committee in November 2022.
- The programme integrates and coordinates the work of several pre-existing advisory structures dealing with population health and inequalities (Population Health and Prevention Board, Health Inequalities Advisory Group, Deep End Steering Group).
- Responsibility and accountability of many of the current NHSE national objectives aligned to the Healthier and Fairer programme sit currently with other parts of our system for example Clinical Networks.
- Work has commenced across the programme with Strategic managers and clinical network leads on developing SMART metrics across all domains and will be supported at a Healthy and Fairer development session 23rd June.
- Outputs from the development session will be incorporated into this report in due course.

Quality implications

Governance of the programme has now been developed with 3 key workstreams:

- Prevention,
- Healthcare Inequalities
- NHS contribution to social and economic inequalities.

Recovery/delivery

Supporting the programme are 3 enabling workstreams:

- Population Health Management,
- Workforce
- Community Asset Based approaches.

Each of the workstreams have developed their five year plan and have identified key measures and metrics to monitor delivery against.

These broader plans have been incorporated into a single plan to inform the ICB Joint Forward Plan.

Prevention and Health Inequalities including Core20+5: Children

Objective	Plan 24	Actual	Trend	Benchmark
Asthma – address over reliance of medications				
Decrease the number of asthma attacks				
Increase access to glucose monitors and insulin pumps				
Proportion of diabetes patients (type 2) receiving 8 NICE care processes		46.5%		46.7%
Access to epilepsy specialist nurses				
Reduce tooth extractions due to decay for children admitted as IP in hospital aged <+10				
Improve access rates to children and young people`s mental health service for: 0-17 yr olds, certain ethnic groups, age, gender and deprivation.	100%	94.6%		

Observations See Prevention and Health Inequalities: Adults section	**Actions/learning** See Prevention and Health Inequalities: Adults section
Quality implications See Prevention and Health Inequalities: Adults section	**Recovery/delivery** See Prevention and Health Inequalities: Adults section

Safety – April/May 2023

	Plan Mar 24	Plan YTD	Actual (month)	Actual YTD	Trend	Benchmark
Never events * (May)	0	0	1	2		
Serious incidents (SIs)			70	152		
SIs reported within 2 days	Range from 36.4% to 100% across our FTs					
MRSA (Apr)	0	0	4	4	Worsening	
C diff		50	50	50		
E coli		75	96	96		
Mortality	All Trusts within expected range.					

Observations

- NENC is over trajectory for the key HCAI infections – 50% FTs for MRSA and 25% for ecoli.
- Despite good progress pre-pandemic, infection control management progress continues as a challenge with a deteriorating national picture.
- NENC is challenged with the number of C-diff cases across the system – 50% FTs over threshold although the FT aggregate is on plan.
- Increased demand on Trust estate and daily challenge to ensure patient flow through the hospitals adding to current pressures for infection control management
- 3 Never events reported since Apr 23 from 2 FTs.
- No Trusts are currently an outlier for mortality
- Themes for SIs are monitored through the serious incident process.

Actions/learning

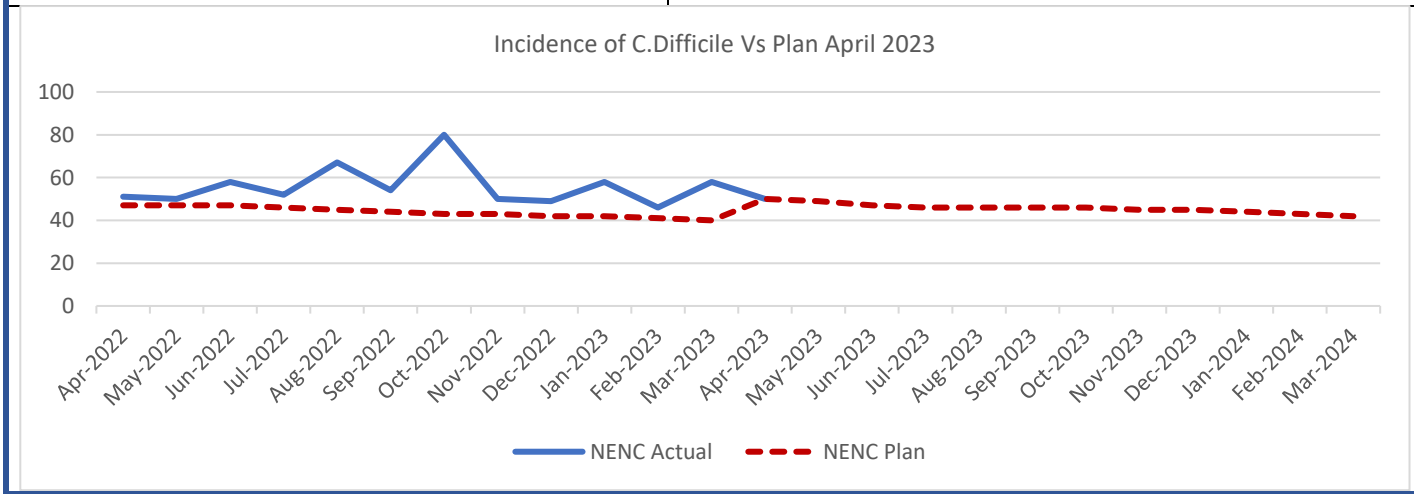
- Oversight through the NENC Anti Microbial Resistance/Health Care Associated Infections (AMR/HCAI) Subcommittee where learning and good practice is shared for discussion at place and local Quality Review Groups.
- NENC deep dive being undertaken in relation to C-Diff on 21st June. Similar processes to be undertaken for all key infections across the system.
- HCAI and gram-negative improvement plans in place, with some areas looking to complete research.
- Greater communication with patient flow teams and Infection control teams.
- All Trusts raising the importance of the fundamental precautions.
- Work continues to review open caseloads of SIs and Never events to gain assurances.

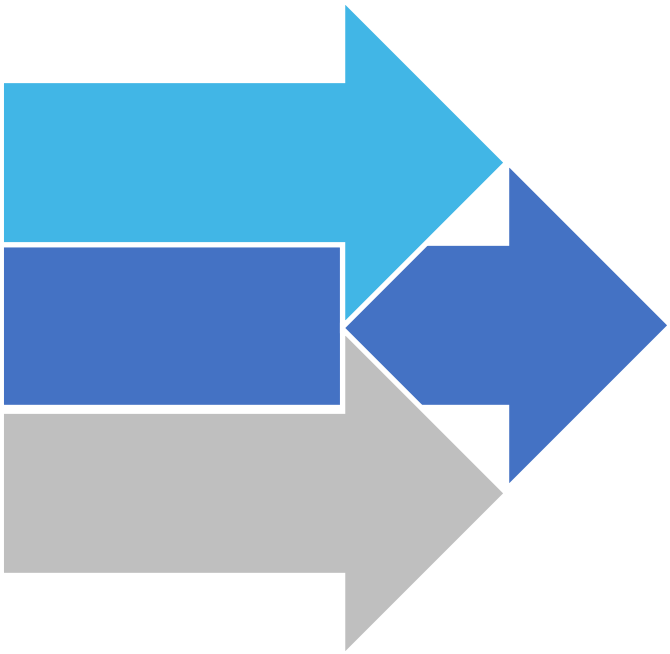
Quality implications

- MRSA cases have been subject to post infection review to explore any lapses in care and learning.
- Impact of increased infection risk on patient safety and length of stay in hospital
- Never event learning shared through established forums and clinical networks
- Mortality reviews undertaken with increased scrutiny through the medical examiner process

Recovery/delivery

- SIs & Never events – a NENC network meeting has been established supported by the Academic Health Science network
- Work continues to support providers with implementation of patient safety incident response framework (PSIRF)
- Sound risk assessments have been developed by our Trusts for management of HCAI.





Appendices

Appendix 1 – 2023/24 National objectives description

	Recovering core services and improving productivity
Urgent and emergency care	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
	Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
	Reduce adult general and acute (G&A) bed occupancy to 92% or below
Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals: Expand direct access and self-referral where GP involvement is not clinically necessary. By September 2023, systems are asked to put in place: • direct referral pathways from community optometrists to ophthalmology services for all urgent and elective eye consultations • self-referral routes to falls response services, musculoskeletal services, audiology-including hearing aid provision, weight management services, community podiatry, and wheelchair and community equipment services.
Primary care	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
	Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
	Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
	Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
	Deliver the system- specific activity target (agreed through the operational planning process)
Cancer	Continue to reduce the number of patients waiting over 62 days
	Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
	Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
Maternity	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
	Increase fill rates against funded establishment for maternity staff
Use of Resources	Deliver a balanced net system financial position for 2023/24

	NHS Long Term Plan and transformation
Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
	Increase the number of adults and older adults accessing IAPT treatment
	Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
	Work towards eliminating inappropriate adult acute out of area placements
	Recover the dementia diagnosis rate to 66.7%
	Improve access to perinatal mental health services
People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
	Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults are cared for in an inpatient unit
	Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
	Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
	CORE 20PLUS5: Increase uptake of COIVD, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions
	Hypertension case finding and optimal management and lipid optimal management
	Asthma – address over reliance of medications
	Decrease the number of asthma attacks
	Increase access to real time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic backgrounds
	Increase proportion of those with type 2 diabetes receiving recommended NICE care processes
	Epilepsy – increase access to epilepsy specialist nurses and ensure access in the first year of care for those with LDA
	Reduce tooth extractions due to decay for children admitted as IP in hospital aged <+10
	Improve access rates to children and young people`s mental health service for 0-17 year olds, certain ethnic groups, age, gender and deprivation.

Appendix 2 - Supplementary Data Pack attached separately

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	

BOARD 25 July 2023	
Report Title:	**NENC ICB and ICS Finance Report – M2**

Purpose of report

To provide 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 2023/24 for the period to 31 May 2023.

Key points

ICS Revenue Position:

As at 31 May 2023, the ICS is reporting an overall year to date deficit of £30.46m compared to a planned deficit of £28.66m, an adverse variance of £1.8m, as shown in Table 2.

The £1.8m year to date overspend compared to plan reflects pressures in provider positions relating to costs associated with strike action and achievement of elective recovery funding.

This year-to-date variance is expected to be brought back in line with plan by the end of the year, hence the forecast ICS position for the year is a deficit of £49.87m in line with plan.

As highlighted within the final 2023/24 financial plan, there are significant potential financial risks to delivering this position. See risks and issues section below.

ICB Revenue Position:

As at 31 May 2023 the ICB is reporting a year to date surplus of £5.38m, broadly in line with plan, with a forecast surplus for the year of £32.4m.

At this stage of the year there is always very limited data available which creates an additional level of risk and uncertainty in the forecast outturn position.

A number of potential financial risks were identified within the financial plan. Based on initial information available at this early stage of the year, there are unmitigated net risks estimated at £26m in total which will potentially impact the ICB.

This reflects risks around the delivery of stretch efficiencies, growth in continuing healthcare costs and prescribing costs, predominantly relating to the impact of Category M drugs.

This will continue to be reviewed as further information on current year costs becomes available, however in recognition of the financial pressures and unmitigated potential risks, the ICB Executive Committee have agreed to implement additional financial controls.

This includes a pause on all non-discretionary non-staff spend, alongside the existing vacancy controls already in place, whilst additional risk mitigations are identified. The practical application of these controls is currently being reviewed with a process to make exceptional requests via an executive led panel.

ICB Running Costs:

The ICB is reporting a breakeven position against running cost budgets. Additional funding has now been confirmed to reflect the final 2023/24 pay award, this is being reviewed to consider any impact on the reported position.

This remains a potential risk area on a recurring basis with work continuing on the development of ICB 2.0 in response to the forthcoming 30% real terms reduction in running cost allowances.

ICS Capital Position:

Capital spending forecasts are currently in line with plan, however this includes an allowable 5% 'over-programming', hence the forecast is £9.44m in excess of the ICS capital departmental expenditure limit (CDEL) allocation. This will need to be managed over the remainder of the year.

NHSE plan letter conditions and financial controls:

Attached as appendix 1 is a copy of a letter received from NHSE in June 2023 providing feedback on the final 2023/24 plan submission and highlighting a number of conditions and expectations around financial controls across the system, given the planned deficit position.

The ICB Executive Director of Finance is leading discussions across the ICS Directors of Finance to consider the most effective practical application of these controls and how assurance is provided as to the consistent operation of controls.

In the majority of cases, appropriate controls are already in place within individual organisations, although these may need to be reviewed. In some cases the process for suggested controls will need to be considered, for example in relation to investment oversight panel and provision of related papers to NHSE.

The financial controls and conditions outlined within the letter will be reviewed in detail and updates provided via Finance, Performance and Investment Committee and Executive Committee.

Risks and issues

The 2022/23 financial position across the ICS included significant non-recurring benefits, with significant underlying financial pressures which present a risk to the 2023/24 position.

The final submitted financial plan for 2023/24 included overall net financial risks of £102.5m across the ICS. This included a large number of mitigations yet to be identified, excluding those, total unmitigated risk amounts to almost £252m.

As at 31 May 2023 this position remains largely unchanged, with net unmitigated risk of £101.6m being reported across the ICS.

For the ICB this includes unmitigated net risk of £26m, predominantly relating to potential pressures in continuing healthcare and prescribing costs, and potential non-delivery of stretch efficiency targets.

Additional net unmitigated risk across providers amounts to over £75m.

Work will continue across the system to review the position, seek to identify mitigations and collectively work to manage potential risks. Additional spending controls (in-line with NHSE expectations) have been agreed in the Executive Committee which in essence have paused all "discretionary" spending until financial risk is mitigated.

Work has commenced on the development of a medium-term financial plan, incorporating a financial recovery plan. This is being developed across the ICS with support from Chief Executives and Directors of Finance, with the intention to develop a high-level plan by the end of September which will support NHSE requirements and support delivery of the 2023/24 financial position. More detailed plans will then be developed by the start of 2024/25 to support future years.

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 review the ICS finance position including the delivery of efficiency targets.

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.

Work is progressing on development of a medium-term financial plan for the ICS, incorporating a financial recovery plan.

Recommendation/action required

The Committee is asked to:

- note the latest year to date and forecast financial position for 2022/23,
- note there are a number of financial risks across the system still to be managed,
- note the attached letter from NHSE and in particular the expectation around financial controls which will be reviewed across the ICS.

Item: 9.2

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

Executive Committee Approval	11 July 2023
Sponsor/approving executive director	David Chandler, Executive Director of Finance
Date approved by executive director	17/07/2023
Report author	Richard Henderson, Director of Finance (Corporate) Anthea 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						
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?	Yes, engagement within the ICB and the wider ICS

Version Control

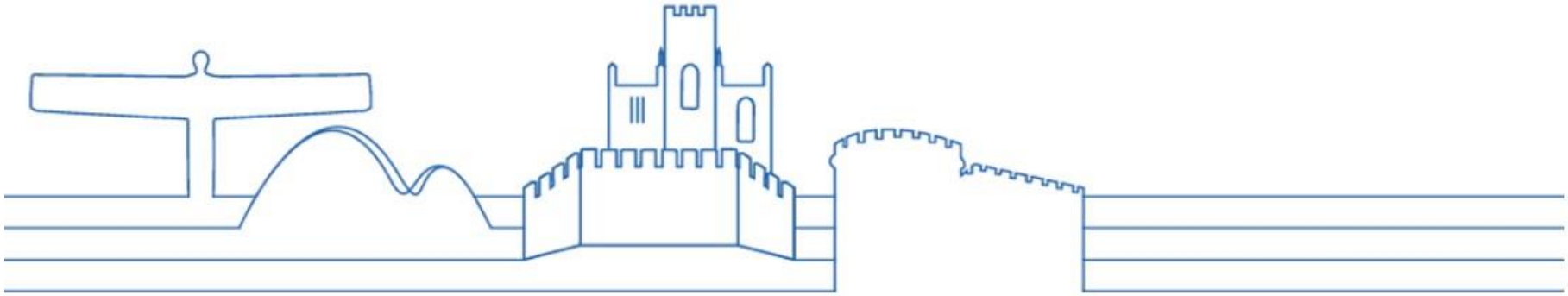
Version	Date	Author	Update comments
1.0	16/06/2023	Anthea Thompson	Reviewed and updated by Richard Henderson
2.0	28/6/2023	David Chandler	**Final Approved**

Item: 9.2

North East and North Cumbria

NENC ICB

Finance Report for the period ending 31st May 2023



Executive Summary

	M02 - May 2023		YTD	Forecast
Key Statutory Financial Duties	**Overall ICS 2023/24 In Year Financial Position - (Surplus) / Deficit**			
	For the financial year 2023/24 the ICS, is on track to deliver the planned deficit position of £49.8m at Month 2	Plan	£28.66 m	£49.87 m
		Actual	£30.46 m	£49.87 m
	Overall ICB 2023/24 In Year Financial Position - (Surplus) / Deficit			
	Overall ICB 2023/24 In Year Financial Position prior to retrospective funding - (Surplus) / Deficit	Plan	(£5.40) m	(£32.40) m
	The ICB is reporting a year to date planned surplus of £5.38m and a forecast outturn surplus of £32.40m, in line with the approved plan submitted to NHSEI - Deficit / (Surplus)	Actual	(£5.38) m	(£32.40) m
	2023/24 ICB Running Costs Position			
	The ICB is reporting a year to date and forecast outturn breakeven position.	Plan	£9.57 m	£57.41 m
		Actual	£9.57 m	£57.41 m
		Variance	£0.00 m	£0.00 m
	Overall ICS 2023/24 Capital Funding			
	The ICS is reporting a forecast outturn overspend against the capital allocation of 9.45m.	Allocation	£33.16 m	£198.95 m
		Actual	£34.73 m	£208.39 m
		Variance	£1.57 m	£9.45 m
Other Financial Performance Metrics				
	Overall ICS 2023/24 QIPP/Efficiency	Plan	£47.64 m	£408.36 m
	The ICS is reporting year to date QIPP savings of £43.64m and forecast savings of £408.14m with the ICB forecasting delivery of £94.9m in line with the submitted QIPP/Efficiency plan. Providers are currently forecasting a slight under-delivery against target of £0.22m.	Actual	£43.64 m	£408.14 m
		Variance	(£4.00) m	(£0.22) m
	Overall 2023/24 Mental Health Investment Standard (MHIS)		6.73%	6.73%
	The ICB is on track to achieve the MHIS target for 2023/24 (growth in spend of 6.73%).			
	Cash		0.27%	<1.25%
	The ICB cash balance for May is 0.27% and within the target set by NHS England of <1.25% of the monthly cash drawdown.			
	BPPC		by volume	by value
	The BBPC target is for 95% of NHS and Non NHS invoices to be paid within 30 days	NHS	100.00%	100.00%
		Non NHS	99.48%	99.00%

Overview of the Financial Position

This report provides an update on the financial performance of the ICB and wider ICS in the financial year 2023/24 for the period to 31st May 2023.

The overall ICS financial position is a year to date deficit of £30.46m compared to a planned deficit of £28.65m. This adverse variance of £1.8m reflects pressures in provider positions relating to costs associated with strike action and achievement of elective recovery funding. This is expected to be managed back in line with plan by the end of the year, hence the forecast ICS position is a deficit of £49.87m.

The ICB is currently reporting a year to date surplus of £5.38m and a forecast surplus for the year of £32.4m in line with plan.

ICS capital spending forecasts are currently in line with plan, however this includes an allowable 5% 'over-programming', hence the forecast is £9.44m in excess of the ICS capital departmental expenditure limit (CDEL) allocation. This will need to be managed over the remainder of the year.

The ICB is on track to deliver the Mental Health Investment Standard, with growth in relevant spend of 6.73%.

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.

The financial plan for 2023/24 included overall net financial risks of £102.5m across the ICS. This included a large number of mitigations yet to be identified, excluding those, total unmitigated risk amounts to almost £252m. As at 31st May 2023 this position remains largely unchanged, with net unmitigated risk of £101.6m being reported across the ICS.

For the ICB this includes unmitigated net risk of £26m, predominantly relating to potential pressures in continuing healthcare and prescribing costs, and potential non-delivery of stretch efficiency targets. Additional net unmitigated risk across providers amounts to over £75m.

Work will continue across the system to review the position, seek to identify mitigations and collectively work to manage potential risks. Work has commenced on the development of a medium term financial plan, incorporating a financial recovery plan. This is being developed across the ICS, with the intention to develop a high level plan by the end of September which will support NHSE requirements and support delivery of the 2023/24 financial position.

Table 1: ICB Financial Position

Month 2 - May 2023	YTD Plan	YTD Actual	YTD Variance	2023/24 Annual Plan	2023/24 Forecast Outturn	2023/24 Forecast Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Revenue Resource Limit	(1,185,710)			(7,114,272)		
Programme						
Acute Services	573,035	573,024	(11)	3,438,210	3,438,210	(0)
Mental Health Services	143,914	143,879	(35)	863,486	863,486	(0)
Community Health Services	113,076	113,076	0	678,458	678,458	(0)
Continuing Care	74,969	74,976	6	449,817	449,817	(0)
Prescribing	94,332	94,332	0	565,992	565,992	0
Primary Care	18,405	18,449	44	110,431	110,431	(0)
Primary Care Co-Commissioning	153,919	153,919	(0)	923,523	923,523	(0)
Other Programme Services	23	(5,574)	(5,597)	136	136	0
Other Commissioned Services	4,670	4,677	8	28,019	28,019	(0)
Programme Reserves	(5,601)	0	5,601	(33,609)	(33,609)	0
Contingency	0	0	0	0	0	0
Total ICB Programme Costs	**1,170,741**	**1,170,758**	**16**	**7,024,462**	**7,024,462**	**(0)**
Admin						
Running Costs	9,568	9,568	0	57,406	57,406	0
Total ICB Admin Costs	**9,568**	**9,568**	**0**	**57,406**	**57,406**	**0**
(Surplus) / Deficit	5,401	0	(5,401)	32,404	0	(32,404)
Total In Year ICB Financial Position	**1,185,710**	**1,180,325**	**(5,384)**	**7,114,272**	**7,081,868**	**(32,404)**

Table 1.1: ICB In Year Financial Position

Month 2 - May 2023	YTD Plan	YTD Actual	YTD Variance	2023/24 Annual Plan	2023/24 Forecast Outturn	2023/24 Forecast Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Financial Position Analysis						
North Cumbria	17,062	17,062	0	102,375	102,375	0
North Cumbria Area	**17,062**	**17,062**	**0**	**102,375**	**102,375**	**0**
Newcastle	19,514	19,515	0	117,087	117,087	(0)
Gateshead	14,317	14,317	0	85,902	85,902	(0)
North Tyneside	9,323	9,323	0	55,941	55,941	0
Northumberland	16,278	16,278	0	97,667	97,667	0
North Area	**59,433**	**59,433**	**0**	**356,597**	**356,597**	**(0)**
County Durham	27,649	27,649	0	165,894	165,894	0
South Tyneside	8,258	8,258	0	49,550	49,550	(0)
Sunderland	15,397	15,397	(0)	92,381	92,381	0
Central Area	**51,304**	**51,304**	**0**	**307,825**	**307,825**	**(0)**
Tees Valley	43,081	43,081	0	258,488	258,488	0
Tees Valley (South) Area	**43,081**	**43,081**	**0**	**258,488**	**258,488**	**0**
System	**1,014,829**	**1,009,444**	**(5,385)**	**6,088,987**	**6,056,582**	**(32,404)**
Total ICB Financial Position excl. Allocations	**1,185,710**	**1,180,325**	**(5,384)**	**7,114,272**	**7,081,868**	**(32,404)**

Table 2: Overall ICS (Surplus) / Deficit

Month 2 - May 2023	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)	(5,401)	(5,384)	16	(32,404)	(32,404)	(0)
Total In Year ICB Position	**(5,401)**	**(5,384)**	**16**	**(32,404)**	**(32,404)**	**(0)**
NENC Providers	34,058	35,845	1,787	82,277	82,276	(1)
Total Provider Position	**34,058**	**35,845**	**1,787**	**82,277**	**82,276**	**(1)**
Total ICS Financial Position 2023/24	**28,658**	**30,461**	**1,804**	**49,873**	**49,872**	**(1)**

Table 3: ICS Efficiencies

Month 2 - May 2023	YTD Plan	YTD Actual	YTD Variance	2023/24 Annual Plan	2023/24 Forecast Outturn	2023/24 Forecast Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Acute	1,414	1,414	0	8,480	8,480	0
Community Healthcare	1,448	1,448	0	8,692	8,692	0
Primary Care (inc. Primary Co-Commissioning)	6,868	6,868	0	41,205	41,205	0
All Age Continuing Healthcare	4,410	4,410	0	26,455	26,455	0
Other Programme Services	420	1,684	1,264	2,523	2,523	0
Unidentified	1,264	0	(1,264)	7,589	7,589	0
Total ICB Efficiencies	**15,824**	**15,824**	**0**	**94,944**	**94,944**	**0**
Of Which:						
Recurrent	7,740	7,740	0	46,441	46,441	0
Non Recurrent	8,084	8,084	0	48,503	48,503	0
Total ICB Efficiencies	**15,824**	**15,824**	**0**	**94,944**	**94,944**	**0**
Providers within system	31,819	27,817	(4,002)	313,416	313,195	(221)
Total Provider Efficiencies (within system)	**31,819**	**27,817**	**(4,002)**	**313,416**	**313,195**	**(221)**
Of Which:						
Recurrent	14,964	8,610	(6,354)	181,619	169,096	(12,523)
Non Recurrent	16,855	19,207	2,352	131,797	144,100	12,303
Total Provider Efficiencies (within system)	**31,819**	**27,817**	**(4,002)**	**313,416**	**313,195**	**(221)**
Total ICS Efficiencies	**47,643**	**43,641**	**(4,002)**	**408,360**	**408,139**	**(221)**
Of Which:						
Recurrent	22,704	16,350	(6,354)	228,060	215,537	(12,523)
Non Recurrent	24,939	27,291	2,352	180,300	192,603	12,303
Total ICS Efficiencies	**47,643**	**43,641**	**(4,002)**	**408,360**	**408,139**	**(221)**

ICS Efficiencies key points

The tables above shows the efficiency targets set out in the ICS plan. For the ICB this is by ISFE category and at Month 2 the ICB is forecasting delivery in line with plan although this remains a considerable challenge given the scale of stretch efficiency targets included in plan.

For providers within the system there is a YTD under-delivery against target of £4m and a small forecast under-delivery of £0.2m. The forecast outturn for recurrent efficiencies is an underachievement of £12.5m, largely mitigated by a forecast over delivery of non-recurrent schemes totalling £12.3m. As with the ICB, this represents a significant challenge given the increased efficiency targets in plan for 2023/24, and this is reflected within ICS risks.

Table 4: ICS Risks and Mitigations

Risks	Potential risk before mitigations	Mitigating actions	Remaining risk after mitigations
	£000s		£000s
ICB Risks			
Continuing Healthcare - risk around activity increases and fee rates	(10,074)	NR measures / stretch efficiency	(8,392)
Prescribing	(11,424)	NR measures / stretch efficiency	(9,517)
Potential additional IS activity pressures (Elective Recovery Fund gap)	(15,000)	Anticipated ERF income	0
Risk on Efficiency delivery	(13,845)	NR measures / stretch efficiency	(8,095)
TOTAL ICB RISKS	**(50,343)**		**(26,004)**
System Risks			
ERF and other pay/non-pay provider risks	(336,472)	System actively working collaboratively to develop plans to mitigate this risk	(75,558)
TOTAL ICS RISKS (ICB + SYSTEM)	**(386,815)**		**(101,562)**

NHS England

To: Sam Allen
Chief Executive
North East and North Cumbria ICB

Richard Barker
NHS England
(North East & Yorkshire)
6E54 Quarry House
Quarry Hill
Leeds
LS2 7UE
richardbarker.neyrd@nhs.net

15 June 2023

Dear Sam

I am writing to acknowledge receipt of North East and North Cumbria Integrated Care Board's (ICBs) final system operating plan for 2023/24 and set out next steps.

The objectives set out in 2023/24 priorities and operational planning guidance are framed around three tasks for the coming year. Our immediate priority is to recover our core services and productivity. Second, as we recover, we need to make progress in delivering the key ambitions in the NHS Long Term Plan. Third, we need to continue transforming the NHS for the future.

You have developed your plan during a period of intense pressure on services and in the context of industrial action and uncertainties around pay and inflation. Systems will receive additional funding for the cost impact of the recently announced 2023/24 pay award. The finance and contracting actions that ICBs and NHS providers should take have been set out in the recently published guidance on the 2023/24 pay award.

We have reviewed your submission in this context and I have set out below some of the key elements of your plan that you are committed to deliver on as a system. Where appropriate, I have also highlighted issues for you to keep under review and / or that require specific action. Please could you share this letter with your full Board for consideration.

Emergency care and system resilience

Your plan is for the system to be delivering the 4 hour A&E standard at 80.8% by the end of March 2024 in line with the national planning requirement.

In support the plans indicate an average of a 0.2% increase across 2023/24 in available G&A beds to facilitate this increase in performance and the required system flow. The associated planned bed occupancy rate across 2023/24 is 90.9% which sits positively against the national 92% benchmark.

The virtual ward plans indicate 84.4% utilisation for 2023/24 which will be an important factor in ensuring the wider models of care are used in support of the G&A pathways. Although we note the aspiration, it is important for systems to ensure capacity of virtual wards in in line with the local demand profile and meets the expectations set out in the final planning submission.

The plan for the ambulance category 2 mean response time for North East Ambulance Service NHS Foundation Trust (NEAS), for whom you are the lead commissioner, is 30 minutes which is consistent with the national planning requirement for 2023/24. We note that this is dependent on your continued work with all providers in your system on initiatives to support improved handover times including those detailed in your plan, and those of ICBs who are also served by NEAS.

NHS England has allocated additional resource to increase system capacity for ambulance and emergency care. For 2023/34 North East and North Cumbria ICB has been allocated £13.03m additional capacity revenue funding, and £10.0m capital funding from the Additional Capacity Targeted Investment Fund (ACTIF). £8.6m has been allocated to your ICB as lead commissioner for North East Ambulance Service NHS Foundation Trust to increase ambulance service capacity in 2023/24, including in your system.

We will continue to work with you to ensure that these investments deliver improvements for patients.

Elective and cancer care

Your final plan submission shows a plan to deliver weighted activity in 2023/24 at 112% of 2019/20, against a target of 109%, which demonstrates a compliant and stretching plan in support of the wider elective recovery agenda.

Eliminating waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties) is a key objective for 2023/24. We note that the plan you have submitted does not meet this requirement with a projection of 14 spinal long waiting patients remaining untreated at Newcastle Hospitals NHS Foundation Trust. We expect you to work towards delivery of this objective and will continue to engage with you and Newcastle through the Tier process to monitor progress and where possible provide support to develop plans to get these remaining patients treated.

Your final plan submission shows a plan that delivers your system Cancer 62 day backlog target, delivery of the Faster Diagnosis Standard and that you are planning to deliver the FIT pathway. Underpinning the elective and cancer care plans will be the delivery of timely diagnostic tests and your plan to get to 10.6% patients waiting less than 6 weeks by March 2024 will be a key component to this delivery but an area that we will look for further improvement to ensure that the system gets down to 5% or below by March 2025.

Overall general and acute position

You described the key local goals around delayed discharge and ambulance handovers and delays. The aggregate position can mask local variation which you are tackling through a co-produced oversight framework with organisations in your system. We also challenge you to improve the rigour of outpatient transformation plans.

You consider that cancer performance is getting back on track, with Newcastle being a particular pressure but with a plan and improvements in diagnostics.

Mental health and Learning Disability and Autism

The North East and North Cumbria ICB plans demonstrate compliance with the mental health planning requirements for increase the number of adults and older adults accessing Talking Therapies treatment and recovering the dementia diagnosis rate.

The plans for improving access to mental health support for children and young people (-13.3% variance to trajectory), increasing the number of adults and older adults supported by community mental health services (-17.8% variance to trajectory), improving access to perinatal

mental health services (-25.8% variance to trajectory) are not currently at the levels of the national planning requirements and will be areas of ongoing oversight and focus given the materiality of the current gaps. The plans not to eliminate your inappropriate Out of Area Placements will also be an area of continued focus.

For Learning Disability (LD) and Autism services your plans demonstrate compliance with the requirements for people receiving an annual health check and reducing reliance on inpatient services for under 18s. The plan to reduce reliance on inpatient care for adults with a learning disability and/or who are autistic is slightly behind the target level of 30 patients per million head of population.

In the context of discussions on fragile services, issues in LD placements in your system was brought to attention as an area in view.

Workforce

Workforce optimisation will be key to delivery during 2023/24 including balancing growth with effective deployment of your existing workforce, reducing turnover, agency spend and sickness to support your activity and finance plans.

All ICBs are expected to monitor delivery against their workforce plans and work with colleagues at all levels to consider whether actions to improve substantive recruitment, retention and staff health and wellbeing are sufficient to optimise the use of your workforce and meet workforce demand.

Finance

Delivering system-level financial balance remains a key requirement for all ICBs. We note that you have submitted a deficit plan, with this deficit being in-line with the level recently discussed in the meeting with Amanda Pritchard and Julian Kelly. Given that the level of deficit is in-line with expectations the additional inflationary funding we communicated has been added to your allocation.

Although the level of deficit in your plan is in-line with our expectations at this stage as we have described previously we still expect you to work to mitigate this in-year and strive to deliver a break-even out-turn position. Via regions we will continue to monitor progress.

We expect that all systems and providers continue to apply the following conditions stipulated in 2022/23:

- Commit to recurrent delivery of efficiency schemes from quarter 3 to achieve a full year effect in 2024/25 to compensate for any non-recurrent measures required to achieve 23/24 plans. Within this we expect all systems to be able to describe how this will be achieved by the end of quarter 1.
- Fully engage in national pay and non-pay savings initiatives, in particular around national agreements for medicines and other non-pay purchasing.
- Monitoring of agency usage by providers, and compliance with usage and rate limits.
- Any revenue consultancy spend above £50,000 and non-clinical agency usage continue to require prior approval from the NHS England regional team based on agreed regional process.

We also expect that by the end of quarter 2 every system will prepare a medium-term financial plan, demonstrating how recurrent financial sustainability will be delivered. These plans should provide a clear demonstration how the recurrent exit run-rate from 2023/24 will be consistent with this, and how this run-rate will be improved through 2023/24.

In addition, because your system did not submit a balanced plan, you will also be required to comply with the following conditions (all of which should be shared with Regional teams for oversight and sign-off, with agreed process for assuring implementation):

- Review your current processes and arrangements around the pay controls described in the appendix to this letter.
- Ensure that you have a vacancy control panel in place for all recruitment.
- That you apply the agency staffing and additional payment controls stipulated in the appendix to this letter
- Ensure you have an investment oversight panel in place to oversee all non-pay expenditure, with papers shared with NHSE. Within this process we would not expect approval of any non-funded revenue or capital business cases.
- Where revenue or capital cash support is required the additional conditions described in the appendix to this letter will apply.

Review meetings involving Regional and National colleagues will be held at the end of the first quarter and half year positions. The purpose of these meetings is to review progress to date and adjust actions & requirements for the remainder of the year accordingly.

Triangulation

The work undertaken to develop plans following the draft submission on 23 February 2023 to those submitted on 4 May demonstrated material developments in some areas of plans including the financial plan.

Alongside this we understand the work undertaken to ensure an understanding of the triangulation of activity, workforce and finance plans including where further work is required to strengthen this join up.

Next Steps

Where this has not been done already, ICBs must ensure that all contracts are agreed and completed in line with final plans, and signed as soon as possible.

We will continue to work with you to address the issues highlighted above and ensure you are able to access the necessary development support to strengthen the system's capability and capacity for delivery.

We will review progress through our regular meetings.

If you wish to discuss the above or any related issues further, please let me know.

Your sincerely

Richard Barker CBE
Regional Director (North East & Yorkshire)

Cc:

Sue Jacques	Chief Executive	County Durham and Darlington NHS Foundation Trust
Trudie Davies	Chief Executive	Gateshead Health NHS Foundation Trust

Lyn Simpson	Chief Executive	North Cumbria Integrated Care NHS Foundation Trust.
Helen Ray	Chief Executive	North East Ambulance Service NHS Foundation Trust
Neil Atkinson	Managing Director	North Tees and Hartlepool NHS Foundation Trust
James Duncan	Chief Executive	Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
Jim Mackey	Chief Executive	Northumbria Healthcare NHS Foundation Trust
Sue Page	Chief Executive	South Tees Hospitals NHS Foundation Trust
Ken Bremner	Chief Executive	South Tyneside and Sunderland NHS Foundation Trust
Brent Kilmurray	Chief Executive	Tees, Esk and Wear Valleys NHS Foundation Trust
Jackie Daniel	Chief Executive	The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Appendix – Standard Financial Controls

Where the system has not submitted a balanced plan the following standard reviews and controls should be applied across organisations in the system.

1. Pay Controls
Review of Recruitment and Processes
1.1 Produce and review a complete reconciliation of staff increases since 19/20 with full justification for post increases based on outcomes/safety/quality/new service models. A review of the value for money of the outcomes of these new posts should be included. Where value for money is not demonstrated a plan for the removal of the post needs to be in place. The overall plan to be signed off by the Board and the ICB.
1.2 Review all current open vacancies to consider where the removal or freezing of posts is appropriate. This should initially focus on posts which have been vacant for over 6 months with a starting assumption that these should be removed or re-engineered.
1.3 Review the establishment to remove partial posts not required and identify unfunded/unapproved posts which should be removed.
1.4 Review current governance arrangements for recruitment and temporary staffing (panels and sign off at all levels of the organisation including groups, terms of reference, SFIs and sign off rights).
1.5 Ensure workforce plans are in place and that these are in a granular level of detail (e.g. by service, workforce type and substantive / temporary) and align to approved establishment levels and budget.
1.6 Ensure that rigorous illness policy and procedure is in place and consistently applied.
1.7 Ensure that retention processes are reviewed – including exit interviews, flexible working options and retentions schemes.
1.8 Ensure that rota processes are reviewed to provide assurance to the Board that they are embedded and operate as anticipated across the organisation.
General Vacancy Controls
1.9 Ensure that a regular vacancy control panel or equivalent is in place to check and challenge recruitment to ensure all vacancies remain within authorised budgetary limits.
1.10 Ensure Vacancy Control Panel terms of reference enable flexibility to avoid operationally delaying opportunities for savings and considering clinical need.
Non-Clinical Posts
1.11 No use of non-clinical agency staff, with exceptions authorised by an executive director and then requiring onward approval by ICB and NHSE regional director.
Nursing
1.12 Review one to one nursing policies, approvals, and tracking process to ensure standardised approach linked to patient need/acuity.
Medical
1.13 Review consultant job planning compliance and policies.
1.14 Benchmark waiting list initiative and other additional payments against local organisations. An enhanced authorisation process for these payments should be in place, ensuring that such payments deliver value for money or are operationally critical before approving.

Agency Controls and Additional Payment Controls
1.15 Established governance process to oversee agency staffing with clear terms of reference (either at overall level or by key staffing group e.g. nursing, medical, corporate) to be chaired by an executive director.
1.16 Limit the authorisation of agency staff to Executives or named senior managers. Executive level sign-off of locum spend and off-framework spend.
1.17 Agree an implementation date for the removal of all non-framework agency staffing with an associated organisation-wide temporary staffing policy.
1.18 Clear Board accountability and reporting of plans and actual spend.
2. Non-pay
2.1 Commitment of additional expenditure over £10,000 which will add to the expenditure run-rate, excluding categories out of scope, to be approved at an executive chaired group.
Non-pay categories of spend out of scope of non-pay controls: Supplies and services - clinical (excl. drugs) Drug costs Clinical negligence fees Audit fees Depreciation and Amortisation
3. Cash
3.1 Where a trust is seeking cash support for their revenue or capital position they will need to continue to provide all of the documentation required as part of this process.

Item: 11

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 25 July 2023	
Report Title:	**Independent Report into North East Ambulance Service**

Purpose of report

The purpose of this report is to provide the Board with an insight into the Department of Health Independent Report into the North East Ambulance Service. To provide the Board with assurance that the recommendations highlighted in the report are being addressed and that learning is being shared.

Key points

Following a high-profile whistleblowing case relating to the coronial process within NEAS and subsequent criticism of the handling of the whistleblowing process, Government commissioned Dame Marianne Griffiths to independently investigate the issues identified.

Please note that the issues identified pre-dates the creation of the ICB. Prior to this Northumberland Clinical Commissioning Group acted as lead commissioners for this service.

The report was published on the 12 July 2023 and will be shared with the families referenced within the report on 11 July 2023.

As part of the publication process, NHS England stipulated the requirement for NEAS and NENC ICB to share the final report with Boards in Private in advance of the publication date. In addition, Boards were asked to approve a required Assurance Statement.

The Chair and Chief Executive of NEAS will attend the Board and share the learning from the report and give an oversight on the progress with the recommendations from the report.

Risks and issues

It is important that the issues identified and update regarding progress on the recommendations are discussed in full.

Assurances
• The recommendations within the report which are specifically for NENC ICB have been actioned. • NENC ICB continue to work with NEAS to monitor progress against all of the actions detailed within this report alongside monitoring performance as part of the oversight role the ICB fulfils.

Recommendation/action required
The Board are asked to: • Receive the Independent Investigation Report • Take assurance that the recommendations are being implemented timely.

Acronyms and abbreviations explained	
ICB – Integrated Care Board NENC -North East and North Cumbria NEAS – North East Ambulance Service	
Sponsor/approving executive director	Samantha Allen, Chief Executive
Date approved by executive director	17 July 2023
Report author	David Purdue, Executive Chief Nurse

Link to ICB corporate aims (please tick all that apply)	
CA1: Improve outcomes in population health and healthcare	✓
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

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?	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?	Stakeholders are engaged and briefed and a full communications plan in development which is being led by NHS England

Assurance Statement

Introduction

The following assurance statement has been compiled by the NENC ICB in response to the Dame Marianne Griffiths report into the North East Ambulance Service.

Specific commissioning points raised within the Independent Report

The following recommendations have been made within the Independent Report which are specific to the NENC ICB.
16. To endorse the proposal currently being put forward by the commissioners to change the commissioning framework moving forward to improve governance oversight arrangements
17. To develop a coherent medium term resource plan with ambulance service commissioners to secure safe and sustainable services

Assurance Statement

The North East and North Cumbria Integrated Care Board fully accept the findings of the report written by Dame Marianne Griffiths and acknowledge her work in investigating the serious issues identified.

The issues raised precede the creation of the Integrated Care Board (ICB) and, as such, this report recognises the transition of responsibility to the ICB on the 1st July 2022. Prior to this date, Northumberland Clinical Commissioning Group acted as a lead commissioner for ambulance/patient transport services on behalf of the NHS across the North East.

Following a number of quality concerns identified in 2022 as part of the whistleblowing process, the shadow ICB instigated a risk escalation meeting jointly with NHS England. The outcome of this was to place the Trust into a quality improvement process led jointly between NHS England and the then shadow ICB in which the CQC also attends. This arrangement continued as the ICB was formally constituted and is continuing as part of ongoing oversight. In addition, additional support has been provided to NEAS to strengthen its governance processes. We are assured that this has had a positive impact on the management of governance within the team and the ICB will continue to review this as part of the ongoing oversight meetings.

Since this time, the ICB has implemented new commissioning arrangements for the Ambulance Service within the ICBs Executive team.

Recognising there is a relatively new leadership team in place within NEAS, the ICB has secured well-led support through a 'buddying arrangement' from Northumbria Healthcare NHS Foundation Trust, a Trust rated 'Outstanding' by the CQC. The ICB also acknowledge the significant effort by the NEAS team to rectify the issues identified and is encouraged by the results of the most recent CQC inspection. We are confident such improvements will continue as part of the Trust's ongoing commitment to learn and improve.

We can confirm that additional funding was secured in 2023 for the North East Ambulance Service. £8.6M Additional Ambulance Capacity Fund provided by NHS England has been received. In addition, £18M has been included recurrently in the 2023/24 contract from the ICB.

This level of additional funding was agreed with NEAS within this year's planning round and is based on bringing the organisation much more in line with other ambulance services across England. The ICB is committed to ensuring all NHS providers including NEAS are adequately funded to provide safe and sustainable services and will work with NEAS to ensure this is the case as part of developing ICS medium term financial plans making the best use of the funding provided to the ICB by NHSE.

The North East Ambulance Services leadership team continue to work hard to address the serious findings detailed within the report. The ICB will continue to support them, alongside having oversight of their progress with the delivery of an improvement plan which has been created to address the recommendations in this report and the CQC Inspection findings.

The Report of the Independent Review in to alleged failures of patient safety and governance at the North East Ambulance Service (NEAS)

Dame Marianne Griffiths DBE

Contents

Open letter to Amanda Pritchard, Chief Executive Officer of NHS England

The services that ambulances deliver form a vital part of our urgent care response in the NHS. The public depends and relies on those emergency services at particularly vulnerable and worrying times and the need for confidence and trust is paramount.

The investigation in this report specifically addresses issues where this confidence and trust has been lost and has been made in response to a whistle-blowing allegation revealed in the Sunday Times on 22 May 2022. This allegation was that the North East Ambulance Service NHS Foundation Trust (NEAS) covered up fatal paramedic errors and deliberately altered or omitted important facts that families and the relevant coroners had a right to know. In addition, the whistle-blower alleged that they were bullied and victimised for raising these concerns.

The investigation team spoke to four of the families that were named in the report and there is no doubt that their concerns expressed about openness and candour are justified. In addition, for most of these cases, the management of their concerns and complaints were poorly handled. The families simply wanted an acknowledgement of the complaint, acceptance of accountability and a full apology. They also wanted assurance that the organisation would learn from these episodes and deliver actions that would reduce the risk of these shortcomings happening to anybody else in the future.

Whilst there has been a genuine desire by NEAS, the Integrated Care Board and the North East and Yorkshire Region to understand the concerns and address them, the issues are complex, and some are long standing.

Several other external reviews have been commissioned, which have been very thorough and helpful and have made reasonable recommendations within the scopes of their Terms of Reference. Each has addressed a particular issue or problem area, but there has been no general holistic review that looks more broadly across the organisation to understand the culture and leadership systems that have led to the concerns being raised. The Terms of Reference for this review does incorporate these elements, and the findings of the other reviews have been taken into account. This report, then, does present a holistic review.

The findings from our investigation do highlight some significant cultural and behavioural issues that will have contributed to the failings experienced by the families. However, I do also believe that the new leadership team in place is committed to addressing these issues, though they will require some support to do so.

Governance processes in NEAS were found to be weak in some areas. The policies and processes are in place, but it is the consistency of application that needs some significant improvement and specialist support particularly in the area of serious incident management and Duty of Candour.

In addition, there was an overreliance on certain individuals giving reassurance on existing processes that was not found to be warranted.

The Coronial Service within NEAS has had a difficult time and communications between teams within the Trust have not been operating effectively. The failure of this has significantly contributed to the lack of transparency experienced and observed both in respect of the Families and the Coroner and the weaknesses in Governance.

This was not helped by some dysfunction that existed in the executive team which was addressed by the Chief Executive at the time but unfortunately the damage was done. It should be noted that the Trust is now in a much better place.

The Trust has devoted significant effort to improving the systems and staff have reported improvements but also recognise that there is more to do.

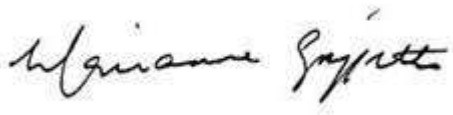
These concerns were made public by a whistle-blower and related to incidents that occurred in 2018 and 2019. The whistle-blower had raised concerns within the Trust, but the experience of that was poor.

The Freedom to Speak Up processes were flawed and need to be amended. There were divergent opinions on whether people would speak up if required and "defensive culture" was cited as a long-term challenge. The Trust have accepted these challenges and are implementing changes to improve.

We were disappointed that the whistle-blower would not engage with us as we were very keen to hear from him and his contributions would have been valued by us.

Finally, it is important to acknowledge how NEAS like all other ambulance trusts are experiencing very challenging capacity constraints and this affects its ability to deliver timely urgent care and safe and effective systems.

As it is a particularly small trust, it does need to be resourced to deliver a quality and safe service so that public confidence is sustained.



Dame Marianne Griffiths DBE
Chair of the Independent Review

December 2022

Acknowledgements

We would like to express our sincere thanks and appreciation to the four families we interviewed as part of our review for sharing their experiences and for the openness with which they told their stories even though this was very difficult and challenging for them.

They have been extremely generous with their time throughout the process and we are deeply appreciative for this and grateful to them for the contributions they have made throughout.

Our thanks also go to everyone who assisted with this review including staff from North East Ambulance Service and NHS England, South Western Ambulance Service NHS Foundation Trust; representatives who worked in Northumberland Clinical Commissioning Group; representatives from the Integrated Care Board; NHS Employment Services; NHS Improvement and Lynn Woolley, special advisor to the panel.

Background

On 22 May 2022, media coverage in the Sunday Times alleged that the North East Ambulance Service NHS Foundation Trust (NEAS) was covering up evidence in relation to patient deaths and withholding key evidence from Her Majesty's Coroners (HMC) linked to service failures. The news article made reference to seven incidents and the names of five individuals were included. The report said that families were not always told the full facts of the circumstances surrounding the death of their relatives.

In addition, the whistle-blower who reported these concerns to the Sunday Times also alleged that he had raised concerns about patient safety in NEAS a number of times and that he was bullied and victimised as a result of his actions.

Some of the concerns raised by the whistle-blower were known in NEAS and the wider NHS system particularly in relation to some specific complaints from families and the robustness of coronial processes and reporting. The alleged incidents took place between December 2018 to December 2019.

Whilst we have focussed on these specific cases, we have also reviewed the findings of the previous external reports which look at a greater number of patients. We have similarly examined the underlying systems and processes within NEAS in a holistic way and as such our conclusions are pertinent to all.

Consequently, a number of specific pieces of work were commissioned from independent sources to test whether the concerns were real and justified. Each of these reports produced a set of improvement recommendations.

In addition, an internal task and finish group was set up to undertake a comprehensive review of action taken to address identified weaknesses.

A Desk Top Review was also commissioned by NHS England and the ICB Chief Executive Designate and carried out by three directors of nursing from NHS Northumberland Clinical Commissioning Group (CCG), NHS England and Improvement (North East and Yorkshire Region) and NHS Newcastle Gateshead CCG. The key task was to assess whether recommendations from other reviews were implemented and to ensure that improvements had been made.

It is also important to note from a background point of view that there have been significant executive changes since 2018 including Chief Executive Officer, Chief Nurse, Chief Operating Officer, and leadership of the HR function. Many other key staff in place at this time have also either left for other posts or have retired. It should be noted that the new ICB did not formally come in to being until July 2022.

Following concern expressed after the Sunday Times article, on 14 June 2022 the then Secretary of State for Health and Social Care Sajid Javid confirmed that the NHS had agreed to an Independent Review. This Independent Investigation began on 17 August and was scheduled to be completed in four months. This Report is the outcome of that work.

Its Terms of Reference are set out as the headings of each Chapter of this Report. We have looked at the circumstances of each case, the findings of previous reports, our own investigation evidence and set out our own findings.

We have considered the coronial processes. These are the internal NEAS arrangements for communicating with the Coroner.

We have then reviewed the effectiveness of NEAS arrangements for communicating with the Coroner, the governance framework, the HR and Freedom to Speak up processes, and finally set out our overall conclusions and recommendations.

The Terms of Reference for this investigation can be found in Appendix A.

Chapter 1: Terms of Reference 1

"To fully understand the concerns raised in relation to the cases being considered, and the impact both of the incident and the subsequent processes, through speaking with families, where possible, and relevant stakeholders."

Introduction

1.1 We reviewed four of the five cases that were identifiable by the whistle-blower. We could not establish the whereabouts of the family of the fifth despite efforts made by NHS England to track them.

1.2 We contacted and wrote to the four families in August 2022 to seek their agreement to participate in the investigation and contribute to the final Terms of Reference.

1.3 They all agreed to do so and have been extremely generous with their time and contribution throughout the process. We are genuinely grateful to them for telling their stories and being so open even when at times this proved difficult.

1.4 The final Terms of Reference for the investigation and amendments were all agreed, and the families' needs and concerns were incorporated into the review.

1.5 We also met or spoke with them to hear their stories and views and have listened carefully to their concerns and kept them updated on our progress.

1.6 We have also taken into account findings from previous independent reviews and where appropriate have considered them as additional evidence in coming to our conclusions.

1.7 We have also conducted interviews, reviewed policies and procedures, read all the existing reviews and have sought from the Trust all relevant documentation relating to the cases in question. The four families have also contributed considerably to the body of evidence that has enabled us to come to our conclusions.

1.8 We have not adopted a criminal standard of proof in this investigation but have come to our views based on all the evidence outlined above, and on our own experience and skills, and have looked at the balance of probabilities and tests of reasonableness in arriving at our conclusions.

The Cases

Case 1, Patient A – 09 December 2018

The facts

1.9 This is a terribly sad case where a 17-year-old girl (A) was found hanging from a tree a short walk away from her home on 09 December 2018. A 999 call was made, and police officers arrived within minutes. They cut her from the tree and immediately commenced cardiopulmonary resuscitation (CPR) believing they had felt a pulse. The family are keen to stress that A's feet were on the floor at this time.

1.10 A rapid response paramedic (Paramedic 1) was one of the first staff to attend the scene. Paramedic 1 very quickly declared 'ROLE' (Recognition of Life Extinct) which meant that all CPR attempts were ceased and no further Advanced Life Support (ALS) given.

1.11 Following that declaration of ROLE, a community paramedic (Paramedic 2) arrived on the scene soon followed by two further ambulance crew members (Paramedic 3 and Paramedic 4).

Declaration of ROLE

1.12 The declaration of ROLE by Paramedic 1 is the first area of contention between the family and NEAS and is a substantial element of the family's complaint.

1.13 The two attending ambulance crew members (Paramedic 3 and Paramedic 4) had significant concerns about how the ROLE process had been enacted. They contacted their Clinical Care Manager (CCM) to express concerns and they attended the scene later to discuss those concerns with them. They then had to take A to the Royal Victoria Infirmary (RVI) but got together later with their CCM to complete the NEAS07 incident form and submitted it on 10 December. The incident was formally about the conduct of Paramedic 1 and whether they had sufficiently undertaken all the tests required before declaring ROLE.

1.14 In addition, a further NEAS07 was completed by the clinical audit team raising the same concerns again, within 24 hours of A's death.

1.15 The declaration of ROLE is a major decision and is governed by very clear national guidelines set by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). NEAS has developed its own guidelines in line with national policy.

1.16 In terms of NEAS's own ROLE forms, there is a Group B category that sets out the circumstances where CPR does not need to be initiated or in this case continued. The guidelines clearly state that to establish no realistic chance that CPR would be successful**,** all of the following must be present:

- No CPR over a period of 15 minutes since the onset of cardiac arrest (e.g., no bystander CPR)

- No evidence of drowning, hypothermia, poisoning, overdose or pregnancy
- A reading of asystole (a flat line) for a period of 30 seconds as shown on the Electrocardiogram (ECG) monitor (Defibrillator) and rhythm strip to be taken

1.17 Once the NEAS07 form was received, the standard procedures were initiated.

1.18 The NEAS07 is the internal incident reporting system for NEAS. If the completed form is assessed at level 3 or below it will go directly to the CCMs to investigate. If marked 3 or above it goes to the Clinical Operations Managers (COMs) initially before dissemination to the wider team.

1.19 In this case the risk was judged to be 5 and was sent to one of the COMs to investigate and COM 1 undertook this investigation.

1.20 The aim is to complete the investigation within 28 days, enacting Duty of Candour within that timescale. However, the investigation was complex and took longer, and the investigator report was completed and sent to managers for review on 18 March 2019 (over two months late).

1.21 The initial report prepared by the Investigator found that ROLE had not been enacted correctly but this report was directed to be altered by a Strategy Group who disagreed with the outcome.

Communication and Duty of Candour

1.22 This leads us to the second point of contention. Once an incident has been raised, there is an expectation that the family members should be notified about it within 28 days. It does not matter whether an investigation is taking place or that the findings are not yet known.

1.23 This did not occur and indeed the family were unaware of any concerns until 15 April 2019 when they were visited by the Family Liaison Officer (FLO) a few days before the first inquest hearing was scheduled. Here they were briefed that an administration error had occurred and that Paramedic 1 had filled out the ROLE form incorrectly and that they would receive additional training. They were not aware that any investigation had taken place into Paramedic's 1 response at the scene or informed of any concerns raised at the time.

1.24 NEAS did say that the FLO mentioned above had tried to telephone a few times but got no answer. The family say that they were there, but no calls were received or missed calls registered. In addition, there was no formal Duty of Candour letter written and sent to the family. The reason given for this is that the Trust and partners did not want to distress the family prior to the funeral. The family do not believe that NEAS should have taken that stance as it was not for them to determine what was best for the family at that time.

1.25 It wasn't until 19 April 2019, the Thursday before the Easter bank holiday, that the investigation report was received by the family (without appendices). The inquest was due to be heard on the Tuesday after the bank holiday.

1.26 The family were shocked and deeply distressed by what they read and could not understand how what they read in the body of the investigator report reconciled with its conclusion. In addition, they were shocked that nobody had shared these concerns with them earlier.

1.27 They did attend the inquest and listened to the report writer give evidence to the hearing. It became apparent at the outset that the family had not received all of the information relevant to the case. They felt that the investigator struggled with explaining the conclusions and asked relevant and searching questions. Only then, were they given all the papers including the appendices.

1.28 Given the issues and concerns now raised about the investigator report, the Assistant Coroner was not happy to come to a conclusion and adjourned the hearing to 01 August 2019. The Assistant Coroner wanted to call an expert witness to review the incident and provide a report. The family was very unhappy with the way the process was managed by the Trust and believed that the Trust was pushing for the inquest to continue and to come to a conclusion.

1.29 An expert witness was commissioned and made their report in June 2019. The expert's findings were that the ROLE was made without good cause and was inappropriate at the time as the criteria for ROLE was not met. They would have expected the paramedic to continue with resuscitation efforts and transport A to an Emergency Department. However, they did also add that whilst all effort should have been made and may have increased chances of survival, they still felt that on balance A would not have survived. However, the failure to provide advanced life support made her death a certainty. Paramedic 1 disagrees with the conclusion and believes that their declaration of ROLE was appropriate.

1.30 The family submitted a complaint to NEAS on 05 June 2019 following the inquest and registered their significant concerns. They also secured some legal representation to support them through the process.

1.31 In response to the complaint the Trust commissioned Ward Hadaway to do an independent review of the case. The investigation report was commissioned on 13 June 2019 and completed and submitted on 23 September 2019.

1.32 As a result of the investigation, the inquest scheduled on 01 August 2019 had to be adjourned again at the family's request as they wanted to see the findings from the report before the inquest recommenced.

1.33 The inquest into A's death resumed in October 2020 (following a series of delays, some due to the pandemic) and the Coroner recorded a narrative verdict.

Governance of incident

1.34 The third area of contention and concern for the family lies with the internal governance processes surrounding the investigation report.

1.35 As stated earlier, a NEAS07 form had been submitted with an initial assessment of a level 5 severity of harm. This warranted investigation and in

accordance with the Trust's own policy should have been presented at the Clinical Review Group (CRG) to review the case and assess the actual categorisation against the National Reporting and Learning System (NRLS) definitions, as well as to agree next steps. Any incident graded as moderate or higher is then allocated a senior investigating officer.

1.36 There were a number of delays due to insufficient information and the case was deferred to a meeting of the CRG on 20 December 2018. This too did not happen and was again deferred to 17 January 2019.

1.37 Prior to the December meeting, a group met, commonly referred to as a Strategy Group at that time, (these are meetings that look at Fitness to Practice issues) which decided that the incident was not deemed as a serious incident (SI) but no other categorisation was agreed. This group did not hold the remit or have the delegated power to make this decision, and this should not have occurred.

1.38 The CRG did take place on 17 January 2019 but did not really discuss the merits of the case and simply noted the outcome and decision from the strategy meeting. Duty of Candour also appeared to be questioned at this point. Delays were also attributed to other parallel reviews ongoing.

1.39 Despite this confusion and complexity, the investigation report was completed by the Investigating Officer (COM 1) on 18 March 2019. This original and primary report was judged to be thorough by Ward Hadaway. The investigator did interview all the NEAS staff connected with the incident including Paramedic 1. They also checked the ECG recordings and other evidence to establish the facts. The only element that could have been stronger but was addressed by Ward Hadaway themselves was the fact checking over an assertion that the printer wasn't working on the scene and concerns that emerged about this issue (see 1.43 below).

1.40 On completion of the report, COM 1 forwarded it to their line manager (acting Clinical Services Manager), Head of Patient Safety and Head of Risk and Regulatory Services. COM 1's final report on the investigation was discussed at the extraordinary Strategy Group that met on 26 March 2019. In attendance were the Medical Director, Deputy Director of Quality and Safety, Head of Patient Safety, Lead Consultant Paramedic, Head of Risk and Regulatory Services and line manager.

1.41 In summary, the investigator found:

"In conclusion, in relation to this incident, the investigating officer has established that local procedures and JRCALC guidelines with regards to Recognition of Life Extinct have not been applied correctly. Equally, the NEAS ROLE form and initial recordings on ePCR has not been completed to the expected standard. Given the circumstances, recorded and explained by all who attended. Advanced Life Support could and should have been provided".

1.42 This conclusion was attributed to two key factors. One was that the ECG recording only lasted for 16 seconds and not 30 seconds, as is required in both national and local guidelines, and secondly it did not indicate a reading of asystole (a flat line). It did indicate significant disturbance throughout with no rhythm recognition.

However, the investigator wishes to stress that the initial conclusions were derived from all of the presenting information gathered whilst compiling the investigation report. The other related to the fact that bystander CPR had been given and was not continued by Paramedic 1.

1.43 In addition, there was no rhythm strip printed, as is the normal procedure, as Paramedic 1 said that the printer was broken. This was retrieved from the stored data but there was concern whether this had occurred as no fault could be found on the printer.

1.44 The investigator also wrote that following the conversations with Paramedic 1 on the rationale used to come to this decision that Paramedic 1 confirmed on reflection that he should have provided ALS at the incident.

1.45 A discussion was held in the Strategy Group (referred to in 1.40) on the investigation and some members of the Strategy Group felt that the report should be changed including the conclusion reached by the Investigating Officer. The reasons for this were not minuted but essentially some senior members of the Strategy Group felt that A would not have survived further intervention and discussions with those present attest to this. The severity attributed to the case was also reduced to a 2. The Lead Consultant Paramedic was delegated to draft the agreed amendments outside of the meeting. It should be noted however, that the acting Clinical Services Manager and COM 1 believed the findings in the initial report were factual and did not support the changes.

1.46 The amendments were made in four key areas of the report and one of the appendices removed. It has been made clear to the investigation team that these amendments were not discussed or agreed with all those attending the Strategy Group. The amended conclusion was as follows: -

“In conclusion, in relation to this incident, the investigating officer has established that local procedures and JRCALC guidelines with regards to Recognition of Life Extinct have not been applied correctly. However, the decision not to start ALS upon reflection was the correct decision, the patient had fixed and dilated pupils, had absent pulses and purple ligature markings around the neck and CPR with ALS would not have had a positive outcome. It was found however during the investigation that the NEAS ROLE form and initial recordings on ePCR has not been completed to the expected standard and further training is required to ensure these issues are addressed.”

1.47 References to the investigator’s findings relating to the ECG only being recorded for 16 seconds were removed from the narrative as were the sentences where concern was expressed about the fact that no efforts were made to clear the patient’s airways, and that Basic Life Support (BSL) was not continued, and ALS not given.

1.48 And finally, the lines referencing Paramedic 1 himself having acknowledged that he should have done it differently were also removed.

1.49 The Investigating Officer (IO) who wrote the report was asked to accept the amendments and he did (although reluctantly). He did not agree with the

amendments and raised concerns at this and discussed with his line manager who supported and agreed with him. He feels disappointed that this happened and would never allow it to happen again.

1.50 The amended report was the one that was shared with the family and the Coroner. The original investigator report was forwarded to the Coronial and Claims (C&C) Team and only came to light through the Ward Hadaway investigation and was then shared with the family.

Coronial processes

1.51 There were also concerns expressed by the staff about the coronial processes in this case. Ward Hadaway undertook an independent investigation into the management of coronial cases following concerns being raised. This was a separate and different investigation to Case 1.

1.52 The Coroner was not notified about the concerns and investigation by the Trust as it was obliged to do. The Coroner approached the Trust on 20 March 2019 to say he had been advised by the Police Professional Standards Body that the Trust was carrying out an investigation in relation to CPR on A at the scene and asked why the Coroner was not told about it. The Coroner then requested as a matter of priority the outcome of the investigation as the inquest was due to be heard on 23 April 2019.

1.53 The Trust responded and said that the report was going through internal governance processes and would be with the Coroner on 29 March 2019. The report was sent but without the appendices that were critical to the report. The report was also shared with Ward Hadaway.

1.54 On 1 April 2019 the Coroner asked the Trust whether the report could be sent to the family. The Trust agreed to do so without redaction, but this was not shared until later in the month.

1.55 There appeared to be significant confusion during April between the various NEAS teams about what had been sent and what should be sent to the Coroner. Ward Hadaway contacted the C&C Team in NEAS to enquire if all documents were sent to the Coroner and asked for appendices to the COM 1 report. Further reports were sent on 18 April 2019 to Ward Hadaway who disclosed them to the Coroner.

1.56 It was also agreed that all hard copies would be made available at the inquest on 23 April 2019. Some of these documents had not been seen by NEAS's own C&C Team.

1.57 Disclosure from the Coroner was then received and sent through to the Trust on 17 April 2019. This included statements from the Police who had attended the scene. Some inconsistency regarding observations carried out on A were noted.

1.58 The inquest on 23 April 2019 was adjourned due to the issues that were raised about CPR until August 2019. An expert witness was going to be called and a

statement from the Clinical Manager who signed off COM 1's report. This statement was delivered on 07 May 2019.

1.59 The expert witness statement was also shared with the Trust in June 2019, the findings of which have been shared earlier in this report.

Other areas of concern

1.60 Concerns have been raised by the family on other matters within the Trust. These include accountability, sickness return policies, HR processes, including fitness to practice, learning from incidents, equipment management within the Trust and social media behaviour.

1.61 We have focussed this investigation on the large key issues which do also have a bearing on all the other concerns raised. Many of the other concerns have been raised as part of a formal complaint and the Trust have responded.

1.62 We have also assessed the thoroughness of the Ward Hadaway Report and have found their findings to be sound and reasonable in all the other domains.

1.63 Unfortunately, the whistle-blower has refused to meet with us, so we have no new evidence from him to add in this particular case.

What we found

Declaration of ROLE

1.64 As can be seen above, there is a significant difference between the Trust and the initial view of the investigator and indeed the Ward Hadaway and Coroner's expert findings in respect of the application of ROLE in Case 1.

1.65 The policy derived from national guidelines is clear about the criteria that must all be checked before ROLE can be performed. The guidelines clearly state that to establish no realistic chance that CPR would be successful**,** all of the following must be present:

- No CPR over a period of 15 minutes since the onset of cardiac arrest (e.g., no bystander CPR)
- No evidence of drowning, hypothermia, poisoning, overdose or pregnancy
- A reading of asystole for a period of 30 seconds as shown on the ECG monitor (defibrillator) and rhythm strip to be taken

1.66 It is quite clear in terms of the evidence that the first and third part of these criteria was not complied with. Paramedic 1 did not get a reading that lasted a minimum of 30 seconds and the reading that was recovered did not indicate a reading of a flat line. The evidence seen by all concurs with that. This is disputed by Paramedic 1. Point One was also not met within the facts of the Investigation – No CPR over a period of 15 minutes since onset of cardiac arrest.

1.67 The interpretation of the importance and mandatory nature of the guidelines is a point of difference. The Trust's most senior paramedic and some other clinical members of the group believed that these can be overridden if there is a strong clinical case to do so. The Investigating Officer and his line manager, Acting Clinical Services Manager, did not agree with the line taken by senior managers as they did view them as mandatory.

1.68 This approach is also at odds with other paramedics views who were also connected to the case where the guidelines are seen as mandatory, and this indeed was why the ambulance crew escalated their concerns in the first place. This is also not substantiated by the expert witness at the inquest.

1.69 Even if this was the case, we did not see any evidence that was presented to the Strategy Group or reasons recorded or any request for additional information that might be relevant to overriding national guidelines that are in place.

1.70 The investigator's report was the only evidence on which this decision was made. The report was not questioned in thoroughness or approach by the Strategy Group and the conclusion was not agreed by all the members attending.

1.71 There were some genuine flags to note in this report which would reasonably suggest the need for further evidence before any decision was made to deviate from guidelines. Two different NEAS07 forms had been submitted by different staff to raise professional concerns about this case.

1.72 It was also noted that Paramedic 1 seemed concerned that he was due to finish his shift and was wanting to leave. That of itself is not unreasonable but would signal a further conversation and exploration of the case given that ROLE was not appropriately carried out. In our interview with Paramedic 1, they still do not agree with conclusions that ROLE was not carried out appropriately. They genuinely believed that they relied on their extensive experience in calling ROLE and that further interventions were not necessary.

1.73 Other worrying indicators included reports that Patient A was warm, may have had a radial pulse when Police arrived. It would be reasonable to exhaust all lines of ALS given the circumstances and age of A, however slight the chances of recovery might be. There had also been no evidence, documentation or stated attempt of airway management prior to cessation of bystander CPR. ALS was not commenced and the investigator believed the guidelines and protocols had not been followed.

1.74 There were also inconsistencies in what was reported to have been seen on the monitor and on further investigation by Ward Hadaway, the ZOLL[1] specialist has clarified that what you see on the screen is what is printed out. This was not a flat line. It is accepted that it did not have a recognisable rhythm but there were some fluctuations to be seen.

1.75 Paramedic 1 also stated that the printer was not working and could not print out the reading taken. This had not been reported prior to the incident and the printer

[1] *Zoll is the manufacturer of defibrillators*

appeared to be working after the incident. The reading is fortunately recorded on the system which enabled the staff to access it later.

1.76 The major issue that concerned Paramedic 1's colleagues, was the timescale within which ROLE was called. It was called very quickly and before a full ECG reading of 30 seconds was achieved. The reading only lasted 16 seconds.

1.77 Given the issues outlined above and the investigator's conclusions, we cannot support the direction given to the investigator to change the report and delete parts of the report and alter the conclusion. Questions should have been asked at this meeting to elicit responses that were pertinent to the case and more information required if relevant from the crew who submitted the NEAS07. There is no record of any discussion other than from those interviewed recently and that is only from memory.

1.78 We have spoken to members of the Strategy Group including the Lead Consultant Paramedic who drafted the amendments about this on behalf of the Strategy Group, but our concerns remain. As stated in 1.77 above, more details should have been sought, and further investigations carried out on the case before any addendum if required was agreed. The original document should never have been changed in any circumstances. Concerns about coronial processes had also been raised at this meeting by the Acting CSM and Head of Risk and Regulatory Services.

1.79 We cannot assign intent as to the reasons the Strategy Group made the decision to alter an independent investigation report other than they agreed with Paramedic 1's actions. However, if the Group felt strongly about their reasoning for this then they should have provided an addendum to the report. The original report should have remained intact.

1.80 Whilst the Investigating Officer raised his concerns about the changes to his report, he was overruled and adhered to the decision made by his senior managers. He still felt very concerned about the changes and did communicate that to his colleagues. We also believe that the Trust should not have put him in a position to attend the inquest to defend a conclusion he had not reached.

1.81 In summary, we have come to the view that Paramedic 1 did not adhere to national and local guidelines and consequently did not provide any ongoing CPR or provide ALS for A. However small the probability of recovery was, A deserved that chance and so did her family.

1.82 The Trust has apologised for many aspects of this case to the family, but at the time this report was written it had accepted the argument that the non-adherence to these guidelines was reasonable and within Paramedic 1's scope of practice. We disagree. We have recently been told that the Trust's position has shifted on this. The family still feel that a full personal apology has not been given to them face to face.

1.83 The Trust had supported the decision of the Strategy Group whilst it recognises that the Group was operating outside of its remit.

1.84 The Trust also claims that the investigator went along with the suggestions for change but, we are not sure that that conclusion is reasonable. The Investigating Officer was dealing with very senior managers whom he professionally trusted. He did share his concerns but believed that the senior managers must be aware of other matters and went along with their recommendations to change.

1.85 In the light of all the above, we believe that the family deserves an unreserved, unconditional apology for the impact this has had on them.

1.86 Nobody disputes the fact that the likelihood of recovery was very slight, but all can recognise the importance of believing everything was done to save their child and the distress that follows when you believe this not to be the case.

1.87 This is particularly relevant to A's family. The shock on receiving the report outlining the investigation and then believing that the Trust was not acting in an open and transparent manner has been devastating to them. Their one other child (a son) has since ended his own life and the family believe that the death of A and the way it was handled was a large contributing factor to this.

Governance of incident

1.88 The governance surrounding this incident has also been poor. The normal policies and processes were not followed. There appeared to be no clear accountability or ownership of the case and decisions were made in groups that had no remit to do so.

1.89 There are some concerns also about how serious incidents are dealt with and criteria being consistently applied. This incident was downgraded from a 5 to a 2 and to our mind that was not substantiated.

1.90 The Trust has acknowledged that the process failed the family, and the current Chief Executive has written to the family and stated:

"All the errors in the handling of the investigation into A's death were made with good intentions, but were disorganised, fragmented, outside of the scope of usual processes, not followed up quickly enough, and allowed to drift from timeframes which are set and agreed specifically to stop this type of situation from occurring".

"The investigation was not listed on any trackers, did not have a root cause analysis (RCA) scheduled to discuss it with a multi-disciplinary team, and the report was therefore not scheduled to be delivered anywhere for oversight or challenge."

1.91 We will pick up recommendations later in the report when we look at governance issues more widely.

Duty of Candour

1.92 Duty of Candour was not followed and applied and indeed the general communications with the family were very poor initially. This too was acknowledged

by the current Chief Executive in her letter to the family and subsequent correspondence.

1.93 There is a concern for us that Duty of Candour is only seen as important when an incident has been classed as moderate or higher. Candour and good communication should be operating at all levels and at all times within the organisation.

1.94 There are of course legal imperatives within the legislation that must be met, it should be the underpinning principle for all incidents and communication.

1.95 This pertains to patients and families but also there is also a clear expectation on public bodies to be open and candid in their communication with coroners. (*Please refer to Chapter 5 for more details on Duty of Candour*)

Coronial processes

1.96 The evidence in this case clearly indicates that the Trust's coronial processes were not followed.

1.97 The Coroner was not informed of the initial investigation as would be required and this affected the whole timescale and added to the complexity of the case and distress to the family. It was the Police Professional Standards body who made the Coroner aware of what was happening in terms of the investigation.

1.98 In addition, the C&C Team within the Trust were equally not informed or included in the relevant discussions.

1.99 There is evidence that when disclosures are required to be sent to the Coroner this ends up in information being passed from one team to another for permission to send and this adds to the delays in the process.

1.100 We will pick up some more specific issues in relation to wider coronial processes later in Chapter 3 of this report.

1.101 Obviously, the key coronial process concern in this case was that not all information was passed to the Coroner initially and then disclosures had to be made later. This also materially affected what the Coroner could share with others including the family.

Case 2 – Patient B – 14 March 2019

The facts

1.102 This is a case where a 62-year-old gentleman (B) who was experiencing shortness of breath made a 999 call. On further discussion on the call, it was noted that B had a medical history including Chronic Obstructive Pulmonary Disease (COPD) and required 24-hour home oxygen therapy.

1.103 The purpose of the call was to report a power cut which had resulted in the oxygen supply ceasing (as it relied on electricity) and B who was alone could not get out of bed to access the alternative oxygen cylinder. B was very reliant on this oxygen and was now suffering with shortness of breaths.

1.104 The call was triaged using the NHS Pathways System and a Category 2 disposition was given.

1.105 An ambulance crew was allocated from the nearest ambulance station (only 3 minutes away). However, the ambulance crew were unable to leave the station as the power cut had also affected the local ambulance station and the automatic gates would not open. The crew allocated to this case did not know how to use the manual override and were unable to depart.

1.106 Once this was known, a second ambulance crew was allocated to the case, but this crew was delayed due to refuelling enroute to the property.

1.107 There was a further delay encountered when the crew could not find the key safe to access B's property.

1.108 The key was finally found, and the crew were able to access the property but B was declared dead on the scene.

1.109 The family have a number of concerns relating to their father's case. They do not feel that NEAS have acknowledged process failings and their contributing factor to their father's death.

1.110 They also have concerns about the plans and timescales in place to improve that clearly demonstrate organisational learning and action.

Delays to opening gates at ambulance station

1.111 The first issue to explore is the delay associated with opening the gates at the ambulance station.

1.112 As stated earlier, the ambulance was allocated to the incident from an ambulance station only a 3-minute drive away from the patient's home. Unfortunately, the power cut affected the ambulance station also and the crew did not know how to operate the manual override system.

1.113 On reading the Strategic Executive Information System (StEIS) investigation report, NEAS recognises that at the time of the incident, staff were not trained in how to manually override ambulance station gates in the event of a power failure.

1.114 They also found that subsequent efforts to source assistance from both the Emergency Operations Centre and a CCM were also unsuccessful.

1.115 There were also no readily available information sources to support teams should this occur.

1.116 The 999 call was initially received at 4.01am on 14 March 2019 and the first ambulance crew was allocated to the case at 4.04am. This meant that if all had gone well, the first ambulance crew would have arrived outside the property at 4.07am approximately.

1.117 Given the failure to open the gates a second crew was allocated and despatched at 4.15am (14 minutes after the 999 call). The lag between first and second allocation is assumed to be down to attempts to open the gates and leave the ambulance station. However, witness statements were not provided from the first ambulance crew.

Delays associated with refuelling of ambulance

1.118 When the ambulance was activated to attend B they requested to refuel enroute to the incident. The Control Team confirmed this was ok. The newly qualified paramedic who requested the refuel states: -

“I was aware that we needed fuel so had requested to refuel and used the phrase ‘we only have one bar’”, as I had heard that phrase used before, but I was actually unsure of the meaning of this phrase.”

1.119 On investigation, the fuel capacity at the time of incident was recorded and at 3.58am prior to refuelling the ambulance tank had 29 litres of fuel remaining which is close to half a tank full. In other words, there was more than enough fuel available to get to the incident without stopping.

1.120 General guidance on training suggests that it is good practice to try and keep the tank half full in case of emergencies and on handover to new shifts. However, there is no policy that stipulates when a vehicle should be refuelled so the “one bar” rule is not actual policy although in this case there was more than one bar in the tank.

1.121 The family were provided with the newly qualified paramedic’s statement which outlines this. However, the same statement sent to the Coroner has an additional note from the same paramedic handwritten on it which says: -

“At the time I was not corrected by my crew mate for the terminology used and that we had enough fuel”.

1.122 The delay added to the journey for refuelling was four and a half minutes approximately.

Delay associated with accessing the property

1.123 On arrival, the crew were unable to find B’s key safe. They tried to ring B for more information but did not get a response. At this point they were considering forced entry but then did find the safe so that was averted. The crew contacted the Emergency Operations Centre informing them that the key safe had been located and they were about to enter the premises.

1.124 The delays in finding the keys and accessing the property were nearly 12 minutes in total.

1.125 The main contributor here was the inability to find the key safe. The family believe that clear instructions were given on the initial 999 call. We have listened to the call and B does state that there is a key safe and it is "up the drive" and what the passcode is. It doesn't specify further but we are not quite sure what the specific difficulties were in accessing it.

1.126 It would have also been very dark as there was an ongoing power cut and this may have affected visibility.

What happened when crew accessed the property?

1.127 When the crew did access the property, they found B lying in bed with a nasal cannula in place attached to a portable oxygen machine that was running, which suggested that he had accessed the extra oxygen. The BIPAP (Bi-Level Positive Airway Pressure) machine was unattached to B at that point.

1.128 The crew checked for signs of life but assessment revealed B was deceased. It is also worth noting that the power was still cut off at that point.

1.129 The crew also stated that later when they returned to the property and the lights were on that they discovered a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) on the top of the microwave. This however was not relevant as the ROLE had been called prior to the discovery of this.

The use of Low Harm categorisation

1.130 This incident was initially categorised as a Low Harm. The explanation for this is that NEAS arrived within the National Standard applicable to a Category 2 incident which is 90% of patients to have received a response within 40 minutes and overall average to be within 18 minutes.

1.131 The ambulance crew arrived at the scene which was 36 minutes and 37 seconds after the initial 999 call was received which means it was within the 90% standard.

1.132 In addition, the explanation for this categorisation which was agreed in April 2019 "*to downgrade the incident to low harm as the root cause of patient harm was the lack of/battery malfunction in the CPAP equipment".*

1.133 The other consequence is that there is no regulatory Duty of Candour if the incident was graded as low.

1.134 The family's contention is that if the ambulance had got there sooner their father might still be alive and that it was NEAS's failures in processes that contributed to the likelihood of death. Their belief and experience of their father's condition is that he could manage for about 20 to 30 minutes without oxygen. They

also contend that he was very clear about the urgency of the oxygen when the 999 call was made. We have listened to the call and can attest to this fact.

1.135 They therefore believe that this should have been treated from the onset as a serious incident.

1.136 They are also distressed that all investigations and responses to date have focused on his underlying health condition and the DNACPR.

Communication with coroners

1.137 Given the case was graded as Low Harm, the Trust took the same stance that it did on Duty of Candour in Case 1 and did not let the Coroner know about the delays and reasons for delays.

1.138 The inquest was delayed but the Coroner requested a statement from the responding paramedic in October 2019. The incident and the Coroner's request were reviewed at a meeting called SEACARE (Patient **S**afety incidents, patient **E**xperience concerns, **A**dult safeguarding concerns, **C**hildren's safeguarding concerns, **A**udit from the learning from deaths process, **R**isk which incorporates coronial requests and concerns and **E**xternal requests for information related to care provided by NEAS).

1.139 It was requested by SEACARE for a new statement to be provided by the paramedic because the previous statement was deemed to be about the incident and refuelling rather than one drafted for a coroner. This second statement focussed only on the oxygen issues and did not mention any issues about delays.

1.140 The family do not believe this to be transparent and do not understand why the original statement was not shared with the Coroner.

1.141 In May 2020, following an independent review of the coronial processes within the Trust, additional documents were provided to the Coroner in this case. These included all the paramedics reports and the incident reports.

Communication with families

1.142 As stated earlier, the incident was deemed to be Low Harm and consequently the family were not informed of the delay issues.

1.143 The matters came to their notice due to the whistle-blowing processes where their case was used as an example of a cover up.

Learning from incidents

1.144 This is the second most important ask of the families. There is a sense that action plans are not actively implemented and are not robustly governed. Consequently, the learning coming from these are diminished. This is a concern also that has recently been picked up by the Care Quality Commission (CQC).

What we found

Delays to opening the gates

1.145 The most recent investigation by the Trust is clear that no real process or policy existed in respect of manual overriding of gates at the time of the incident and consequently staff were not trained to deal with the incident.

1.146 The report made three recommendations which we believe are sensible and we support. These are:

1. Trust wide communication to be issued via Operational Alert identifying how to manually override a station gate. Supporting information to include invoking business continuity should a station gate fail to open.

2. Information regarding how to manually override a station gate to be added to the Care Platform and included within 1-2-1 ride outs conducted by Clinical Team Leaders with staff members. Training to include both a demonstration and test exercise.

3. Information regarding how to manually override a station gate to be added to stations in a location that is deemed to be easily accessible and in the same place in every station, for example, in the garage, near the garage door.

1.147 Unfortunately, this newer investigation found that recommendations made after the incident were not systematically applied across all stations within the Trust. Only one cluster fully complied. In addition, the CQC shared that this was also a concern in their recent inspection.

Delays associated with refuelling of ambulance

1.148 As mentioned previously, there were no clear policies within the Trust that set out the guidelines when a vehicle should be refuelled. Some custom and practice behaviours have grown in the absence of a clear policy.

1.149 Again, the Trust have recognised this and have agreed to:

1. Develop a new policy that is relevant for the service.
2. Develop guidance and a roll out plan to support implementation of said policy.

Delay associated with accessing the property

1.150 It was deeply unfortunate that a delay occurred. Although B did mention that the key box was “up the drive” the instructions were not very specific. It might be useful for the call handler to try and extract some more details that would be useful to crews to avoid any future delays.

What happened when the crew accessed property?

1.151 No recommendations to make. The crew appeared to carry out all relevant assessments as would be required of ROLE.

The use of Low Harm categorisation

1.152 NEAS believes that they met the response standard for Category 2 in this case so did not believe that this was a serious incident at the time (2019). In addition, they also contend that one of the real problems associated with this case is the fact that the machine did not have a failsafe battery in the event of a power cut.

1.153 We agree with NEAS in respect of the need for wider learning in this case. There are questions that need to be addressed across the wider system to improve learning and avoid future deaths.

1.154 What we do not agree with is the fact that this was never called as a serious incident in the first place, however it is important to note that the Trust have retrospectively classified the incident as an SI in 2022 and it has now been investigated.

1.155 It is factually correct that the national standard in respect of time was met. However, there is no doubt that this patient could have been seen earlier if processes were operating effectively and this earlier intervention could have led to a very different outcome.

1.156 The fact that the response standard was achieved appeared to inhibit an objective review of the incident and was not sufficiently patient or family focussed.

1.157 There are sufficient concerns about failures in processes, unnecessary delays and other wider issues that to our estimation make this a serious incident. Even with a legitimate delay while searching for the key safe, B could have been seen earlier and may not have died on that day.

1.158 This position is strengthened by other general concerns about oxygen provision and failsafe policies where wider learning would also have benefitted the system.

1.159 The family also feel that a huge amount of effort went into saying that B had a very serious life-threatening condition which was indeed true and B had a DNACPR. This appeared to deflect the focus from the issues and concerns in hand.

1.160 There were some questions to explore about oxygen provision but the reality was that if the ambulance crew had arrived earlier than they did, the patient may not have deteriorated so rapidly and died.

1.161 Also, an automatic Duty of Candour should have been in place and the family would have had time to react and deal with their grief. (*See Paragraph 5.12*)

Communication with coroners

1.162 As stated earlier, the fact that the ambulance paramedic was asked to provide a separate statement is a little unusual and, unfortunately, we have not been able to secure additional evidence as to why this was done. All documents have now been provided to the Coroner in May 2020 following a recommendation from a previous review and the Coroner has had all the information to come to their own view.

1.163 The decision not to share the original statement in 2019 has however affected the confidence of the family in respect of NEAS's candour and transparency.

Communication with families

1.164 Given that this case was originally deemed to be Low Harm, the family were not contacted or aware of potential process failures and delays.

1.165 They only found out about issues when the whistle-blower raised concerns. This is obviously not an ideal situation, and the family are very upset about this.

1.166 The Trust has tried to rectify the situation and believes it is now in close communication with the family. The family does not support that assertion and feel the communications they have had have been reactive and not proactive. They believe they have had to chase for responses and there is no doubt that their trust has been lost.

Learning from incidents

1.167 We think all the families recognise that mistakes can happen and that there are a number of human factors in play in busy NHS organisations. However, they do demand that mistakes are acknowledged and communicated and that organisations demonstrate a willingness to learn if trust is to be maintained.

1.168 This is an area where there are some opportunities for improvement in NEAS. First, it is important to acknowledge and recognise the mistake. Secondly, it is important to engage and communicate with patients and families on those mistakes and thirdly, it is essential that a clear robust monitoring system is in place to follow up any actions agreed.

1.169 In this case there are weaknesses in the first two areas which has led to lack of confidence on the third action. It would also be the case to say that later reviews have also found that not all actions have been properly or effectively followed through.

1.170 We think trust could be improved by including families in implementing and monitoring recommendations and learning processes.

1.171 This is a very important governance issue that will be picked up in its entirety later in this report.

Case 3 – Patient C – 19 December 2019

The facts

1.172 This case is about a 62-year-old gentleman (C) who fell onto a washing basket and suffered a penetrating injury from a piece of wood. The family made five calls over an hour period and regrettably the patient was in cardiac arrest when the ambulance arrived an hour and 8 minutes after the initial call and died. The call had been categorised as a Category 2.

1.173 The family were deeply upset and traumatised and struggle to understand why NEAS did not escalate the severity of the case sooner to a Category 1. The family were present (including the niece of the gentleman who is a nurse) and were able to communicate the deterioration of C with each successive call. They suspected the patient had a punctured lung and he was actively bleeding.

NHS Pathways categorisation

1.174 The first 999 call was made at 10.15am on 19 December 2019. The family told the call handler about the fall and that C may have possibly punctured his lung. C was confirmed as breathing and confirmed after questioning that nothing was stuck in the wound. The call handler was also informed that he had lost about a pint of blood.

1.175 This first call was categorised as a Category 2 call in accordance with the NHS Pathways tool. Heavy blood loss is identified in NHS Pathways as being over two mugs full of blood and is categorised as a Category 2.

1.176 A Category 2 call should be responded to within 18 minutes or 90% of the time no later than 40 minutes.

1.177 It is possible to override NHS Pathways disposition if the clinician within the Emergency Operations Centre (EOC) feels that is appropriate given the clinical presentation.

1.178 The second call was made at 10.28am by C's niece who is the nurse. This is 13 minutes after the first call. Concerns were raised about C and the family's inability to stop the bleeding despite pressure being put on the wound. Again, nothing was confirmed as being stuck in the wound. This was still judged to be a Category 2 disposition by the computerised system.

1.179 The third call was made at 10.56am (41 minutes after the initial 999 call) again by C's niece. This time additional concerns were raised about C becoming drowsy and bleeding had not slowed down and indeed fresh blood had spurted when he moved. The nurse expressed worry that C was going into shock. This was still assessed as a Category 2 case by the computerised system.

1.180 The fourth call was made at 11.04am (49 minutes after initial 999 call). C's niece once again described a further deteriorating situation and stated that he was

dying, he was unable to breathe and was actively bleeding. Those on the scene had managed to acquire a defibrillator and this was attached to C's chest.

1.181 At this time the family were told that a clinician would ring them back.

1.182 A fifth call was made at the same time by C's sister initially, but the phone was handed to the manager of the housing facility where C lived. The Housing Manager reiterated that it was a suspected lung puncture, and that C was struggling to breathe and appeared to be in shock and that there was heavy bleeding. The case remained as a Category 2.

Escalation to clinician

1.183 The clinician who had been requested to ring the family back at 11.04am didn't manage to ring back until 11.14am and then spoke to the Housing Manager at 11.14am. C was reported as barely conscious and breathing. C was still bleeding but while still on the call he stopped breathing and CPR commenced. At this point the clinician upgraded the incident and Category 1 was now called at 11.19am. This means that response should be within 7 minutes and for 90% of cases no longer than 15 minutes.

1.184 The clinician's call to the family had been delayed due to the inability to access C's case as the notes were locked (only one member of a team can amend a case at any one time). This happened a number of times.

1.185 However, an emergency rapid response car (RR) was allocated at 11.09am to the incident prior to the clinician speaking to the family. A double crew ambulance was despatched once the case was upgraded to Category 1 at 11.20am.

1.186 The RR arrived at 11.22am (one hour and eight minutes after first 999 call was made).

1.187 At this point too, the Great North Air Ambulance Service (GNAAS) also assigned a resource once they were aware of CPR.

1.188 Full ambulance crew arrived at 11.26am and GNAAS arrive at 11.39am. In addition, a specialist major trauma NEAS practitioner was also assigned to the case and arrived at the scene at 12.11pm.

1.189 Full resuscitation attempts were made until 12.26pm when the decision was made by GNAAS to cease.

1.190 On review, it is clear to see why this has been so hard for the family concerned. All attempts were made by the family to escalate concerns and to clearly depict a growing concern about the level of deterioration in the condition of C. These concerns were fully grounded, and C ended up dying.

1.191 The impact and ongoing distress the family has experienced has been significant. The stain that the blood left on the carpet in the corridor outside C's flat was a daily reminder of the trauma. C's sister who had lived next door had to

eventually move to stop reliving the details of the incident.

Communication and behaviours

1.192 Another issue that also contributed to the family's distress and difficulties were the perceived poor behaviours on some of the interactions with NEAS staff, and this has formed part of the family's complaints.

What we found

NHS Pathways categorisation

1.193 The NHS Pathways tool would not categorise a major haemorrhage a Category 1 unless the patient is unconscious and not breathing. As can be seen from the case above, this was not the case until the very end. This is based on evidence that if the crew achieved normal Category 2 wait times that that should be safe practice.

1.194 There are two issues at play in our opinion, one is why the response time was so delayed and the other question to be answered is why didn't the existing protocol get overridden given the level of deterioration of C?

1.195 With respect to the first issue, the Trust did carry out a detailed review of the contributing factors that led to this substantial delay. One of the reasons for delays was the increased number of 999 calls that the ambulance service was experiencing at the time of the incident. Another reason given was that some of the ambulance resources were tied up in hospitals where there were significant handover delays thus not releasing ambulances to respond to incidents. There were also some shortfalls in staffing at the time which also had an impact on the availability of ambulances to respond.

1.196 At 10.00am there were 51 999 calls and 11 urgent cases awaiting ambulance allocation, this rose to 69 outstanding 999 calls and seven urgent cases. In this scenario, given the Category 2 allocation, it was inevitable that some delays would occur. This is an issue across all ambulance trusts in the country now and is also a resource issue for NEAS.

1.197 Unfortunately, in this case, the ambulance service did not meet the standard wait time for Category 2 waits and the outcome was catastrophic for C. If the national standard had been met then C may not have died.

1.198 NEAS is a relatively small ambulance trust and evidence suggests that it has not been adequately funded for the service required. Some progress has already been made on securing additional investment for front line services from the Commissioners. It is important to continue to review, monitor and benchmark the service to support it to deliver what is required from a patient safety and quality perspective and avoid harm.

1.199 The second issue as to why the designation of Category 2 didn't change in the light of the level of deterioration of C is a little more complex.

1.200 The NHS Pathways Tool is based on a set of algorithms which support decision making in ambulance services. This is a national tool and is used by many ambulance trusts in the country. However, whilst it is good practice to adhere to these algorithms it is also accepted that clinicians can use their judgement and experience to override these in certain circumstances.

1.201 Indeed the initial investigation and response stated that:

"Once there have been three calls received from people at a scene (the initial call, and then two ETA calls) this should be identified for highlighting to a clinician who may then determine that the response needs to be upgraded if there is evidence of sufficient patient deterioration".

1.202 This was obviously not complied with in this circumstance. At call two NEAS were informed by C's niece (who was a nurse) that he was having trouble breathing and that the bleeding was not under control. C was unable to speak after this call and his niece was advised to get a defibrillator.

1.203 At call three, the ambulance service was again informed that C was deteriorating further in terms of being able to breathe and when moved, blood was spurting out of the wound. The niece stated that her uncle was going into shock.

1.204 In accordance with the policy, that should have been the time to engage a clinician and potentially upgrade to a Category 1 disposition. That might also have alerted GNAAS and other specialist trauma paramedics to attend the scene and stabilise the bleeding to support transfer to a trauma unit and thus improving the chances of survival. Unfortunately, others only got involved when C went into cardiac arrest and was receiving CPR.

1.205 When this lack of adherence to the policy was challenged by the family through a complaint, it emerged that the report was factually incorrect. The policy referred to in the report was not in place when this incident occurred and had only been put in place on 31 December 2019 which was after the date of the incident. The staff member who wrote the report had made an error.

1.206 The policy actually in force at this time was that the Estimated Time of Arrival calls (ETA) would not be highlighted to a clinician but would remain on the Dispatch "stack" to be reviewed. A clinician would then contact the patient or caller where possible, to reassess the patient and to determine whether a different response would be appropriate. Given the demand on the service at the time, this was not done in a timely way.

1.207 The fact is, had the new policy been in place at the time, a clinician could have contacted the family much earlier and this may have led to a very different outcome.

1.208 However, irrespective of which policy was in place at the time, we find it difficult to understand why nobody appeared to recognise that the level of deterioration was rapid and life threatening and thus seek help.

1.209 Policies, protocols, and systems are of course important and there to assist the staff member but not at the expense of sound professional judgement. It is imperative that staff have the permission to raise clinical concerns at any time in the process irrespective of policies in place at the time.

1.210 This did not happen in this case and given that the deterioration was being communicated very clearly by a qualified and experienced nurse, we find the response inadequate and think further steps should be taken to remind all staff of the supremacy of safety in all clinical matters.

1.211 The Trust have been open and acknowledged failings in this case. They have also responded to the family's complaint and apologised for the delay and the consequences of those delays and the impact that has had on the family.

1.212 NEAS has also contacted NHS Pathways about this case and have asked them to consider this scenario in the future as a Category 1 with the focus being on uncompressible or uncontrollable haemorrhaging continuing over a period of time. This was agreed by NHS Pathways and the new pathway was implemented in April 2021. In addition, they will be carrying out a larger piece of work with stakeholders on catastrophic blood loss more generally.

1.213 It is good to see that learning has taken place in this case and that steps have been taken to both learn and improve for the future. There were also additional learning points picked up about inputs into "crew notes" or "call notes" that got confusing for those accessing the notes. This is a process issue that the Trust is also intending to address.

Communications and behaviour

1.214 With respect to the concerns raised about the behaviour of an individual at the scene of the incident, this too has been investigated and an apology given to the family. However, in an earlier communication with the family, the Trust got the details of the person being complained about wrong which distressed the family further. It remains clear that the patient's family perceive the interactions with the individual that was complained about very differently to that of the staff member.

1.215 However, the Trust have acknowledged the further distress caused to the family and have apologised further. It is also important to stress that everyone else involved in the direct care at the scene behaved very professionally and this was appreciated by the family.

1.216 The family are still not quite assured about the robustness of the response and would want the case to be used as a learning exercise for staff training and insight.

1.217 In terms of the communication with the family, there have been a number of instances where the exchanges of information and the style of those communications could be improved. Some of these concerns related directly to the incident itself.

1.218 As this was judged to be a serious incident, a Family Liaison Officer (FLO) was assigned to the case and part of their role is to be the conduit between the Trust and the family and to make sure that good communications operate. They will also pick up the concerns of the family and seek to address those.

1.219 The family were concerned about the time taken to investigate the case and the fact that the report was significantly delayed. These concerns were raised and communicated to the FLO.

1.220 They were also upset that nobody contacted them when they received the report to check if they needed any support. The normal expectation would be for the FLO to hand the report directly to the family and go through the details with the family.

1.221 The Trust reports that due to Covid and staff illness this did not occur. The family do not accept this excuse and feel that given the nature of the complaint somebody should have been on hand to help the family or rearrange a time that would have been mutually accepted.

1.222 In addition, there were also concerns mentioned earlier, that the first report sent to them had a number of factual inaccuracies which caused further distress to them and the report had to be resent with revised addendums.

1.223 There were also concerns raised about the style of interaction experienced from a clinician who did eventually ring the family during the incident. The Trust has acknowledged this and has dealt with the concern appropriately.

Case 4 – Patient D – 30 November 2019

The facts

1.224 This is another sad case that related to the inability of NEAS to respond within national standards to a 999 call. The case refers to a 52-year-old lady (D) who rang 111 at 6.36am complaining about pain in her shoulder and arm and who was also experiencing difficulty in breathing.

1.225 The call was classified as a Category 2 at 6.43am which again meant that D should be seen within 18 minutes or in 90% of cases no longer than 40 minutes.

1.226 D made a further call at 7.04am to report that she was now experiencing tightness in her chest as well as pain. This was again triaged as Category 2. The crew finally arrived at the scene at 7.50am and very sadly D was declared deceased at 8.03am.

1.227 This means that the attendance occurred one hour and 14 minutes after the call was made, or one hour and seven minutes after the call was categorised. This was 34 and 27 minutes outside of the national standard waiting times respectively.

1.228 The family were contacted by the Trust and spoken to, and an investigation was initiated in January 2020.

What we found

1.229 The family had two questions that they wanted answering, namely, why did it take so long for the ambulance to get there, and would it have made any difference if the ambulance had got there earlier?

1.230 The internal investigation was completed on 18 February 2020 and the family were contacted on the telephone on 19 February 2020 to discuss the findings. A formal letter was sent to the family on 21 February 2020 to respond to the family's concerns.

1.231 The reasons for delay were again attributed to high demand that outstripped available resource and again there were some impacts due to the inability to hand over patients in hospital in a timely manner. There were also some shortfalls in staffing that contributed to the pressure.

1.232 The reports state that there were 46 emergency patients queuing and 10 urgent cases queueing at the time of the initial call.

1.233 There had been an ambulance assigned at 7.20am but unfortunately this got reassigned to a Category 1 case who was a patient that was unconscious and needed to be urgently seen.

1.234 The Trust did not escalate the categorisation of D to a Category 1 as the patient was conscious and still breathing at that point.

1.235 There was a review of all the dispatch data at the time of the incident and the Trust believes there was nothing further that they could have done given the pressure on the system at that time.

1.236 With respect to the family's second question, it is difficult to answer in the absence of a clinical judgment on the matter.

1.237 The Trust did consider the question and carried out a multidisciplinary review of the case. Their conclusion was that an earlier ambulance was highly unlikely to have changed the outcome for D.

1.238 The family had shared the results of the post-mortem and that the Coroner deemed the patient had died from natural causes, specifically that part of a blockage had travelled into the Aorta. The family felt that it was highly unlikely that patient D would have survived.

1.239 On speaking to the family, they are obviously devastated to lose a relative so unexpectedly but are satisfied with the responses received and do not want the issue to go any further. They did not speak to the Sunday Times and simply wish to move on and deal with their grief as a family. We have respected their wishes and have not taken this case any further.

1.240 However, there is one more key point to make about this case which is about the coronial process.

1.241 The Trust as part of their own Coronial Process Task and Finish Group identified that the information first sent to the Coroner had inaccuracies in it on this case. This summary report stated that the ambulance response times were only 13 minutes outside of national standards which was incorrect, and the summary did not disclose any learnings.

1.242 The Trust disclosed a further 10 documents to the Coroner and apologised for the lack of disclosure which should have been sent at an earlier stage. They also felt that the timing error was a typing one as the timeline enclosed had the real times stated.

1.243 The issues arising from concerns about coronial matters will be picked up in Chapter 3 of this report.

Conclusions

1.244 These cases have been difficult to review and there is no doubt that if the failings identified had been acknowledged earlier, accountability accepted and a robust process for overseeing the recommendations and involving the families, then the Trust and confidence between families and NEAS would be very different.

1.245 There are some similar themes emerging about governance, compliance with existing policies and procedures, openness, candour, judgement and timely communication which can be seen in the cases reviewed. There are also concerns emerging about the capacity of the ambulance trust to meet national waiting standard and the risks that that brings.

1.246 In addition, there are consistent messages in relation to the coronial processes. We will explore the latter in more detail later in the report.

Chapter 2: Terms of Reference 2

"NEAS has previously commissioned six independent reviews / audits, and seven reports which were published between August 2019 to May 2022.

Review the seven reports and any associated relevant documentation, and determine:

- The quality of the investigations and reviews, sufficiency of enquiry and adequacy of their findings, recommendations, and subsequent action plans
- The progress made to implement the learning and recommendations to date
- Whether changes implemented within the Trust's governance, and coronial processes have resulted in effective and measurable improvement
- Whether there is further work required to ensure improvements to governance, and specifically coronial processes, are sustainable"

Introduction

2.1 The Trust has commissioned several external reports over the last few years in response to the whistle-blowing allegations and the families' complaints. There has also been a Desk Top Review carried out by professionals in the system to test the effectiveness and implementation of recommendations made and the Trust itself had set up a task and finish group led by a non-executive director to address the issues raised by the reports in 2019/20 and ensure recommendations were implemented by 2020/21. None of these reports were shared outside of the organisation or published via Board.

2.2 We have reviewed these documents and evaluated them against a number of criteria agreed with NHS England as outlined above.

What we found

2.3 A summary of the external reviews is found below and our overall view of the quality and sufficiency of the Reports. It needs to be remembered that the Terms of Reference for some of these are very specific and do not cover wider issues. We are judging against the agreed scope and not any wider considerations:

Document	Scope of Investigation	Quality of Investigation	Sufficiency of Enquiry	Number of Findings or Recommendations
(1)Ward Hadaway Review of Coronial Cases August 2019	Independent Review of 4 NEAS Coroners Cases arising	Good	Yes	5 Findings

	from concerns raised			
(2)Ward Hadaway Review of 'A' Case 23/09/2019	Conduct an investigation into Case 'A', determine facts where appropriate and make recommendations	Good	Yes Very thorough Report	9 Recommendations made in respect of specific incident for improvement
(3)Workforce One Interim Report 20/03/2020	To establish whether Trusts coronial process meets legislative and policy requirements particularly in respect of the accuracy and completeness of information disclosed. Also tested whether Ward Hadaway recommendations implemented	Good and adhered to own Terms of Reference	Yes	5 Recommendations made all relating to Coronial Processes
(4)Workforce one - Review of 'A' Case 01/06/2020	To check whether the Trust's coronial process meets legislative requirements. The investigation was to incorporate a review of sample cases including Case 'A'	Good	Yes Very thorough	6 Recommendations made
(5)Workforce one - Final Report 19/06/2020	Builds on interim report and tests whether concerns	Good	Yes	Concludes that concerns not fully addressed 7 Recommendations

	raised by Ward Hadaway have been addressed and implemented			Made
(6)Capsticks 02/12/2021	To support Coronial and Claims Team for 3 months and suggest improvements	Good	Yes but scope limited	6 Recommendations made all relating to Coronial Improvements
(7)Internal Audit- Compliance Review of Coroners Processes 20/05/22	To test the application of key controls focussing on specific aspects of the Coroner Process	Good	Yes but scope limited	5 recommendations about compliance with control framework and 1 recommendation on design of framework

2.4 As mentioned earlier, as a result of investigations one to five above, and the fact that some of these reports had stated that some of the recommendations from earlier reports hadn't been implemented, a Coronial Process Task and Finish Group was formed by the new Chief Executive and Chair in April 2020. (The Terms of Reference for this can be found in Appendix C)

2.5 This group comprised of three non-executive directors, two executive directors alongside the relevant subject matter experts.

2.6 The scope of the Coronial Process Task and Finish Group was to consider the findings and recommendations from the independent reports.

2.7 The group met weekly from 28 April 2020 to 14 August 2020. It then met fortnightly up until September 2020 and then held monthly meetings in October and November 2020 and January 2021. The Trust Board agreed to close the Coronial Process Task and Finish Group on 25 February 2021.

2.8 Aside from reviewing the recommendations arising from the independent investigations, the task and finish group was to undertake a review of historic cases.

2.9 They first looked at 208 coroners' cases between 6 June 2019 and 31 May 2020 and the findings were discussed on 12 June 2020.

2.10 There were cases where not all the appropriate information had been sent to coroners. The Medical Director then wrote to all coroners and provided additional data where relevant and apologised for oversight.

2.11 The second review covered the period 9 June 2020 and 29 December 2020 and also looked at another 208 cases. The findings from this were reported back on 15 January 2021. Assurances were provided that NEAS's systems and processes

were working. There were no serious concerns raised although some minor errors noted.

2.12 On 22 May 2022, the Sunday Times ran a story alleging that NEAS was covering up the truth about patients' deaths.

2.13 A whistle-blower had contacted the newspaper and had provided information to show that NEAS had withheld key evidence from coroners and the families involved that would implicate them in terms of service failures.

2.14 The news article made reference to seven incidents and five individuals' names were also included.

2.15 In responding to the Sunday Times story, the lead commissioner for the ambulance service NHS Northumberland Clinical Commissioning Group (CCG) undertook to set out the chronology of events. This was discussed with the Chief Executive designate of the newly forming/shadow Integrated Care Board (ICB) and a decision was made to undertake a Desk Top Review to inform further action. A final report was completed on 11 August 2022.

2.16 The review team acknowledged that they did not interview staff as part of this review and the scope was limited to a review of documentation.

2.17 The review focussed on five things:

1. Have recommendations from internal and external reviews, investigations and audits been implemented?
2. Has due process been followed in the historical cases referenced in the media report?
3. Is there assurance that current practices are safe and effective?
4. Reflections
5. Recommendations as to next steps

2.18 With respect to the implementation of recommendations from the independent reviews we will take the reports one by one.

Report 1 – Ward Hadaway Review of NEAS Coroner Cases

2.19 The report came up with a number of findings, which were as follows:

- Coroners have not always been made aware of internal investigations
- Too many people were involved in investigations and it was unclear who was the decision maker
- NEAS internal teams working in silos and not sharing information
- Protracted investigations caused distress to families and potentially raised other issues
- They did not believe in three of the cases reviewed that information was being deliberately withheld but it was being delivered in an untimely and uncoordinated way

2.20 In essence, this report describes the ineffectiveness of the existing systems and identifies the key components of the problem.

2.21 We could not see an actual action plan that was put in place to address these issues at the time, but the solution was deemed to be setting up SEACARE Group which was believed to be the process that would address sharing of information.

Report 2 – Ward Hadaway Independent Review of Case 1 (A Case)

2.22 This report is the outcome of findings in respect of Case 1 that we have already described earlier in the report.

2.23 There were nine recommendations in this report and discussions about them with the Director of Quality and Safety went on for some months. The Director of Quality and Safety has subsequently stated that the action plan work was halted by the Chief Executive and on that basis was not progressed and that concern about that was expressed at the time.

2.24 We have seen some draft actions, but they read more as statements of intent. We have not seen an action plan that is time phased, has measurables and staff assigned to own actions. We also cannot see any evidence that an action plan was delivered and signed off by the Trust Board and executive team. This was acknowledged by the incoming new Chief Executive who joined in September 2019 and who requested the Workforce One investigation.

2.25 The Ward Hadaway Review Team stated that a further review into this case happened (Workforce One - Report 4) and that the actions from this review superseded the actions alluded to in this report.

2.26 However, Report 4, which we will come to, did not report until 01 June 2020 nearly 9 months later.

Report 3 – Workforce One - Interim Report looking at Coronial Cases and Report 5 – Workforce One - Final Report

2.27 The interim report had six recommendations and the final report had seven. The reviews were targeted at concerns raised by the previous reports and to see if recommendations had been implemented.

2.28 The reality was that the team doing this review concluded that NEAS had not followed the advice of the previous reports in 2019 and had therefore not acted on recommendations.

2.29 The same challenges identified in the first report were still present at this time.

2.30 This was not to say that action hadn't been taken. Indeed, the Trust had run a Rapid Process Improvement Workshop (RPIW) in response to the need to improve coronial processes and developed 'SEACARE' as a response in May 2019. Unfortunately, this new process appeared to add to the confusion and add even further delays to information being shared with the coroners.

2.31 The outcome of the RPIW was not really owned by the Coronial and Claims Team (C&C Team) and the reports concluded that it was not fulfilling expectations to ensure quality assurance and quality control in the delivery of disclosure to the coroner. It was causing lengthy delays and the coroners were not being made aware of investigations being carried out by the Trust.

2.32 It was these particular reports that led to the Coronial Process Task and Finish Group to be set up in April 2020 to find solutions for these problems.

Report 4 – Workforce One - Review of individual Case 1 (already reviewed in Report 2 by another Independent Investigator)

2.33 The focus of this report was to follow up on the first and second reports and to do an end-to-end review and to see if the Trust adhered to coronial legislation and whether the Trust adhered to guidance and policies relevant at that time in relation to the coronial process.

2.34 Again, this report went over the details of Case 1 to test it against the aims of the investigation. They did not believe in this case that the Trust adhered to the coronial legislation and in some instances did not adhere to the Trusts' own policies and processes.

2.35 They made a further number of recommendations similar to those that had gone before.

2.36 The recommendations were accepted by the Trust, and the task and finish group was set up to implement the changes to make the improvements.

2.37 Again, we have seen from the task and finish group meetings and closure report that a lot of effort and work has gone into trying to get the processes, systems, and communications to improve.

2.38 However, we have had difficulty reconciling all those actions to the actual recommendations arising from the reports. In addition, the Review Team who did the Desk Top Review reported that not all the recommendations had yet been implemented.

Report 6 - Capsticks

2.39 This report was written by a seconded Capsticks employee into the C&C Team.

2.40 This was a reflective piece of work, but the author made six recommendations that he felt would add benefit to the team and process.

2.41 The Review Team were unsure whether this was being followed up corporately or just left to the internal team. Actions have certainly been taken to improve the data processing and address some of the functional constraints in the system. There has also been a reorganisation and the responsibility for the team has

transferred which is seen as a positive. However, once again, we cannot see a real action plan that responded to this.

Report 7 - Internal Audits Review of Coronial Controls

2.42 This was the latest report and again looked at the compliance review of coroner processes. This covered the period 01 April 2021 to 14 January 2022.

2.43 The auditors concluded that the governance processes and risk management arrangements in place provide reasonable assurance and that risks are managed effectively. However, compliance with the control framework was not always consistent and some recommendations for improvement were made.

2.44 One of the comments that was made was that the rationale for downgrading incidents was not always complete. Minutes were still not being routinely taken and target date for responses to coroners not met. 75% of referrals had target dates that had lapsed.

2.45 The Review Team had looked at 41 out of 440 delayed responses and discussed this with the Trust. It was found that an internal target of 10 days was set although this was not made by the Coroner. The Review Team didn't agree with this and suggested a change back to the accepted 60 days for serious incident cases.

2.46 At the time of the review the action plan was in development, but we have since been advised the plan is now in place, although we have been unable to check this.

Conclusions

2.47 Our overall conclusion is that the seven independent reports discussed in the table have been of good quality and have addressed the areas that were in the scope of their enquiry.

2.48 However, it is important to note that some former NEAS executives did not agree with the Ward Hadaway reports and conclusions as they felt they had no input to factual accuracy. These discussions contributed to delays in responding to the recommendations in 2019. It is our assessment given further reports and interviews with staff that the conclusions are still reasonable and in line with what we heard.

2.49 There is no doubt that a lot of focus and effort has been given to improve the coronial processes by the task and finish group, but we are not yet persuaded that this effort has translated into the delivery of all recommendations (as described above), and not all of the required improvements have yet been realised.

2.50 The conclusions arrived at by the Task and Finish Review Team in respect of whether findings and recommendations from all the independent reviews had been implemented was "yes" in broad terms.

2.51 However, we do not agree with their conclusion as they themselves picked up that some of the recommendations had not been fully implemented. We do agree with their view that the improvement journey is a “work in progress”.

2.52 We also believe that the Chief Executive and Trust are taking the concerns raised seriously and indeed some improvements have been made (which have been acknowledged by staff in the C&C Team in our interviews) but this is more of a work in progress and the senior management have themselves acknowledged that.

2.53 There has been a huge investment in reviews and commissioning reviews, we believe that the focus now needs to be on moving on from identification of problems to investing in the solutions and improvements.

2.54 The key issues drawn from these reports are in part attributed to culture, governance, openness and transparency, legal understanding, difficult relationships that previously existed between teams in NEAS and of course some issues of process also.

2.55 All need to be addressed to run a safe and effective service. The rest of this report will focus on this.

Chapter 3: Terms of Reference 3

"Benchmark the Trust's current coronial processes against peer organisations to determine whether processes are comparable in relation to timeliness and quality of evidence submitted to Coroners and suggest areas for further improvement if required."

Introduction

3.1 For the timeframe of this enquiry, we reviewed NEAS processes in terms of policies, and compared them to other ambulance trusts. National guidance was available for all ambulance trusts at this time.

3.2 Regarding timeliness and quality of reporting, we were only able to review NEAS's processes – but the benchmarks for these are set in law; the main piece of legislation referring to these issues is to be found in Schedules 5 and 6 of the Coroners and Justice Act 2009.

What we looked at

- Benchmarking
- NEAS Coroner processes - timeliness and quality of evidence submitted to His Majesty's Coroner, and the Law
- NEAS response to date
- Developments in ways of working in the NHS more generally

Benchmarking

3.3 In terms of benchmarking the coronial process, NEAS's own processes are set out in the NEAS *Learning from Deaths Policy (December 2019)* which states in paragraph two that "The purpose of the Learning from Deaths policy is to outline how NEAS will respond to deaths, identifying and consistently reviewing, then supporting staff and families whilst striving for continuous improvement in the clinical care provided."

3.4 This document references (and to a great extent is based upon) The National Quality Board's *National guidance for ambulance trusts on Learning from Deaths: A framework for NHS Ambulance Trusts in England on identifying, reporting, reviewing and learning from deaths in care*.

3.5 That document is also referenced in a further five Ambulance Service learning from death reports (out of the ten Ambulance Services in England) which can be found by internet search, those being - the *North West Ambulance Service Policy on Learning from Deaths*, the *East Midlands Ambulance Service learning from deaths policy and procedure*, the *South Central Ambulance Service Policies Procedures and strategies*, the *South East Coast Ambulance Service Learning from Deaths policy*, and the *East of England Ambulance Service Learning from Deaths Policy*.

3.6 Whilst not directly referenced, the *Yorkshire Ambulance Service learning from deaths policy* is significantly similar in content. All were easily found by an internet search. The South Western Ambulance Service also has a Learning from Deaths policy that was not easily found by internet search but is available (ascertained by private communication). Policies for the London Ambulance Service and West Midlands Ambulance Service were not easily found by internet search (but this does not mean they do not exist).

3.7 Issues with reviews into the deaths of patients in England are not new.

3.8 The national guidance for ambulance trusts on learning from deaths references the CQC publication of December 2016 entitled *Learning, candour and accountability - A review of the way NHS trusts review and investigate the deaths of patients in England*. This review considered "all NHS acute, mental health and community trusts, including both inpatient services in hospitals and community services". However, it "did not review ambulance trusts or other NHS-funded care settings such as independent healthcare providers, primary care services or nursing homes". One of the key findings was that "There is variation and inconsistency in the way organisations become aware of the deaths of people in their care across the NHS. This was found to be an issue for acute, community and mental health trusts equally".

3.9 The Francis report of 2013 pre-dates this guidance and has amongst its recommendations that there should be independent review of deaths to enhance the accuracy of their reporting. Despite the Francis report, and the CQC's noting that ambulance service trusts (amongst others) were at the time of their report outside a formal mechanism for the independent review of deaths, there seems to have been no subsequent change in recommendations for ambulance trusts to promote independent oversight.

3.10 It was out of scope of this enquiry for us to attend the relevant committees and meetings of all ambulance trusts to compare in practice, but a member of the investigating team did attend the NEAS Executive Safety Panel meeting of 11 November 2022. It was noted to be well chaired, quorate, with an agenda and relevant accompanying paperwork distributed in a timely manner. Discussions were challenging, and the recent inclusion of a Non-Executive Director to the attendees added some degree of oversight and independence.

3.11 What was notable (by absence) was a truly independent senior doctor's opinion. This however is not unique to NEAS.

3.12 Further comment regarding independent review will follow later in this chapter.

What we found

3.13 Based on the above, most (if not all) ambulance services in England use national guidance as a template and produce their own Learning from Deaths report(s) based on it with adaptations for their own service(s). NEAS therefore benchmarks well against its peers in terms of policies.

NEAS Coroner processes - timeliness and quality of evidence submitted to His Majesty's Coroner (HMC) and the Law

3.14 Whilst it has not been possible to benchmark by visiting other ambulance services and studying their working processes in detail, we reviewed issues with the working processes at NEAS.

3.15 The relevant law pertaining to disclosure to HMC is that found (mainly) in the Coroners and Justice Act of 2009, Schedule 5. The main point being that a person is required to produce any document which is relevant, should they possess it. Schedule 6 of the same legislation sets out that it is an offence to distort or alter evidence, or to prevent evidence from being produced.

3.16 The C&C Team at NEAS – whose role should have included communicating with and referring cases to HMC - raised concerns in April 2019, regarding the quality and timeliness of documents and reports being passed to HMC. A RPIW was held in an attempt to improve matters. This resulted in the establishment of SEACARE (Patient **S**afety incidents, patient **E**xperience concerns, **A**dult safeguarding concerns, **C**hildren's safeguarding concerns, **A**udit from the learning from deaths process, **R**isk which incorporates coronial requests and concerns and **E**xternal requests for information related to care provided by NEAS) in May 2019. Whilst intended to promote cohesiveness, it actually further fragments ways of working.

3.17 The C&C Team raised the point that SEACARE was in fact making the issues worse on 26 June 2019, and were supported in this conclusion by subsequent reports – such as that by Workforce One who found that SEACARE was "not fulfilling its expectations". Significantly, SEACARE was found to "not provide a robust tracking and monitoring system", caused "long delays in disclosure" and "making the conscious decision not to disclose documents".

3.18 In Case 1, Patient A, as timetabled in Audit One's *Counter Fraud, Workforce Investigation: HMC 2011 Report, North East Ambulance Service NHS Foundation Trust*, this case should have been escalated to HMC on 13 December 2018 (following the patient's death on 9 December 2018).

3.19 Despite multiple issues being raised in this case (NEAS07 647233, and NEAS07 647259 – the internal NEAS reporting system), four reports being available and that the death should have been reported as a serious incident as per NHS England's Serious Incident Framework, this was not done. (The relevant area of the serious incident framework being "expected or avoidable death… This includes - suicide/self-inflicted death…Caused or contributed to by weaknesses in care/service delivery (including lapses/acts and/or omission)"). To an outside observer, a serious incident clearly applies in this case.

3.20 The C&C Team were not aware of the above case until 20 March 2019, several months later, and in fact were themselves advised by HMC, not by NEAS – their employers.

3.21 In the meantime, various clinical review group meetings (with no minutes) had been held, and a "strategy call" made. Timelines are detailed in the above report, but by 27 March 2019 the stage is reached where NEAS's conclusions had been changed significantly as stated in 1.41 and 1.46.

3.22 Amendments to the original reports were also made. The internal report submitted to HMC is clearly a change to the original report.

3.23 Additionally, in-house reviews removed the following sentences preventing their consideration by HMC:

1. The attending Paramedic has stated asystole was witnessed on the ZOLL monitor. Retrieval of this activity on the ZOLL does not confirm this.
2. Subsequently Paramedic 1 has confirmed that on reflection they should have provided Advanced Life Support at this incident.
   and
3. Concerns remain in relation to the ECG with no evidence of an asystolic reading. There are additional concerns that no effort was made to clear the patient's airway, that Basic Life Support was not continued, and Advanced Life Support was not attempted.

3.24 The above shows both:

(i) a failure to provide the appropriate documentation to HMC, as the C&C Team seem side-lined from the main purpose of their remit; and
(ii) considerable change in the information provided to HMC.

3.25 The emphasis of NEAS' conclusion was to change a serious incident into an incident needing lesser scrutiny. The first iteration of the report contained the facts, the second contained amendments following an internal review.

3.26 Whilst it is appropriate to have internal review for reaching conclusions about one's own institutions standard of care, and learning lessons, this is for internal improvement purposes only. It may be useful to HMC to be aware that internal review has occurred, lessons learned and changes applied, as this may help HMC decide as to whether a "preventing future deaths report – Regulation 28[2]" is necessary or not. However, such evidence is not to be confused or conflated with the factual evidence required by HMC in law.

3.27 At the time of the issues that are the subject of this report (2018/19), processes seemed unclear. The C&C Team had an extensive list of responsibilities, as detailed in the report of Capsticks Solicitors LLP *3 Month Secondment Synopsis following Secondment to North East Ambulance Service NHS Foundation Trust*. One of the responsibilities not listed however is the responsibility to refer cases to HMC that the C&C Team deem appropriate. In fact, sometimes the C&C Team seem to be the last to become involved. It seems clear to us that the C&C Team were not the

[2] *If any information is revealed as part of the Coroner's investigation or during the course of the evidence heard at the Inquest, which gives rise to "a concern that circumstances creating a risk of other deaths will occur, or will continue to exist in the future;" and if the Coroner is of the opinion that action needs to be taken, under Paragraph 7 of Schedule 5 of the Coroner and Justice Act 2009, the Coroner has a duty to issue a report to a person, organisation, local authority or government department or agency.*

focal point for administering issues that should have been their responsibility to raise for consideration by HMC. This issue has previously been raised to NEAS in the "counter fraud, workforce investigation: interim report" where the point is well made that "if the team are not aware of reports and other documents, there is a very real risk that information which should be given to the Coroner by the Trust is missed".

3.28 NEAS therefore, in their dealings with incidents, conflated internal governance requirements with their legal obligation to HMC.

3.29 Internal meetings such as NEAS's Quality Review Panel and Executive Safety Panel are a valuable forum for review and learning. However, documentation from such sources should be clearly indicated as such. Internal (educated and advised) opinion will always be internal opinion and not the source material. This should always be made clear.

3.30 Of the three other cases reviewed, two showed similar errors where the C&C Team were not included in the case management, and HMC was thus provided with incomplete documentation or no documentation.

3.31 In Case 2, Patient B "the Coroner is clearly not aware of the NEAS delay investigation".

3.32 In Case 4, Patient D "The Coroner was made aware of the delay in ambulance attendance by police. It appears a delay investigation had already been completed … but the Coroner had not been notified by NEAS".

3.33 For a period of time therefore, cases were not passed to HMC appropriately. NEAS were made aware of this by the Audit One report of 20 March 2020 stating "It is the duty of the Coroner to establish the causes and circumstances surrounding a person's death. This is not the duty of the Trust. The duty of the Trust is to disclose to the Coroner any information (document or thing) relevant to an inquest and/or investigation into the death of that person".

3.34 The trend for NEAS to provide confusing/conflated material from its own processes rather than original material, or providing material with delays, or in some cases not at all was – for a period of time – a consistent feature.

3.35 Following an investigating team member attending an Executive Safety Panel of 11 November 2022, and review of action points in the minutes of the subsequent meeting of 16 November 2022 to ensure cases received appropriate follow up, we are clear that there is now a greater understanding of serious incident requirements and coronial requirements, though still room for improvement.

3.36 As an observer, it was not easy to recognise the flow of information. There are several departments within NEAS, each controlling different aspects of a single case. This has been noted before in an independent investigation by a partner at Ward Hadaway who commented "the reality is that so many people and groups are involved in the NEAS system of reporting and investigation of adverse events that the lines of accountability have become blurred". Whilst no one structure is suitable for all organisations, streamlining/simplifying of these flows is recommended, and a

template should be sought from a comparator organisation.

What we found

3.37 The C&C Team were often not included and therefore could not act appropriately.

3.38 The C&C Team were not always given source information for passing to HMC.

3.39 Decisions were made during meetings without minutes taken.

3.40 Internal learning (not original documentation) was passed to HMC.

3.41 Information flows were unclear.

NEAS response to date

3.42 There have been many reports into the concerns about governance and coronial processes. In order for NEAS to mitigate the risks raised, and address the recommendations made, an internal task and finish group was established to consider coronial process.

3.43 The task and finish group reviewed many areas in which there had been noticed to be deficits both internally and when judged against the external reports that had been commissioned at that time. We noted their outputs as:

- improved relations and regular interactions with HMC, including ongoing dialogue during active cases and templates to aid information exchange
- funding secured for the training of 160 investigators for the (then) soon to be introduced PSIRF
- recognition that SEACARE was counterproductive
- improved peer support mechanisms
- advice sought from the Yorkshire Ambulance Service regarding process
- restructuring of the Directorates to promote closer working/flow of information
- improvements to the Ulysses data system
- a review of 416 historical cases
- internal teambuilding meetings
- a system for the internal escalation of “cases which cause concern”

3.44 The task and finish group was stood down by the Trust Board in February 2021, having noted the above. One of the outputs of the task and finish group was to have commissioned an internal audit of compliance with the Coroner’s processes. Work against this again had many outputs, and these were formally presented at the Quality Committee Extraordinary meeting on 23 September 2022. The main outputs are listed below:

- All incidents involving deceased patients, whereby the harm level is downgraded to below moderate (HMC referral threshold) should have the rationale behind the change in harm level clearly documented
- All Clinical Review Panel meetings should have minutes taken, reflecting the discussion and rationale behind the decision-making process for the actual harm level
- Streamline the reporting mechanisms to the Coroner
- Ensure relevant staff are all compliant with the Patient Safety Incident Response Framework (PSIRF) which replaces the current Serious Incident Framework
- Ongoing monitoring of coronial cases to be conducted via internal governance framework.

3.45 The Quality Committee is to continue to monitor compliance with respect to the above.

3.46 Importantly, the Patient Safety Team and the C&C Team are now managed within the same reporting structure within the Quality and Safety Directorate. This prevents silo working, encourages good working relationship and provides a robust governance structure.

3.47 There have also been positive comments from team members, one saying how "communications…have definitely improved" and that as far as it is possible to tell, "all available documents related to the various coroner's cases are now being shared". Another more general comment being that "things are much better", especially "in relation to behaviours".

3.48 Clearly good progress is being made, but one of the main root causes of the issues remains unaddressed, which is "Ongoing monitoring of coronial cases to be conducted via the internal governance framework". This does not change in any way the process that led to the commissioning of this report. If review continues to be undertaken by the internal framework – there is no impartial/independent review and the same problem may recur.

3.49 The issue regarding the extra expenditure required for an independent person (or persons) to scrutinise such deaths is already recognised by NEAS and is on the risk register: "Additional resource will be required to effectively deal with the potential increased workload as a result of the significant high profile adverse national media coverage/ publicity and the resulting loss of confidence in the organisation".

What we found

3.50 Good progress is being made, but there remains a lack of independent review.

Developments in ways of working (in the general NHS)

3.51 One of the recommendations of the Francis report was the creation of a Medical Examiner (ME) service to ensure an independent review of deaths. Whilst

the initial remit of the ME service was to review deaths occurring in acute trusts, the service is currently expanding to cover independent healthcare providers, primary care services, community and mental health trusts, and nursing homes. This service is currently non-statutory but has been incorporated into legislation via the Health and Care Act 2022, and will become statutory shortly. The ME service has a remit to review all non-coronial deaths.

3.52 This relatively new service has been generally well received. In the words of the (then) Minister of State at the Department of Health and Social Care, Nadine Dorries, in April 2021, "every one of us, no matter who we are, deserves dignity – whether that's at the end of our life or when we've lost someone who is close to us. That's what our new medical examiner system does so well, by establishing a vital point of contact for bereaved families, by providing greater safeguards for the public and for being that trusted professional voice at a time of such sensitivity".

3.53 The purpose of the medical examiner system is to:

1. Provide greater safeguards for the public by ensuring independent scrutiny of all non-coronial deaths
2. Ensure the appropriate direction of deaths to the Coroner
3. Provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
4. Improve the quality of death certification
5. Improve the quality of mortality data.

3.54 One of its main functions is to consider: "Are there any clinical governance concerns? (ensuring the relevant notification is made where appropriate)". This is clearly stated in *Implementing the medical examiner system: National Medical Examiner's good practice guidelines*.

3.55 Whilst the ME service was not initially set up to review deaths reported to the Coroner, the issues from the enquiry into the concerns raised about NEAS suggest that this is an area that could be explored within NEAS.

3.56 The current procedure is for NEAS to pass information from their Learning from Deaths systems to HMC. When this occurs, there is no independent Senior Doctor reviewing the deaths. Independence of the scrutiny of deaths was a key recommendation of the Francis Report, mentioned on several occasions.
In NEAS, when a death occurs, it is reported to either the patient's General Practitioner (in the case of an "expected death"), or the coroner - usually via the Police Force (for "non-expected deaths").

3.57 In the case of an "expected death" where the patient has clearly been deceased for some time and therefore there has been no medical intervention by NEAS following their arrival at scene, the case will pass directly to HMC. However patients that have been subject to medical care (or should have been subject to an appropriate medical care which was omitted) by NEAS either on scene or in transit, and die prior to reaching a Hospital, will also pass directly for review by HMC. The medical care (or lack of appropriate medical care) provided will therefore not be subject to any independent Senior Doctor review.

3.58 As the ME service becomes part of normal processes in the wider NHS, the deaths that are attended by NEAS and are considered “expected” will be scrutinised by the ME service, via the General Practitioner. Unexpected deaths will continue to pass to HMC.

3.59 These deaths, although of course subject to trained and experienced independent legal opinion, are not subject to a trained and experienced independent senior doctor’s medical opinion, as stated above.

3.60 This is one of the main points raised by the NEAS investigation in terms of the Trust’s coronial processes. Whilst the organisation did pass information to the coroner, it was not independently assessed, and led in part to the claims made by the whistle- blower.

3.61 Whilst NEAS is not an outlier when compared to other ambulance services, this practice is not in keeping with the scrutiny applied (or currently being developed to apply) to other patients whilst in the care of an NHS body.

3.62 The National Quality Board’s report referred to above, does, in paragraph 4, refer to the introduction of the ME system. That National Quality Board recognises that its own guidance should be reviewed in the future to take account of ME system development. Of all the documentation regarding Learning from Deaths in ambulance services available for review online, only the Yorkshire Ambulance Service, in its Learning from Deaths policy, has a protocol for ME service interaction. Although this only refers to questions sought from the ME service regarding deaths reviewed that occurred in other Trusts where there had at some point in care been ambulance service involvement, it does show progress.

3.63 As stated earlier in this report, the support to the families in the cases that are the subject of this inquiry was poor.

3.64 There was no independent communications with families, again one of the Francis Report recommendations. Family interaction was also one of the recommendations of the Third Report of the Shipman Inquiry. The ME service would greatly improve on the current support (or lack thereof) provided to the bereaved in this context. One of the reasons for the introduction of the ME service was to “provide bereaved families with greater transparency and opportunities to raise concerns”. As stated in the ME good practice guide on supporting the bereaved “….the service is set up for supporting the bereaved, by being compassionate and sensitive … and aware that the bereaved have heightened emotions – denial, anger, guilt and despair which may affect how they behave”. One of the main functions is to “communicate sensitive information with tact and empathy, appreciating its potential impact”. Particularly pertinent to this report - “there are likely to be cases where the bereaved raise concerns that require action, which the service is designed to act upon”.

3.65 Such a service would have lessened the trauma suffered by the relatives in these sad cases.

3.66 As working relationships with HMC are paramount, it is important to recognise that the ME system is valued by HMC in areas where it is already functioning. His

Honour Judge Thomas Teague QC, Chief Coroner, noted[3] the “practical benefits that the medical examiners scheme can bring to the death investigation process”, and that when he questioned local coroners regarding the process, was “heartened by the positive feedback” that he received.

What we found

N/A to this section.

Conclusions

3.67 It is reasonable to say that NEAS has processes equivalent to those of most (if not all) other Ambulance Services.

3.68 It would seem however that in the cases that are the subject of this report, those processes failed in 2018/19.

3.69 Internal review was not centred around the Serious Incident Framework.

3.70 Investigation reports and the obligation to provide HMC with original documentation were conflated.

3.71 Multiple teams were involved, when the C&C Team should be the only team to have dealings with HMC. They should have been provided with all original documentation in a timely manner, for onward transmission to HMC.

3.72 There is a lack of clarity about the flow of documentation and responsibilities.

[3] *2022 National ME Conference*

Chapter 4: Terms of Reference 4

"Review the Trust's Serious Incident process and determine whether SIs are reported and actioned in accordance with best practice, local policy, and national guidance, identifying both areas of good practice and any areas of concern."

Introduction

4.1 The NHS aims to delivers high quality and effective care. However, sometimes things can go wrong for a variety of reasons. The public understand that and still retain high confidence and satisfaction. However, they also demand candour and transparency when things go wrong and want to be assured that learning has taken place so that the NHS can continually improve the safety and quality of the care provided to patients.

4.2 Although like all NHS organisations, NEAS are currently transitioning to the Patient Safety Incident Response Framework (2022), during the reference period, the service would have been working to the NHS Serious Incident Framework (2015) which emphasises the importance of serious incident investigation in relation to learning and prevention.

4.3 The national Serious Incident Framework states that:

"The occurrence of a serious incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm...Serious incidents therefore require investigation in order to identify the factors that contributed towards the incident occurring and the fundamental issues (or root causes) that underpinned these. Serious incidents can be isolated, single events or multiple linked or unlinked events signalling systemic failures within a commissioning or health system.[4]"

4.4 The framework also states that:

"Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm- including those where the injury required treatment to prevent death of serious harm, abuse, Never events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

The needs of those affected should be the primary concern of those involved in the response to and the investigation of serious incidents. Patients and their families/carers and victims' families must be involved and supported throughout the investigation process".

[4] Serious Incident Framework (2015) NHS England Patient Safety Doman. Page 12

4.5 The Trust has, as would be expected, a Serious Incident Policy based on the national framework.

4.6 As stated earlier in the report, a new national Patient Safety Incident Response Framework (PSIRF) was published which supersedes the previous 2015 Serious Incident Framework. The PSIRF makes no distinction between "patient safety incidents" and "Serious Incidents". As such it removes the Serious Incidents classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement. This is a transition year and most organisations will be positioned to go live in April 2023 once incident reporting systems are aligned and must be completed by Autumn 2023.

4.7 The new PSIRF advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety incidents, embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management. We would expect the Trust to be preparing for this now.

4.8 NEAS07 is the internal system adopted by the Trust for the reporting of incidents including those giving rise to patient safety concerns under the previous framework and was in force at the time of these cases. The impact of the incidents is graded 1 to 7 on the form, 1 being no harm, 2 low harm, 3 moderate harm, 4 severe harm, 5 death, 6 near miss and 7 harm not related to NEAS.

4.9 The person completing the NEAS07 grades the actual impact at the time of submission on the form, however, the grading can be changed once the incident is fully reviewed by the Clinical Review Group (CRG).

4.10 Incidents graded 3 and above are allocated to a clinical operations manager (COM) for investigation and those below a 3 to a clinical care manager (CCM). The form includes a section named Outcomes Details which records significant events during the investigation.

What we found

4.11 If we reflect on the cases discussed in Chapter 1, we can see that in some cases the serious incident process was not enacted in the spirit of the framework and the consequences of that were material for the patients and families involved.

4.12 In Case 1, the NEAS07 was initially graded as a 5 which seemed appropriate at the time. In line with the process, a COM was involved, and an investigating officer appointed to carry out the investigation.

4.13 A CRG was called on 13 December 2018. The purpose of this group is to ensure adherence to the NHSE Serious Incident Framework.

4.14 The Patient Safety Team has the responsibility to record and note all written outputs from the meeting and to record who was present and of course agree the

agenda and ensure papers are ready and available. They also must record the agreed outcomes on serious incidents.

4.15 For the meeting on the 13 December 2018, Case 1 was added as AOB (any other business) and both the Investigating Officer (IO) and the COM were in attendance. No minutes were taken but NEAS07 had commented that the Strategy Meeting on 17 December 2018 would establish if it was a serious incident. This contravenes the Trust's own policy.

4.16 It did emerge that an email suggested that Duty of Candour applied which suggested some discussion at that meeting. Given that the key people attended this meeting and had access to all the details at that time that it could have been dealt with there. It was also true that it should have also been disclosed to the Coroner.

4.17 The Strategy Group held in December 2018 downgraded the incident even though it had no delegated powers to do so. Again, no minutes were taken of the meeting outlining the rationale for the decision.

4.18 The second CRG was held without the IO and COM on 20 December 2018. They were not aware of decision of the Strategy Group in relation to the serious incident.

4.19 The case went for a third time to the CRG on 17 January 2019 where the Strategy Group decision was noted.

4.20 Given the seriousness of the concerns, the death of a 17-year-old girl and the fact that two NEAS07 forms were raised and that there were initial concerns that adherence to ROLE had not occurred, there is no reasonable explanation as to why the incident was downgraded. As a result, the family were not informed, the Duty of Candour was not met, and the Coroner was not informed. The Trust's own serious incident process was not followed.

4.21 The same failing applies to Case 2, where similarly, an opportunity for learning was missed.

4.22 Evidence from some of the other independent reviews and investigations also pick up similar issues.

4.23 There is variation in interpretation among staff in NEAS about national standard waiting times for ambulances and the decisions arrived at in some cases. The fact that an ambulance arrives within the standard time does not exclude the possibility that harm, or omissions of care, may have occurred and there is learning to be gained from an appropriate investigation.

4.24 This thinking appears to have affected the rating in Case 2. This seems to miss a key point in the framework: that organisations should err on the side of candour and learning and not deal with cases in a mechanistic way.

4.25 It is not suggested that all staff do this, but this review heard evidence and has seen the outputs of the previous independent investigations that together with recent discussions with regulators, suggest that consistency remains an issue.

4.26 The issue of training and consistency raises the importance of peer review and challenge to maintain objectivity and focus on learning and improvement.

4.27 One of the other concerns raised by partners and by NEAS itself is the change in the numbers and ratios of serious incidents in the organisation relative to others over the last few years. The concerns being expressed by system partners and regulators is whether the thresholds for serious incidents have altered.

4.28 Previous Executives in NEAS also told us that the CQC on a previous inspection had said that their serious incidents were too high and this has completely changed to a point where it now appears very low comparatively**.** The CQC do not believe that to be true and had challenged the Trust when they heard it at the time. Serious incidents were monitored each month. In 2018 NEAS were the second highest reporting ambulance trust in the country. This is particularly significant as this is not a CQC position on reporting incidents where high reporting is encouraged and is an indicator of positive safety.

4.29 The Desk Top Review Team also decided to go beyond the scope of their review and looked at serious incidents more generally to gain insights into the learning culture of the Trust. They looked at quarterly reports prepared by the commissioners. The data indicated that the numbers of serious incidents reported by NEAS are low, compared to the amount of activity and patient contacts.

4.30 We have spoken to the commissioners (the former CCG) of the service and have discussed our concerns in respect of the low numbers of serious incidents. They too had concerns and have increased their own oversight of the quality and governance issues within the Trust. They now always attend the Quality Review Group (QRG) and recognise that their own commissioner processes were not as robust as they should have been. When the whistleblowing came to light the commissioner established a risk escalation group.

4.31 The commissioners were concerned about not being sighted on NEAS internal incidents and that some wider learning opportunities had been lost.

4.32 They have reflected on this and are considering the case for the adoption of the National Ambulance Framework for Commissioning of Ambulance Services with specialist oversight. We support this approach and believe it will provide a better framework for NEAS to operate in.

4.33 We have also asked the lead commissioner for the ambulance service to provide us with the latest quarterly data which can be found below:

North East Ambulance Service NHS Foundation Trust
Incident reporting data 1 January to 31 October 2022

Organisation	Degree of Harm	Q4 Total March - 22	Q1 Total June-22	Q2 Total Sep-22	Overall Total
EAST MIDLANDS AMBULANCE SERVICE NHS TRUST	Death	0	0	0	56
	Severe	21	18	17	
EAST OF ENGLAND AMBULANCE SERVICE NHS TRUST	Death	0	3	0	89
	Severe	16	39	31	
LONDON AMBULANCE SERVICE NHS TRUST	Death	2	3	13	28
	Severe	2	2	6	
NORTH EAST AMBULANCE SERVICE NHS FOUNDATION TRUST	Death	0	2	2	21
	Severe	0	3	14	
NORTH WEST AMBULANCE SERVICE NHS TRUST	Death	5	21	10	46
	Severe	0	6	4	
SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST	Death	27	43	39	146
	Severe	4	16	17	
SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST	Death	0	2	0	30
	Severe	3	14	11	
SOUTH WESTERN AMBULANCE SERVICE NHS FOUNDATION TRUST	Death	0	0	0	8
	Severe	8	0	0	
YORKSHIRE AMBULANCE SERVICE NHS TRUST	Death	8	4	8	65
	Severe	11	11	23	
WEST MIDLANDS AMBULANCE SERVICE NHS FOUNDATION TRUST	NOT AVAILABLE				

4.34 The commissioners have raised this apparent disparity with the Trust on a number of occasions and the responses appear to suggest that not all ambulance trusts count incidents in the same way or share common thresholds for serious incidents. This is difficult to validate and is an area of work where we will make a recommendation for the commissioners of the service.

4.35 In addition, we have reviewed the Board's papers and looked at data in respect of serious incidents. There were no serious incidents reported by NEAS in Quarters 3 and 4 of 2021/2022. Numbers since then still appear to be small in single numbers up until September.

4.36 Report 7 also incorporated a view on the controls in place in respect to the classification of harm within incidents.

4.37 Auditors took an extract from Ulysses (which is the Trust's incident recording system) showing all incidents where the harm level had been downgraded. All incidents were between the dates of 01 April 2021 to 14 January 2022.

4.38 The audit team filtered the extract to show all incidents where initial harm level was Death and the actual harm level was Low Harm or below.

4.39 A sample of 10 was chosen randomly and checked to test whether the harm level changes had a rationale behind the change recorded.

4.40 20% of the sample did not have a rationale to support the downgrade. In the absence of evidence to support recategorising the level of harm, the organisation would be unable to defend the decision not to refer to the coroner and enact the Duty of Candour with the family.

4.41 The auditors also reviewed the minutes of the Clinical Review Panel for a period of five weeks to ensure that any incident with a harm of moderate or above was adequately reviewed and discussed.

4.42 For the 10 meetings, only five sets of minutes were available. There had been one cancelled meeting. Again, this is not in compliance with the Trust's own policies. For the cases identified for more senior review by the Executive Safety Panel (ESP) the auditors identified that in eight out of 11 reviews there were no details or evidence of the reviews taking place or having been recorded and actions taken.

4.43 The Trust has acted and developed an action plan to respond to the Audit recommendations. A further review of cases on Ulysses was carried out and other actions reported to the Board's Quality Committee on 23 September 2022. There were still some data issues found but certainly some evidence of improvement.

4.44 Due to the scope and limited time tabling of this review, we were not able to review all serious incidents or do an in-depth evaluation of all related management systems. We do however suggest that this is done, and specialist advisors brought in to support the Trust.

Conclusions

4.45 The review finds that the Trust do have reasonable processes and policies in place, but that the thresholds adopted for serious incidents are variable and that there are potential risks that may lead to understating the number of serious incidents and missing the opportunity for learning.

4.46 It should also be noted that there appears to be wide variation nationally on reporting of serious incidents. Further work would be helpful to provide more focussed guidance to help ambulance trusts.

4.47 It is also evident that the processes in place are not always followed, and the Trust needs to improve the compliance culture within the service.

4.48 In respect of the cases discussed in Chapter One, there was a failure in two of the cases (Case 1 and Case 2) in respect of the missed opportunity to declare a serious incident sooner. This would have made a significant difference to the families and to the establishment of trust between NEAS and the families.

Chapter 5: Terms of Reference 5

"Consider whether the statutory Duty of Candour is appropriately applied within the Trust's Serious Incidents process and procedures and consider specifically its application in relation to the specific cases being considered."

Introduction

5.1 The Duty of Candour is a general duty to be open and transparent with people receiving care from you.

5.2 There are two types of Duty of Candour, statutory and professional. Both have similar aims: to make sure that those providing care are open and transparent with the people using their services, whether or not something has gone wrong.

5.3 The CQC regulates the Duty of candour as part of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20, while the professional duty is overseen by regulators of specific healthcare professions such as the General Medical Council (GMC), Nursing and Midwifery Council (NMC), the General Dental Council (GDC) and the Health Care Professionals Council (HCPC).

5.4 The statutory duty also includes specific requirements for certain situations known as "notifiable incidents". A notifiable safety incident must meet all three of the following criteria:

1. It must have been unintended or unexpected.
2. It must have occurred during the provision of an activity that the CQC regulate.
3. In the reasonable opinion of a healthcare professional, it already has, or might, result in death, or severe or moderate harm to the person receiving care.

5.5 This element varies slightly depending on the type of provider. If any of these three criteria are not met, it is not a notifiable safety incident but the overarching Duty of Candour, to be open and transparent, always applies.

5.6 Regulation 20 (7)[5] defines the harm thresholds for Health Service Bodies:

In the reasonable opinion of a healthcare professional, the incident could result in or appears to have:

- resulted in the death of the person - directly due to the incident, rather than the natural course of the person's illness or underlying condition
- led to the person experiencing severe harm, moderate harm or prolonged psychological harm. These definitions of harm are linked to the National Reporting and Learning System (NRLS) definitions.

[5] The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

5.7 Once a Duty of Candour requirement has been called then the Trust should (as required by the legislation):

1. Tell the relevant person, face-to-face, that a notifiable safety incident has taken place.
2. Apologise. Regulation 20: Duty of Candour Page 19 of 28.
3. Provide a true account of what happened, explaining whatever you know at that point.
4. Explain to the relevant person what further enquiries or investigations you believe to be appropriate.
5. Follow up by providing this information, and the apology, in writing, and providing an update on any enquiries.
6. Keep a secure written record of all meetings and communications with the relevant person.

5.8 The Trust has developed and indeed updated its policy on 28 October 2022 and monitors it through a Duty of Candour Dashboard that is presented to the Trust Board on a Quarterly basis.

5.9 The Policy appears to have encapsulated the key themes outlined in the Regulations and Professional Duty of Candour guidance.

5.10 We have looked at Board Reports and an SPC chart depicting Duty of Candour notified within 28 days is in the pack. Currently the Duty of Candour notification compliance has dropped to 14.2% due to the increased number of serious incidents and moderate harms declared and a shortage of available FLOs due to operational pressures.

What we found

5.11 The Trust have a plan to train some more FLOs and hope to improve performance once that has taken place. Given that the Board are monitoring the data, we have more assurance that focus is being given to it.

5.12 With respect to the cases discussed in Chapter 1, it is already clear that in two of the cases (Case 1 and 2) that Duty of Candour was not declared due to the grading of the incident not being above moderate harm and not appropriate. Because of this, Duty of Candour was not applied in our view as it should have been.

5.13 The Duty of Candour was enacted in Cases 3 and 4, although in Case 3, the family did not have face to face contact initially and feel that communications were not handled well at all. This was more difficult as it was in one of the acute phases of Covid but the Trust itself acknowledged that it should have done better.

5.14 NEAS have recognised the importance of Duty of Candour, but this also relies on incidents being flagged for the duty to be enacted. As stated previously, this still appears to be a challenge.

5.15 The Trust have already identified appropriate action to improve the timeliness of enacting Duty of Candour and we do not have any further recommendation.

Chapter 6: Terms of Reference 6

"Seek to determine whether the arrangements in place for staff to escalate concerns, both during the period under review and now, are effective and appropriate. Including whether the Trust provides an environment in which staff feel safe, supported, and encouraged to report and escalate concerns.

This will include formal Freedom to Speak Up arrangements. The review will include speaking with relevant staff and leaders and a desktop review of relevant data."

Introduction

6.1 A safe, healthy culture in the NHS relies on everyone in the organisation being able and willing to speak up about anything that concerns them.

6.2 For people to speak up they have to know it's expected of them; they have to understand how important it is and have that message consistently reinforced; they have to feel safe to speak up without fear of detriment or censure; they have to feel it's worth their while (in other words, know how to raise their concern and have faith it will be addressed), and see improvements happen as a result.

6.3 Safety therefore relies on having the right culture in place, and on robust systems and processes. We therefore looked at the systems in place to enable staff to raise concerns in 2018/19 and now. We describe these systems in some detail in other chapters (see Chapters 2, 4 and 7 specifically).

6.4 We looked at evidence of the culture in place during these periods of time, and whether that culture made staff feel safe, and encouraged to speak up. We looked at the previous reports, and the national staff survey results and Care Quality Commission (CQC) reports. We also spoke to staff in the organisation about systems and processes and the culture.

6.5 As the CQC were concurrently surveying staff regarding culture we did not replicate that but will reference their evidence and findings.

6.6 We reviewed the current Freedom to Speak Up (F2SU) arrangements. However, we are aware that the Trust is awaiting the outcome of a national review by the National Freedom to Speak Up Guardian (F2SUG) and will need to take account of that in finalising any review of its arrangements.

What we found

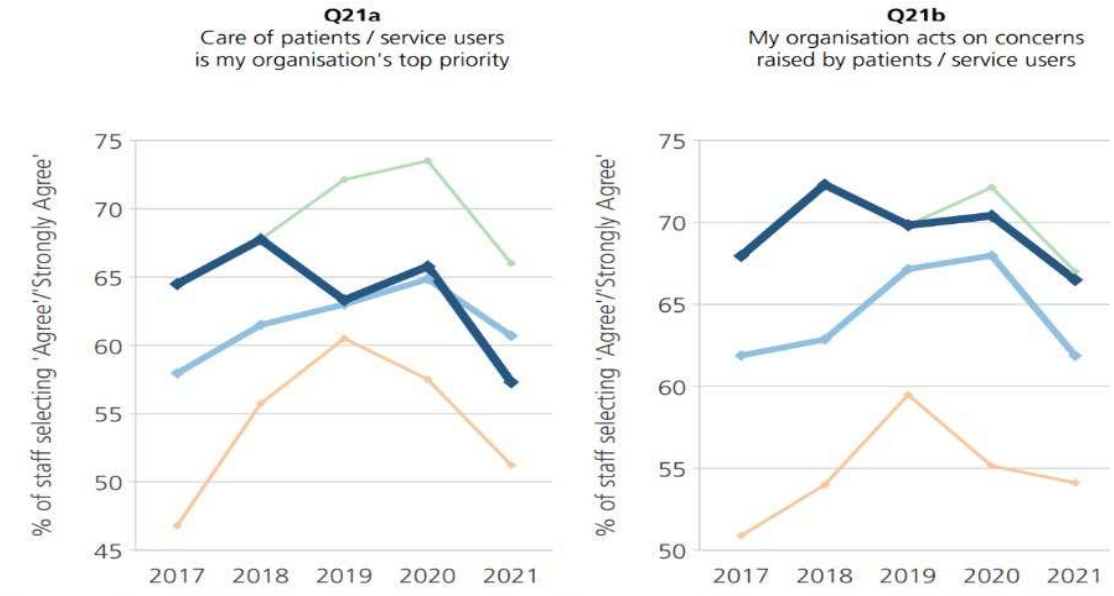
Culture

6.7 In early 2019 the CQC rated NEAS as Good overall, including Good for the Well led domain which takes account of staff engagement and morale. The report was largely positive regarding organisational culture.

6.8 The NHS National Staff Survey is the most comprehensive, benchmarked measure of staff engagement and morale in the NHS, and a basis on which to assess culture overall. There are also specific questions which give insight into the extent to which staff feel inclined and confident to speak up about any concerns.

6.9 In 2018 (reported early 2019) NEAS had some of the most positive responses in the sector for the questions relating to overall morale and recognition of the values of the organisation – see below the extract from the national results portal.

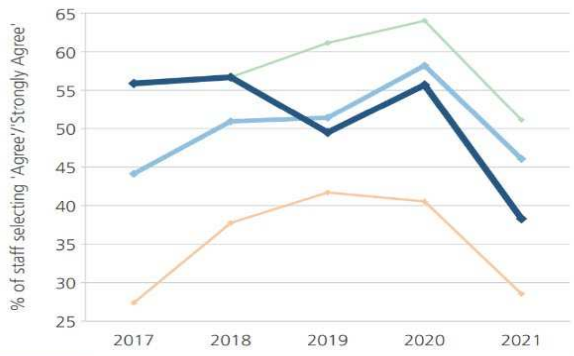
6.10 However, by late 2019 and the next staff survey, results had deteriorated significantly against the national trend. We know there is a subsequent staff survey but this was not available to us at the time that the report was written. Apparently this demonstrates further deterioration.



	2017	2018	2019	2020	2021
Best	64.5%	67.8%	72.1%	73.5%	66.0%
Your org	64.5%	67.8%	63.3%	65.8%	57.3%
Average	58.0%	61.5%	63.0%	64.9%	60.7%
Worst	46.8%	55.7%	60.5%	57.5%	51.2%
Responses	1,300	1,179	1,220	1,254	1,452

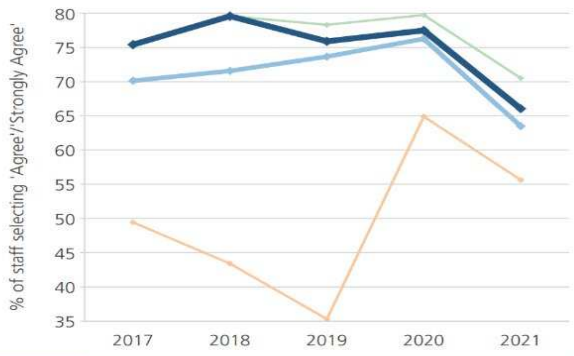
	2017	2018	2019	2020	2021
Best	68.0%	72.3%	69.8%	72.1%	67.0%
Your org	68.0%	72.3%	69.8%	70.4%	66.5%
Average	61.9%	62.9%	67.2%	68.0%	61.9%
Worst	50.9%	54.0%	59.5%	55.1%	54.1%
Responses	1,296	1,176	1,218	1,252	1,448

Q21c
I would recommend my organisation as a place to work



	2017	2018	2019	2020	2021
Best	55.9%	56.7%	61.1%	64.0%	51.1%
Your org	55.9%	56.7%	49.5%	55.7%	38.3%
Average	44.1%	50.9%	51.4%	58.2%	46.1%
Worst	27.4%	37.7%	41.7%	40.5%	28.5%
Responses	1,299	1,179	1,218	1,256	1,452

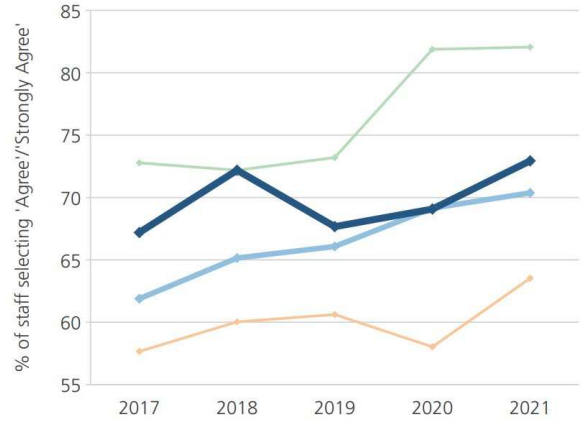
Q21d
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



	2017	2018	2019	2020	2021
Best	75.4%	79.6%	78.3%	79.8%	70.5%
Your org	75.4%	79.6%	75.9%	77.5%	66.0%
Average	70.1%	71.6%	73.7%	76.3%	63.5%
Worst	49.4%	43.4%	35.3%	64.9%	55.6%
Responses	1,292	1,175	1,217	1,254	1,451

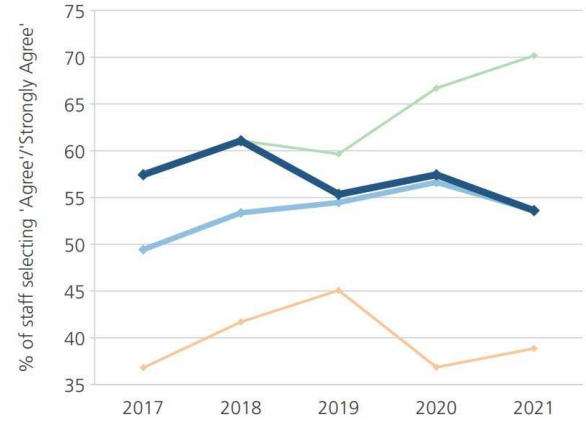
6.11 In response to questions related to staff feeling able to speak up, again NEAS were in a positive position in 2017/18 and then saw a more mixed picture.

Q17a
I would feel secure raising concerns about unsafe clinical practice



	2017	2018	2019	2020	2021
Best	72.8%	72.2%	73.2%	81.9%	82.1%
Your org	67.2%	72.2%	67.7%	69.1%	72.9%
Average	61.9%	65.1%	66.1%	69.1%	70.4%
Worst	57.7%	60.0%	60.6%	58.0%	63.5%
Responses	1,310	1,185	1,211	1,253	1,453

Q17b
I am confident that my organisation would address my concern



	2017	2018	2019	2020	2021
Best	57.7%	61.1%	59.7%	66.7%	70.2%
Your org	57.4%	61.1%	55.3%	57.4%	53.6%
Average	49.4%	53.4%	54.5%	56.6%	53.6%
Worst	36.8%	41.7%	45.1%	36.8%	38.9%
Responses	1,304	1,187	1,210	1,252	1,448

6.12 In 2018/19, the organisation started to take steps to make changes to improve the systems and processes for reporting and investigating incidents and the way those processes impacted on the organisational culture. Steps were apparently taken to decentralise some of the resource for investigating incidents and to engage others (for example, the broader quality and safety team, operational managers, and other clinical staff in investigations), and consequently improve organisational ownership and learning.

6.13 Some senior staff also expressed concerns that the processes for investigating incidents were feeling overly formal and potentially punitive such that the type of culture needed to encourage reporting was not flourishing and that staff were being treated in ways that could deter them from speaking up.

6.14 Work was started to implement a "just culture" and indeed was championed by the then CEO. This was also being supported by some directors based on experience of successful work done in other NHS sectors and involved workshops, training sessions and policy reviews.

6.15 We were repeatedly told that the working relationships between different members of the corporate teams involved in quality and safety processes were, at best "fractured" and generally "toxic" with personal as well as professional animosity reported. The changes being mooted to systems appear to have exacerbated those tensions. For example, a Strategy Group was put in place to deal with Fitness to Practice issues (such as whether suspension of an individual was warranted during an investigation). An aim of the group was to bring consistency and clarity to the decision making and ensure the decisions and the management of individuals was in line with good practice and "just culture". However, we were told that it was undermined by the group exceeding its brief, and some of those involved not adhering to the process, and/or making "arbitrary" decisions outside of it.

Systems and processes

6.16 In addition to work to improve culture in late 2018-19, a need to improve the rigour, timeliness, connectivity, and transparency of how concerns and incidents were investigated emerged. The Quality and Safety team wanted to improve the organisation's ability to join up the information it had and satisfactorily oversee and learn from incidents.

6.17 There are differing views as to whether the changes being made to systems, and to improve culture and encourage reporting were warranted and would be successful. Tensions between those involved were evident, whether fuelled by the need for change or as a result of changes being made is debated. The common examples given appear to have focused on those incident investigations that were within the remit of the Coroner, but it has also been suggested that there were similar underlying concerns related to other quality and safety incident issues and investigations.

6.18 To address these tensions and questions a series of changes were being proposed, and a Rapid Process Improvement Workshop was held in May 2019. The impact of these changes and how they operated, and were subsequently reviewed and changed, are described in detail in Chapter 7 in relation to specific concerns raised by staff involved in supporting those services at that time. They are also described in previous reports. In Chapters 2 and 3 of this report the frailties of the systems and the impact of that is also summarised. They are pertinent to the efficient running of the overall process and the impact that would have on staff confidence and inclination to raise issues and so do need to be noted here.

6.19 The frailties in the process for reporting incidents, grading, and investigating and reporting serious incidents is likewise pertinent and is detailed in Chapter 4.

Leadership

6.20 Several people in senior leadership roles at the time have commented on the dissonance between the cultures and expectations they had experienced in other sectors of the NHS and what they found in the ambulance sector. They cited examples relating to a command-and-control structure, and the paramedicine profession working differently to the nursing /medical framework in place, for example, in an acute trust. Indeed, the Nurse and Doctor roles on the Board, a feature of all NHS Foundation Trusts (NHSFTs), do not seem to have operated with the level of clarity, and of ownership of the quality, safety, and governance agendas one would expect.

6.21 The process for the reporting and investigation of incidents can be complex. It relies on people working together, particularly where several operational staff will be involved, and clinical judgements and decisions must be taken account of. Frequently, broader system issues and system partners need to be engaged. It is vital that a robust structure for reporting and investigating incidents is in place with clear leadership – that was not the case in NEAS at that time.

6.22 Whilst the need for change and improvement of culture and systems was recognised, the impact of the changes being made were compounded by tensions and disagreements within some of the senior leadership team and within the teams dealing with the issues.

6.23 The tensions within the teams appear to have been fed by a level of mistrust, for example proposed changes to the way investigations were to be done were seen as a desire to obfuscate or hide facts. The concerns being raised by the C&C Team, were seen as a desire to inappropriately maintain control of the wider patient safety agenda and “police” the workforce.

6.24 Some tensions are to be expected during a system change, and some attempts were made to address these tensions and improve working arrangements. However, it is also clear that very real tension existed amongst senior staff, and amongst executive directors too.

6.25 When the cluster of serious incidents arose in late 2018/19 (Case 3 Patient C in November 2018: Case 1 Patient A in December 2018: Case 2 Patient B in March 2019) the “new” SEACARE process was not in place until May 2019, and it is not clear what level of oversight and assurance, collectively, executive directors had, or had sought. Some of those directors one would expect to lead the quality and safety agenda, claim not to have been close to the details, and there is a sense that the C&C Team and Patient Safety teams were left to “fight it out” to the detriment of the care due to the families, to organisational learning and the cost to the individual members of staff involved through lack of support.

6.26 A feature of what we were told, and was described in previous reports, is that responsibility and accountability for some areas of work appear to be designated to

groups. Individual responsibility is vested in professional roles and cannot be abdicated to groups.

6.27 There still appear to be divergent views regarding the current processes, including the approach to investigatory processes, or regarding the approach to categorising serious incidents.

Board oversight

6.28 Boards of NHSFTs are jointly and severally responsible for the delivery of the entirety of the Trust's objectives in line with regulation. That will include delivery of quality, financial, and employment responsibilities and objectives. Executive directors will lead on specific portfolios in line with their professional expertise, but there is not a separation where a director is responsible for only one element. There is evidence that at that time, executive directors at NEAS were not acting collectively to ensure delivery of overall key objectives. For example, when reviewing the process for investigating and learning from incidents, clear ownership is not evident, nor is the challenge and collective attention one would expect to see. Several directors told us they were unaware, or not involved in some of the cases we were reviewing, or in dealing with the issues arising within governance processes.

6.29 On occasion, the executive directors appear to have been working in silos with both professional and personal tensions evident – these tensions were not just reported by executive directors themselves but by their teams. Modelling this uncoordinated way of working and lack of collective ownership and focus, as well as a level of mistrust and, in some cases, poor personal behaviours, impacted on the way others worked and behaved.

6.30 Clinical leadership must drive the delivery of NHS services. However, tensions between clinical and operational priorities, and clinical priorities and HR processes feature in the descriptions we were given and should have no place in the functioning of executive and senior teams in the NHS.

6.31 We know that the then Chief Executive was aware of this and did take action with the specific individuals to resolve. However, it appears that the damage to the teams involved was already significant and the consequences of that are evident in this report.

6.32 The role of Non-Executive Directors (NEDs) is to bring diversity of experience and insight to the Board and provide scrutiny and challenge on behalf of the population the Trust serves. However, some NEDs told us that they had concerns about transparency at that time, they had concerns about "ownership" of issues, and they witnessed unacceptable behaviours – but they found it difficult to challenge. There is no evidence of action to remedy the situation until May 2019 when the external review was commissioned, and action subsequently taken at the end of that year.

6.33 A NED-led task and finish group did provide focus and oversight to the implementation of the Ward Hadaway recommendations and appears to then have

had the confidence to handover to the new Director of Quality and Safety (See Chapter 2).

6.34 Between 2019-20 there was a significant change in executive leadership; a new Chief Executive (CEO) (following a gap of 4 months), new Director of Quality and Safety, new Finance Director and new (and the organisation's first substantive) Director of HR (HRD). The incoming CEO put the new executive team together including investing in Board development work. She also actioned the outcome of reports relating to behaviours and culture including meeting staff who had raised concerns.

6.35 However, it is noteworthy that for many of the incoming executive directors, this was their first Board level post and their first post in the ambulance sector. All of the individuals are capable and committed, however that collective lack of experience given the challenges faced by the organisation (including the pandemic) will have been extraordinary and could have contributed to some of the frailties in the organisation despite the very hard work of those involved.

6.36 Whilst relationships appear to improve then, there remains a lack of collective ownership of the quality issues and focus on resolving the outstanding areas of concern.

6.37 Staff Side organisations are formally recognised with a full-time Trade Union lead in place. Work has been done to develop relationships but given the opportunity for staff side to bring a perspective and level of challenge to these issues they should be developed, and the potential to expand their input explored further.

Speaking up, then and now

6.38 In the case of the incidents we examined for this report, there were clear failings in how staff were supported to speak up and have concerns addressed. Those issues are dealt with in Chapter 8.

6.39 Regarding speaking up more generally it is clear that there were attempts to improve the culture to support that in 2018-19.

6.40 A substantive HR Director (HRD) is now in post and there is some recognition that senior leaders are making efforts to engage with staff and listen to their concerns.

6.41 In the national Staff Survey (2021) the organisation was above average for staff being secure to raise concerns, but below average for trust in process or confidence.

6.42 The HRD has implemented a "case conference" approach to grievances and disciplinary matters to ensure there is transparency and consistency to how concern impacting or raised by staff are dealt with. This process involves colleagues from operational management and quality and safety and will report themes to the People and Development Committee.

6.43 An action plan to deliver improvements to culture has been developed in 2022/23 and forms part of a CQC improvement plan workstream. Its implementation will be overseen by the People and Development Committee.

6.44 A sense still pervades for some staff that someone will be blamed if a concern comes to light. An example given is that there is a structured process in place to audit calls and feed back to or offer coaching to, individuals. Despite the right intention, of monitoring quality and focusing on learning, it appears to some staff to be too focused on individual performance. However, they expressed frustration that a process for auditing the quality of the call handling system overall and ensuring the learning from that can inform quality assurance or feed a formal improvement process, appears confusing with no feedback loop.

6.45 As part of their recent inspection the CQC surveyed staff regarding speaking up. Too many staff feel that a blame culture exists and are either fearful of speaking up or are disinclined to as they don't feel things will change as a result.

6.46 The National Guardian's office has recently done a review of speaking up in Ambulance Services in England. It recommends that a review of broader cultural matters should be carried out in ambulance trusts. We support that view given our findings of this investigation. There is no doubt that this would be of benefit to NEAS.

Freedom to Speak Up

6.47 A formal process to support speaking up in the NHS was implemented following the Mid Staffordshire enquiry in 2013 and is described in *F2SU: Whistleblowing policy for the NHS*.

6.48 The Trust has recently (July 2022) revised its Freedom to Speak Up (F2SU) policy. It is in line with national expectation: they have a named NED in place, a named Guardian and a reporting structure in line with national policy.

6.49 The number of concerns raised through the process are reported to be lower than expected – that isn't necessarily a sign of concern and there is evidence of active engagement within the organisation to make staff aware of the F2SU role and encourage reporting.

6.50 The F2SU Guardian (F2SUG) role is currently vested in the Company Secretary role with the current postholder at the time of this review 'inheriting' it when they took up the Company Secretary role in 2021. It is supplemented by an additional F2SUG, the CQC Compliance Officer. Whilst both are experienced, and committed to the principles of F2SU, there are some questions that this raises:

- It was pointed out that there is an advantage to the F2SUG role being held by staff "close" to the senior team and Board. However, the perception of impartiality could be damaged by that closeness.
- Neither postholder would claim to be close to, or indeed demonstrably very familiar with, frontline services. Again, this could impact the perception of their accessibility and understanding of issues.

- Capacity is clearly an issue. Benchmarking the resource available needs to take account of other variables to make the capacity appropriate and will form part of the national review: however, concern was expressed at the lack of capacity and accessibility of the current resource available.
- There was a plan to recruit F2SU Champions. This would mean staff in a range of roles identified and trained to support the Guardians and increase access, but this appears to have faltered.

6.51 In November 2022 the Trust agreed, following consultation, a revised approach including the appointment of a new F2SUG with additional resource supported by a network of F2SU champions. They are in the process of recruiting to that role. It has shared its revised arrangements with the national F2SU Guardian.

6.52 NEAS has recently been included in a national review of F2SU in ambulance trusts and acknowledges it may need to look again at its revised arrangements once that review is published.

6.53 We note that one of the aims of the new operational management structure is to provide additional support to developing a speaking up culture.

Conclusions

6.54 NEAS did seek to improve the culture to enable staff to speak up in recent years but there was a lack of collective ownership of the approach being taken which undermined it. We believe the Trust would benefit from engaging with the wider national review arising from the National Guardian's recommendations into 'speaking up' in ambulance trusts published in 2023.

6.55 Systems and processes were not in place that would enable best practice in reporting and, investigation. Thereby potentially hindering staff from speaking up and issues being addressed. These systems deteriorated because of the dissonance within the senior team.

6.56 Whilst data suggests staff will report concerns in that they know it is expected of them, they lack confidence in actions being taken, and still perceive a punitive approach in some cases.

6.57 Work to improve culture is actively ongoing; it would benefit from broader ownership, for example, the formal engagement of staff side in monitoring the plan. New operational leadership structures provide an opportunity to support cultural development further.

6.58 Revised F2SU arrangements have been agreed and are being implemented.

6.59 The Board has undergone considerable change and faces more with the appointment of a new Medical Director and Director of Quality and Safety.

Chapter 7: Terms of Reference 7

"Assess whether the action taken by the Trust in response to concerns raised by members of staff in Spring 2019 regarding safety matters and coronial processes were appropriate, and in compliance with best practice, local policy and national guidance in relation to HR practice, Whistleblowing and Freedom to Speak Up."

Introduction

7.1 In the press article of May 2022, reference was made to how staff had tried, over a period of time, to bring their concerns to the attention of the organisation.

7.2 We reviewed the records of the concerns being raised at that time. These included those raised through line management channels, and through formal grievances and through the use of F2SU processes.

7.3 We looked at all the previous reports, and at the formal grievances and reports raised, and the outcome of them. We have relied on the content and findings of those reports as having been fully independent and sufficiently thorough in fulfilling their remits.

7.4 We also spoke to staff involved in the processes at that time to understand what happened, and to assess whether concerns were dealt with appropriately whether raised through formal processes or not. Whilst views were in some cases contradictory, we have taken the view that staff were reporting their experience in good faith.

7.5 In many of the examples shared with us a link was evident between the concerns staff had about safety matters and the frameworks and processes in place to manage them. A further link was also made to the behaviours exhibited by, or tolerated by, some people at that time. These were in some cases linked, as the behaviours were potentially attributed to staff having spoken up, or the behaviours were stopping people speaking up, or were hampering those concerns being addressed. Given the clear link between behaviour, culture, and safety, we have included the concerns regarding behaviours in our review.

7.6 Responsibility for ensuring appropriate processes for staff to raise concerns lies within management structures, and with professional and clinical leaders, and with those responsible for quality and safety governance processes, including the HR function. Consequently, we looked at how those functions were working, and how they were working together, at that time.

7.7 Concerns raised by other staff during that period, for example those about Case 1 Patient A, are referenced in Chapter 1 and therefore, not included here.

What we found

Safety and governance processes

7.8 In our meetings with staff, several described concerns and tensions about the Trust's approach to quality and safety governance processes, and the handling of coronial issues, emerging during 2018. They described the approach taken to specific incidents and a lack of structure and consistency in how they were investigated and handled.

7.9 Some senior staff were concerned that the approach to the investigation of incidents felt automatically punitive in the way staff were treated, they described staff involved in incidents being summoned to reviews that felt like "pseudo disciplinary" panels. Work was being done on culture and improving staff engagement across the organisation, and there were concerns that a different approach was needed to the investigation of incidents to ensure an open culture that encouraged staff to speak up about concerns.

7.10 We found that there were very strong, but dissonant, views about how that could or should have been taken forward. We were told that operational services were concerned with being able to "maintain control" of the workforce, with others leading what they saw as a "culture change" agenda designed to engage and empower staff.

7.11 There was a clear distinction in the views of those involved in operational management, leadership of quality and safety governance structures, risk management including the investigation and learning from incidents, and the handling of the responsibilities to the Coroner and the coronial process.

7.12 Staff involved in delivering the corporate services that were in place to support staff in raising concerns and ensuring they are dealt with – in Quality and Safety, Risk, Legal, Human Resources (HR); have all expressed frustrations at shortfalls in capacity, oversight, and a lack of collective working at that time. It is clear that in addition to a lack of an agreed collective approach, there was a significant lack of trust between some people and teams with a reluctance to share relevant information transparently and professionally.

7.13 Examples include the use of the Strategy Group. The remit of this group appears to have been to deal with Fitness to Practice issues, so to review what action was appropriate regarding an individual member of staff when an incident occurred thereby bringing consistency, transparency, and good practice to the process. We were repeatedly told that this group often exceeded its remit, dealing with matters that should have been formally discussed elsewhere. We were also told that some directors would overturn or change decisions outside of that meeting. The response to the overall concerns appears to have led, in early 2019, to the Rapid Process Improvement Workshop (RPIW) and subsequent setting up of SEACARE.

7.14 The RPIW was commissioned by two executive directors (the Director of Quality and Safety and the Medical Director) and facilitated by the Quality Improvement function. The directors were not present at the workshop.

7.15 Several staff at the RPIW expressed concern and frustration at some of the behaviours exhibited. Consequently, they felt they were not able to voice their concerns, or they were not heard. They were "shouted down" or intimidated. Their professional expertise was questioned and/or disregarded. Other staff suggest that some colleagues came along with an entrenched view and were determined not to contribute or make improvements.

7.16 Notwithstanding the difficulties at the workshop, the SEACARE group/process was set up as a result in May 2019.

7.17 SEACARE was described to us as making the process worse – too many people involved and a lack of clarity regarding decision making. A view subsequently supported by external reviews.

7.18 It appears to have led to further tensions and concerns being voiced and then several formal grievances being raised within weeks by staff, concerned that they did not have a clear process to follow, and that it was putting them and the organisation in an untenable position. These concerns were reported to the Board who commissioned Ward Hadaway to review Coronial Processes in May 2019. The conclusions reached in this report supported the concerns that staff were articulating.

7.19 As these concerns continued to escalate, people described colleagues being villainised – either for raising concerns with the original processes, or for raising concerns about the revised one.

7.20 No formal process appears to have been put in place to review the outcome of the RPIW, or SEACARE and its effectiveness, as would be expected following a formal Quality Improvement process. Given the feedback being given by staff and the concerns being raised, this was a serious misjudgement.

HR processes

7.21 Operational and clinical managers told us they were concerned about a lack of visibility of some process at that time, such as the length of time people were suspended following incidents. Concerns were also raised, including by the CQC, related to DBS checks and DBS risk assessments in August 2020. Indeed In August 2020, the CQC served the Trust with a warning notice under Section 29A of the Health and Social Care Act 2008 which required the Trust to make significant improvements in quality of health care. This was in relation to concerns raised about staff including safeguarding concerns, their conduct and managing positive disclosures on DBS checks.

7.22 Leadership of the HR function underwent considerable change during 2018-20. Until January 2019, executive leadership of HR sat in a mixed portfolio at executive level with strategy and transformation, and was led operationally by a Head of HR. On their retirement an interim HR Director was appointed (April 2019) with a substantive HR Director from March 2020.

7.23 HR practice in the NHS needs to take account not just of good employment practice, it must include the requirements of professional frameworks and

registration. So, for example, the technical recruitment process will be led by HR, but the identification of skills needed and the selection of staff is led by professional leads and operational managers. Ownership of other supporting governance processes including, for example, DBS checks, decisions relating to professional conduct and performance, must be carried out with the full support and direction of professional leads and operational managers.

7.24 HR staff reported feeling undermined, with their professional expertise not respected. Professional leads expressed frustration that they were not always aware of issues they felt related to their areas of professional responsibility, for example, decisions regarding DBS disclosures, referrals to professional bodies, details of individual practitioners being inappropriately shared during investigations. These comments again pointed to a level of mistrust between teams.

7.25 The Board was aware, and sufficiently concerned about the HR infrastructure issues to agree to strengthen the provision of HR and appoint a Board level HR Director in early 2019.

7.26 The tensions however appear to have persisted through to 2020, through three changes of executive oversight of the HR function.

Response to formal processes

7.27 Several formal grievances and F2SU reports were made during 2019-2020. It would not be appropriate, for the sake of confidentiality for individuals, to detail those here. They broadly covered two sets of concerns – those relating to safety matters and coronial processes, and those relating to the behaviours of some senior staff, and the impact of that. The issues and the responses are summarised here.

Concerns raised formally about the coronial/investigatory processes during 2019

7.28 Concerns, including a formal grievance, were lodged in early 2019 specifying the lack of a clear process for staff involved to follow. It included allegations of information being withheld or suppressed, and allegations of poor behaviour by senior staff.

7.29 An internal investigation into the formal grievance was initiated but stood down: this appears to be on the basis that the Board agreed that a Ward Hadaway (WH) review should be commissioned. The scope of that review was confined to the coronial process issues.

7.30 Whilst subject to delay the outcomes of this review in August did ultimately appear to deal with the issue regarding processes contained within the grievance. Action was also subsequently taken to support staff including training for those involved in the coronial processes, and work to improve the working arrangements and relationships between the Quality and Safety and Risk management teams. However, the grievance in June 2019 had also raised concerns regarding behaviours, and other staff had expressed concerns regarding behaviours exhibited

during this period – those concerns did not form part of the Ward Hadaway review.

7.31 The recommendation regarding the management of the grievance, the WH review, was made by the then Director of Quality and Safety. That director was responsible for the service that was the subject of the grievance, leading to the perception of partiality and a lack of transparency in proposing the way forward. Given the nature of the allegations regarding transparency this was unhelpful. It appears to have been assumed by the rest of the Executive that the WH review would deal with the totality of the concerns, which left part of it unattended.

7.32 The Interim Human Resources Director (HRD) at that time sought to conclude the grievance, writing to the individual in October 2019. An appeal was then lodged, and the individual made numerous efforts to be heard and have their concerns addressed and they were not.

7.33 An external review into the coronial processes was then commissioned by the new Chief Executive in February 2020 with the support of the Chair.

7.34 In May 2020**,** the CEO, and the incoming HRD, did meet the individual and attempted to resolve the outstanding issues, apologised for the delay and lack of adherence to process. The individual was acknowledged as a whistle-blower at that time.

Concerns raised formally through F2SU, December 2019

7.35 Concerns were separately raised relating to HR processes and professional employment matters and the behaviours of senior staff in December 2019 to the F2SUG.

7.36 An external investigation was commissioned by the F2SUG and lead NED with the support of the Chair. It was extensive and appears to have covered all the areas raised.

7.37 The concerns were partly upheld, and those individuals named were advised of that in June 2020.

7.38 The findings made clear that the functioning and leadership of HR, and relationships between senior staff, had been difficult for some time and had not been addressed effectively up to 2020.

7.39 Senior leaders had allowed dissent and factions to interfere with proper processes and therefore added to serious risk for HR and professional matters, and to the support given to the organisation, including to the staff raising concerns and grievances.

7.40 There was clear evidence of a lack of professional respect, and a lack of acknowledgement of professional duties and responsibilities and the consequent need to co-design processes.

7.41 There was a lack of transparency and consistency between the operational management of services and professional leadership.

7.42 It was agreed that a plan to make improvements to culture, based on the learning from the review, would be completed in October 2020. There was no formal report made in October. The recommendations were prioritised by the incoming HRD and there is a current action plan. Implementation of that plan is ongoing with oversight and assurance through the People and Development Committee.

Reflections on the current position

7.43 The current arrangements for quality and safety and coronial processes are detailed elsewhere in this report.

7.44 With regard to the confidence of the staff involved in delivering these services, some of whom were in place in 2018/19 and some who are new, they unanimously report that relationships have improved.

7.45 The Coronial and Claims service has moved back to the Quality and Safety Directorate and work done to ensure greater cohesion.

7.46 The process for raising concerns, and the supporting HR processes have been strengthened (See Chapter 6).

Conclusions

7.47 Staff worked hard and were right to raise their concerns about patient safety processes, specifically but not uniquely those related to the coronial process. However, the differing views of senior staff about how quality and safety governance systems should be managed appear to have hampered these being heard and /or a solution being found. This was a regrettable lack of leadership that impacted not just on safety but the wellbeing of staff who were left anxious, frustrated, and stressed. It undoubtedly led to a loss of expertise from the organisation and a loss of confidence in the calibre of the leadership, systems, and processes in place.

7.48 Whilst there will be reasons for delay and confusion in a busy service, it is hard not to conclude that in this case the delay in dealing with such serious allegations, and the way they were handled, had an impact on the organisations opportunity to work with the individual to satisfactorily resolve the issues – processes and executive ownership and oversight were neither efficient nor effective.

7.49 Assumptions were made about the motivations of some of the staff who were expressing concerns, and some of those dealing with them, which appears to have hampered all voices being heard. These concerns regarding behaviours and motivations should have been transparently addressed at the time.

7.50 Given the seriousness of the issues, and concerns being expressed it is unfortunate, and hard to understand, that the actions to resolve the safety

governance issues – the RPIW and consequent SEACARE process – did not have more senior support or its outcome more oversight, for example a formal review.

7.51 There appears to have been a reliance on the accountability and responsibility of "groups" to solve problems – with a gap in clear accountability and ownership by individual directors or senior members of staff to address the issues being raised.

7.52 It was known by the Board that HR processes were suboptimal and were being exacerbated by silo working and antagonism between lead executives and members of their teams. This continued despite an interim HRD being employed. Indeed, the situation seems to have worsened until a substantive HRD was appointed in early 2020. This should not have been allowed to continue and it created real risks to the organisation and stress to staff.

7.53 The formal F2SU process at that time worked effectively in that appropriate external reviews were commissioned, and things were moved forward – for further comment on F2SU see Chapter 6.

Chapter 8: Terms of Reference 8

"Review the Trust's HR processes and polices and underpinning governance arrangements in relation to the use of settlement agreements and associated confidentiality clauses and determine whether the actions taken in the period since 2018 were in line with local and national policy, and guidance."

Introduction

8.1 It was alleged in the press article in May 2022 that NEAS asked some members of staff to sign non-disclosure agreements (NDAs) in relation to the matters of concern, offering them more than £40,000 to do so.

8.2 We met with colleagues in NHS England to confirm national arrangements and expectations and reviewed national guidance and protocols (1), and the arrangements in place in NEAS.

8.3 We have looked at the Settlement Agreements (SAs) NEAS has made since April 2020 to date including those referenced in the media, and we have reviewed them against local and national guidance and looked in particular at the Non-Disclosure/Confidentiality clauses.

Settlement Agreements

8.4 SAs are used to manage the ending of an employment relationship. They can represent value for money and NHS guidance recognises that and does not preclude their use.

8.5 However, whilst they can be in all parties' interest they should, in the NHS, be not just clear about representing value for money and be open to public scrutiny, but also be scrutinised to ensure they do not compromise best practice in terms of employment.

8.6 NHS guidance, issued by NHS employers in February 2019[6] states that "they can 'help minimise potentially long, drawn out processes, or where your employee has raised a grievance which you have not been able to resolve. In cases where Trust and confidence has irretrievably broken down, it can be mutually agreed that a termination of employment would be in everyone's best interest.' It is also clear that 'Settlement agreements should not be used to short-cut any investigations in relation to any matter that may prevent an organisation from delivering high quality safe care."

[6] The use of settlement agreements and confidentiality clauses - Outline of the legal boundaries which employers need to think about when considering the use of settlement agreements when terminating employment. 18 February 2019

Non-disclosure/Confidentiality clauses

8.7 SAs will normally contain a confidentiality clause – ranging from not disclosing details of the agreement itself, for example the level of compensation agreed, to agreeing not to share any knowledge held due to the nature of the work undertaken.

8.8 It is unacceptable for a confidentiality clause in the NHS to fetter anyone from speaking up regarding a patient safety or health and wellbeing concern. The NHS Employers guidance contains model clauses to clarify these points.

8.9 NHS employment contracts, and any other contractual agreement, such as SAs must contain a "carve out" clause that ensures "a worker cannot sign away their rights to speak up about or disclose any issue which would be a protected disclosure under current law".

What we found

8.10 NEAS have sought to make nine SAs since April 2020. One has since been withdrawn. We have not reviewed any agreement made prior to that due to a central record not being available.

8.11 There is no national data regarding whether this would be more or less than expected as reaching such agreements is a matter for the individual employer and necessity for their use will vary. NEAS appears to have predominantly considered the agreements it has made based on them representing value for money and/or concluding lengthy/long-standing processes by mutual agreement.

8.12 In some circumstances there is a requirement for oversight by His Majesty's Treasury (HMT). It is not clear in reviewing the NEAS records whether they have consistently acted in line with that. This relates to the categorisation of some payments and approvals being sought retrospectively in, at least, one case.

8.13 In reviewing the details of the nine agreements, they appear to cover different circumstances and roles within the organisation, that is they have arisen from different issues and do not indicate a pattern of specific areas of concern.

8.14 Whilst pragmatic, SAs signal the end of an employment relationship and consequently good practice would be to ensure they are scrutinised for probity, and value for money, and to learn what went wrong and understand what has been done to learn and prevent the situation arising again. The Board are of the view that oversight has been managed by the People and Development Committee – this does not appear to be the case. Nor would the broader context of probity and reputational risk necessarily be the purview of that Committee.

8.15 The SA process was strengthened in July 2022, but it remained unclear where decisions would be made, how oversight of the circumstances and themes are scrutinised to ensure learning and prevention of future issues, nor consideration of any reputational issues or risks that may arise. A further revised process was

agreed in 2022.[7] It is intended that this will be monitored by the People and Development Committee.

8.16 NEAS has confirmed that seven of the nine agreements met the standard NHS non-disclosure guidance, which makes it clear that the right to speak up on safety matters is not fettered by the agreement.

8.17 Two of the SAs contained non-disclosure agreements that were inappropriate in the circumstances because they related to individuals where safety concerns were at the heart of the issue, and the oversight of the decision making in offering these agreements is unclear. Given the circumstances of those agreements, they could be considered inappropriate.

8.18 NEAS accepts in hindsight that the circumstances of one agreement could have been construed as potentially fettering speaking up, despite them having taken legal advice at the time the agreements were drawn up. They then sought further legal advice in reaching this view and have taken account of that in revising their processes.

8.19 One of these SAs was enacted; it was agreed by the other party and is in place. That party has been invited to share any concerns with this review without any risk to the agreement; they have declined to do so.

8.20 One was amended to address that clause but has not in fact been enacted and has since been withdrawn.

8.21 Organisational learning and consideration of reputational risk has not been sufficiently visible at NEAS. The organisation has recently strengthened the oversight of SAs but need to further strengthen and embed the assurance of the process.

Conclusions

8.22 Except for the two cases quoted in the media, there is no evidence that NEAS has used SAs or NDAs inappropriately to fetter people from speaking up.

8.23 In those two cases, the circumstances were sufficiently sensitive and contentious as to make any form of proposed settlement open to potential misinterpretation. NEAS accept that there were perception issues with that, and its processes have been strengthened.

8.24 Of those two, there was only one agreement reached: that individual declined to speak to us or share any concerns.

8.25 In the case of the agreement drafted but not ultimately agreed, that individual declined to speak to us or share any concerns with this review.

[7] Settlement agreement process at NEAS

8.26 There is no evidence of inappropriate use of public funds in reaching these settlements although it is not clear that proper process re HMT approvals has been followed in all cases.

8.27 There has been insufficient oversight of the SA process by the Board – this has been rectified with a proposed new process overseen by the People and Development Committee on behalf of the Board.

Chapter 9: Terms of Reference 9

"Identify any issues in relation to culture, capacity or resources that may have impacted on the Trust's response to the concerns raised and, on the Trust's current arrangements for ensuring safe and effective care."

Introduction

9.1 This report focuses on answering the questions posed within the scope of the review. However, using the insight we have been given into the organisation and the context within which it was working, we were able to identify a number of additional points that we think worthy of note.

Executive leadership

9.2 NEAS is a relatively small organisation (the second smallest ambulance trust in the country). As we have noted elsewhere, they have undergone significant changes of leadership at executive level in the years since the incidents detailed in this report – they are going through more with a change to their Board level Medical and Nurse Director roles at present. Whilst all the directors we have met are capable and committed, at the time of writing the report, the organisation is presented with a challenge in that some new appointees will likely be taking on these roles without previous Board level experience and, in many cases without ambulance sector experience.

9.3 They also seem to have wrestled with being clear about the role of the Medical and Nurse Directors on the Board when the predominant clinical body is paramedicine. The Board took a decision in 2022 to appoint an additional Director of Paramedicine/AHPs – the individual is now in post.

9.4 Whilst they recognise the challenge, and have paid attention to Board development previously, they would benefit from ensuring individual directors, and the executive cadre collectively, have access to good quality mentoring and support. The Board should assess how it can be assured regarding professional competence and performance as would be expected by all NHS Boards.

9.5 The size of the organisation limits the relative capacity available at board level but does not limit the range of challenges it faces, or the need for a robust infrastructure through which to deliver. It would be helpful to assess whether there is sufficient capacity available or if other support for example sharing of some services, could be explored.

Commissioning

9.6 The services delivered by NEAS were commissioned by NHS Northumberland CCG as lead commissioner for the service until the ICB came into force in July 2022.

9.7 The lead commissioner is responsible for agreeing the contract with NEAS to deliver the services specified in the contract for an agreed sum of money.

9.8 The lead commissioner will usually act as the key contact in the system should any concerns or issues be raised.

9.9 They are also responsible through their contracting and quality teams to deal with any quality issues that may arise with a provider (NEAS in this instance) and report them to the other commissioners that they are being lead for.

9.10 They can ask a provider to develop action plans to improve and will seek assurance that those plans have been enacted. These actions are normally monitored through their Quality Review Groups (QRG) and through Contract Review Meetings (CRM). These CRM meetings have been held on a regular monthly basis throughout the last 4 years as have QRG on a two monthly cycle. A chronology of these meetings was captured by the 'Desk Top Review'.

9.11 From a commissioning perspective, there are two points that need to be asked:

1. Has the lead commissioner been sufficiently aware of the challenges facing the Trust and the consequent impact that has had on quality and risk within the organisation?

2. Has the commissioner done an impact assessment on the sufficiency of resources required for NEAS to run a safe and quality service?

9.12 With respect to question 1, we are not sure this was the case. The commissioners (as above) and Trust were meeting regularly but we were informed that they were not sighted on the significance of the issues that were reported to the press. The view of the commissioner was that some of the quality issues are discussed at NEAS private board and that they were not party to this information on occasions. We were concerned that more attention was not given to the serious incident issues given that they had dropped significantly and that none were reported at all for several months.

9.13 We appreciate that the lead commissioner was part of the Desk Top Review in June 2022 and the commissioners do look at serious incident reports and benchmarking, but we wonder if the approach and challenges were sufficient and effective prior to 2022.

9.14 Following the Desk Top Review, there was an initial rapid review made to the ICB in May 2022 followed by a final report in June 2022. A presentation was made to the risk escalation meeting in June 2022 which involved NHSE, lead CCG, the CQC and CEO designate of the ICB. The chronology and findings to date were reviewed. The outcome of that was to move the Trust in to a Quality Board Meeting which continues to this day. This reflects the seriousness of the issues which had been raised and need for greater oversight of those issues.

9.15 The CQC also have concerns about the oversight and implementation of action plans developed in response to incidents or issues raised.

9.16 We did discuss with the commissioner whether the current commissioning model was fit for purpose and whether there were any plans to change. It is a highly specialist function and perhaps need to be elevated to a larger and more specialist team that can focus on the characteristics of the service and provide a higher degree of oversight and assurance. Fortunately, the commissioners agree and are taking a paper to the ICB in January 2023 to propose a fundamental change. We would strongly endorse this. We do also think there is a need to review this nationally given the specialist skills required to do this well.

9.17 NEAS has also reported that they were one of the lowest funded service per capita (this has been validated by the commissioner) and we are aware that additional funding of £38 million was secured this past year. However, we are not aware of a medium-term financial plan that will enable the service to deliver what it needs to in the medium term, and what impact assessment has been carried out. Again, the commissioner has confirmed that that they are working on this plan. We would encourage that this is done as soon as possible.

9.18 We have been told that most of the additional funding will be targeted at the front line, but we are concerned that the infrastructure for governance does not feel robust and the teams are already struggling and not able to meet their own investigation and quality metrics and that a plan to address would also be important. We would suggest that some of this additional funding is allocated to improve the effectiveness of the governance system but only after a fundamental review of governance as per our earlier recommendation.

Quality governance and oversight

9.19 As can be seen from the earlier chapters, concerns regarding the robustness of Quality Governance Assurance Systems have been variable and does require significant attention. The basic policies and processes themselves are in place but the consistency of application and oversight is an issue.

9.20 Other concerns around the governance of some HR processes, Freedom to Speak Up and leadership behaviours have been addressed earlier and recommendations made. A comment made by this review team is that the quality of some of the action plans we have seen lack rigour and would benefit from actions being owned, time measured, and metrics being agreed.

9.21 Some focus needs to be given to general compliance culture within the organisation and this could be addressed as part of the Leadership Development Plan that is already underway. The Annual Audit Plan could also be used to provide assurance that this is progressing and presented to Board on a regular basis.

Information and Infrastructure

9.22 A frequent issue raised by staff has been the lack of agility within current systems and IT infrastructure to ‘make the right thing to do the easy thing to do’.

9.23 Attempts have been made to improve current systems like Ulysses but staff still currently state that communications are not easy.

9.24 It may be useful for NEAS to consider whether a task and finish group could be set up to include C&C staff and others to try and remedy this. There is still some ongoing frustration with staff who recognise that efforts are being made to improve culture and transparency, but communication links and information are still somewhat of a constraint.

Conclusions

9.25 The Trust is a relatively small trust and has seen a significant amount of turnover of executive staff in the last few years. In most cases, these are first time Board roles and whilst the leaders involved are capable and committed, it is important to recognise this and ensure that support, coaching and mentorship or indeed sharing of functions with other trusts is considered by the Trust but also the ICB and the Region.

9.26 A Board Development Plan would also be of benefit and again needs to be delivered by experienced and skilled people.

9.27 We would also support the current commissioner's proposals to change those commissioning arrangements for the future. The proposals being made take into account the specialist nature of these services but also to provide an assurance framework that is more robust. This is also something which would be useful to explore nationally given the specialist commissioning challenge.

9.28 Given that NEAS have required additional funding and resources in 2022/23, it will be essential to include this as part of a medium financial plan that allows the Trust to plan effectively for its future.

9.29 As suggested earlier in the report, there is a need for a full governance review to support the Trust to ensure that it is delivering its governance responsibilities in the most effective way.

9.30 We would also like to suggest that the Trust does build on the improvements to the existing exchange of information processes and enhance them further to enable staff to deliver their roles more effectively.

Chapter 10: Conclusions and recommendations

Conclusions

10.1 The scope of the investigation has been broad and has revisited many of the themes raised in previous reports.

10.2 The case studies included in this investigation have been difficult to read and we know have been extremely challenging and upsetting for the families involved. We would hope that this report can serve to give some relief and closure to those families although we accept that their grief will remain a constant.

10.3 Both this investigation and previous reports have found a number of failings in how the Trust should have responded to the incidents and then in their response to concerns about how failings were accepted and followed up.

10.4 It is important that the Trust formally and publicly reiterates that there have been failings and restates its wholehearted apologies to the families concerned. It would also be positive to seek the families' engagement in the oversight and improvement that is currently underway. This could go some way to restoring confidence and trust in NEAS. The families may or may not wish to engage, but the proposal is a constructive one.

10.5 It is also important to recognise that the publication of this report will bring back difficult memories for the families affected. The Trust should consider offering access to counselling and support that best meets their needs.

10.6 There is no doubt that there are many wonderful staff and leaders in NEAS and the review team have met or spoken to many of them.

10.7 However, leadership dysfunction was allowed to continue for far too long and this had a major impact on how teams within different directorates operated. A defensiveness grew and affected team operations, transparency, candour and judgement. They also clearly impacted the health and wellbeing of staff.

10.8 The C&C Team particularly suffered as a result of this and were unable to discharge their roles in an effective way. Some of the coronial communication failures were not a direct fault of this team but down to the way information was exchanged within the organisation. This led to significant staff dissatisfaction and suspicion and may have tainted the way the organisation responded to concerns being raised.

10.9 In some cases, the families believe that changes to reports and not sending original documentation to the Coroner was a deliberate act to avoid negative attention and accountability. We cannot say what the intent was of those individuals who authorised those changes or did not share information as we were not there, but we have looked in detail at the reasonableness of those decisions and have expressed our views earlier in the report. We have not agreed with some of those decisions taken or some of those judgements made and believe that there are

significant learning opportunities to be gained in the organisation in using these cases as a vehicle for improvement.

10.10 The executive team have undergone numerous changes since 2018 and there is broadly a new team in place that is responsible for driving forward improvements. For some, this is their first Board role or CEO role, and others are new to the sector.

10.11 We do believe that the Board are taking the concerns seriously and some improvements have been made and progress has been acknowledged by the staff involved. We do feel however that some of those improvements should have happened sooner. Discussions reveal that there was some delay in acting due to the defensiveness of some senior executives and an overreliance on reassurances given to the Board.

10.12 Governance management systems and compliance would benefit from some specialist support to assist the Trust in moving forward. It may require some additional investment, as the teams are small, but this would be subject to the specialist assessment.

10.13 We think the executive team and the Board would benefit from some development work both individually and as part of a team to grow their confidence and skills to meet the challenges of a post pandemic ambulance service. This is particularly important given the newness of some of the executive team with other changes pending.

10.14 There have been some cultural issues found and some staff still report being frightened to raise concerns or to challenge those in authority. Some have shared their fears directly with us and we know the CQC have similar concerns following their latest inspection. There are wider national concerns that a more focussed review of culture should be undertaken in response to the recommendations arising from the National Guardian's speaking up review of ambulance trusts. We support that recommendation and believe it would benefit trusts like NEAS.

10.15 The Trust recognise this and are putting some focussed cultural work in place and amending their Freedom to Speak Up Arrangements. We suggest that these are reviewed after six months, and findings presented to the Board for assurance that changes are being implemented.

10.16 NEAS will also need the support of their ICB and Regional colleagues particularly in addressing the commissioning, governance and resource challenges. The service has been historically one of the lowest funded services in England and whilst additional funding was secured this year, a medium-term financial plan would be an essential step for securing service sustainability.

10.17 We also believe that Ambulance Commissioning arrangements have not been as robust as they might have been and we very much support consideration being given to strengthen these arrangements. These changes would also fit with the national direction for ambulance commissioning.

10.18 Talking to the families it is clear that they were devastated in how their loved ones and their concerns were responded to by the Trust. We know that a concern of theirs is that no other families experience similar trauma.

10.19 We strongly endorse this and believe that the Trust now needs to focus on implementation and driving the improvements required throughout the organisation.

10.20 We believe that time and focus would now be better spent in delivering the planned improvements and strongly recommend the Trust to put in place an oversight committee to assure that the organisation is delivering the safe and effective emergency services for the people that they serve.

10.21 The Oversight Committee should in its first meetings agree the detailed actions arising from the recommendations and assign accountability, timeframes for delivery and who is carrying the responsibility for the task in hand. Once that is agreed, the Implementation Programme should be signed off by Oversight Committee and presented to each sovereign Board involved in the discharge of the action plan.

10.22 We also believe that the Oversight Committee might benefit from having a Chair independent of the Trust to oversee implementation and report back through existing Governance Structures to ensure that all organisations involved have full transparency and understanding of progress being made. The Oversight Committee should remain in place until all actions have been delivered and assurance secured.

Recommendations

Our intention is that all of these recommendations are in direct response to the issues raised by the families and take account of our determination to improve things on their behalf.

Apology to the families

1. NEAS to meet with families and formally apologise for failings and impact on them.

Governance

2. To undertake a specialist support review of governance in the Trust with specific attention being given to Serious Incident management and compliance processes.

3. To address concerns that reports were changed inappropriately and consider whether accountability arrangements in the organisation have been followed through and whether further action needs to be taken.

4. To ensure that training given to all call handlers and health advisors reinforces the need for staff to ask for help where clinical safety of patients is an issue.

5. The Board should seek assurance of the ongoing coherence and confidence of the Quality and Safety directorate given the painful experiences they have had during this period and the imminent further change of executive leadership of that function.

6. To develop an oversight committee with family involvement to ensure that all recommendations made in respect of the cases and this independent investigation have been sustainably implemented. It is also suggested that the committee should have a Chair independent of the Trust to oversee these arrangements. (*See 10.22*)

7. A Senior Doctor, independent of the Trust, is included in the review of deaths, their referral to HMC, and engages with the families in an appropriate and timely manner. To facilitate this at speed, the organisation should consider adopting the Medical Examiner model into its processes.

8. The teams should have a clear structure for information flows, clear responsibilities, and the C&C Team acting as the only conduit to HMC.

9. The function of statutory reporting to HMC via the C&C Team and internal governance processes should be explicitly separate.

Governance in relation to the use of Settlement Agreements

10. NEAS's latest revised process should be followed, and assurance arrangements put in place by the Nomination and Renumeration Committee to ensure it is.

11. All situations leading to potential settlement agreement should be scrutinised on behalf of the Nomination and Remuneration Committee, including independent challenge, to ensure best practice is assured.

12. The Nominations and Remuneration Committee should consider requesting a report providing assurance about any SAs agreed prior to April 2020.

Leadership and Culture

13. External support for developing, and providing support and challenge, to the Board overall and new directors specifically should be commissioned and a process for rigorously assuring performance put in place.

14. The revised F2SU arrangements must be implemented as a priority and external review of them, and any recommendations from the national review, commissioned at an appropriate time.

15. The Culture Development plan should be prioritised and a process to assure delivery put in place by the Board.

16. We recommend that the Trust needs to engage with the forthcoming national review of broader cultural matters in ambulance trusts arising from the National Guardian's speaking up review report.[8]

Commissioning

17. To support the proposal currently being put forward by the commissioners to improve the commissioning arrangements moving forward. We would also recommend that that the National Framework for the Commissioning of Ambulance Services be updated to better reflect the commissioning complexity and specialist nature of these essential services and improve the governance and oversight arrangements.

18. To develop a coherent Medium Term Resource plan with ambulance commissioners to secure safe and sustainable services.

[8] Listening to Workers
A Speak up Review of ambulance trusts in England (February 2023)
National Guardian Freedom to Speak Up

Appendix A: Terms of Reference for an Independent Review of NEAS

Terms of Reference for an Independent Review

into alleged failures of patient safety and governance at the North East Ambulance Service (NEAS)

Introduction and background

On 22 May 2022, media coverage in the Sunday Times alleged that the North East Ambulance Service (NEAS) was covering up evidence in relation to patient deaths and withholding key evidence from HM Coroners linked to service failures. The news article made reference to seven incidents and the names of 5 individuals were included. The report said that families were not always told the full facts of the circumstances surrounding the death of their relatives.

On the 14 June 2022 the former Secretary of State for Health and Social Care Sajid Javid confirmed that the NHS has agreed to an independent review.

Purpose and scope of the review

NHSI/E has commissioned the Independent Review which will be led by an independent leader with appropriate experience and impartiality, supported by recognised, impartial subject matter expertise, to focus on **patient safety and governance processes** within the Trust, to:

- Establish the facts surrounding the individual cases highlighted by the whistle-blower in May 2022
- Critically analyse the sequence of events following concerns first raised by Trust staff in spring 2019
- Review the processes surrounding coronial investigations during the period when the alleged incidents took place (December 2018 – December 2019) in comparison with the processes in place today
- Determine whether changes implemented to coronial processes following the previous reviews and investigations undertaken have resulted in the expected and required improvement
- Seek to understand the extent to which the culture of the Trust enables staff to feel safe, supported and encouraged to report and escalate any concerns, including through Freedom to Speak Up arrangements.
- Review the Trust's Serious Incident (SI) process and determine whether SIs are reported and actioned in accordance with best practice, local policy and national guidance, identifying both areas of good practice and any areas of concern
- Review the Trust's HR and whistleblowing processes and the handling of concerns raised by staff since the issues were first raised in spring 2019

It is anticipated that the review will take up to 4 months, depending on any other required lines of enquiry identified as a result of review activity.

Involvement of the affected patients' families and staff

The independent, external review will include input from the families of the patients identified, i.e., within the previous investigations and the reviews undertaken, and the concerns raised by the whistle-blower in May 2022. It will also include input from staff (past and present) involved with those concerns, the escalation of them or the relevant governance processes of the Trust during the period of the specific concerns, and currently.

The independent reviewer will ensure that affected family members and relevant staff are fully informed of the review process, understand how they can contribute to the design of the final Terms of Reference and will maintain contact and update individuals throughout the review as appropriate.

Terms of Reference (ToR)

These Terms of Reference have been developed in collaboration with the independent Chair/ reviewer, key stakeholders, key individuals, affected patients' families and staff.

1. Fully understand the concerns raised in relation to the cases being considered, and the impact both of the incident and the subsequent processes, through speaking with families, where possible, and relevant stakeholders

2. NEAS has previously commissioned 6 independent reviews / audits, and 7 reports which were published between August 2019 to May 2022. Review the seven reports and any associated relevant documentation, and determine:

- The quality of the investigations and reviews, sufficiency of enquiry and adequacy of their findings, recommendations, and subsequent action plans
- The progress made to implement the learning and recommendations to date
- Whether changes implemented within the Trust's governance, and coronial processes have resulted in effective and measurable improvement
- Whether there is further work required to ensure improvements to governance, and specifically coronial processes, are sustainable

3. Benchmark the Trust's current coronial processes against peer organisations to determine whether processes are comparable in relation to timeliness and quality of evidence submitted to coroners and suggest areas for further improvement if required.

4. Review the Trust's Serious Incident process and determine whether SIs are reported and actioned in accordance with best practice, local policy, and national guidance, identifying both areas of good practice and any areas of concern.

5. Consider whether the statutory Duty of Candour is appropriately applied within the Trust's Serious Incidents process and procedures and consider specifically it's application in relation to the specific cases being considered.

6. Seek to determine whether the arrangements in place for staff to escalate concerns, both during the period under review and now, are effective and appropriate. Including whether the Trust provides an environment in which staff feel safe, supported, and encouraged to report and escalate concerns.

   This will include formal Freedom to Speak Up arrangements. The review will include speaking with relevant staff and leaders and a Desk Top Review of relevant data.

7. Assess whether the action taken by the Trust in response to concerns raised by members of staff in Spring 2019 regarding safety matters and coronial processes were appropriate, and in compliance with best practice, local policy and national guidance in relation to HR practice, Whistleblowing and Freedom to Speak Up.

8. Review the Trust's HR processes and polices and underpinning governance arrangements in relation to the use of settlement agreements and associated confidentiality clauses and determine whether the actions taken in the period since 2018 were in line with local and national policy, and guidance.

9. Identify any issues in relation to culture, capacity or resources that may have impacted on the Trust's response to the concerns raised and, on the Trusts, current arrangements for ensuring safe and effective care.

Deliverables

A final written report will be made to NHS England, it is anticipated it will be delivered within four months. It is planned to be published to support wider learning.

The report will clearly identify any areas of best practice, opportunities for learning and areas where improvement are required.

Based on the review findings, the report should make organisational specific outcome-focused recommendations for improvement, propose priority ratings and expected ownership and expected timescales for completion.

The review team will operate in accordance with data protection legislation, ensuring compliance with GDPR and the Data Protection Act (2018), and Confidentiality: NHS Code of Practice. Information sharing and record storage systems utilised by the review team will be sufficiently secure as to ensure all personal data held and processed by the review team is safeguarded at all times.

Appendix B: Investigation Team

Panel members

Dame Marianne Griffiths DBE (Chair)
Denise Farmer
Dr David Crossley, Independent Medical Examiner

Specialist Advisers

Lynn Woolley, SIs and Duty of Candour

Secretariat

Sian Finlay

Appendix C: Coronial Process Task and Finish Group Terms of Reference

Coronial Process – Task and Finish Group Terms of Reference

Background

Following concerns raised through a number of channels about the robustness of the Trust's coronial process, the Trust Chairman initiated an independent review, duly conducted by WorkforceOne.

The review revealed areas of the Trust's processes which fall short of best practice and made several recommendations outlining where processes could be improved.

Purpose

The task and finish group has been established to take forward the recommendations and oversee the implementation of an action plan to address the shortcomings.

The task and finish group should not limit its activities solely to the WorkforceOne report recommendations and should establish a root and branch principle to implementation.

Membership and reporting lines

The task and finish group will report directly to the Board of Directors via the Audit Committee and have the following composition:

- Non-Executive Director (Chair)
- Non-Executive Director
- Non-Executive Director
- Medical Director
- Director of People and Development
- Head of Risk and Regulatory Services
- Trust Secretary
- Secretary to meeting

The above individuals should form the core standing membership of the task and finish group, with additional attendees on an "as required" basis at the invitation of the Chair. Additionally, the group should ensure that there is appropriate involvement in "solution testing" by those NEAS staff associated with the coronial process.

Reporting

The group shall report to the Board of Directors via the Audit Committee.

The group should conduct its initial meeting by 30 April 2020 (by video conferencing) and produce a first progress report to the subsequent meeting of the Audit Committee. The action plan should be targeted to be implemented by 30 June 2020, with the task and finish group retained for a period to ensure that the improvements are fully embedded.

In order to meet the timescales set the group shall meet weekly.

Appendix D: Glossary of Terms

ALS	Advanced Life Support
BIPAP	Bi-level Positive Airways Pressure
BLS	Basic Life Support
C&C	Coronial and Claims Team (at NEAS)
COPD	Chronic Obstructive Airways Disease
CPAP	Continuous Positive Airways Pressure
CPR	Cardiopulmonary Resuscitation
CQC	Care Quality Commission
CRG	Clinical Review Group
DNACPR	Do not attempt Cardiopulmonary Resuscitation
ECG	Electrocardiogram
ePCR	Electronic Patient Care Record
FLO	Family Liaison Officer
F2SU	Freedom to Speak Up
GNAAS	Great Northern Air Ambulance Service
HMC	His/Her Majesty's Coroner
IO	Investigating Officer
JRCALC	Joint Royal Collages Ambulance Liaison Committee
ME	Medical Examiner
NEAS	North East Ambulance Service NHS Foundation Trust
NDA	Non-Disclosure Agreement
NHS	National Health Service
NRLS	National Reporting and Learning System
PSIRF	Patient Safety Incident Response Framework
ROLE	Recognition of Life Extinct
RPIW	Rapid Process Improvement Workshop
RR	Rapid Response
RVI	Royal Victoria Infirmary
SA	Settlement Agreement
SEACARE	SEACARE (Patient **S**afety incidents, patient **E**xperience concerns, **A**dult safeguarding concerns, **C**hildren's safeguarding concerns, **A**udit from the learning from deaths process, **R**isk which incorporates coronial requests and concerns and **E**xternal requests for information related to care provided by NEAS)
SI	Serious Incident
StEIS	Strategic Executive Information System

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 25 July 2023	
Report Title:	Updated Governance Handbook (Issue 7)

Purpose of report

To request approval from the Board on the proposed amendments to documents held and published in the ICB's Governance Handbook, including the Scheme of Reservation and Delegation, financial limits, committee terms of reference and ICB committee structure.

Key points

NHS North East and North Cumbria Integrated Care Board (the ICB) is the statutory decision-making body of the North East and North Cumbria Integrated Care System. The ICB is responsible for the commissioning of health services and effective stewardship of NHS spending for all the people living in the North East and North Cumbria (NENC).

The ICB's Constitution and supporting documents create the framework for the ICB to delegate decision-making authority, functions, and resources to ensure it meets the diverse needs of our citizens and communities. The Constitution sets out the functions that the ICB will undertake and is supported by the governance handbook.

The handbook includes several key documents including a functions and decisions map, scheme of reservation and delegation, financial limits, and committee terms of reference. The documents have previously been approved by the Board with subsequent issues for further amendment from (issue 1) approved on 1 July 2022 to the current (issue 7) to seek approval at by the Board in line with the new changes.

As part of a process of ongoing review of the documents within the Governance Handbook, further amendments have been identified to ensure the documents remain fit for purpose. The amended documents are attached with changes highlighted or tracked and summarised below:

Material Changes to the Scheme of Reservation and Delegation (SORD)

(Appendix 1)

- Page 33 – Human Resource Policies - remove (Approves) from reserved to ICB Board to Executive Committee (Approves) in the Delegated to Committee or Sub-Committee section.

Primary Care Services

On 1 April 2023 the ICB formally accepted the delegation of pharmacy, optometry and dental (POD) services from NHS England. Whilst services transferred on 1 April, the staff transfer did not take place until 1 July 2023. For this interim period, the SoRD was amended to incorporate the delegation of decisions to be made relating to all primary care functions. This also included an interim statement regarding any decisions that were required to be made between 1 April and 30 June 2023, which NHS England Primary Care Managers would ordinarily have delegated authority to make in respect of finance and contract transactions, would seek approval via the relevant sub committees, or if it was an urgent time sensitive decision, written approval received via the Executive Area Director. Now the staff transfer has been completed, the SoRD and supporting statement has been updated to reflect the revised delegation approval and formal ICB decision making process.

- Page 39 – Appendix 2 – "Primary Care Services: Allocation of Roles and responsibilities in the ICB" – removal of the four paragraphs of wording for Accountability, delegations, decision making and Senior Responsible Officer (SRO).
- Page 42 – Appendix 2c (3)- minor amendments to wording: "Primary Care Services – Dentistry". Inclusion of additional text to reference number 5.
- Page 43 – Appendix 2c (5) – "Pharmaceutical Services – Delegation to the Pharmaceutical Services regulations [Sub] Committee - PRSC – inclusion of additional wording to reference numbers: 1, 2, 4 and 6 in relation to delegations.
- Page 46 - Appendix 2e – "Primary Care Dental Services - Decisions Delegation to an ICB Primary Care Officer or Manager" added.
- Page 47 - Appendix 2f – "Primary Care Pharmaceutical Services – Decision Delegated to and ICB Primary Care Officer or Manager" added.
- Page 48 - Appendix 2g – "Primary Care Optometry Services – Decisions Delegation to an ICN Primary Care Officer or Manager" added.

Financial Limits – Increase in Financial Delegation Limits for Care Packages

On 13 June 2023 the Executive Committee received a proposal from the Executive Chief Nurse with regards to increasing the financial delegation limit of agenda for change band 8d Deputy Directors of Nursing/Commissioning Managers responsible for approving all age continuing healthcare packages. The current limit is £75,000.

The request is to support the development of a consistent approach to the full process, including documentation and decision making for each area and removed unwarranted variation currently being experienced.

The Executive Committee recommended an increase in the limit to £150,000 with a review date of three months from the date of approval.

The Financial Limits are attached at Appendix 2 for consideration and approval.

Executive Committee Terms of Reference

The terms of reference for Executive Committee were reviewed at the Executive Committee meeting in May 2023. The membership of the Committee was updated to reflect a change in job title for the Executive Director of Improvement and Experience (previously Executive Chief People Officer). The Board is asked to note this change of the revised terms of reference - version 4.0.

Please note this is a minor amendment only to the committee's terms of reference and therefore they have not been included on this occasion.

Remuneration Committee Terms of Reference

The Committee reviewed its terms of reference in May 2023 and some minor amendments have been made to reflect some changes to the workforce portfolio within the executive team and the inclusion of two additional regular attendees to offer human resources and governance expertise.

A further amendment has also been made to reflect the Committees responsibility to 'oversee the arrangements regarding performance to include succession planning for the executive team, diversity of the executive and performance of the individual executives and team'.

The terms of reference are attached at Appendix 3, with the changes highlighted for ease of reference, for consideration and approval.

NENC ICB Committee Structure

The NENC ICB Committee Structure has been updated to include the additional sub-committees of the Executive Committee and Quality and Safety Committee that have now been approved and established. These are included within the revised document (version 4.0) and listed below:

- Human Resources (HR) and Organisational Development (OD) Steering Group
- Mental Health, Learning Disabilities and Autism Sub-committee
- Contracts Group (Sub-committee)
- Place Sub-committees x 12
- ICB 2.0 Programme Group (Sub-committee)
- All Ages Continuing Care Strategic Transformation Group (Sub-committee)
- Patient Voice Sub-committee

The Board is asked to note the changes to the Committee structure as shown in Appendix 4.

Risks and issues

There is a risk the ICB does not have a robust and clear control environment in relation to the effective stewardship and management of public funds and levels of delegation may not support local decision-making.

Assurances

The SORD, and terms of reference have been reviewed to ensure they remain fit for purpose and are in line with statutory guidance.

Recommendation/action required

The Board is asked to note the proposed changes to the governance documents described above and to approve the updated versions for insertion into the Governance Handbook (issue 7), as follows:

- Scheme of Reservation and Delegation **(Appendix 1)** – **version 5-0**
- Financial Limits **(Appendix 2) – version 3-0**
- Remuneration Committee Terms of Reference – **(Appendix 3) – version 2-0**
- NENC ICB Committee Structure – **(Appendix 4) – version 4-0**

Acronyms and abbreviations explained

SORD - Scheme of Reservation and Delegation
NENC – North East and North Cumbria
ICB – Integrated Care Board
PRSC – Pharmaceutical Regulations Sub-Committee

Sponsor/approving executive director	Claire Riley, Executive Director of Corporate Governance, Communications, and Involvement
Date approved by executive director	14 July 2023
Reviewed by	Deborah Cornell, Director of Corporate Governance and Board Secretary
Report author	Lynda Hutchinson, ICP Development and Governance 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	**Yes**		**No**	✓	**N/A**	

impact assessment been undertaken? (please tick)						

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

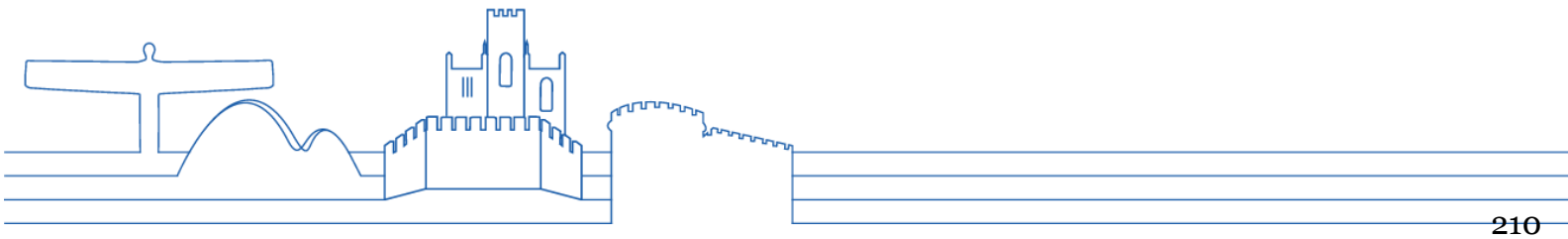
Item: 12.1

NHS
North East &
North Cumbria

North East and North Cumbria Integrated Care Board

GOVERNANCE HANDBOOK

Issue 7-0
Approved TBC



Introduction

Who are we?

The North East and North Cumbria Integrated Care Board (NE & NC ICB) is a statutory health body established to arrange for the provision of health services within the North East and North Cumbria.

What is the Governance Handbook?

The NE & NC ICB must publish its constitution. The constitution sets out the duties of the ICB, the makeup of its board and the overarching rules by which it operates. The constitution is available here https://northeastnorthcumbria.nhs.uk/about-us/corporate-information/governance/

The governance handbook is supplementary to the constitution and sets out how the ICB makes it decisions. This is captured in several documents which make up this handbook.

Scheme of Reservation & Delegation

This document sets out those decisions reserved to the ICB board and those decisions which are delegated to others. Delegations may be made to individuals, committees, or other organisations.

Functions & Decisions Map

This map sets out those functions and decisions taken by the ICB centrally or by the ICB at place. There are 14 places in the NE&NC ICB, and these are listed in the ICB constitution, available here https://northeastnorthcumbria.nhs.uk/about-us/corporate-information/governance/

Committee Terms of Reference

The ICB has established five committees of the board. Each of these has a terms of reference which sets out their remit and the decisions that each committee may make.

Financial Documents

The ICB has three key financial documents which set out the rules for making decisions, who decisions are delegated to, and the financial limits applicable to ICB staff.

Standards of Business Conduct Policy/Conflicts of interest policy and procedures

The ICB must maintain registers of the interests of members of the ICB Board, members of its committees or sub-committees, and its employees. These registers are included in this governance handbook.

Members of the board, committees, sub committees, and all staff must comply with the ICB's Standards of Business Conduct Policy/Conflicts of interest policy. This is also included in this governance handbook.

How you can inform decision making

Communities and People Involvement and Engagement Strategy for the North East and North Cumbria

No decision will be made about **substantial** changes to health and care services that people receive without talking and listening to people receiving those services or who may do in the future, about it first. It is important that people have their say to shape and improve local services.

The ICB's Communities and People Involvement and Engagement Strategy sets out how the ICB will engage and involve people and is available here https://northeastnorthcumbria.nhs.uk/get-involved/

Healthwatch

There is a local Healthwatch in every area of England which acts as the independent champion for people who use health and care services. Healthwatch find out what people like about services, and what could be improved, and share these views with those with the authority to make change happen.

Healthwatch also help people find the information they need about services in their area, and we help make sure their views shape the support they need. Healthwatch will be an important critical friend to the ICB.

ICB Board Meetings

ICB board meetings are held in public. The ICB will hold its board meetings throughout the North East & North Cumbria and all members of the public are welcome to attend. The dates of the board meetings, agendas and papers are posted on the ICB's website here Meetings and agendas | North East and North Cumbria (northeastnorthcumbria.nhs.uk)

Version Control

Issue Number	Changes to the Governance Handbook	Date of Board Approval
Issue 1	All documents in the Governance Handbook v1-0	1 July 2022
Issue 2	As for Issue 1 but with the following changes: Executive Committee Terms of Reference updated to v1.1 which shows a change in quoracy to allow nominated deputies	27 September 2022
Issue 3	As for Issue 2 but with the following changes: Amendment to Scheme of Reservation & Delegation updated to v1-1 to include arrangements for the approval of individual funding requests in accordance with the ICB policy (approved retrospectively from 1/7/2022) and arrangements for the approval of Value Based Commissioning Policy. Approval of Healthier and Fairer Advisory Group (sub-committee) Terms of Reference.	29 November 2022
Issue 4	As for Issue 3 but with the following material changes: <u>Scheme of Reservation & Delegation updated to v2-0 as follows:</u> Audit Committee to recommend changes to the Scheme of Reservation and Delegation to Board for approval instead of the Chief Executive. Audit Committee to recommend changes to the SFIs, Financial Delegations and Financial Limits to the Board for approval, instead of the Finance, Performance & Investment Committee. Clarification of approval limits as approved by Board on 29 November 2022. Deleted the determination of governance arrangements at Place, as all committees or sub committees must be approved by Board. Control of the staff establishment (tier 1- tier 3) added. Approve the appointment of internal auditors, changed from Board to Audit Committee. Approval of standard operating procedures (SOPs) changed from Executive Committee to the relevant executive director for than function. Footnote 1 replaced by table 1 which provides updated guidance. Individual Funding Request Panels (sub-committee) as approved by Board in September 22) and Healthier and Fairer Advisory Group (sub-committee) as approved by Board in November 2022) added to list of sub committees at Appendix 1; and	31January 2023

Issue Number	Changes to the Governance Handbook	Date of Board Approval
	Job title of the Executive Director of Place Based Delivery, changed to Executive Area Director.	
	<u>Material amendments to the Standing Financial Instructions, January 2023 v2-0 (based on Version 1.3 template published by NHS England):</u> Paragraph 4.1.4, bullet point removed as this is effectively covered in the following two bullet points Paragraph 10.1.4 (losses and special payments) updated to reflect latest guidance.	
	<u>Key amendments to the Financial Delegations, (now version 2-0:</u> Paragraph 1.1 and 1.2 have been updated to allow an ICB Director of Finance to approve capital schemes of up to £250,000, consistent with delegated revenue expenditure limits. Paragraph 2.1 has been added to clarify the limits above which competitive quotations are required and relevant procurement thresholds. This is in line with the current agreed position, the addition is simply to make the position clearer in the document Paragraph 2.6 – previously the signing of contracts was reserved to Executive Directors which was impractical and out of sync with delegated financial limits. The proposed amendment will allow other individuals to sign contracts in line with delegated limits and allow other ICB Directors to sign contracts up to £1m that have been appropriately approved. Paragraph 6.1 – previously the engagement of solicitors was reserved to Executive Directors. The proposed amendment confirms this will now be approved in accordance with the legal services Standing Operating Procedure to be maintained by the Executive Director of Corporate Governance, Communications and Involvement, and in line with delegated financial limits. Paragraph 13 has been added to confirm arrangements for approval of any non-audit services from the external auditors, including compliance with relevant National Audit Office guidance Job title of the Executive Director of Place Based Delivery, changed to Executive Area Director where referenced.	
	<u>Amendments to the Financial Limits (updated to v2-0) as follows:</u> Delegated limits for admin budgets such that expenditure up to £4,999,999 would be approved by Executive Committee rather than Finance, Performance and Investment Committee. Job title of the Executive Director of Place Based Delivery, changed to Executive Area Director.	
	<u>Executive Committee version Terms of Reference now v2-0</u>	

Issue Number	Changes to the Governance Handbook	Date of Board Approval
	Job titles of some members changed to reflect their new titles. (Membership remains unchanged). Removed reference to approving standard operating procedures which is now delegated to the relevant executive director. Added to responsibilities of committee: Develop and implementation of Primary Care Strategy	
	<u>Quality & Safety Committee Terms of Reference now version 2-0</u> Job title of Executive Director of Strategy and System Oversight changed to Chief of Strategy and Operations. (Membership remains unchanged). Vice chair deleted from this statement: The Committee will be chaired by an Independent Non-Executive Member of the Board. The Chair cannot also be the Audit Committee Chair ~~or Vice Chair~~.	
	<u>Finance, Performance & Investment Committee Terms of Reference now version 2-0</u> The following updates to the committee terms of reference have been made: • Combine Part 1 and 2 of the meeting agenda and the Chair will manage any conflicts of interest in the normal way • Appropriate amendments to the membership • Removal of "To recommend SFIs and financial delegations and limits to the Board for approval" as this is the remit of the Audit Committee • Removal of "To develop a finance staff development strategy to ensure excellence by attracting and retaining the best finance talent" as this responsibility is not one for an individual committee but for the organisation • Following approval of ICBP006 Commercial sponsorship and joint working with the pharmaceutical industry Policy, inclusion of 'Ratification of pooled budget arrangements relating to commercial sponsorship and joint working with the pharmaceutical industry'.	
	<u>Audit Committee Terms of Reference now version 2-0</u> Added to the following to the remit of the Audit Committee: • To recommend SFIs, financial delegations* and limits to the Board for approval. *The financial delegations include approval of Non-Audit Services (previously this was the responsibility of the Finance, Performance and Investment Committee)	

Issue Number	Changes to the Governance Handbook	Date of Board Approval
	• To recommend the Scheme of Reservation & Delegation to the Board for approval (previously this was the responsibility of the Chief Executive). • Approving the appointment of Internal Auditors, retrospectively from 1 July 2022. Amended reference to the NHS Standards for Commissioners, Fraud, Bribery and Corruption to Government Functional Standard 013 Counter Fraud: NHSCFA requirements.	
	<u>Governance Structure, now v2-0:</u> Appendix 1 includes the following approved sub committees: • Healthier and Fairer Advisory Group (sub-committee) • Individual Funding Requests Panel North (sub-committee) • Individual Funding Requests Panel South (sub-committee)	
	Updated list of eligible providers of primary medical services v2-0 (supplied by NHSE 26/10/2022)	
Issue 5	As for issue 4 but with the following changes: <u>Scheme of Reservation & Delegation updated to v3-0 as follows:</u> • Revised delegation to parent committees to approve their sub-committee terms of reference • ICB Statutory duties copied from Constitution for completeness • Added delegations relating to primary care services • Appendix 1 - updated list of Committees, Sub Committees and Joint Committees • Appendix 2 - Primary Care Services Appendix 2 replaced to include Pharmacy, Optometry and Dentistry • Appendix 3 - Delegation Summaries added to the SORD • Appendix 4 - Remuneration Guidance added to the SORD **<u>Functions and Decisions Map (Appendix 2)</u>** Minor updates to ensure consistency with the SORD. **<u>Executive Committee Terms of Reference</u>** The following has been added to the responsibilities of the committee: Commissioning services for veterans and families, who form part of the NENC registered populations.	28 March 2023

Issue Number	Changes to the Governance Handbook	Date of Board Approval
	Place Governance Arrangements Approval to establish ICB place sub committees and approve their terms of reference V1-0. **North East & North Cumbria Integrated Care Partnership (ICP) and Area ICPs** Approval the North East and North Cumbria Integrated Care Partnership (ICP) terms of reference V1-0. **Establishment of the following Sub Committees and Approval of their terms of reference:** • Medicines • Quality and Safety Area x 4 • Safeguarding • NENC Antimicrobial Resistance (AMR) and Healthcare Associated Infection (HCAI) • Pharmaceutical Services Regulatory [Sub] Committee • Primary Care Strategy & Delivery • IFR Panel x 2	
Issue 6	As for issue 5 but with the following changes: **Material Changes to the Scheme of Reservation and Delegation (SORD)** • Page 10 - Parent Committees approve the establishment of subcommittees and their terms of reference (not Board) • Page 13 – inclusion of the ICB's serious violence duties through the Police, Crime, Sentencing and Courts (PCSC) Act 2022. The ICB is a 'specified authority' and responsible for delivering the Duty. • Page 19 – inserted the requirement for the Board to approve the capital plan for the ICB and partner NHS Foundation Trusts across the ICS • Pages 20 and 21 – approval of the ICB's non-programme budgets and approval of variations to non-programme costs – changed to Executive Committee recommending this to Board for approval (previously allocated to Finance, Performance and Investment Committee) • Page 38 - Appendix 1 - updated list of committees, Subcommittees and Joint committees • Page 40 – Appendix 2 - minor amends to wording: changing 'Primary Medical Services' to 'Primary Care Services' relating to delegations of primary care services.	30 May 2023

Issue Number	Changes to the Governance Handbook	Date of Board Approval
	Quality and Safety Committee Terms of Reference Main changes are changes to the membership of the Committee and also clarifying the Committee's responsibility for public and patient involvement. **Finance, Performance and Investment Committee** Minor amends have been made to the Finance, Performance and Investment Committee to reflect the Committee's responsibility to "review and prioritise any relevant investment proposals in line with the ICB Investment Business Case policy." **Mental Health, Learning Disabilities and Autism sub-committee** Subject to approval, the Mental Health and Learning Disabilities and Autism (MHLDA) sub-committee is a sub-committee of the Executive Committee and is responsible for providing leadership and direction in relation to the delivery and commissioning of all NHS mental health and learning disability services across the life course, including young people, adults and older adults across North East and North Cumbria.	
Issue 7	As for issue 6 but with the following changes:	--/--/--
	Material Changes to the Scheme of Reservation and Delegation (SORD) - Appendix 1 Page 33 - Human Resources Policies – Remove (Approves) from reserved section to ICB Board to Executive Committee (Approves) in the "Delegated to Committee or Sub-Committee" section. Primary Care Services Incorporated the delegation of approvals relating to all primary care functions as detailed below. • Page 39 – Appendix 2 – "Primary Care Services: Allocation of Roles and responsibilities in the ICB" – removal of the four paragraphs of wording for Accountability, delegations, decision making and Senior Responsible Officer (SRO) • Page 42 – Appendix 2c (3)- minor amendments to wording: "Primary Care Services – Dentistry". Inclusion of additional text to reference number 5 • Page 43 – Appendix 2c (5) – "Pharmaceutical Services – Delegation to the Pharmaceutical Services regulations [Sub] Committee - PRSC – inclusion of additional wording to reference numbers: 1, 2, 4 and 6 in relation to delegations. • Page 46 - Appendix 2e – "Primary Care Dental Services - Decisions Delegation to an ICB Primary Care Officer or Manager" added.	

Issue Number	Changes to the Governance Handbook	Date of Board Approval
	• Page 47 - Appendix 2f – "Primary Care Pharmaceutical Services – Decision Delegated to and ICB Primary Care Officer or Manager" added. • Page 48 - Appendix 2g – "Primary Care Optometry Services – Decisions Delegation to an ICN Primary Care Officer or Manager" added.	
	Financial Limits – Increase in Financial Delegation Limits for Care Packages An increase to the financial delegation limit of agenda for change band 8D Deputy Directors of Nursing/Commissioning Managers responsible for approving all age continuing healthcare packages. The delegated limit is to be increased from £75,000 to £150,000 to allow continuity of care for patients. This will be reviewed after a period of three months from the date of approval - version 3-0.	
	Executive Committee Terms of Reference The terms of reference for Executive Committee have been updated to reflect a change in job title for a member of the Committee. - version 4.0	
	Remuneration Committee Terms of Reference The membership of the Committee has been updated to reflect the change in responsibilities within the executive team for responsibility of the workforce function. In addition, two additional regular attendees have been added to provide specialist human resources and governance expertise to the Committee. An additional amendment has also been made to reflect the Committee's responsibility to 'oversee the arrangements regarding performance to include succession planning for the executive team, diversity of the executive and performance of the individual executives and team' - version – 2-0	
	NENC ICB Committee Structure The Committee structure has been updated to include the approved additional subcommittees of the Executive Committee and Quality and Safety Committee (version 4.0) as follows: • Human Resources (HR and Organisational Development (OD) Steering Group • Mental Health, Learning Disabilities and Autism • Contracts Group • Place subcommittees x 12 • ICB 2.0 Programme Group	

Issue Number	Changes to the Governance Handbook	Date of Board Approval
	• All Ages Continuing Care Strategic Transformation Group • Patient Voice Subcommittee	

Contents

Document Number	Title	Version
24	Pharmaceutical Services Regulatory [Sub] Committee Terms of Reference	V1-0
25	Individual Funding Requests (IFR) Panel Terms of Reference	V1-0
26	NENC ICB Remuneration Guidance	V1-0
27	Mental Health, Learning Disabilities and Autism Sub-committee	V1-0

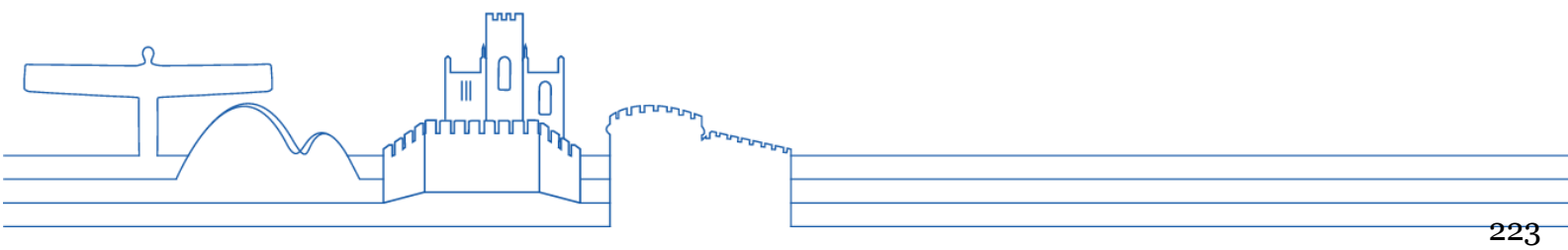
Item: 12.1
Appendix 1

NHS
North East and
North Cumbria

NHS North East and North Cumbria

Scheme of Reservation and Delegation

Draft Version 5-0, TBC



Schedule of Matter Reserved to NHS North East and North Cumbria and Scheme of Delegation

Introduction

The arrangements made by the North East and North Cumbria, hereafter referred to as the Integrated Care Board (ICB) for the reservation and delegation of decisions are set out in this scheme of reservation and delegation.

The ICB remains accountable for all its functions, including any that it has delegated.

Table of Contents

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Regulation and Control						
Constitution 1.6	Consideration and approval of applications to NHS England on any matter concerning changes to the ICB's constitution, including arrangements for taking urgent decisions, and standing orders	✓ Approval of proposed changes		✓ Chair and/or Chief Executive may periodically propose amendments to the constitution		
Constitution 1.6.2	Approve Constitution (including Standing Orders)	✓ Approves (subject to NHS England approval)			✓ NHS England	
Constitution 4.4.2	Approve the ICB scheme of reservation and delegation (SoRD) and amendments to the SoRD	✓ Approves	✓ Audit Committee (Recommends)	✓ Chief Executive (Prepares)		
Constitution Appendix 2, Section 5	Suspension of Standing Orders			✓ Chair in discussion with at		

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				least two other members		
Constitution Appendix 2, 4.9.4	Urgent Decisions			✓ Chair and Chief Executive (or relevant lead director in the case of committees)		In the first instance, every attempt will be made for the Board to meet virtually. Where this is not possible, the delegation to the Chair and Chief Executive (or relevant lead director in the case of committees) applies. The exercise of such powers shall be reported to the next formal meeting of the board for formal ratification and the Audit Committee for oversight
	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.	✓				

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Constitution 4.6	Establish ICB Committees, Subcommittees, and Joint Committees	✓ Board approves the establishment of ICB Committees. Board approves ICB Committees terms of reference. Board and partners approve the establishment of Joint Committees and their terms of reference.	✓ Parent Committees approve the establishment of subcommittees and their terms of reference			Definition: A Committee is established by and accountable to the ICB Board. A Subcommittee is established by the relevant parent Committee and accountable to its parent Committee. Parent Committees Audit Committee; Finance, Performance and Investment Committee; Quality and Safety Committee; Remuneration Committee; and Executive Committee
	Approve the ICB operating framework	✓ (Approves)		✓ Chief Executive (Recommends)		
	Approve the ICB operating structure	✓ (Approves)		✓ Chief Executive (Recommends)		

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Constitution 1.4 Health and Care Act 14Z32 to 14Z44 and 14Z49	Approve the arrangements for discharging the ICB's functions including but not limited to: a) Having regard to and acting in a way that promotes the NHS Constitution (14Z32) b) Exercising its functions effectively, efficiently, and economically (14Z33) c) Securing continuous improvement in the quality of services (14Z34) d) Reducing inequalities (14Z35) e) Promote involvement of each patient (14Z36) f) Patient choice (14Z37) g) Obtaining appropriate advice (14Z38) h) Promote innovation (14Z39)	✓				

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	j) Research (14Z40) k) Education and training (14Z41) l) Promote integration (14Z42) m) Duty to have regard to effect of decisions (14Z43) n) Duties as to climate change etc (14Z44) o) Duty to keep experience of members under review (14Z49)					
Constitution 1.4.5 c-g	Approve the arrangements for discharging the ICB's statutory duties, including but not limited to: 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)	✓				

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	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 h) Serious violence duty through the Police, Crime, Sentencing and Courts (PCSC) Act 2022. The ICB is a 'specified authority'					See section 11 of, and Schedule 1 to, the Police, Crime, Sentencing and Courts Act 2022 for the definition of specified authorities - for the health sector these are Integrated Care Boards in England
Constitution 3.3.1	Appointment of ICB Chair				✓ NHS England, with the approval of the Secretary of State	

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Constitution 3.4.1 and 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 NHS England in accordance with any procedure published by NHS England
	Exercise or delegation of those functions of the ICB which have not been retained as reserved by the ICB Board, delegated to a committee or sub-committee or specified individual			✓ ICB Chief Executive		
Constitution 3.5.4, 3.6.5, 3.7.4	Appointment of Partner Member/s: • Trusts • Primary Medical Services • Eligible Local Authorities			✓ Approval ICB Chair*		*Supported by an Appointment Panel

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Constitution 3.8.3, 3.9.3, 3.10.3, 3.12.3	Appointment of: • Executive Medical Director • Executive Chief Nurse • Executive Director of Finance • Other Executive Board Members			✓ Appointed by ICB Chief Executive* ✓ Approval ICB Chair		*Supported by an Appointment Panel
Constitution 3.11.2	Appointment of Independent Non-Executive Member/s			✓ Approved by ICB Chair*		*Supported by an Appointment Panel
	Approve the System Collaboration and Financial Management Agreement	✓ (Approves)	✓ Finance, Performance and Investment Committee (Recommends)			In consultation with partners
Constitution 1.7.3 (c)	Approve Standing Financial Instructions (SFIs), Financial Delegations and Financial Limits	✓ (Approves)	✓ Audit Committee (Recommends)	✓ Executive Director of Finance (Prepares)		

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	Approval of individual funding requests in accordance with the ICB policy		✓ IFR Panels[2]		✓ Individual members appointed as decision makers (as approved by the Executive Medical Director) to make decisions on behalf of the ICB relating to individual funding requests, in line with ICB Policy[1]	[1]Appointed decision makers may make decisions not reserved to the IFR Panels. [2]The IFR Panels are subcommittees of the Executive Committee
Standing Orders, Section 6	Set out who can execute a document by signature / use of the seal	✓ In approving Standing Orders		✓ Authorised to authenticate the use of the seal by their signature: - ICB Chair - Chief Executive - Executive Director of Finance		

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Appoint ICB: • Caldicott Guardian • Conflicts of Interest Guardian • Senior Information Risk Officer • Data Protection Officer • Chief Information Officer • EPRR Accountable Emergency Officer			✓ ICB Chief Executive		
	Approve Patient Group Directions			✓ ICB Medical Director, following review by the Quality and Safety Committee		
Strategy and Planning						
	Agree the vision, values, and overall strategic direction of the ICB	✓				
	Approving the strategy for improving population health and reducing health inequalities	✓				Having regard to the Integrated Care Partnership, Integrated Care Strategy

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Approve the Commissioning Strategy	✓ (Approves)	✓ Executive Committee (Recommends)			
Health and 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 and Investment Committee in the development of the plan
	Complementary to the System Plan, agree a plan to meet the health and healthcare needs of the population within each place	✓ (Approves)		✓ Executive Area Director (Recommends)		
	Approval of the ICB's non-programme budgets	✓ (Approves)	✓ Executive Committee (Recommends)			
	Approval of the ICB's programme budgets	✓ (Approves)	✓ Executive Committee (Recommends)			

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Approval of the capital plan for the ICB and partner NHS Foundation Trusts across the ICS	✓ (Approves)		✓ Executive Director of Finance (Recommends)		Finance, Performance and Investment Committee will seek assurance around the development and delivery of the capital plan
	Develop an approach to distribute ICB resources through commissioning and direct allocation to drive agreed change based on the ICB strategy	✓ (Approves)	✓ Finance, Performance and Investment Committee (Recommends)			
	Approve all ICB programme costs	✓ Approved by the Board or as delegated in accordance with financial delegations and financial limits	✓ Executive Committee*	✓ Refer to financial delegations*		*Contracts will be approved by either the ICB Board, Executive Committee, or relevant individual in accordance with the financial delegations and financial limits
	Approve all ICB non-programme costs	✓ Approved by the Board or as delegated in	✓ Executive Committee*	✓ Refer to financial delegations*		* Non-programme contracts will be approved by either the ICB Board, Executive Committee, or relevant

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		accordance with financial delegations and financial limits				individual in accordance with the financial delegations and financial limits.
	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 and Investment Committee (Recommends)			
	Approve a Performance and Outcomes Framework for Providers	✓ (Approves)	✓ Executive Committee (Recommends)			
	Monitor provider performance against contract and report material exceptions to the Board		✓ Executive Committee			
	Agree arrangements regarding the System Oversight Framework		✓ Executive Committee			
	Approval of variations to annual planned budgets	✓	✓	✓		*Variations to budgets will be approved by the

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		Approved by the Board or as delegated in accordance with financial delegations and financial limits	Finance, Performance and Investment Committee*	Refer to financial delegations*		Board, or Finance, Performance and Investment Committee, or an individual, in accordance with financial delegations and financial limits.
	Approval of variations to non-programme contracts	✓ Approved by the Board or as delegated in accordance with financial delegations and limits	✓ Executive Committee*	✓ Executive Director*		*Variations to non-programme contracts will be approved by the Board, or Executive Committee, or an Executive Director, in accordance with financial delegations and financial limits.
	Approval of variations to programme contracts	✓ Approved by the Board or as delegated in accordance with financial delegations and 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

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	In accordance with ICB policy, lead significant service reconfiguration programmes to achieve agreed outcomes	✓ (Approves)	✓ Executive Committee (Assurance)	✓ Executive Director (Recommends)		In leading service reconfiguration, the ICB will work with providers at scale and place
	Planning and commissioning of services (to include procurement and evaluation strategies and recommended bidder reports).	✓ Approved by the Board or as delegated in accordance with financial delegations and limits	✓ Executive Committee*	✓ Executive Director*		* Approval by the Board, or Executive Committee, or an Executive Director. in accordance with financial delegations and financial limits
Delegation agreement	Specialist Commissioning delegation from NHS England Approve decisions on the review, planning and procurement of specialist commissioned services (consistent with the terms of the delegation agreement with NHS England)		✓ Executive Committee			

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Delegation agreement	Primary Care Services delegation from NHS England Approve decisions on the review, planning and procurement of primary care services (consistent with the terms of the delegation agreement with NHS England)	✓ Primary Care Services Approval of strategies as shown in Appendix **2b**	✓ Primary Care Services Delegation to the Primary Care Strategy and Delivery Sub Committee as shown in Appendix **2c (1-4 and 6)** ✓ Primary Medical Services Delegation to the to ICB sub committees at Place as shown in Appendix **2d**	✓ Primary Medical Services - delegation to ICB Chief Executive or Executive Director of Finance or ICB Chair as shown in Appendix **2a**		Primary Care Services consists of: • Primary Medical Services • Pharmacy • Optometry • Dentistry
Delegation Agreement	Pharmaceutical Services delegation from NHS England Determination of applications submitted under the NHS (Pharmaceutical Services)		✓ Primary Care Services Delegation to the Pharmaceutical Services			*The Pharmacy Manual complements the Regulations and any Directions issued by the Secretary of State for Health and Social Care and should

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Regulations 2005 (as amended), which fall to be determined by virtue of the transitional provisions set out in the Pharmacy Manual, Version 2, 10 February 2023*		Regulations (sub) Committee as shown in Appendix **2c(5)***			be read alongside them (and not in place of them). Where any discrepancy or contradiction between the content of this manual and the Regulations/Directions is identified, the legal underpinning documents (i.e., regulations/directions, etc) are to take precedence
	Primary Care Services – Urgent Decisions			✓ ICB Senior Responsible Officer (SRO) for Primary Care Services or his/her named deputy		See Appendix 2
	Primarey Medical Services – Special Allocation Scheme, decisions on reviews and commissioner instigated removals			✓ ICB Medical Director		

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Workforce planning		✓ Executive Committee			
	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 Director Lead for People (System leadership)		
	Agree system-wide strategy and action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services .	✓ (Approves strategy)	✓ Executive Committee (Monitors)	✓ Executive Chief Digital and Information Officer (System leadership)		

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	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 Report and Accounts						
	Approval of the ICB's annual report and annual accounts	✓ (Approves)	✓ Audit Committee (Assurance)			
Human Resources						
	Code of Conduct for staff (titled: Standards of Business Conduct Policy and Declarations of Interest policy and procedures)	✓ Approves	✓ Executive Committee (Recommends)			

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Constitution3.14	Approve the arrangements for determining the terms and conditions, remuneration and travelling or other allowances for Board members, employees and others who provide services to the ICB, including pensions and gratuities.	✓ In approving Terms of reference of Remuneration Committee			✓ NHS England (Terms of appointment of the Chair will be determined by NHS England)	
Constitution 3.14	Approve the terms and conditions, remuneration and travelling or other allowances for Board members, including pensions and gratuities (subject to Prime Minister limit)	✓ (The Panel of the Board determines Remuneration for Non-Executive Members)	✓ ICB Remuneration Committee (Approves all except those delegated to the Panel of the Board or NHS England)		✓ NHS England (Remuneration for the Chair will be set by NHS England)	The Panel of the Board comprises the Chair, Chief Executive and Executive Director Lead for People
	Approve the terms and conditions, remuneration and travelling or other allowances for employees of the ICB and to other persons providing services to the ICB		✓ ICB Remuneration Committee			
	Approve arrangements for staff appointments		✓ Executive Committee (Approves)	✓ Executive Director Lead for People (Prepares)		

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Changes to staffing establishment, Tier 1			✓ Director (Approves)		Tier 1 Definition Exact like-for-like replacement of a leaver or any changes to post, grade or WTE with positive financial implications (i.e., a reduction in cost). This can be approved by the relevant place-based or corporate Director (i.e., a director who reports to an executive director)
	Changes to staffing establishment, Tier 2			✓ Executive Director (Approves)		Tier 2 Definition Backfill for maternity, secondments or sickness absence; temporary acting up where funding is already available; and hosted/seconded-in posts where funding is already available. These can be approved

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
						by the relevant Executive Director
	Changes to staffing establishment, Tier 3		✓ Executive Team (Approves)			Tier 3 Definition Any changes to post, grade or WTE with negative financial implications (i.e., an increase in cost); permanent re-gradings; agency workers; and any other changes not covered in Tiers 1 or 2. Changes of this type can only be approved by the Executive Team.
Quality and Safety						
	Approve arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes		✓ Quality and Safety Committee			
	Provide the ICB with assurance that it is delivering its functions in a way that delivers high quality safe patient care in commissioned services and secures continuous improvement in the quality of services		✓ Quality and Safety Committee (assures the Board)			Quality and Safety Area Sub Committees will review quality and safety issues and escalate any concerns

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
						or issues to the Quality and Safety Committee.
Operational and Risk Management						
	Approve the appointment of Internal Auditors		✓ Audit Committee (Approves)	✓ Executive Director of Finance (Recommends)		
	Approve the appointment of External Auditors	✓ (Approves)	✓ Auditor Panel (Recommends)			Note: the Auditor Panel is made up wholly of Audit Committee members (see Audit Committee Terms of Reference)
	Approve the ICB's counter fraud and security management arrangements	✓ (Approves)	✓ Audit Committee (Recommends)			
	Approve the ICB's risk management arrangements	✓ (Approves)	✓ Executive Committee (Recommends)			

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Approve the ICB's arrangements for managing conflicts of interest	✓				In proposing ICB Constitution to NHS England
	Establish a comprehensive system of internal control across the ICB		✓ Executive Committee			
	Approve arrangements for action on litigation against or on behalf of the ICB		✓ Executive Committee			
	Approve arrangements for planning, responding to and leading recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England		✓ Executive Committee			
	Approve the ICB's arrangements for handling complaints		✓ Executive Committee			

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Approve arrangements for ensuring the ICB has an integrated approach to the management standards of health and safety and has appropriate strategy and policies in place		✓ Executive Committee			
	Approve arrangements for complying with the NHS Provider Selection Regime		✓ Executive Committee			
	Approve Communications and Engagement Strategy	✓ (Approves)	✓ Executive Committee (recommends)			
	Approve and implement the ICB's information governance policies, including handling Freedom of Information requests, ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data		✓ Executive Committee			

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	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 human resources policies for employees and for other persons working on behalf of the ICB	✓ ~~(Approves)~~	✓ Executive Committee (~~Recommends~~) (Approves)	✓ Executive Director Lead for People (Prepares)		
	Approve clinical, quality and safety policies		✓ Quality and Safety Committee			
	Approve corporate policies (unless specified elsewhere)		✓ Executive Committee			
	Approve ICB standard operating procedures (SOPs)			✓ Directors, as relevant to their function		
	Approve the risk management strategy		✓ Executive Committee			

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change)		✓ Remuneration Committee			
	Approve the complaint's policy		✓ Executive Committee			
	Approve health and safety policies		✓ Executive Committee			
	Approve information governance policies		✓ Executive Committee			
	Approve the value based commissioning policy		✓ Executive Committee			

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Partnership Working						
Integrated care boards Guide to developing a SoRD, page 9	Approve arrangements for coordinating supra* commissioning arrangements with other ICBs or with local authorities, where appropriate	✓ (Approves)	✓ Executive Committee (Recommends)			*Where one service provider spans more than one ICB
Constitution 4.3.2 – 4.3.3 and 4.7	Authorisation of arrangements made under section 65Z5 or section 75 of the 2006 Act	✓ Approved by the Board or as delegated in accordance with financial delegations and financial limits	✓ Executive Committee*	✓ Refer to financial delegations*		*Arrangements will be approved by either the ICB Board, Executive Committee, or relevant individual in accordance with the financial delegations and financial limits See Table 1
	Approve decisions that individual members or employees of the ICB participating in joint arrangements on behalf of the ICB can make	✓				Such delegated decisions must be disclosed in this scheme of reservation and delegation

Table 1: Key legislative mechanisms for collaborative working

Mechanism for collaboration	Organisations	Description of mechanism
Section 65Z5 delegation	NHS England, ICBs, NHS trusts and foundation trusts	This is a voluntary arrangement whereby NHS organisations listed under s65Z5 delegate responsibility for carrying out specific functions to other listed NHS organisations and/or to local authorities (LAs) and/or to combined authorities (Cas). There are some constraints on what functions can be delegated and how these delegations are made, which are set out in the 2022 Regulations and in Annex E of the statutory guidance. NHS organisations cannot delegate their functions to non- statutory, non-public organisations (that is, independent or voluntary sector providers). LAs and CAs cannot delegate their functions to statutory NHS organisations using this mechanism – although they can receive delegated responsibility for the functions of NHS organisations under s65Z5 arrangements. For delegation of LA functions, see s75 arrangements below.
Sections 65Z5 and 65Z6 joint exercise arrangements	NHS England, ICBs, NHS trusts and foundation trusts	Two or more NHS organisations within the scope of s65Z5 can choose to come together (including via a joint committee) to make legally binding decisions and pool funds across agreed functions. Any constraints on how these arrangements are made and which functions can be part of them are set out in the 2022 Regulations and in Annex E of the statutory guidance. LAs and CAs can be part of these arrangements – but they cannot include their own functions in any joint decision- making using this mechanism. Joint working between Las and NHS organisations, including for LA functions, can be achieved using s75 and s65Z5 arrangements.
Section 75 partnership arrangements	NHS England and/or ICBs with LAs and/or CAs NHS trusts and/or foundation trusts with LAs and/or CAs	Section 75 partnership arrangements are a longstanding collaboration mechanism under the 2006 Act. These enable collaborative working between at least one NHS organisation (NHS England/ICB **or** NHS trust/foundation trust) and at least one LA to exercise or delegate a range of the NHS organisation's functions and the LA's health-related functions. Any delegation/joint exercise of health-related LA functions to/with NHS organisations will continue to be achieved using the powers in s75 of the 2006 Act and the associated partnership arrangement

Mechanism for collaboration	Organisations	Description of mechanism
		regulations. The 2022 Act requires ICPs to consider the use of section 75 arrangements in preparing their strategy for their system.
Conferral of discretions	NHS England, ICBs, NHS trusts and foundation trusts	This provision has been included to make clear the lawful scope of contractual arrangements between commissioners and providers. It confirms that a commissioner can lawfully give providers a wide degree of latitude as to the services they provide under a contract, both in terms of which services are delivered and how they are delivered, so as to resolve any doubt on this issue. The commissioner will still set the broad scope of what the provider is expected to achieve (clinical outcomes, for example) under a contract. A contract that confers discretion on a provider in respect of some or all services under the contract may be a useful alternative or precursor to delegation to trusts or foundation trusts under s65Z6.

[Extract from publication reference PR1560 - Statutory guidance: Arrangements for delegation and joint exercise of statutory functions, Guidance for integrated care boards, NHS trusts and foundation trusts (September 2022)]

Appendix 1

Committees and Sub Committees of NHS North East and North Cumbria Integrated Care Board (ICB)

1. Committees

The ICB has established the following Committees

- Audit Committee
- Remuneration Committee
- Finance, Performance, and Investment Committee
- Quality and Safety Committee
- Executive Committee

2. Subcommittees

The ICB has established the following subcommittees:

- Healthier and Fairer Advisory Group (subcommittee)
- Individual Funding Requests Panel (subcommittee) x 2
- ICB subcommittees at place
- Primary Care Strategy and Delivery
- Medicines
- Safeguarding
- Quality and Safety (Area) x 4
- Pharmaceutical Services Regulatory [sub] Committee
- Antimicrobial Resistance and Healthcare Associated Infection
- Mental Health, Learning Disabilities and Autism

3. Joint Committees

The ICB and Partners have established the following joint committees:

North East and North Cumbria Integrated Care Partnership (ICP), and the following Area ICPs:

- **North Area** Integrated Care Partnership (ICP)
- **Central Area** Integrated Care Partnership (ICP)
- **Tees Valley Area** Integrated Care Partnership (ICP)
- **North Cumbria Area** Integrated Care Partnership (ICP)

Appendix 2

Primary Care Services: Allocation of Roles and Responsibilities within the ICB

Delegation of Primary Care Services from NHS England (NHSE) to NHS North East and North Cumbria Integrated Care Board (the ICB)

These tables set out how the ICB has delegated responsibilities within the organisation.

~~Accountability for Pharmacy, Optometry, and Dentistry was delegated to the ICB from 1 April 2023.~~

~~The Primary Care Services delegation is from NHS England to NHS North East and North Cumbria ICB. The ICB has not delegated decisions outside of the ICB (see Primary Care Delegation Agreement Frequently Asked Questions 29 July 2022 – Version 2, Publication reference: PR1749).~~

~~For the period 1 April 2023 to 30 June 2023, NHS England staff supporting pharmacy, optometry, and dentistry on behalf of the ICB may not make decisions and instead must make recommendations to the Primary Care Strategy and Delivery Subcommittee or the Pharmaceutical Services Regulations [Sub] Committee (as appropriate) for decision.~~

~~Where a decision is urgent, the Board has determined that the Senior Responsible Officer (SRO) for primary care services or his/her named deputy may make primary care services urgent decisions for reporting to Primary Care Strategy and Delivery Subcommittee or the Pharmaceutical Services Regulations [Sub] Committee (as appropriate), or formal ratification by the Executive Committee in line with financial limits.~~

Appendix 2a

Primary Care Services - delegation to ICB Chief Executive or Executive Director of Finance or ICB Chair

Reference	Delegation	NHS England Approval
1	Taking any step or action in relation to the settlement of a Claim, where the value of the settlement exceeds £100,000	NHS England Head of Legal Services and Local NHS England Team Director or Director of Finance
2	Any matter in relation to the primary care Delegated Functions which is novel, contentious or repercussive	Local NHS England Team Director or Director of Finance or NHS England Region Director or Director of Finance or NHS England Chief Executive or Chief Financial Officer
3	The entering into of any Primary Care Services Contract which has or is capable of having a term which exceeds five (5) years	Local NHS England Team Director or Director of Finance

Appendix 2b

Primary Care Services – reserved to ICB Board

Reference	Delegation
1	Approval of strategies

Appendix 2c(1)

Primary Care Services - delegation of Primary Care Services to Primary Care Strategy and Delivery Subcommittee: **GENERIC**
(decisions by subcommittees are limited to the financial limits of the most senior ICB officer present)

Reference	Delegation
1	Occupational health contract commissioning and management
2	Escalation of disputes
3	Forward plans for all functions
4	Enabler plans for all functions including estates, workforce and digital
5	Local professional network proposals (for decision)
6	Decisions in respect of Quality Assurance Frameworks
7	Commissioning needs analysis and commissioning of ad-hoc primary care services
8	Decisions in respect of investigations (commencement and outcome excluding Primary Medical Care Services)
9	Clinical Waste contract commissioning and management

Appendix 2c(2)

Primary Care Services - delegation to Primary Care Strategy and Delivery Subcommittee - **OPTOMETRY**
(decisions by subcommittees are limited to the financial limits of the most senior ICB officer present)

Reference	Delegation
1	Primary Care Audits - Assurance Framework outcome
2	Optometry National and Local Enhanced Services commissioning and contracting
3	New optometry contracts
4	Variations decisions affecting existing contracts

Appendix 2c(3)

Primary Care Services - delegation to Primary Care Strategy and Delivery Subcommittee - **DENTISTRY**

(decisions by subcommittees are limited to the financial limits of the most senior ICB officer present)

Reference	Delegation
1	Commissioning needs analysis for dental services
2	Primary Care Audits - Assurance Framework
3	Dental National and Local Enhanced Services commissioning and contracting
4	New dental contracts
5	Variations decisions affecting existing contracts with exception of those noted in Appendix 2e

Appendix 2c(4)

Primary Care Services - delegation to Primary Care Strategy and Delivery Subcommittee – **PHARMACY**

(decisions by subcommittees are limited to the financial limits of the most senior ICB officer present)

Reference	Delegation
1	Primary Care Audits- Community Pharmaceutical Assurance Framework (CPAF)
2	Community Pharmacy National and Local Enhanced Services commissioning and contracting
3	Pharmacy Integration Fund decisions

Appendix 2c(5)

Pharmaceutical Services - Delegation to the Pharmaceutical Services Regulations [Sub] Committee - **PRSC**

(decisions by subcommittees are limited to the financial limits of the most senior ICB officer present)

Reference	Delegation
1	Determination of applications (current and future) with exception of those listed in Appendix 2f
2	Determination of controlled localities including 'serious difficulty' applications with exception of those listed in Appendix 2f
3	Contract commissioning, performance, and management decisions
4	Designation, review, and cancellations relating to LPS areas with exception of those listed in Appendix 2f
5	Fitness to practice
6	Disputes and appeals with exception of those listed in Appendix 2f

Please refer to the NHS Pharmacy Manual 2023 for full detail breakdown on regulations

Appendix 2c(6)

Primary Medical Services - delegation to Primary Care Strategy and Delivery Subcommittee:

(decisions by subcommittees are limited to the financial limits of the most senior ICB officer present)

Reference	Delegation
1	Decision to procure a new Primary Medical Services contract[1]
2	Decision to award (following procurement) of a new Primary Medical Services contract[1]
3	Interface and management of assurance to the ICB Executive Committee - ICB wide strategy development and delivery oversight
4	Govern and manage assurance of delegated commissioning from Place to ensure the ICB meets its duties in relation to delegation
5	Strategic oversight of Place operational planning, delivery and management in respect of Primary Medical Services
6	Interface and management of assurance to NHS England North East and Yorkshire region
7	Clinical waste contract oversight (General Practice)
8	National funding scheme development and oversight
9	Quality on Outcomes Framework (QOF) annual sign off of scheme and approval of payments

Reference	Delegation
10	Manage the design (where applicable) and commissioning of any regional services, including re-commissioning these services annually where appropriate
11	Decision making and budget management regarding primary care estates strategies and overarching revenue consequences
12	Decision making and budget management regarding primary care GPIT
13	Revenue decisions relating to premises (affecting more than one Place)
14	Decisions escalated from Place where it exceeds financial limits and risk

Notes
[1] For contracts which have or are capable of having a term which exceeds five (5) years, see Appendix 2a.

General Note
Any matter in relation to the primary medical delegated functions which is novel, contentious or repercussive must be referred to the ICB Chief Executive or Executive Director of Finance or ICB Chair (see Appendix 2a)

Appendix 2d

Primary Medical Services - ICB subcommittee at place

(decisions by subcommittees are limited to the financial limits of the most senior ICB officer present)

Reference	Delegation
1	Management of delegated funds in relation to Primary Medical Services
2	Assessing quality and outcomes (including clinical effectiveness, patient experience, patient safety and addressing inequalities) in collaboration with others in the ICB with responsibility for quality and safety
3	Take decisions relating to dispersing the patient lists of Primary Medical Services Providers at place
4	Approving Primary Medical Services closures including branch closures[1]
5	Manage the Primary Medical Services Contracts and perform all NHSE's obligations under each of the Primary Medical Services Contracts
6	Planning Primary Medical Services including carrying out needs assessments[1]
7	Undertaking reviews of Primary Medical Services
8	APMS contract management

Reference	Delegation
9	Actively manage each of the relevant Primary Medical Services Contracts including agreeing local prices, managing agreements or proposals for local variations and local modifications
10	Commissioning Needs Analysis for Primary Medical Services contracting[1]
11	Disputes
12	Estates (Primary Care)[1]
13	General Practice investigations (for sanctions see Appendix 2a)
14	Home Office Resettlement Schemes
15	Local Resilience Schemes/Support for General Practice Contractors
16	Mergers, boundary changes, list closures, incorporations[1]
17	Patient list management and allocations
18	Primary Care Network (PCN) contracting and commissioning[1]
19	Local Primary Care workforce plans[1]
20	Collation of General Practice data/information; performance management and quality assurance of General Practice
21	Management of Quality and Outcomes Framework (QOF)[2]
22	Winter pressures – primary care
23	Operational Plan
24	Access
25	Manage the design (where applicable) and commissioning of any Local Enhanced Services, including re-commissioning these services annually where appropriate
26	Design and offer Local Incentive Schemes for Primary Medical Services Providers, sensitive to the differing needs of their particular communities. This includes in addition to or as an alternative to the national contractual frameworks (including as an alternative to QOF or Enhanced Services), provided that such schemes are voluntary, and the ICB continues to offer the national schemes.
27	Make decisions on Discretionary Payments or Support at place (subject to available budget)
28	Manage Primary Medical Services Providers providing inadequate standards of patient care at place
29	Revenue decisions relating to premises[1]
30	General Practice sanctions
31	Decision to extend an existing Primary Medical Services contract in accordance with contract terms

Notes

[1] Must be escalated for action or decision to the Primary Care Strategy and Delivery Subcommittee where the action/decision would impact across more than one place.
[2] For authorisation of QOF annual scheme and approval of payments see Appendix 2c(2)

General Note
Any matter in relation to the primary care delegated functions which is novel, contentious or repercussive must be referred to the ICB Chief Executive or Executive Director of Finance or ICB Chair (see Appendix 2a) via the Primary Care Strategy and Delivery Subcommittee and the Executive Committee.

Appendix 2e

Primary Care Dental Services – decisions delegation to an ICB Primary Care Officer or Manager

Reference	Delegation
1	Contract delivery performance: • mid year reviews and agreement of action plans (including issuing of remedial and breach notices for non-compliance with submission of action plans) • end of year performance review and reconciliation including decisions on adverse events/exceptional circumstances/force majeure requests for dental relief (greater carry forward of activity) and issuing of breach notices for under-performance of contract activity. NB: decisions on sanctions, other breach notices (excluding the year end under-performance) and withholding of payments to be escalated to PCSDSC
2	Contractor disputes /appeals– requirement to escalate should local resolution fail
3	Contract variations (decisions and signing of variation notices) limited to: • 24 hour retirements; • Change of ownership/legal entity (excluding incorporation/dis-incorporations and contract novations which would be escalated to PCSDSC for decision) • Changes of opening hours (where there is no overall contractual reduction in hours) • Changes of activity (where activity change is within total contract value) • Minor relocation (within 5 miles) • Mergers where the same legal entity ensues
4	Management of practice/performer issues identified via the Dental Assurance Framework or contract monitoring process (including decision on undertaking further investigation ie practice visit/record card checks etc.
5	Orthodontics – decision on 2nd course of treatment (following national guidance within dental policy book)

Appendix 2f

Primary Care Pharmaceutical Services – decisions delegation to an ICB Primary Care Officer or Manager

Reference	Delegation
1	Change of ownership applications (Reg 26)
2	Temporary arrangements during emergencies or because of circumstances beyond the control of NHS chemists (Reg 29)
3	Deferrals arising out of LPS designations (Reg 32)
4	Serious difficulty applications (Reg 48)
5	Applications to increase core opening hours (Reg 65)
6	Decisions under the following paragraphs of Schedule 2 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 Para 1 (10) Para 11 (1) and 2 (b) Para 14 Para 19 Para 22 (2) Para 28 Para 30 Para 31 Para 32 Para 33 Para 34 Para 35
7	Decisions under the following paragraphs of Schedule 4 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 Para 27 Para 27B Para 28A
8	Decisions under the following paragraphs of Schedule 5 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 Para 13 (6)
9	Determination of action where the contractor exceeds the maximum number of appliance use reviews that may be done in any one year

Appendix 2g

Primary Care Optometry Services – decisions delegation to an ICB Primary Care Officer or Manager

Reference	Delegation
1	Contract delivery performance –performance review and reconciliation (decisions on sanctions, breach notices and withholding of payments to be escalated to PCSDSC)
2	Contractor disputes – requirement to escalate should local resolution fail
3	Contract variations limited to: 24 hour retirements; Change of legal entity; Changes of opening hours (where there is no overall contractual reduction in hours) Minor relocations (within 5 miles)
4	Management of practice/performer issues identified via the Optometry Assurance Framework
5	Fitness to practice assessments for Directors

Appendix 3

Delegation Summaries

NHS North East and North Cumbria has entered into the following delegation agreements from NHS England:

Delegated Functions	Schedule	Effective Date of Delegation
Primary Medical Services Functions	Schedule 2A –	1 July 2022
Primary Dental Services and Prescribed Dental Services Functions	Schedule 2B –	1 April 2023
Primary Ophthalmic Services Functions	Schedule 2C –	1 April 2023
Pharmaceutical Services and Local Pharmaceutical Services Functions	Schedule 2D –	1 April 2023

NHS North East and North Cumbria has not delegated any of its functions to other organisations.

Appendix 4

REMUNERATION GUIDANCE

Introduction

This statement summarises NHS North East and North Cumbria Integrated Care Board's (the ICB) approach to staff remuneration.

The ICB Chair is appointed by NHS England with the approval of the Secretary of State. The ICB Chief Executive is appointed by the ICB Chair subject to approval of NHS England.

The ICB Chair approves the appointment of Board members.

Governance

The ICB has established a Remuneration Committee (made up wholly of non-executive director members) responsible for:

- Approving the terms and conditions, remuneration and travelling or other allowances for employees of the ICB and other persons providing services to the ICB. The ICB is guided by Agenda for Change.

- Approving the terms and conditions, remuneration and travelling or other allowances for Board members, including pensions and gratuities, except for the following:

- A Panel of the Board (comprising the Chair, Chief Executive and Executive Director lead for people) determines remuneration for non-executive members of the Board

- Remuneration for the ICB Chair is set by NHS England.

Where a conflict arises then the Chair will remove conflicted parties from the meeting.

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:
	  ○ sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act),
	  ○ sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act),
	  ○ paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), and
	  ○ 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.

North East and North Cumbria

Financial Limits

1. Introduction

1.1 The tables below set out the financial limits up to which officers of the Integrated Care Board may exercise executive functions. These financial limits form an integral element of the financial governance arrangements for the ICB as part of the detailed operational policies which support the scheme of reservation and delegation and prime financial policies.

1.2 Appendix 1 outlines the delegated limits to be provided to staff in North of England Commissioning Support (NECS) to ensure effective processing of transactions.

2. Administrative Budgets

2.1 Initial budgets and relevant contract values will be reviewed by the Finance, Performance and Investment Committee and approved by the ICB Board prior to the start of the financial year. The following limits will then apply to administrative budgets:

Limit	Authoriser
Over £5,000,000	Integrated Care Board
Up to £4,999,999	Executive Committee
Up to £1,999,999	ICB Chief Executive **and** ICB Executive Director of Finance **and** ICB Chair
Up to £1,000,000	ICB Chief Executive **and** ICB Executive Director of Finance
Up to £250,000	Individual ICB Executive Directors
Up to £100,000	Band 9 and VSM
Up to £50,000	Senior Managers (Band 8b-d)
Up to £10,000	Managers (Band 7 to 8a)

Invoices for less than £250: All invoices for less than £250 in total can be authorised by an approved member of the finance team without any further authorisation being required by relevant budget holders

3. Commissioning Budget and Functions

3.1 Contracts will be agreed at the start of the year through the Executive Committee and approved by the ICB Board.

3.2 Related requisitions will then be processed on the ISFE system for the agreed contract value and relevant invoices will then be processed without further authorisation being required (up to the requisition value).

3.3 Within this framework the following authorisation limits will then operate:

Limit	**Authoriser**
Over £30,000,000	Integrated Care Board
Up to £29,999,999	Executive Committee
Up to £4,999,999	ICB Chief Executive **and** ICB Executive Director of Finance **and** ICB Chair
Up to £2,999,999	ICB Chief Executive **and** ICB Executive Director of Finance **or** ICB Chief Executive **and** Executive Area Directors
Up to £1,000,000	Executive Area Directors and Finance Director
Up to £500,000	Individual ICB Executive Directors
Up to £250,000	Band 9 and VSM
Up to £75,000 Up to £150,000 *Responsible for approving all age continuing healthcare packages only**	Senior Managers (Band 8b-d) Deputy Directors of Nursing (Band 8d)
Up to £10,000 *Up to £75,000 Individual packages of care only **	Managers (Band 7 to 8a)
Up to £10,000	Nominated Officers for non-contract activity and individual funding requests

Invoices for less than £250: All invoices for less than £250 in total can be authorised by an approved member of the finance team without any further authorisation being required by relevant budget holders

Notes:

The limits above refer to individual contract values or individual contract variations (cumulative value over the life of the contract/variation, i.e. 3 year contract for £50,000 p.a. would be considered £150,000 in context of limits above). Where expenditure relates to individual packages of care, the limits above will apply to the annual package value.

Values represent total expenditure on each contract/variation (including where relevant any VAT not recoverable by the ICB).

The delegations noted above relate to the use of budgets approved by the ICB and within the individual's own areas of responsibility. Authorisation limits, based on these rules, will only be allocated to staff where this is appropriate to their role. Therefore not all staff at the banding levels listed above will be allocated these authorisation limits.

Managers (Band 7 to 8a) will have approval to agree individual packages of care up to £75,000 pa. This will also apply to relevant Band 6 case managers where agreed by Executive Director of Finance. This includes Continuing Healthcare packages, Funded Nursing Care, Section 117 healthcare, children's packages, joint funded packages.

These limits are also applicable for the approval of tenders, provided the relevant tender process has been fully complied with.

An operational authorised signatory list, confirming the relevant individuals holding delegated authority in line with the limits set out below, will be maintained by the ICB finance team and approved by the ICB Executive Director of Finance. This may include certain individuals employed by NECS to work on behalf of the ICB, in accordance with the delegated limits outlined below.

Relevant senior finance staff will have higher (in some cases unlimited) approval limits within the financial ledger system to enable the processing of high value orders/invoices relating to contracts which have been approved in line with the limits above.

Approval limits for the financial ledger system, including journal authorisation limits, will reviewed and approved by the Executive Director of Finance and included within the operational authorised signatory list. This list will be available for scrutiny by the Audit Committee as required.

Additional authorisation or procedure may be required for non-financial aspects of any planned expenditure or where exceptional arrangements are contemplated. It is the responsibility of the budget holder to ensure that any such authorisation has been obtained or procedure completed in advance of any financial commitment. Examples would be:

- expenditure requiring quotations, tenders or business case approval
- service change requiring clinical approval
- contracts of unusually long duration
- non-employed individuals where there may be taxation or employment rights issues requiring expert HR advice
- ex gratia or compensation payments, which have specific procedural requirements

APPENDIX 1

NECS Delegated Limits

1. Healthcare spend

1.1 Under the ISFE system, formal requisitions should be processed for healthcare payments in order for any payments to be made to providers. It is essential that we agree the boundaries in terms of what NECS can authorise on behalf of the ICB to ensure efficient processing of transactions whilst managing any potential financial risk to the ICB.

1.2 The scheme of delegation for the following key areas is as follows:

Contract Type	Signed contract by ICB?	Authorisation of requisition and receipting of service on a monthly basis	Contract Over / Under Performance
Acute / Community / Mental Health / 999 / PTS / contracts	Yes - Signed standard NHS contract is in place, which includes an agreed monthly payment profile	All requisitions can be processed by contract manager in line with rules as identified in the ISFE. This does not require additional authorisation from ICB.	Relevant NECS staff can authorise additional payment / credit up to £75,000 without additional authorisation from ICB for each contract. Amounts above £75,000 would require approval in accordance with ICB scheme of financial delegation. Excluded from the above is where a service is currently not commissioned from the provider. A variation appropriately authorised in accordance with the ICB scheme of financial delegation is required.
AQP	Yes - Signed standard NHS contract is in place with zero activity and financial value	All requisitions can be processed by contract manager in line with rules as identified in the ISFE. This does not require additional authorisation from ICB.	NECS can authorise additional payment / credit up to the overall budget agreed by ICB. Budgets will be reviewed monthly and reset where appropriate. If budget is exceeded, approval in accordance with the ICB scheme of financial delegation will be required for payment above 2% or £75,000 whichever is the lowest for each service line, e.g. AQP Adult Hearing (not provider level).
NCAs including PTS NCAs (all	No signed contract in place.	Requisition not required.	NECS can authorise additional payment / credit up to the overall budget agreed by the ICB.

Contract Type	Signed contract by ICB?	Authorisation of requisition and receipting of service on a monthly basis	Contract Over / Under Performance
other PTS will be covered above)			Budgets will be reviewed monthly and reset where appropriate. NCAs with an individual value above £10,000 will require approval in accordance with the ICB scheme of financial delegation. Emergency air ambulances / decompression chambers above £50,000 will require approval in accordance with the ICB scheme of financial delegation. PTS air ambulance/transport above £10,000 will require approval in accordance with the ICB scheme of financial delegation.
Enhanced Services	Yes – signed enhanced service agreement in place	All requisitions can be processed by contract manager in line with rules as identified in the ISFE. This does not require additional authorisation from ICB.	NECS can authorise additional payment / credit up to the overall budget agreed by ICB. Budgets will be reviewed monthly and reset where appropriate. If budget is exceeded, approval will be required for payment above £10,000 for each service line, e.g. minor aliments (not provider level).
Continuing Healthcare Agreements / Individual packages of care (including MH/LD and children's packages)	Yes - Signed standard NHS contract is in place with zero activity and financial value	All requisitions can be processed by contract manager in line with rules as identified in the ISFE. This does not require additional authorisation from ICB.	NECS can authorise additional payment / credit up to the overall budget agreed by the CCG. Budgets will be reviewed monthly and reset where appropriate. Individual continuing care packages above £75,000 (annual value) will require individual approval in accordance with the ICB scheme of financial delegation.
Local Authority Agreements	Yes - Signed section 256 or section75 in place	All requisitions can be processed by contract manager in line with rules as identified in the	NECS can authorise additional payment / credit up to the overall monthly budget agreed by ICB. Budgets will be reviewed monthly and reset where appropriate.

Contract Type	Signed contract by ICB?	Authorisation of requisition and receipting of service on a monthly basis	Contract Over / Under Performance
		ISFE. This does not require additional authorisation from ICB.	Only if the section 75 covers continuing health care, any individual continuing care packages above £75,000 will require individual approval in accordance with the ICB scheme of financial delegation.

2. Non-healthcare spend

2.1 It is suggested that the ICB delegates to NECS sufficient authority to allow NECS to make low value non-healthcare payments on behalf of the ICB. The proposed areas and levels of payment are as follows:

Payment Type	Value of delegated authority
Collaborative fees, blue badges, adoption forms etc	NECS can authorise individual payments up to £100.
Childcare vouchers	NECS can authorise individual payments where the cost to the ICB is up to £100.
Any other incidental expenditure	NECS can authorise individual payments up to a value of £1,000.

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Integrated Care Board
REMUNERATION COMMITTEE - TERMS of REFERENCE

1. Constitution

The Remuneration Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These terms of reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Authority

The Committee is authorised by the Board to:

- Investigate any activity within its terms of reference
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservation and

Delegation (SoRD) but may not delegate any decisions to such groups

For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions, and SoRD will prevail over these terms of reference other than the committee being permitted to meet in private.

The Committee may not establish any subcommittees without prior Board approval as stated in the Constitution and SoRD.

3. Purpose

The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. In summary:

- Confirm the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including board members) but excluding non-executive Board member directors[1] and excluding the Chair.

The Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

4. Membership and attendance

4.1 Chair and Vice Chair

In accordance with the constitution, the Committee will be chaired by an independent non-executive member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

Committee members may appoint a Vice Chair from amongst the other ICB non-executive director members.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

[1] Remuneration for Non-Executive Members will be set by a Panel, comprising the Chair, Chief Executive and Executive Chief Nurse.

4.2 Membership

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than three independent members of the Committee including at least two non-executive members of the Board. Other independent members of the Committee need not be non-executive members of the Board.

The Chair of the Audit Committee may not be a member of the Remuneration Committee.

The Chair of the Board may be a member of the Committee but may not be appointed as the Chair or Vice Chair.

When determining the membership of the Committee, active consideration will be made to diversity and equality.

The Board has determined the membership of the Remuneration Committee as:

- 3 Non-Executive Members of the Board (excluding the Audit Chair).

4.3 Attendees

Only members of the Committee have the right to attend committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:

- ICB Chief Executive or their nominated deputy
- ICB Executive Chief Nurse or their nominated deputy
- ICB Executive Director of Finance or their nominated deputy
- Director of Workforce or their nominated deputy
- Director of Corporate Governance and Board Secretary or their nominated deputy

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

No individual should be present during any discussion relating to:

- any aspect of their own pay
- any aspect of the pay of others when it has an impact on them

4.4 Attendance

Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable deputy may be agreed with the Chair.

5. Meetings Quoracy and Decisions

The Committee will meet in private.

The Committee will meet at least twice each year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

The Board, ICB Chair or Chief Executive may ask the Remuneration Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

5.1 Quorum

For a meeting to be quorate a minimum of two of the non-executive members is required, including the Chair or Vice Chair.

If any member of the Committee has been disqualified from participating on any item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

Where the meeting is not quorate, owing to the absence of certain members or due to conflicts of interest, the discussion will be deferred until such time as quoracy can be achieved. Where quoracy is not possible owing to the arrangements for managing conflicts of interest, the Chair of the meeting shall

consult with the Chair of the ICB to establish an appropriate course of action to progress the item of business. These arrangements must be recorded.

5.2 Decision making and voting

Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

6. Responsibilities of the Committee

The Committee's duties are as follows:

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 (decisions requiring dismissal shall be referred to the Board)

- Oversee the arrangements regarding performance to include succession planning for the executive team, diversity of the executive and performance of individual executives and team

- Receive assurances in relation to ICB statutory duties relating to people, such as compliant with employment legislation, including Fit and Proper

Persons Regulations.

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.

7. Behaviours and Conduct

7.1 Benchmarking and guidance

The Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care. NHS England and the wider NHS in reaching their determinations.

7.2 ICB values

Members will be expected to conduct business in line with the ICB values and objectives.

Members of, and those attending, the Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

7.3 Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

8. Accountability and reporting

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board.

The Remuneration Committee will submit copies of its minutes and a report to the Board following each of its meetings. Where minutes and reports identify individuals, they will not be made public and will be presented at part B (i.e. private meeting) of the Board. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.

The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

9. Secretariat and Administration

The Committee shall be supported with a secretariat function which will ensure that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead
- Records of members' appointments and renewal dates are kept and the Board is prompted to renew membership and identify new members where necessary
- Good quality minutes are taken in accordance with the standing orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept
- The Chair is supported to prepare and deliver reports to the Board
- The Committee is updated on pertinent issues/ areas of interest/ policy developments
- Action points are taken forward between meetings.

10. Review

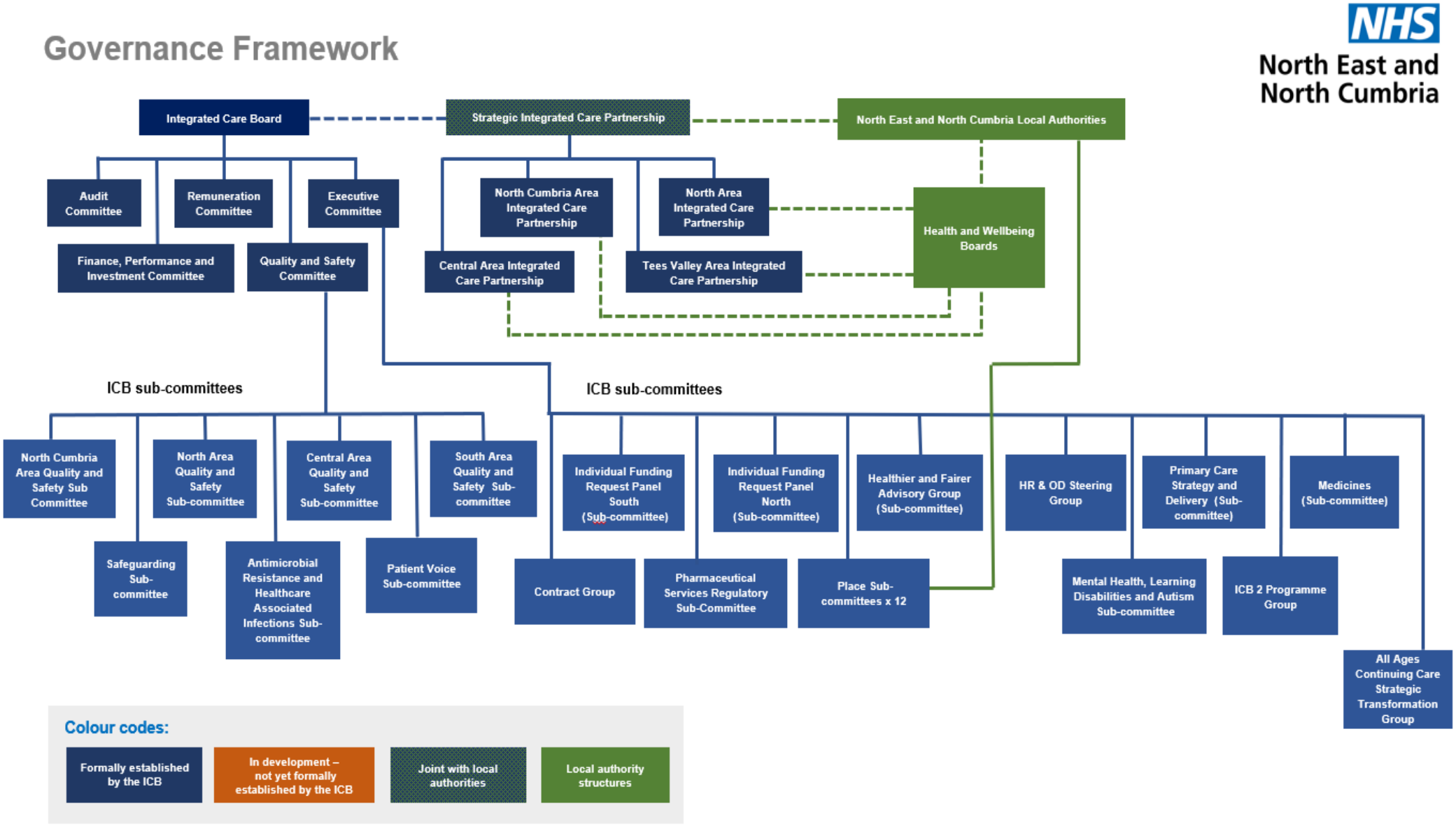
The Committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Version: Draft v2-0
Date of approval: 1 July 2022
Date of review: 30 May 2023

Item: 12.1
Appendix 4

NENC ICB Committee Structure V4-0



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Source: Governance Map 130623 Executive Committee

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Appendix 4

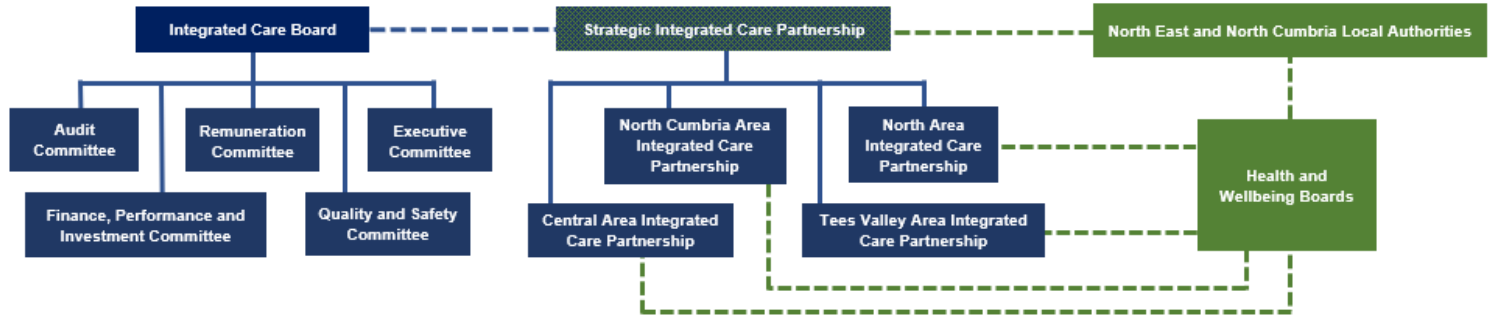
NENC ICB Committee Structure V4-0

Source: Governance Map 130623 Executive Committee

Item: 12.1
Appendix 4

NENC ICB Committee Structure V4-0

Governance Framework



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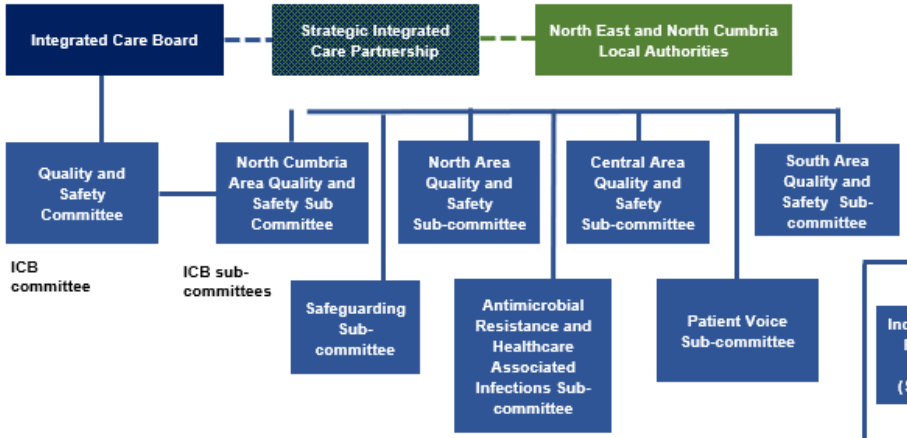
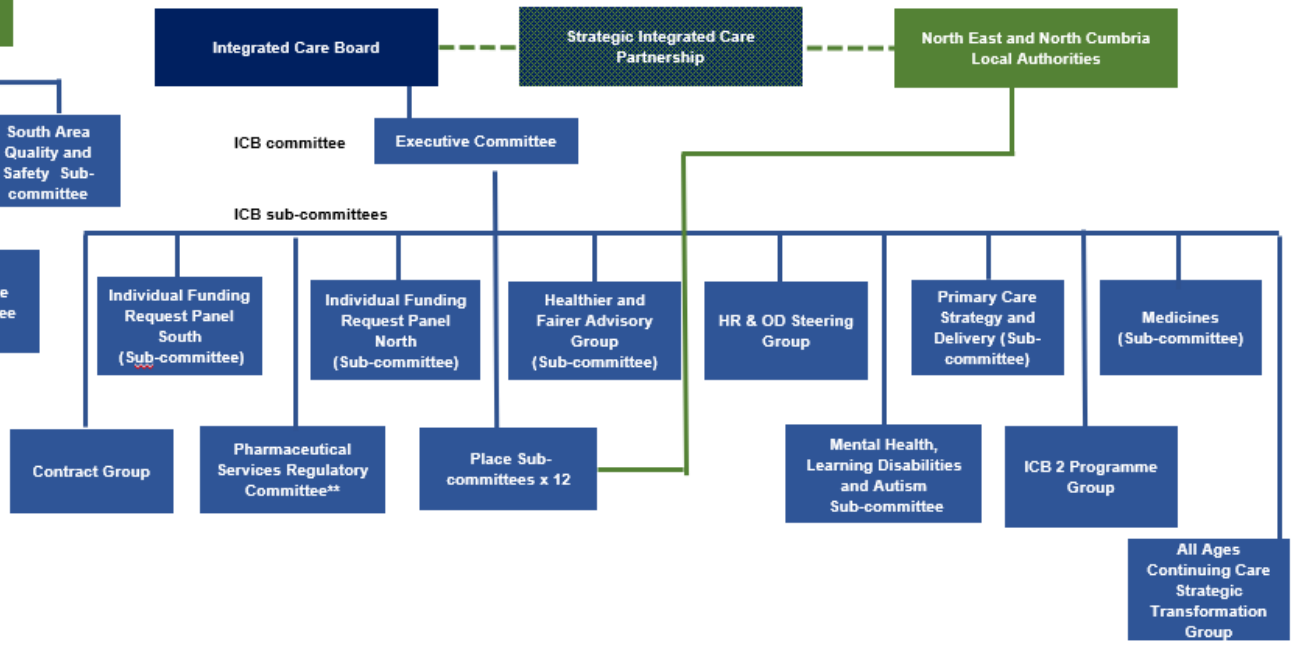
Colour codes:

- Formally established by the ICB
- In development – not yet formally established by the ICB
- Joint with local authorities
- Local authority structures

Quality and Safety Committee Governance Framework



Executive Committee Governance Framework



Source: Governance Map 130623 Executive Committee

Item: 12.2.1

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

BOARD 25 July 2023	
Report Title:	**Executive Committee Highlight Report and Confirmed Minutes**

Purpose of report

To provide the Board with an overview of the discussions and approved minutes from the Executive Committee meetings in May and June 2023.

Key points

The Executive Committee, chaired by Samantha Allen, Chief Executive, met on 9 May and 13 June 2023.

The key points to bring to Board's attention from each meeting are set out below.

9 May 2023

- **Winter Planning:** A report was received which provided the Committee with the impact of the interventions for Winter Operating Resilience 2022-23 for urgent and emergency care and progress against actions and impact which will inform future planning and provided an insight into what measurable impacts have been faced following actions taken during winter. Winter Planning priorities for 23/24 are being developed

- **Provider Collaborative Responsibility Agreement:** The Committee approved the Responsibility Agreement between the ICB and the NENC Foundation Trust Provider Collaborative which sets out the areas the ICB are requesting the provider collaborative to focus on

- **CQC Self-Assessment:** The Committee received a verbal update on the planning for the ICB CQC inspection and noted that there are three key themes for consideration, namely leadership, integration, and quality & safety. The CQC self-assessment will be submitted to the Committee once finalised

- **Branding Strategy:** The proposed refreshed branding strategy for 2023-24 was approved by the Committee which will provide a good opportunity to include partners and a co-branding approach. The relaunch date of 1 July 2023 was agreed which will align with the significant milestone of the ICB's first year of formation

- **Board Assurance Framework:** It was noted that there have been changes to the BAF for 2023/24, which have been aligned to the organisations risks and will include the four aims from the Better Health and Wellbeing for all Strategy. The Committee approved the submission of the BAF to a future meeting of the Board.

13 June 2023

- **Delivery of Prescribing Efficiencies 2023/24:** The Committee was asked to consider the recommendations outlined in the report on how the ICB should manage the prescribing budget and associated resources to best receive assurance about delivery of prescribing efficiencies, as well as ensuring consistent, high-quality outcomes. New technologies and approaches to using data across the population will be key to delivering efficiencies and reducing variation, therefore pilot use of a proactive tool to support this was proposed. The Committee supported the recommendations

- **Waiting Well Programme Plans for 2023/24 and 2024/25:** An update was presented on the latest position and a proposed plan for investment in 2023/24 and 2024/25 and how this programme can be safely contracted to maintain continuity of service for patients whilst balancing procurement risk. All places have submitted plans on how this will be delivered, budgets set based on the population in deciles one and two and the number of patients on priority four waiting lists. The Committee agreed to support the procurement approach with the agreement that medium term proposals are developed by the Healthier and Fairer Advisory Group for discussion at a future Executive Committee meeting

- **Covid Medication Delivery Units (CMDU) Update:** The Committee approved a short-term solution to service continuity due to concerns raised regarding the proposed changes to the commissioning and delivery of a NENC CMDU, noting that funding has been withdrawn however, the expectation is that the service will continue to be delivered albeit providers wish to cease delivery of the service. Further discussions will take place with NHS England (NHSE).

The confirmed minutes from the meetings held on 9 May and 13 June 2023 are attached as Appendix 1 and Appendix 2 respectively.

Risks and issues

- The ICB corporate risk log was discussed, and the Committee noted the organisations existing five top risks and the mitigating actions being put in place to address these
- The Committee discussed the NENC ICB and ICS finance report, noting there are several financial risks across the system still to be managed
- It was acknowledged that healthcare acquired infections are increasing which is being managed by the Quality and Safety Committee; a deep dive exercise will be carried out
- Waiting Well Programme Plans for 2023/24 and 2024/25 – noted that a full procurement process would cause significant risks to the delivery of the programme; patient safety risks of pausing service delivery need to be balanced with any procurement risk.

Assurances

The Committee also received several items for assurance, and these included:

- Executive area directors' reports (Tees Valley and Central, and North and North Cumbria) – an information and assurance summary report of business within respective areas
- 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

- Information Asset Register - a formal document provided the Committee with a brief update and overview of the Information Asset Register (IAR) for 2022/23
- Executive Committee Annual Report – a report which provided the Committee with the achievements and assurances the committee has gained throughout the year to demonstrate its roles and responsibilities, includes any risks identified as part of this work and gave assurance that the Committee met its terms of reference
- A risk management report – a position statement on the ICB's current risks
- Governance Assurance report - provided assurance on the governance processes in place to ensure safety and the organisation's effective management of governance
- The committee cycle of business for 2022/23.

Recommendation/action required

The Board is asked to receive the highlight report and confirmed minutes for the Executive Committee meetings held on 9 May and 11 June 2023 for information and assurance.

Acronyms and abbreviations explained

NENC – North East and North Cumbria
ICB - Integrated Care Board
ICS – Integrated Care System
NHSE – NHS England
CQC – Care Quality Commission
BAF – Board Assurance Framework
CMDU - Covid Medication Delivery Units
CYPCC - Children and Young People's Continuing Care
DHSC – Department of Health & Social Care

Executive Committee Approval	N/A
Sponsor/approving executive director	Samantha Allen, Chief Executive
Reviewed by	Deb Cornell, Director of Corporate Governance and Board Secretary
Report author	Jane Leighton, Senior Corporate Governance Lead

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?	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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North East and North Cumbria Integrated Care Board
Executive Committee (Public)

Minutes of the meeting held on Tuesday 9 May 2023, 10:15hrs in the Joseph Swan Suite, Pemberton House, Colima Avenue, Sunderland

Present:
Samantha Allen, Chief Executive (Chair)
Levi Buckley, Executive Area Director (North and North Cumbria)
David Chandler, Executive Director of Finance
Graham Evans, Executive Chief Digital, and Information Officer
David Gallagher, Executive Area Director (Tees Valley & Central)
Annie Laverty, Executive Director of Improvement and Experience
Rachel Mitcheson, Director of Place (Northumberland)
Jacqueline Myers, Executive Chief of Strategy and Operations
Dr Neil O'Brien, Executive Medical Director
David Purdue, Executive Chief Nurse
Claire Riley, Executive Director of Corporate Governance, Communications, and Involvement
Aejaz Zahid, Executive Director of Innovation

In attendance:
Rebecca Herron, Governance Manager (minutes)
Neil Hawkins, Senior Governance Lead
Hayley Campbell, PA to the Director of Corporate Governance and Involvement (shadowing for minutes)
Rob Common, Head of Quality, South Tyneside and Sunderland Foundation Trust (shadowing Executive Chief Nurse)
Francesca Best, Medical Student (shadowing Chief Executive)

EC/2023-24/28	**Agenda Item 1 - Welcome and introductions** The Chair welcomed all those present to the meeting.
EC/2023-24/29	**Agenda Item 2 - Apologies for absence** Apologies for absence were received from Deb Cornell, Director of Corporate Governance, and Involvement (Board Secretary) who was represented by Neil Hawkins, Senior Governance Lead.
EC/2023-24/30	**Agenda Item 3 - Declarations of interest** There were no declarations of interest made at this point in the meeting.

EC/2023-24/31	**Agenda Item 4 - Minutes of the previous meeting held on 11 April 2023** **RESOLVED:** **The Executive Committee AGREED that the minutes from the meeting held on 11 April 2023 were a true and accurate record.**
EC/2023-24/32	**Agenda Item 5 - Matters arising from the minutes and action log** The Chair noted that action log was significantly long and requested all executive committee members review and update their allocated actions by 13 June 2023. **ACTION:** **All executive directors to review and update their allocated actions on the action log.**
EC/2023-24/33	**Agenda Item 5.1 – Current Key Risks** The risk log was considered and discussed by the committee members. The Executive Director of Finance asked the committee members if they were clear on the top five risks on the risk log. The Executive Director of Corporate Governance, Communications and Involvement recommended the committee to review the risks collectively and not individually which will ensure the question raised by the Executive Director of Finance can be answered. It was agreed by the committee to hold a development session to confirm risk scoring is correct and agree the top five risks. The Executive Area Director (North and North Cumbria) welcomed the development session to highlight any risks which may sit under the responsibility of the directorate. The Executive Area Director (Tees Valley & Central) requested the risk log is presented with a report cover sheet to include the key risks within the summary. **ACTION:** **1) The Chair to allocate 30 minutes at the next executive team meeting to review and revise the risk scoring on the corporate risk log.** **2) The Director of Corporate Governance to include a report front sheet to the risk log to highlight any key risks and changes to the committee.**

EC/2023-24/34	**Agenda Item 6 - Notification of urgent items of any other business** No items of any urgent business had been received.
EC/2023-24/35	**Agenda Item 7.1 - Executive Area Directors Update Report May 2023 (North and North Cumbria)** The Director of Place (Northumberland) provided a brief summary of the report. The committee was asked to particularly note from the report: • Northumberland Lloyd George Digitisation Project – The current contract is not delivering; practices are struggling with clinical space being taken up. It was noted that funding is available to support placing records into storage, however, the funding will come to an end. The Executive Chief Digital and Information Officer stated digitisation of paper records is the way forward, but it does come at a cost. There is no national approach. The Executive Chief Digital and Information Officer suggested it would be useful to be part of the conversations around this project. • Newcastle We Are Human Too – Positive work is ongoing focussing on halting the sometimes-inhumane treatment and abuse of people with a learning disability or who are autistic and are using in-patient services. Colleagues noted that an informative video can be viewed at https://youtu.be/fbFRu6VRov0 • Gateshead Falls Service – North East Ambulance Service (NEAS) have advised it is no longer viable for them to run the service. Discussions have been underway at place to establish how these fit with community transport, community falls response and 2-hour responses. There is further work to be undertaken and an update will be provided to the committee in due course. The Executive Area Director (North and North Cumbria) noted there is a significant amount of information on mental health, learning disabilities and Autism work within the report. Work is ongoing to identify which portfolio/s the work sits under and once identified the report will not contain as much granular detail going forward. An update will be provided to the committee. **ACTION:** **1) The Director of Place (Northumberland) to link with the Executive Chief Digital and Information Officer regarding the General Practice Lloyd George Digitisation Project in Northumberland.** **2) The Executive Area Director (North and North Cumbria) to review the work around mental health, learning disabilities and Autism to ensure there is no duplication and submit findings to the committee.**

	RESOLVED: **The Committee RECEIVED the report for assurance and NOTED the decisions and assurance logs included within the report.**
EC/2023-24/36	**Agenda Item 7.1 - Executive Area Directors Update Report May 2023 (South)** The Executive Area Director (Tees Valley & Central) provided a brief summary of the report which was submitted to the committee for information purposes. The committee was asked to particularly note from the report the following themes: • Urgent care and GP provision of out of hours services over the Bank Holiday weekends • Community mental health and hub arrangements • Place based sub-committee arrangements are being established. The Executive Area Director (Tees Valley & Central) highlighted a local risk in Tees Valley, namely admin support for the four place sub-committees is currently being supported by one individual and therefore more resilience is required within the system. Other areas to note from the report are: • County Durham – GP Special Allocations Scheme and Quality Strategy approach • Tees Valley – Hospices work is ongoing; an update will be provided to the committee • Teesside – Family Hubs The Chair enquired if Place Directors have sight of the area directors report. The Director of Place (Northumberland) confirmed that reports are shared. The Executive Director of Corporate Governance, Communications, and Involvement commented on the amount of content within the appendix of the report. The Executive Area Director (Tees Valley & Central) noted that the report has developed over time and the place sub-committees will assist with the flow of information. The Chair and Executive Chief of Strategy and Operations supported the report and noted the report was an informative summary of discussions underway at Place.

	ACTION: **1) The Executive Area Directors (North & North Cumbria; Tees Valley & Central) to link with the Senior Governance Lead to review the appendix format within the Area Directors Report.** **RESOLVED:** **The Committee RECEIVED the report for assurance and NOTED the decisions and assurance logs included within the report.**
EC/2023-24/37	**Agenda Item 8.1 – Winter Planning** The Executive Chief of Strategy and Operations presented the report which provided the committee with the impact of the interventions for Winter Operating Resilience 2022-23 for urgent and emergency care and progress against actions and impact which will inform future planning. The report provided an insight into what measurable impacts have been faced following actions taken during winter. It was noted there are good metrics within the report and a suggested focus for planning. The Executive Chief of Strategy and Operations advised that the Urgent Treatment Centre developments require further work. The Committee thanked the Director of Transformation (System) for the good work undertaken regarding the production of an informative the report. The Executive Medical Director confirmed this year's work programme is being considered and noted that some successes from last year did incur a cost. This has resulted in a contracting issue which will need to be considered. The Executive Director of Corporate Governance, Communications, and Involvement suggested developing a communications output to establish if planned communications have had any impact on patients. It was agreed to align a communications team member to the Urgent Emergency Care Programme Group. The Executive Area Director (North and North Cumbria) enquired how this information had been socialised to obtain one sense of reality. The Executive Medical Director confirmed this paper had been presented at Urgent Emergency Care Board and the full Urgent Emergency Care work programme will be submitted to the next Urgent Emergency Care Board meeting. The Executive Director of Improvement and Experience queried if any fresh learning had been identified. The Executive Medical Director stated that the additional resource which was given was insufficient however, the

	difference was the concept which the whole system bought into from Chief Executive level all the way to the front line. The Executive Director of Improvement and Experience noted that it would be good to explore behaviours which drive improvement rather than targets. The Chair strongly agreed that this is missing from the report and would be beneficial to capture. The Chair noted that bed capacity/occupancy tracking through providers was not easy to obtain. It was suggested that a plan be put in place which everyone is signed up to regarding bed occupancy this winter – it was acknowledged that this piece of work will be a useful exercise. It was noted that clarity is needed regarding the ICBs three priority actions. The Executive Medical Director confirmed these priority areas would change and are currently being developed. The Executive Director of Corporate Governance, Communications, and Involvement noted that the governance processes of partners will also need to be considered for the socialising of the agreed priorities. **ACTION:** **1) The Director of Transformation (System) to link with the Director of Communications to establish a communications team member to join the Urgent Emergency Care Group.** **2) The Executive Medical Director to link with the Executive Chief of Strategy and Operations to add a section on behaviours to the Winter Planning report.** **3) The Executive Medical Director to clarify the Winter Planning priorities for 23/24 and submit to the committee.** **4) The Executive Chief of Strategy and Operations to consider a meaningful measurement of bed capacity.** **RESOLVED:** **1) The Committee REVIEWED the evaluation of the five main intervention areas in Urgent Emergency Care and the suggested focus for two-year planning based on the findings.** **2) The Committee NOTED the performance improvement against a range of national metrics indicating impact on the overall significant pressures across the system which these interventions are trying to mitigate.** **3) The Committee NOTED the intervention areas of the Discharge Programme and the System Coordination Centre that have not yet been fully evaluated but have significantly contributed to managing flow in UEC.** **4) The Committee NOTED the main compounding factor is the significantly increased demand across the system which means that some interventions have simply mitigated against increased demand without necessarily improving performance.**

EC/2023-24/38	**Agenda Item 8.2 - Provider Collaborative Responsibility Agreement** The Executive Chief of Strategy and Operations presented the report which provided the committee with the Responsibility Agreement between the ICB and the NENC Foundation Trust Provider Collaborative. The committee was informed that the agreement clearly sets out the areas the ICB are requesting the provider collaborative to focus on, the agreement also covers the agreed ways of working including governance arrangements. The Executive Director of Corporate Governance, Communications, and Involvement suggested it would be good practice to include a sign off protocol for any communications. The committee agreed this approach. **ACTION:** **The Executive Director of Corporate Governance, Communications, and Involvement to link with the Director of Communications, South Tyneside, and Sunderland Foundation Trust to develop and incorporate a sign off protocol for communications to go alongside the Provider Collaborative Responsibility Agreement.** **RESOLVED:** **The Committee APPROVED the Provider Collaborative Responsibility Agreement with the addendum of a communications sign off protocol.**
EC/2023-24/39	**Agenda Item 8.3 - Research and Innovation Draft Strategy** The Executive Director of Innovation provided the committee with a verbal update on the Research and Innovation Draft Strategy. Interviews had taken place with key stakeholders and early learning had been shared with the Executive Team. The aim is to share and socialise the draft strategy with stakeholders and key people by 31 May 2023 and for the Executive Team to receive by 30 June 2023. In response to a question raised in relation to good examples of national learning and good practice around these strategies being made available, the Executive Director of Innovation confirmed the ICB is currently leading the way, there are a great deal of national guidance documents, however, no similar strategies are near completion at present. The Executive Chief Digital and Information Officer noted the strategy work needs to have a digital and data link. The Chair requested the draft strategy to be circulated to the Executive Team.

	The Executive Chief of Strategy and Operations referenced the five year forward plan and noted this is an enabling strategy and the headlines will need embedded into the five year forward plan. **ACTION:** **1) The Executive Director of Innovation to circulate the principles and priority areas within the Research and Innovation Draft Strategy to the committee.** **2) The Executive Chief of Strategy and Operations to circulate a copy of the Five Year Plan to members of the Executive Team.**
EC/2023-24/40	**Agenda Item 8.4 - CQC Self-Assessment** The Executive Chief Nurse provided the committee with a verbal update on planning for the ICB CQC inspection. It was noted that there are three key themes - leadership, integration, and quality & safety. The Executive Chief Nurse informed the committee they were part of the North West London pilot inspection. It was emphasised that ensuring the ICB quality strategy is fit for purpose is a key piece of work. It was noted that the self-assessment will be presented to the committee once finalised. The Executive Director of Improvement and Experience welcomed the opportunity to work together to define the quality approach as an ICB and system. In Durham there is opportunity to pilot measures around patient experience of integration. The Institute for Healthcare Improvement (IHI) has developed standardised self-assessment tools which could be adjusted and applied to this. It was suggested that the IHI tool is circulated to committee members to collate feedback and review how to build on what is already in place. Following discussion the committee supported this approach. The Executive Director of Corporate Governance, Communications, and Involvement proposed a meeting with the Executive Chief Nurse and the Director of Corporate Governance and Involvement to develop a forward plan of content which will presented to at a Board development session. **ACTION:** **1) The Executive Chief Nurse to summarise the CQC self-assessment process and submit to the Executive Committee.** **2) The Executive Director of Improvement and Experience to circulate the IHI tool to the committee members.** **3) The Executive Director of Corporate Governance, Communications, and Involvement, Executive Chief Nurse and Director of Corporate Governance and Involvement to develop**

	a forward plan of content to be presented to Board.
EC/2023-24/41	**Agenda Item 9.1 - NENC ICB and ICS Finance Report (M12)** The Executive Director or Finance introduced the report which provided the committee with an update on the financial performance of the North East and North Cumbria Integrated Care Board (ICB) and NENC Integrated Care System (ICS) for the financial year 2022/23 - for the period to 31 March 2023. The ICB is reporting an outturn surplus of £2.7 million subject to audit, however, this does mask a deficit of £95 million which supports the recurrent financial measures which have been put in place for this year. The ICS outturn position is a surplus of £58.2 million largely driven by significant income received by Northumbria Healthcare Foundation Trust relating to the settlement of a court case in respect of building rectification work. Only one Foundation Trust was off track for this financial year. It was noted that running costs were underspent this year due to a number of vacancies. The Executive Director of Finance informed the committee that they would each receive a month 12 running cost report in which staff will be included. The Chair suggested a deadline date to be incorporated to the covering email for budget and staff alignment queries. The Executive Director of Finance provided the committee with an update on the ICS Capital Position. The ICS is reporting an outturn underspend of £7.2 million, following receipt of an additional £15 million funding for the Cedars development. **ACTION:** **The Executive Director of Finance to include a deadline for allocation of staff to budgets when circulating the cost budget reports to Executive Directors.** **RESOLVED:** **1) The Committee RECEIVED the report and NOTED the outturn financial position for 2022/23.** **2) The Committee NOTED there are a number of financial risks across the system still to be managed.**
EC/2023-24/42	**Agenda Item 10.1 - Integrated Delivery Report** The Executive Chief of Strategy and Operations introduced the report which provided the committee with an overview of quality and performance, highlighting any significant changes, areas of risk and

	mitigating actions. It was noted by the Executive Chief of Strategy and Operations that this is the new report format and encouraged feedback from the committee. The meeting was informed that the re-formatting will extend to the appendices going forward, also the content has not yet been finalised as it was agreed to include broader content. The committee strongly supported the new report format. The key points were highlighted within the report, and it was noted that for the first time all eight Foundation Trusts, as a system, achieved the 28-day faster diagnosis standard. It was noted that the financial year ended with 163 x 78 week waits and 21 x 4 week waits. The Executive Medical Director observed that healthcare acquired infections appear to be increasing and suggested this should be picked up at the Quality and Safety Committee. The Executive Chief Nurse confirmed this was being looked at. The Chair enquired if this was only happening at one trust or at number of trusts. The Executive Chief Nurse confirmed this is increasing in a number of trusts and a peer review has been conducted at these trusts. The Chair requested a deep dive on infection control to be carried out. The Executive Director of Corporate Governance, Communications, and Involvement referred to previous communication campaigns to the public around infection control and that more can be done to re-promote infection control practices. The Executive Chief of Strategy and Operations provided an update to the committee regarding the progress of the elective recovery plans. Work is currently ongoing with the provider collaborative to clarify the recovery plans. It has been recognised that there is added value in providers working together in four main areas including mutual aid, outpatient transformation with the use of digital out patients, getting it right first time, and working together to maximise capacity. Current plans are still focussing on what the problems are. The Chair raised that as the accountable officer for the elective recovery plans it would be prudent to schedule an escalation meeting with the provider collaborative within a week. The Committee agreed this approach. The Executive Area Director (North and North Cumbria) raised a potential risk of a disconnect between the strategic conversation and how we transfer this to what is done in and across organisations. It was agreed clarity of ownership is needed. It was noted that the format of the report is very good, and the committee thanked the Director of Performance and Improvement for the hard work which has been put into producing this report.

	ACTION: **1) The Executive Chief Nurse and Executive Chief of Strategy and Operations to conduct a deep dive exercise on infection control and share the results with the Executive Committee.** **2) The Executive Director of Corporate Governance, Communications, and Involvement to consider updated communications to the public regarding infection control.** **3) The Chair to write to the provider collaborative to arrange a meeting around elective recovery escalation before the Chief Executives meeting.** **RESOLVED:** **The Committee RECEIVED the report for information and assurance.**
EC/2023-24/43	**Agenda Item 11 – Commissioning** No update was required for this item.
EC/2023-24/44	**Agenda Item 12.1 - Branding Strategy** The Executive Director of Corporate Governance, Communications and Involvement introduced the presentation which provided the committee with the rationale to agree the proposed refreshed branding strategy for 2023-24. The presentation key points were noted as: • Branding infrastructure is currently quite disordered, conversations are underway in terms of how this is managed more efficiently going forward • This branding strategy will evolve over time • At this moment we are competing against each other and there is some alignment which needs to take place. The Executive Chief of Strategy and Operations noted this is a good opportunity to include partners who do not have a brand and strengthen those relationships. It was suggested that there may be some resistance to rebranding and the need to tread carefully with partners. The Executive Director of Corporate Governance, Communications, and Involvement agreed there potentially could be resistance to this, however, the benefits and the impact of cohesion are much greater. It was raised that there are partner brands which are not the organisations to align and whether the ICB will have any impact on them. In response the Executive Director of Corporate Governance, Communications, and

	Involvement referenced a co-branding approach with these partners to show collaboration. Following discussions and feedback the committee strongly supported the proposed branding strategy. The Executive Chief Digital and Information Officer suggested the relaunch date of 1 July 2023 to align with the significant milestone of the ICB's first year of formation. The Executive Chief of Strategy and Operations noted two points, the first is to be clear when we use the vision and when we use best at getting better. Also, to review the icons to ensure they are the correctly aligned. The Executive Director of Corporate Governance, Communications, and Involvement confirmed there would also be brand guidelines developed to run alongside this branding strategy to communicate the rules and procedures for creating icons. It was recommended that all branding pictures not be clinically based; the Committee was that this would be implemented. The committee approved the full alignment of branding option. **RESOLVED:** **The Committee APPROVED the Branding Strategy and the relaunch date of 1 July 2023.**
EC/2023-24/45	**Agenda Item 13.1 -** The Executive Director of Corporate Governance, Communications and Involvement introduced the report which provided the committee with a brief update and overview of the Information Asset Register (IAR) for 2022/23. The Executive Chief Digital and Information Officer informed the committee this was a formal document at a point in time which shows 139 current assets. This is a measurement tool which is linked to the Data Security Protection Toolkit (DSPT) return. One of the key benefits is this allows the ICB to monitor shadow IT and is a partnership between Corporate Governance and Information Governance. **RESOLVED:** **1) The Committee RECEIVED the IAR for assurance.** **2) The Committee NOTED the ongoing actions highlighted within the briefing.** **3) The Committee NOTED the progress towards the final submission date of the DSPT remains on track.**

EC/2023-24/46	**Agenda Item 13.2 - Citizens Panel Proposal** The Chair noted the Citizens Panel Proposal had been deferred.
EC/2023-24/47	**Agenda Item 13.3 - ICB 2.0 Programme Steering Group Terms of Reference** The Executive Chief Digital and Information Officer introduced the report which provided the committee with the draft Terms of Reference for the ICB 2 Programme Steering Group. The Committee was asked to approve the Terms of Reference for the ICB 2 Programme Steering Group. The Executive Chief Digital and Information Officer informed the Committee the principle objectives have been clearly identified and socialised with the senior leadership team. **RESOLVED:** **The Committee APPROVED the Terms of Reference for the ICB 2 Programme Steering Group.**
EC/2023-24/48	**Agenda Item 13.4 - Statutory and Mandatory Training Recommendation** The Executive Chief Nurse introduced the report which provided the committee with recommended statutory and mandatory training for the organisation. The Executive Chief Nurse requested a view from the committee on the compliance target which was previous set at 100% which is unobtainable due to staff sickness and maternity leave. The consensus of the Committee was to lower the compliance target to 90%. The Executive Chief Nurse raised the importance of all staff being trained in basic life support. The Committee supported this proposal. **ACTION:** **The Executive Chief Nurse to consider the percentage of completion and update the recommendation within the paper.** **RESOLVED:** **The Committee APPROVED the recommended Statutory and Mandatory training with the addendum of the compliance target.**

EC/2023-24/49	**Agenda Item 13.5 - Executive Committee Annual Report** The Executive Director of Corporate Governance, Communications, and Involvement introduced the report which provided the Committee with the achievements and assurances the committee has gained throughout the year to demonstrate its roles and responsibilities and includes any risks identified as part of this work. The Executive Director of Corporate Governance, Communications, and Involvement noted this is part of the review process required to be carried out as a committee. The Chair enquired to the inclusion of the results of the self-assessment questionnaires into this report. The Executive Director of Corporate Governance, Communications, and Involvement confirmed this would need to be included within this report. **ACTION:** **1) The Executive Director of Corporate Governance, Communications, and Involvement to include the results of the self-assessment questionnaires into the report.** **2) The Executive Director of Corporate Governance, Communications, and Involvement to circulate the results of the self-assessment questionnaires to the committee.** **RESOLVED:** **The Committee APPROVED the report to be submitted to the Board for assurance.**
EC/2023-24/50	**Agenda Item 13.6 - Draft Annual Report** The Executive Director of Corporate Governance, Communications, and Involvement introduced the report which provided the committee with the first ICB draft annual report and the interim National Audit Office (NAO) disclosure checklist for the period 1 July 2022 – 31 March 2023. The Executive Director of Corporate Governance, Communications, and Involvement noted this is a draft report, however, corporate governance team is continuing to work with colleagues over the coming weeks to ensure any further annual report updates / amendments can be reviewed and collated. It was noted the deadline for comments is 17 May 2023. **RESOLVED:** **1) The Committee RECEIVED the Draft Annual Report for assurance.** **2) The Committee NOTED the annual assessment requirements for 2022/23 update from NHS England.** **3) The Committee NOTED the key dates/milestones for the annual**

	report process. **4) The Committee NOTED the corporate governance team is continuing to work with colleagues over the coming weeks to ensure any further annual report updates / amendments can be reviewed and collated by 17 May 2023.**
EC/2023-24/51	**Agenda Item 13.7 – Board Assurance Framework 2023/24** The Executive Director of Corporate Governance, Communications, and Involvement introduced the report which provided the committee with an update for the Board Assurance Framework (BAF) for 2023/24. The Executive Director of Corporate Governance, Communications, and Involvement informed the committee there have been changes to the BAF for 2023/24, which have been aligned to the risks and have been linked to the Better Health and Wellbeing for all Strategy. The Executive Chief of Strategy and Operations noted that the set of strategics aims are not the aims which are set out in the organisation's strategy. The Chair confirmed these are the four strategic aims of all ICB's. The Committee agreed that the four aims from our strategy should be used within the BAF. The Executive Chief Digital and Information Officer noted our risk appetite is not alluded to within the report. The Executive Director of Corporate Governance, Communications, and Involvement confirmed more work needed to be carried out around risk appetite and features on the Board development plan. The Executive Chief Nurse suggested the actions and issues should be dated. This was agreed to be amended within the report. Following discussions, it was agreed to review the format of the BAF. **<u>ACTION:</u>** **The Executive Director of Corporate Governance, Communications, and the Executive Chief Nurse to review the format of the Board Assurance Framework and update with the suggestions noted.** **<u>RESOLVED:</u>** **1) The Committee NOTED the changes to the BAF for 2023/24.** **2) The Committee APPROVED submission of the BAF to the Board for assurance.**
EC/2023-24/52	**Agenda Item 13.8 - Governance Map** Noted for information only.

	RESOLVED: **The Committee NOTED the governance map for information purposes.**
EC/2023-24/53	**Agenda Item 13.9 - Committee Cycle of Business** Noted for information only. **RESOLVED:** **The Committee NOTED the committee cycle of business.**
EC/2023-24/54	**Agenda Item 13.10 - Mental Health, Learning Disabilities and Autism Sub-Committee Terms of Reference** The Executive Chief of Strategy and Operations introduced the report which provided the committee with the draft Terms of Reference for the Mental Health, Learning Disabilities and Autism Sub-Committee. The Committee was asked to approve the Terms of Reference. **ACTION:** **The Executive Area Director's to disseminate the Mental Health, Learning Disabilities and Autism Sub-Committee Terms of Reference to places.** **RESOLVED:** **The Executive Committee APPROVED the Mental Health, Learning Disabilities and Autism Sub-Committee Terms of Reference.**
EC/2023-24/55	**Agenda Item 14 – Subcommittee Assurance** No update was required for this item.
EC/2023-24/56	**Agenda Item 15.1.1 - Intellectual Property Management and Revenue Sharing Policy** The Executive Director of Finance noted that 'annual' needs to be included within the policy. **ACTION:** **The Executive Director of Innovation to insert 'annual' into the policy.** **RESOLVED:** **The Executive Committee APPROVED the Intellectual Property Management and Revenue Sharing Policy subject to the suggested amendment.**

EC/2023-242/57	**Agenda Item 15.1.2 - Procurement Policy** The Executive Chief of Strategy and Operations noted the changes to the procurement policy were not visible or highlighted within the report. It was agreed the Procurement Policy will be resubmitted to the committee with the changes highlighted. **ACTION:** **The Procurement Policy to be resubmitted to the Committee which changes highlighted within the policy.**
EC/2023-24/58	**Agenda Item 15.2.1 - Work Life Balance Policy** **RESOLVED:** **The Executive Committee APPROVED the Work Life Balance Policy.**
EC/2023-24/59	**Agenda Item 15.2.2 - Annual Leave Policy** **RESOLVED:** **The Executive Committee APPROVED the Annual Leave Policy.**
EC/2023-24/60	**Agenda Item 15.2.3 - Induction and Probation Policy** **RESOLVED:** **The Executive Committee APPROVED the Induction and Probation Policy.**
EC/2023-24/61	**Agenda Item 15.2.4 – Secondment Policy** **RESOLVED:** **The Executive Committee APPROVED the Secondment Policy.**
EC/2023-24/62	**Agenda Item 15.2.5 – Freedom to Speak up Policy** **RESOLVED:** **The Executive Committee APPROVED the Freedom to Speak up Policy.**
EC/2023-24/63	**Agenda Item 15.2.6 – Retirement Policy** **RESOLVED:** **The Executive Committee APPROVED the Retirement Policy.**
EC/2023-24/64	**Agenda Item 15.2.7 – Armed Forces Reserves and Cadets Policy** The committee thanked the team for the work on this policy. **RESOLVED:**

	The Executive Committee APPROVED the Armed Forces Reserves and Cadets Policy.
EC/2023-24/65	**Agenda Item - 16 Any Other Business** Executive Committee Terms of Reference have been updated to reflect the change in portfolio for the Executive Director of Improvement and Experience.
EC/2023-24/66	**Agenda Item 17 - CLOSE** The meeting was closed at 13:15pm.
	Date and Time of Next Meeting Tuesday 13 June 2023 10:30am.

Signed: **Sam Allen**

Position: **Chief Executive (Chair)**

Date: **13 June 2023**

Item: 12.2.1

NHS
North East and
North Cumbria

North East and North Cumbria Integrated Care Board
Executive Committee (Public)

Minutes of the meeting held on Tuesday 13 June 2023, 10:50 in the Joseph Swan Suite, Pemberton House, Colima Avenue, Sunderland

Present:
Samantha Allen, Chief Executive (Chair)
Levi Buckley, Executive Area Director (North & North Cumbria)
David Chandler, Executive Director of Finance
Graham Evans, Executive Chief of Digital, and Information Officer
Annie Laverty, Executive Director of Improvement and Experience
Jacqueline Myers, Executive Chief of Strategy and Operations
Dr Neil O'Brien, Executive Medical Director
David Purdue, Executive Chief Nurse
Claire Riley, Executive Director of Corporate Governance, Communications, and Involvement
Aejaz Zahid, Executive Director of Innovation
Scott Watson, Director of Place (Sunderland)

In attendance:
Rebecca Herron, Governance Manager (minutes)
Jennifer Lawson, Senior Governance Lead
Paul Nicholson, Head of Quality, North East Ambulance Service (shadowing Executive Chief of Digital and Information Officer)
Tom Hall, Local Authority Board Partner Member (Observer)

EC/2023-24/67	**Agenda Item 1 - Welcome and introductions** The Chair welcomed all those present to the meeting.
EC/2023-24/68	**Agenda Item 2 - Apologies for absence** Apologies for absence were received from Deb Cornell, Director of Corporate Governance & Board Secretary who was represented by Jennifer Lawson, Senior Governance Lead; Dave Gallagher, Executive Area Director (Tees Valley & Central) who was represented by Scott Watson, Director of Place (Sunderland).
EC/2023-24/69	**Agenda Item 3 - Declarations of interest** There were no declarations of interest made at this point in the meeting.

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EC/2023-24/70	**Agenda Item 4 - Minutes of the previous meeting held on 9 May 2023** **RESOLVED:** **The Executive Committee AGREED that the minutes from the meeting held on 9 May 2023 were a true and accurate record.**
EC/2023-24/71	**Agenda Item 5 - Matters arising from the minutes and action log** The Chair noted that the action log was significantly long and requested all executive committee members review and update their allocated actions by 11 July 2023. **ACTION:** **All executive directors to review and update their allocated actions on the action log.**
EC/2023-24/72	**Agenda Item 6 - Notification of urgent items of any other business** No items of any urgent business had been received.
EC/2023-24/73	**Agenda Item 7.1 - Executive Area Directors Update Report June 2023 (North & North Cumbria)** The Executive Area Director (North & North Cumbria) provided a summary of the report. The Committee was asked to particularly note from the report: • Gateshead - SEND Inspection - currently awaiting feedback. It was noted that feedback from the team was positive. - The launch of the trauma informed care service for children and young people 'Trusting Hands' took place on 9 May. It has been well received. • Newcastle - 'We are Human Too Coalition' recently held an event in Newcastle; following an event in Sunderland raised concern around moving in different directions and the need for a co-ordinated workplan. - Paediatric Therapy Waiting Lists (speech and language and occupational therapy), it was reported that there is bigger piece of work required and an additional need to understand the baseline positions. There is significant variation in the commissioning of the services across the patch; it was noted that further discussions are taking place between the Executive Area Director (North and North Cumbria) the Executive Chief Nurse.

- North Tyneside
  - Positive feedback from the place sub-committee around hospital discharges was fed into the housing conference which took place in May 2023.
  - LeDeR reviews – it was noted there is a lack of consistency, capacity, and quality. The Executive Chief Nurse confirmed there was work ongoing to address this.
  - Place Sub-Committee Governance – consideration is being given to describing the governance as a plan on a page. There still confusion about the remit of Health and Wellbeing Boards, Place Sub-Committees and Local Delivery Groups. It was noted that it would be beneficial to link in with the Director of Policy, Stakeholder Affairs, and Public Affairs to develop an infographic to ease any confusion.

The Executive Area Director (North & North Cumbria) informed the committee of the intention to hold a seminar with the Board around mental health, learning disabilities and autism now the five priority areas have been agreed.

The Executive Director of Corporate Governance, Communications, and Involvement enquired if the Westgate Road Urgent Treatment Centre (UTC) is linked to Urgent Emergency Care (UEC) plans as the ICB are currently commissioning Newcastle Upon Tyne Hospitals to provide the Westgate Road UTC service. It was confirmed that this has been an ongoing problem before the establishment of the ICB; consultation has taken place and there are ongoing conversations and suggestions of moving the service to the Royal Victoria Infirmary site which would align to the UEC plans, however the impact of this move is yet to be determined.

The Executive Director of Corporate Governance, Communications, and Involvement noted that spirometry is mentioned in several place updates within the report and queried if this could be an opportunity to do something across the system not just in the North. The Executive Area Director North & North Cumbria) agreed to share the work form Northumberland with place directors for consideration.

ACTION:

1) **The Executive Area Director (North & North Cumbria) to link with the Executive Chief Nurse regarding paediatric speech and language waiting times.**
2) **The Executive Area Director (North & North Cumbria) to link with the Director of Policy, Stakeholder Affairs, and Public Affairs to develop an infographic to support place sub-committee governance**
3) **The Executive Area Director (North & North Cumbria) to share Northumberland Spirometry paper with the Director of Place (Sunderland) for dissemination to Directors of Place for**

	consideration of a system approach to spirometry to bring back to the committee. **<u>RESOLVED:</u>** **The Committee RECEIVED the report for assurance and NOTED the decisions and assurance logs included within the report.**
EC/2023-24/74	**Agenda Item 7.1 - Executive Area Directors Update Report June 2023 (South)** The Director of Place (Sunderland) provided a summary of the report which was submitted to the committee for information purposes. The Committee was asked to particularly note from the report the following themes: • All areas are reporting excellent work around hospital discharges transfers of care • Durham have currently achieved a zero-wait list for home care packages • The launch in South Tyneside and Sunderland of a tripartite diagnostic in conjunction with the two Local Authorities. It was noted that there are some significant efficiency savings to be realised • South Tees Discharge Suite implementation is positive • Migrant Health – following a meeting with the university of Sunderland it has been confirmed there will be 4,000 overseas students with a 2.2:1 dependence ratio which will equate to 10,000 overseas residents in and around the Sunderland and Durham areas. Consideration to be given around the services we commission. • Hartlepool SEND Inspection has been completed and is the only area to have achieved the highest possible outcome from that inspection. The committee acknowledged this significant achievement. The Executive Chief of Digital and Information raised a point from both reports on the system pressures and discharges to urge that there is connectivity with the digital team as there are programmes of work running alongside each other. The Chair enquired if a standardised specification for virtual wards had been developed; in response it was confirmed there is a virtual wards implementation group which were given the instruction to agree to the respiratory virtual ward specification developed by the respiratory network. The virtual wards are now expanding into frailty, so areas are progressing further. The meeting was informed that the ICB may not be getting value for money from the virtual wards and this year will be the test to prove the model works. Evaluation is currently underway which will inform any future decisions – there will be no national funding available next year. The

	Executive Chief of Digital and Information informed the committee there is a technology platform which could support virtual wards however further work is required. The Chair noted that neurodevelopment is developing as a genuine theme through complaints, concerns and media enquiries and a better understanding is needed. During discussion it was noted that getting a child assessed proving difficult and therefore as a result children are being failed. The Executive Chief of Strategy and Operations informed the committee that this is a priority area on the business intelligence workplan. Following discussion, it was suggested that consideration be given to Place collaboration (for example, Tees Valley leading of the Termination of Pregnancy) looking at a postcode lottery approach across the region. **ACTION:** **1) The Executive Medical Director to consider the use of digital technology to enhance virtual wards.** **2) Directors of Place to consider appropriate areas for a collaborative approach.** **RESOLVED:** **The Committee RECEIVED the report for assurance and NOTED the decisions and assurance logs included within the report.**
EC/2023-24/75	**Agenda Item 8.1 – Delivery of Prescribing Efficiencies 2023/24** *At 11:20am the Director of Medicines and Pharmacy attended the meeting to present the report for item 8.1 and 8.3.* The Director of Medicines and Pharmacy presented the report which provided the committee with the prescribing efficiency proposals. The Committee were made aware of the key points from the report including the focus of overprescribing and the importance of community pharmacy who are contracted on dispensing volume. A proposal was highlighted to trial a piece of technology, Analyse RX which is an addition to an existing system which is already in place. The system proactively identifies opportunities for optimisation. Efficiencies are expected to be 3:1 on prescribing alone and other gains will include the increased capacity of GPs. The committee was asked to approve the recommendations within the report. The Executive Area Director (North & North Cumbria) enquired as to the cost of the technology; it was confirmed that the cost will be £260,000 although this is only available to practices with EMIS systems which is only

	half of the practices within the NENC. However, this would demonstrate the savings. It was noted that the company is working on a solution for the other systems. Following further discussions, the committee agreed the following: **ACTION:** **The Director of Medicines and Pharmacy to negotiate with the technology company to try and secure a more beneficial agreement for the ICB.** **RESOLVED:** **1) The Committee SUPPORTED the early review of the NECS medicines optimisation service line in ICB 2.0, and the realignment of current vacancies to PCN clinical leadership.** **2) The Committee APPROVED the approach to budget management and efficiency delivery described in the paper.** **3) The Committee NOTED the 2024/25 incentive schemes included significant deprescribing or 'not dispensing' elements aimed at community pharmacy.** 4) **The Committee APPROVED the 1-year trial of novel technology in practices to proactively identify medicines optimisation opportunities, with the caveat the Director of Medicines and Pharmacy to negotiate with the technology company to try and secure a more beneficial agreement for the ICB.**
EC/2023-24/76	**Agenda Item 8.2 - Waiting Well Programme Plans for 2023/24 and 2024/25** The Executive Medical Director presented the report which provided the committee with an update on the latest position and a proposed plan for investment in 2023/24 and 2024/25 with an anticipated approach to contract arrangements for consideration and approval. The key points of the report were outlined. It was noted that all places have submitted plans on how this will be delivered, budgets set based on the population in deciles one and two and the number of patients on priority four waiting lists. It was noted a full procurement process would cause significant risks to the delivery of the programme – it was confirmed that procurement advice has been sought. It was acknowledged that value for money is a potential concern for consideration; further detail regarding outcomes will be shared with the committee. Assurance was also requested that the £200,000 Northumbria HealthCare Foundation Trust Proms money is not linked to this to ensure the same money is not being spent twice. The Executive Director of Improvement and Experience enquired if there was any justification by ways of learning, which has informed the automatic

	transfer of the same budgets for 2024/25. The Executive Medical Director confirmed this should state indicative numbers for 2024/25. Following further discussions, the committee agreed to support the procurement approach with the agreement that medium term proposals to come from the Healthier and Fairer Advisory Group. The Executive Chief of Strategy and Operations appealed to evaluate effectively. **ACTION:** **1) The Executive Medical Director to share further detail on the outcomes of the waiting well programme with the committee.** **2) The Executive Medical Director to link with the Healthier and Fairer Advisory Group to develop medium term proposals to bring back to the committee.** **RESOLVED:** **1) The Committee NOTED the latest position on the Waiting Well programme.** **2) The Committee APPROVED the proposed distribution of funding and approach to relevant contracts for 2023/24 and 2024/25.** **3) The Committee APPROVED the suggested approach to undertake single tender and quotation waivers to enable the direct award of relevant contracts and agreements for 2023/24 and 2024/25.**
EC/2023-24/77	**Agenda Item 8.3 - Covid Medication Delivery Units (CMDU) Update** The Executive Medical Director provided an update on the proposed changes to the commissioning and delivery of a NENC CMDU and informed the committee there is significant concern regarding the delays from NHSE. It was reported that funding has been withdrawn however the expectation is that the service will still be delivered although providers are no longer wanting to deliver the service. The committee was asked to approve a three-month extension to provide stability whilst other options are being explored. The Director of Medicines and Pharmacy confirmed the additional cost is related to the increase of patients who are now eligible for treatment as the criteria has changed. The Committee was asked to consider the options outlined in the report but noted the preferred being option two. The Chair agreed to raise the concerns with NHSE colleagues. It was requested that the finance team compile a list of unfunded national requirements to publish publicly at Board meetings.

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	ACTION: **1) The Chair to discuss CMDUs with NHSE colleagues.** **2) The Executive Director of Finance to compile a list of unfunded national requirements to publish publicly at Board meetings** **RESOLVED:** **1) The Committee APPROVED the extension of current contracts by a further three months, until the 30 September 2023 with an associated cost pressure of £26,000.** **2) The Committee APPROVED preferred option two as recommended within the report.** **3) The Committee APPROVED the next steps in relation to the commissioning, procurement, and mobilisation of a new and sustainable service model.** **4) The Committee NOTED further updates would be received as the project progresses, including more detailed demand and financial modelling based on renewed clinically agreed cohort population.** *At 11:36am the Director of Medicines and Pharmacy left the meeting*
EC/2023-24/78	**Agenda Item 9.1 - NENC ICB and ICS Finance Report** The Executive Director or Finance provided a verbal update to the committee on the medium-term financial plan. With the outlined deficit of the ICB and ICS, a medium-term financial and recovery plan is required to be submitted to NHSE. Discussions have been ongoing with Executive Directors; Directors of Finance and a draft plan has been developed. Support will be necessary to consider how improvements can be made to reduce health inequalities, ensuring collaboration with partners. *At 11:55am the Local Authority Partner Member left the meeting.*
EC/2023-24/79	**Agenda Item 10.1 - Integrated Delivery Report** The Executive Chief of Strategy and Operations introduced the report which provided the committee with an overview of quality and performance, highlighting any significant changes, areas of risk and mitigating actions. Key points were highlighted in the report as outlined below: • North Cumbria Integrated Care Foundation Trust has been removed from Tier 2 for cancer • 2022/23 the target for backlog reduction was achieved in NENC, April 23 into May has become more pressured with only 3/8 Trusts achieving their planned backlog in April • NHSE is introducing a tiering system for UEC; NENC ICB has been

	allocated to tier three which is positive • It was noted that dental activity is now included • Concerns highlighted regarding sickness and talking therapies • Out of area placements is a concern and increasing. It was noted further work will be progressed on the content of the report. The Chair remarked how the organisation is taking learning from complaints and it was noted that patient experiences will be fed into the patient group - this will be noted within the report going forward. It was recognised that whilst 'at a glance' reporting looks positive there is awareness of some unwarranted variation in specific providers and that deteriorating trends require close monitoring. The Executive Chief of Strategy and Operations confirmed this takes place through the oversight framework arrangements and further work is underway to ensure this is observed more closely. The point was raised regarding maternity inspections and that there is an expectation on ICBs to support the organisations where ratings have dropped; the Executive Chief Nurse suggested bringing a paper back to the committee to confirm the process around this. This approach was agreed. It was noted that the format of the report was well received, and the committee thanked the team for the input into the report. **ACTION:** **The Executive Chief Nurse to develop the process to support organisations following maternity inspections and submit to the committee.** **RESOLVED:** **The Committee RECEIVED the report for information and assurance.**
EC/2023-24/80	**Agenda Item 10.2 - ICB/ICS All Age Continuing Care Transformation Proposal** The Executive Chief Nurse presented the report which provided the committee with the proposed development of a Transformation Programme for All Age Continuing Care (AACC) to deliver compliance with statutory duties without unwarranted variation. The Committee was made aware of the key points from the report including the sharing of the principles with Local Authority colleagues and incorporating those views and feedback into the report. The Committee was asked to approve the recommendations as outlined within the report

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	RESOLVED: **1) The Committee APPROVED the development of an All Ages Continuing Care transformation programme.** **2) The Committee APPROVED the Terms of Reference for the All Ages Continuing Care Strategic Transformation Group (AACC STG).**
EC/2023-24/81	**Agenda Item 10.3 - Proposal for Increased Financial Delegated Limits for Care Packages** The Executive Chief Nurse presented the report which provided the committee with the proposal to extend the financial delegated limit for Band 8d Deputy Directors of Nursing/commissioning managers who approve all age continuing care and complex care packages from the current £75,000 p.a. limit to £200,000 p.a. Following discussions, the committee agreed to increase the delegated limit for the Band 8d Deputy Directors of Nursing (AACC) to £150,000 for a period of three months to be reviewed thereafter. **RESOLVED:** **The Committee APPROVED the increased financial delegated limit for the Band 8d Deputy Directors of Nursing (AACC) to £150,000 with a review date set for three months' time.**
EC/2023-24/82	**Agenda Item 11 – Commissioning** No update for this item.
EC/2023-24/83	**Agenda Item 12.1 - DHSC Work and Health Project** The Executive Director of Corporate Governance, Communications and Involvement introduced the report which provided the committee with an update of the ongoing development of a partnership and emerging strategy to address the challenges of worklessness and economic inactivity and their relationship to poor health. Work is now able to start progressing into some of the existing programmes of work linked to the Healthier and Fairer Advisory Group. It was confirmed this was funded through the Department of Health and Social Care. It was raised that this piece of work is not noted within the Healthier and Fairer Advisory Group workplan as yet and discussions will be required to determine how this work will be supported. **RESOLVED:** **The Committee RECEIVED the report for assurance.**

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EC/2023-24/84	**Agenda Item 13.1 - Risk Management Report (incl Risk Register)** The Executive Director of Corporate Governance, Communications and Involvement introduced the report which provided the committee with an updated position on the risks facing the organisation for the period 21 March 2023 to 22 May 2023. It was noted that a new risk described in section 3.2 of the report required the approval of the committee. The Chair noted on page twelve there are several actions with limited controls in place and reiterated the expectation of committee members to review and update their allocated risks including what controls are in place. **ACTION:** **All Executive Directors to review and update their allocated risks including what controls are in place.** **RESOLVED:** **1) The Committee RECEIVED the Risk Management Report for assurance.** **2) The Committee NOTED the profile of the risks as of 22 May 2023.** **3) The Committee APPROVED the addition to the risk register of the new risk described in section 3.2.**
EC/2023-24/85	**Agenda Item 13.2 - Governance Assurance Report (GAR)** The Executive Director of Corporate Governance, Communications and Involvement introduced the report which provided the committee with the updated Governance Assurance Report for Q4 2022/23. The Committee was advised that there is further work to do on the content, quality, and format of the report. The Committee was asked to receive the GAR for assurance. The Chair requested that the ICB HR metrics from the operational HR group is captured in the report and aligned to the well led Key Lines of Enquiries (KLOE). **ACTION:** **The Executive Director of Corporate Governance, Communications, and Involvement to link with the operational HR group to include the ICB HR metrics within the GAR report and to align to the well led KLOEs.** **RESOLVED:** **The Committee RECEIVED the Governance Assurance Report for assurance.**

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EC/2023-24/86	**Agenda Item 13.3 - Governance Map** Noted for information only. **ACTION:** **The Committee Secretary to add the Governance Map to the ICB Intranet.** **RESOLVED:** **The Committee NOTED the governance map for information purposes.**
EC/2023-24/87	**Agenda Item 13.4 - Committee Cycle of Business** Noted for information only. The Executive Director of Corporate Governance, Communications and Involvement informed the committee a refresh of the Board and Board development cycle of business is being developed. **RESOLVED:** **The Committee NOTED the committee cycle of business.**
EC/2023-24/88	**Agenda Item 14.1 – ICB 2 Steering Group Highlight Report** The Executive Chief of Strategy and Operations presented the report which provided the committee with an update of the ICB 2.0 programme of work. It was noted that the work is slightly behind schedule. **ACTION:** **All Executive Directors to collaborate with their teams to ratify organograms.** **RESOLVED:** **The Committee RECEIVED the report for assurance.**
EC/2023-24/89	**Agenda Item 14.2 – Contracts Group Highlight Report** The Executive Chief of Strategy and Operations presented the report which provided the committee with an overview of the discussions at the Contracting Group in May 2023. It was confirmed that there is a definitive contract register and contract signing process in place. **RESOLVED:** **The Committee RECEIVED the report for assurance.**

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EC/2023-24/90	**Agenda Item 14.3 – HR & OD Steering Group** The Executive Chief Nurse presented the report which provided the committee with an update on the creation of the NENC ICB People and OD Steering Group. It was noted that two meetings have taken place and membership has been reviewed. **RESOLVED:** **The Committee RECEIVED the report for assurance.**
EC/2023-24/91	**Agenda Item 14.4 – Pharmaceutical Services Regulatory Sub-Committee Minutes** The Committee noted for information and assurance. **RESOLVED:** **The Committee RECEIVED the minutes for assurance**
EC/2023-24/92	**Agenda Item 14.5 – Primary Care Strategy and Delivery Sub-Committee Minutes** The Committee noted for information and assurance. **RESOLVED:** **The Committee RECEIVED the minutes for assurance**
EC/2023-24/93	**Agenda Item 15.1.1 - Procurement Policy** **RESOLVED:** **The Executive Committee APPROVED the Procurement Policy.**
EC/2023-242/94	**Agenda Item 15.1.2 – Policy Schedule** The Committee noted for information and assurance. **RESOLVED:** **The policy schedule to be resubmitted to the committee following amendments - the committee RECEIVED the report for assurance.**
EC/2023-24/95	**Agenda Item 15.2.1 - Management of Domestic Abuse in the Workplace Policy** **RESOLVED:** **The Executive Committee APPROVED the Management of Domestic Abuse in the Workplace Policy.**

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EC/2023-24/96	**Agenda Item 15.2.2 - Managing Allegations Against Staff Policy** **RESOLVED:** **The Executive Committee APPROVED the Managing Allegations Against Staff Policy.**
EC/2023-24/97	**Agenda Item 15.2.3 - Equality, Diversity, and Inclusion Policy** **RESOLVED:** **The Executive Committee APPROVED the Equality, Diversity, and Inclusion Policy.**
EC/2023-24/98	**Agenda Item – 16.1 Any Other Business** There were no items of any other business for consideration.
EC/2023-24/99	**Agenda Item – 16.2 New Risks to add to the Risk Register** There were no new risks identified.
EC/2023-24/100	**Agenda Item 17 - CLOSE** The meeting was closed at 12:55pm.
	Date and Time of Next Meeting Tuesday 11 July 2023 10:30am.

Signed: **Sam Allen**

Position: **Chief Executive (Chair)**
Date: **11 July 2023**

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

BOARD 25 JULY 2023	
Report Title:	**Finance, Performance and Investment (FPI) Committee Highlight Report and Approved Minutes**

Purpose of report

To provide the Board with an overview of the key points and approved minutes from the FPI Committee meeting held on 4 May 2023.

Key points

The Finance, Performance and Investment Committee, chaired by Jon Rush, Non-Executive member of the Board, met on 04 May 2023.

The key points to bring to Board's attention from the meeting are set out below.

- ICB financial performance update - regular monthly report that Committee members receive for information and assurance
- ICB performance position update - regular monthly report that Committee members receive for information and assurance.
- Task and finish group update - progress to date from the Allocation Group and, now the financial plan has been submitted, there will be a re-focus of programme of work for the Coding and Recording Group
- Committee effectiveness review - provided the Committee with an assessment of the work since its establishment in September 2022. Members also approved the wording for the committee section within the annual report

Please note that due to the number of apologies the June meeting was stood down. The Committee met on 6 July (any key points to bring to the Board's attention will be highlighted by the Committee Chair in the meeting) and the confirmed minutes will come to the September Board meeting for assurance.

Risks and issues

The Committee discussed and noted the following risks:

- Understated revenue funding for non-consolidated pay award

- ICB financial plan position for 2023/24 was at £49.9m deficit and associated financial risks with this position
- A&E 4 hour wait time performance had dipped from 76.7% to 75.2%

Assurances

Assurance was received around the following areas:

- Pharmacy, Optometry and Dentistry due diligence work regarding transfer of services from NHS England to the ICB
- Committee Effectiveness review
- NHS England escalation tier process has seen positive changes with some providers
- no Provider Trusts in the tiering process for Urgent and Emergency Care.

Recommendation/action required

The Board is asked to receive the confirmed Committee minutes of 4 May 2023 for assurance.

Acronyms and abbreviations explained

ICB – Integrated Care Board

Sponsor/approving executive director	Jon Rush, Independent Non-Executive Member and Chair of Committee
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?	**As identified in confirmed minutes**

Has there been/does there need to be appropriate clinical involvement?	**Yes, as part of Committee membership**
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
North East and North Cumbria

North East and North Cumbria Integrated Care Board

Finance, Performance and Investment Committee

Minutes of the meeting held on Thursday 4 May 2023, 10:00hrs
Via MS TEAMS

Present:	Jon Rush, Chair Ken Bremner, Chief Executive, South Tyneside and Sunderland NHS FT David Chandler, Interim Executive Director of Finance Dave Gallagher, Executive Director of Place Based Delivery Eileen Kaner, Non Executive Director Jen Lawson, Governance Lead Jacqueline Myers, Executive Chief of Strategy and Operations Rajesh Nadkarni, Executive Medical Director, Cumbria, Northumberland, Tyne and Wear NHS FT Neil O'Brien, Executive Medical Director
In attendance:	Richard Henderson, Director of Finance David Stout, ICB Audit Committee Chair Emma Ottignon-Harris, Executive Assistant (minutes)

FPI/2023/54	**Welcome and introductions** The Chair welcomed everyone to the Finance, Performance and Investment Committee (FPIC) meeting which was held via MS teams. There was a brief discussion regarding quoracy and it was agreed to add to the agenda for the next meeting.
FPI/2023/55	**Apologies for absence** There were no apologies received.
FPI/2023/56	**Declarations of interest** There were no declarations of interest.
FPI/2023/57	**Minutes of the previous meeting (6 April 2023)** It was **AGREED** that the minutes accurately reflected the FPIC meeting held on 6 April 2023.
FPI/2023/58	**Matters arising from the minutes**

	There were no matters arising from the minutes.
FPI/2023/59	**Action log update** The action log was reviewed and the following updates were provided: **FPI/2023/18/01**: The delivery work plan of the revision to the overall approach to the ICB performance position would be provided during the Performance update in the meeting. Action closed **FPI/2023/37/01**: Risk management update deferred to next meeting. **FPI/2023/51/01 & 02**: Paper on Children and Young People (CYP) Mental Health Services access to be submitted to FPIC at next meeting. **FPI/2023/40/01**: Update of Opthalmology, Dentistry and Pharmacy (POD) to be provided during the Finance Performance update and included in report. Action closed.
FPI/2023/60	**Notification of urgent items of any other business** There were no urgent items of any other business raised.
FPI/2023/61	**ICB financial performance update** The Director of Finance presented the finance report for the period to 31 March 2023 which included the Month 12 financial position. Key points and risks were highlighted: The ICB is reporting an outturn surplus of £2.7m which is consistent with forecast plan, subject to audit. The ICS outturn position is a surplus of £58.2m, predominantly driven by significant income received by Northumbrian Healthcare FT (NHCFT) relating to settlement of a court case in respect of building rectification work. It was explained that plans to defer this income for capital costs of rectification were not feasible due to accounting requirements and that work is underway with NHS England (NHSE) regarding the transfer of revenue to capital resource and has been recognised as a planned surplus. A risk of understated revenue funding for non-consolidated pay award was raised as the offer does not appear to cover maternity, sickness and annual leave. It was confirmed that there was no funding available for community interest companies with staff on NHS terms and conditions, which also applied to subsidiaries within NENC. NHSE had specified that if there is a contractual requirement for Trusts to pay staff within those organisations, this would be deemed as an acceptable reason to not achieve financial target. It was noted that this will impact on South Tees Hospital Trust and assurance was provided that this will not affect the additional capital resources received

	for 2023/24, arising from delivery of 2022/23 forecast positions. The Executive Area Director joined the meeting. The ICS is reporting an outturn underspend against the confirmed ICS capital departmental expenditure limit (CDEL) allocation of £7.2m, following receipt of New Hospitals programme additional funding for the CEDARS development programme at Cumbria, Northumberland, Tyne and Wear (CNTW) which had increased from £17m to £19m. The Committee were asked to acknowledge the challenging and ongoing discussions with NHSE and CNTW regarding programme cost and overspend issues. At this point the Executive Medical Director of CNTW asked to register a conflict of interest and it was agreed that further information regarding any financial impact would be addressed outside of the meeting. It was reported that the latest ICB financial plan position for 2023/24 was at £49.9m deficit, which included additional resources from NHSE of £15m. It was explained that additional excess inflation funding had been allocated on a non-recurrent basis to those Trusts in deficit as they were being required to find additional savings, and the additional funding provided a revenue benefit versus borrowing. The deficit position has been accepted by NHSE but there will be an expectation to improve the position which will be a challenge due to the financial risks identified. The Pharmacy, Ophthalmic and Dental (POD) month 12 position was presented for information and reported a £20m underspend in 2022/23. It was explained that this was due to £10m of non-recurrent benefits due to prior year accruals no longer required, release of contingency, lack of growth in Ophthalmic activity and slippage in dental contracts. Permission has been granted by NHSE to assume unplanned slippage in dental budgets for 2023/24. Next steps for financial plans include: • Progress work to reduce ICB running costs by 30% • Develop a full ICS medium term financial plan by August 2023, although it was noted that this will be unrealistic and therefore a request will be made to NHSE for an extension on the timescale. The Committee were asked for questions and comments; With regard to the non-consolidated staff pay award for subsidiaries, there was a discussion regarding Provider Trusts having a moral and ethical obligation to pay staff as they are recognised as key operating clinical teams, therefore the financial impact should be monitored. A question was raised if there was an ICB sliding scale for payments and if it could be considered for discussion at a later stage. It was reported that the Transformation Director of Primary Care is

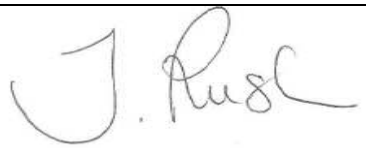
	undertaking a piece of work around efficiencies and enhanced schemes within Primary Care but a nationally agreed contract for General Practice was highlighted. Assurance was provided that due diligence work is underway with regard to risks and issues regarding the transfer of POD services to the ICB. A risk register has been developed. There will be a wider piece of work undertaken to look at the health and need challenges across the NENC region. A request was made for assurance of equal scrutiny be applied to POD efficiencies, running costs and savings targets as per the rest of the system and that it would be useful to have sight of a strategy. The Committee agreed that the timescales given for submitting a credible medium term financial plan to NHSE was not realistic, particularly given the absence of a medium term national framework, the size of the system and consideration would be required for the ICB approach. It was suggested that the Executive Director of Finance would acknowledge the Committee support at the forthcoming finance meetings with ICB and NHSE colleagues. However, there would be an opportunity to focus on underlying deficits in the system. A request was made to prepare a document which could show a comparison of the 42 ICS's for a percentage comparison across turnover deficit, breakeven and CIP comparators which the Executive Director agreed to provide when the data became available. **ACTION: Executive Director of Finance to provide a percentage comparative data document of all 42 ICS's when the data is available.** Provider Trust committee members were asked if the ICB could provide any further support with regard to efficiency savings. In response it was suggested that this should be raised with the Provider Collaborative and to identify what clinical impact can be done across the system to aid financial savings and develop a sustainable strategy. It was confirmed that ICB input is currently provided at appropriate times and levels with mutual collaboration, but it should be the responsibility of Provider Trusts to develop a clinical strategy which the ICB can support. Work is ongoing to develop an overarching clinical strategy which will include acute services and primary care transformation plans to enable a framework of prioritisation of investment. There is an opportunity to deliver good ICB models already in place by supporting the delivery of change to pathways and services and measuring the impact. Following a recent community mental health hospital visit, a description of some positive work through a reorganisation of resources and building relationships with partner organisations such as local authority was given which had resulted in a greater response to patients.

	An explanation of the decision process for excess inflation financial allocations to Provider Trusts in deficits was requested. The Executive Director of Finance described the process undertaken with Directors of Finance and Chief Executive Officers across the ICS and therefore the Committee confirmed their support, particularly noting the short timeframes set during the financial planning process. **RESOLVED:** The Finance, Performance and Investment Committee **NOTED** the content of the report for assurance.
FPI/2023/62	**Task and finish group update** The Allocation Group had made recommendations to the current financial plan and identified areas with below target funding. There is further work required to report on spend versus allocation by sector and geographical area. A question was asked if it was possible to establish if some Provider Trusts had overspent or been underfunded, what were the reasons and how this could be corrected. It was explained that changes had been made due to the COVID pandemic such as allocation of top up monies but a variety of metrics would be required and it was confirmed that NHSE had carried out some independent reviews. The Coding and Recording Group will work on allocations of resources to other areas.
FPI/2023/63	**ICB Performance position update** The Executive Chief of Strategy and Operations introduced the Integrated Delivery report which provided an ICS overview of quality and performance using data covering February 2023 for most metrics and March 2023 for others, unless otherwise stated. Finance data is for Month 11. The Committee were asked to provide feedback on the revised format and reporting style of the report, which will improve when further business intelligence work is complete. It was noted that the report included some quality metrics which are not yet received through official data sources and the report reflected the year end position. Key changes and points to note from the previous report highlighted were: Positive changes with the NHSE escalation tier process as County Durham and Darlington NHS Foundation Trust (CDDFT) had been removed from Tier 2 for elective care and Newcastle upon Tyne Hospitals Trust (NUTH) had been removed from Tier 2 for cancer. Both Trusts will now be placed into routine oversight with the ICB.

	Accident and Emergency (A&E) 4 hour wait time performance had dipped from 76.7% to 75.2%. Industrial action did not appear to have impacted A&E performance but could be linked to the sustained improvement in ambulance handover times. The ICB will need to monitor performance but it was noted that 23/24 improvement targets had been set above the national planning ask of 76%. NUTH remains in Tier 1 for elective care as they have not been able to develop a plan to meet the national ambition to eliminate over 65 week waits at the end of March 2024, due to some complex degenerative spinal cases, and it was reported that this has been a national issue across spinal centres. A pathway has been developed to transfer less complex spinal cases from NUTH in the early stage of the treatment pathway to South Tees Hospitals NHS FT, and this should improve waiting times in the future. Currently there are no Provider Trusts in the tiering process for Urgent and Emergency Care. NENC ICB achieved ahead of trajectory for 78+ and 104+ week wait lists for 2022/23, although further monitoring will be required to achieve the national zero position ambition. Revised trajectories for NUTH have been agreed with NHSE and further information will be provided in future reports. A reminder of the national supply issue for corneal grafts was given as this will continue to impact on 78+ week breaches, but it was confirmed that NHSE do recognise this as an exemption, although this can only be reported within the report narrative. It was advised that international work was underway to supply grafts and further updates will be provided. The dashboards highlighted an improvement to diagnostic tests within six weeks. However, there were areas within Mental Health and People with Learning Disability and Autism services that did not compare favourably against the 2023/24 national objectives. It was explained that, whilst the ICB would achieve the Menial Health Investment Standard in 2023/24, there had been limited scope for investment into the NHS talking therapies and community mental health services, due to the cost pressures within mental health inpatient services. Further work was required to develop a medium-term plan for capacity and to understand waiting times. A counting issue was also reported in the data. The Committee were advised that updates will be provided for further discussion at future meetings. The Committee were asked for questions and comments: It was confirmed that the ICB Board had acknowledged and supported the work that been undertaken with regard to areas that had not met national targets. For Committee assurance, a request was made for a deep dive on Mental Health issues, with a particular focus on learning difficulties in-patient care

	and out of area placements. A suggestion was made to include healthcare acquired infection in future reporting. It was reported that ambulance Category 2 performance had been below 30 minutes in the previous 2 to 3 weeks and it was confirmed that improvement to ambulance handover times would have impacted A&E performance, although it was more important to ensure getting ambulance care sooner for patient safety. A comment was made regarding the limited information in the report regarding Primary Care as GP access and enhanced access was a Healthwatch priority issue. In response it was confirmed that a Primary Care Strategy and Delivery sub-committee had been established which will help to refine the metrics and the agenda at the ICB Board meeting scheduled in May will focus on Primary Care. Further discussion and assurance regarding the safety data in mortality and serious incidents was requested at a future meeting. In response it was confirmed that the revised report will be discussed at the Quality Committee. There was a discussion on how the ICB committees integrate and how to understand what key risk areas require Committee attention. Work in the report which identified the key risks within Mental Health and Learning Disabilities was particularly commended. The Committee were advised that there are plans to reset the population health management (PHM) and business intelligence (BI) functions, produce an IDR calendar and that workshops to focus on 5 year forward plans will be scheduled. Plans are also underway to create a portal which will enable access to more detailed data. It was acknowledged that more work on metrics is required which is scheduled over the next 6 months with the potential to include safeguarding and social care data. **RESOLVED:** The Finance, Performance and Investment Committee **NOTED** the content of the report for assurance.
FPI/2023/64	**Committee Effectiveness Review** Jen Lawson (Governance Lead) introduced the committee effectiveness survey report for Finance, Performance and Investment. It was explained that each NENC ICB committee were required to undertake an annual effectiveness assessment. The Committee were asked to review and comment on 3 areas: • Review and comment on the results of the 2022/23 survey.

	• Agree any improvement actions arising from the discussion regarding the survey. • Agree the suggested text relating to the FPIC committee's effectiveness for inclusion in the ICB's 20233/23 annual report Further clarification on the responsibilities of the FPI Committee and the relationship with Executive Committee was requested. **RESOLVED:** The Finance, Performance and Investment Committee **AGREED** the content of the report for assurance.
FPI/2023/65	**Any Other Business** It was confirmed that the revised FPI Committee terms of reference regarding capital will be submitted as an appendix at the ICB Board meeting scheduled on 30 May for approval. A request was made for a review of the FPI Committee terms of reference to ensure that no items for consideration or approval by the Committee were omitted. **Action: Governance Lead to work with Director of Finance to review FPI terms of reference to ensure no items for consideration or approval by the Committee are omitted.**
FPI/2023/66	**Meeting Review and date of Next Meeting** A decision was made to stand down the next meeting scheduled on 1 June due to the number of apologies received. The next meeting is confirmed to take place on Thursday 6 July at 10.00am at Pemberton House. It was noted that both Provider Trust committee members and one non-executive director were also unavailable for the July meeting.

Signed: 

Position: Chair
Date: 6 July 2023